Vishomil Limited

Swarthdale Nursing Home

Inspection report

Rake Lane
Ulverston
Cumbria
LA12 9NQ

Tel: 01229580149

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Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

The inspection took place on 4 June 2018 and was unannounced. At the last inspection in June 2015, the service was rated Good. At this inspection we found the service remained good. There was no evidence or information from our inspection and ongoing monitoring that demonstrated serious risks or concerns. This inspection report is written in a shorter format because our overall rating of the service has not changed since our last inspection.

Swarthdale Nursing Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Swarthdale Nursing Home accommodates up to 43 older people.

The home is in a residential area of the market town of Ulverston in an older building that has been adapted and extended for its current purpose. Accommodation is provided on two floors, with two passenger lifts. There is a seating area and car parking at the front of the building.

There was a registered manager at the home. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People who lived in the home told us they were satisfied with the way the home was run and the care they received. One person told us, "I would rather be in my own home but they do look after you in here." We observed that staff were polite and considerate and that people who lived in the home seemed to be at ease with care staff.

Risk assessments had been developed to identify and minimise the potential risk of harm to people during the delivery of their care. These and individual care plans had been kept under review and updated when necessary to reflect people's changing needs. We have made a recommendation that the registered manager review their risk assessments on bedrails and bumpers to follow the manufacturer's instruction on their use.

Care plans were based upon the individual needs of people and contained information about people's personal needs, likes and dislikes. We have made a recommendation that the service seek advice about ways of supporting people in the home to be more involved in decisions about their care, treatment and support and record this.

The service worked with local GPs, district nurses and health care professionals and external agencies to provide appropriate care to meet people's different physical, psychological and emotional needs. We found that medicines were being administered safely and records were being kept of the medicines in the home.

Systems were in place to deal appropriately with any complaints or concerns raised about the service. Staff had received safeguarding training and were aware of their responsibilities to report.

We found staff had been recruited safely and were being trained and supported to carry out their roles. Staffing levels were observed to be sufficient to meet the needs of people who lived at the home.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible. The policies and systems in the service support this practice. People's privacy and dignity was being promoted.

People told us they were happy with the variety and choice of meals being provided and that there was always a choice. We observed regular snacks and drinks were provided between meals to help make sure people received adequate nutrition and hydration.

The registered provider continued to improve the environment for the people who lived there. The building was being maintained and was a clean place for people to live. We saw that equipment in use had been serviced and maintained as required.

Quality assurance surveys and meetings were used to seek the views of people who used the service and there were a number of audits being carried out to monitor systems. We have made a recommendation that when the registered providers visit they record their quality assurance monitoring and include the people who lived there in the process.

The registered manager and deputy manager were experienced, knowledgeable and familiar with the needs of the people they supported and worked together to develop the service. We have made a recommendation that the registered providers give greater support to the registered manager and deputy in respect of dedicated time to implement major changes.

Further information is in the detailed findings below

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service remains Good.	**Good**
Is the service effective? The service remains Good.	**Good**
Is the service caring? The service remains Good.	**Good**
Is the service responsive? The service remains Good.	**Good**
Is the service well-led? The service remains Good.	**Good**

Swarthdale Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This comprehensive inspection took place on 4 June 2018 and was unannounced. The inspection team consisted of two adult social care inspectors and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert- by-experience had a background caring for older people, people living with dementia and with physical/sensory impairment.

Before the inspection we reviewed information available to us about this service. The registered provider had completed a Provider Information Return (PIR). The PIR is a form that asks the registered provider to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed safeguarding alerts; share your experience forms and notifications that had been sent to us. A notification is information about important events that the provider is required to send us by law. We looked at the information we held on safeguarding referrals, concerns raised with us and applications the manager had made under deprivation of liberty safeguards.

We spoke with a range of people about the service. They included 10 people who lived at the home, two relatives/visitors, the registered manager, the deputy manager and six staff members, including maintenance, domestic and kitchen staff. We spoke with a visiting GP. We looked at care records of eight people, the service's training matrix, supervision records, records relating to the management of the home and the medication records. We reviewed the services recruitment procedures and checked staffing levels. We also checked the building to ensure it was clean, hygienic and a safe place for people to live.

Prior to our inspection visit we looked at the information we held about the service and information from the local commissioners, the NHS Senior Locality Nurse, Cumbria Fire and Rescue, the local authority social work teams and manager and from the GP surgeries who visit the service. This helped us to gain a balanced overview of what people experienced accessing and coming into contact with the service.

During our inspection we used a method called Short Observational Framework for Inspection (SOFI). This involved observing staff interactions with the people in their care. SOFI is a specific way of observing care to help us understand the experience of people who could not easily talk with us.

Good

Is the service safe?

Our findings

People who lived in the home told us they did feel safe living there and there was always staff around to help when they needed it. We were told, "I am safe enough" and "I feel very safe living here." A relative told us they believed "[Relative] is safe enough."

We saw that there were sufficient staff on duty to meet people's needs. Rotas indicated that staffing levels were monitored and dependency tools used to assess people's care needs. To provide support for people with a learning disability a Learning Disability registered nurse had been employed and the home also had mental health trained nurses (RMN). We heard a variety of views on staff levels from the people who lived in the home. These included, "Is there ever enough staff? I feel they could do with more" and "They have a lot of staff on the notice board but sometimes there does not seem to be enough around. We were also told, "There always seems to be someone around."

The service had a safeguarding policy and procedure. Staff had undertaken safeguarding training and were aware of how to report any concerns. The service had cooperated and worked with safeguarding teams when concerns had been referred to them to investigate. We saw that safe recruitment procedures were in place to help make sure staff were suitable for their roles. This included making sure that new staff had all the required employment background checks and had explained any gaps in that history.

Accidents and incidents were recorded and monitored including environmental risks as well as risks associated with health, wellbeing and lifestyle choices. There were individual risk assessments, such as, skin integrity, falls, nutrition and for the use of equipment, in people's care files and general and environmental risk assessments.

Risk assessments were in place for the use of bedrails but bumpers were not always in place as outlined in the risk assessments. Bedrail bumpers prevent injury and entrapment for people that require bedrails whilst in bed. We recommend that the registered manager review their risk assessments and incorporated the manufacturer's instruction on the use of bedrails and bumpers.. The registered manager began a full audit of all bedrails and bumpers in use.

We looked at medicines management in the home and the use of the electronic eMAR system for the medicine management and administration in the home. The home has its own medicine manager to assist and promote the safe and consistent management of medicines. Medicines, including products to thicken drinks, were kept securely. The home had appropriate arrangements in place for the management of controlled drugs [medicines that require special checks and storage arrangements because of their potential for misuse]. Treatment room and refrigerator temperatures were monitored and the records showed that medicines were stored within the recommended temperature ranges. This helped to make sure that the medicines were in good condition for use.

The building was clean and hand sanitising gel and hand washing facilities were available around the premises. Infection control procedures were in operation to help maintain a clean and hygienic

environment. We observed staff making appropriate use of personal protective equipment such as disposable gloves and aprons.

We found equipment had been serviced and maintained as required. However the five year electrical installation test was overdue. The registered manager had already raised this as a matter of urgency with the registered provider. On day of inspection the registered provider was able to confirm and provide evidence that a contractor would attend to this within a week.

Good

Is the service effective?

Our findings

The people who lived in the home and relatives confirmed to us that the staff were knowledgeable about their needs. One person told us," They do know what they are doing" and another said, "They are not all very good but the majority are." People we spoke with said that the staff would notice if they were unwell and they saw their doctor if they needed to. One person told us, "They do know and they are very good at getting a doctor, if needed, they are getting a physio to visit me."

We asked people about the food provided and were told there was always plenty to eat and drink. Comments we received included, "The meals are very good for me, I get far too much, and "I don't eat too much but if I want it, it is there" and also, "The food is nothing exceptional but it will do." A relative commented, "The meals are excellent, they would even change the menu for [relative], and there is always a drink available." People's care plans had nutritional risk assessments in place and for specific dietary needs. We saw that people had their weight monitored for changes so action could be taken if needed. Training records indicated staff had been given training on food hygiene.

There was an ongoing programme of staff training in place that was being kept under review. There was a programme of induction training for new staff and refresher training was booked for throughout the year. There was also further training for areas of interest, such as end of life and behaviour that challenges. All new staff completed the care certificate and two staff were training as Assistant Practitioners with the support of the University of Cumbria.

We saw that the service worked in partnership with other agencies and made referrals appropriately. Information was recorded about joint work and referrals to other professionals such as dieticians, speech and language therapist (SALT) occupational therapy and physiotherapy. A GP we contacted told us "They are very good at picking up any problems with medication and we have had meetings in the surgery if there has been issues. I have also attended with our case manager and the nurses in Swarthdale have helped with getting care planning done for their residents and making sure they are managed appropriately."

We asked people who lived in the home if they had ever been stopped from doing something they wanted to do. All the people we spoke with said they had never been stopped from doing anything they wanted to do. One person told us, "I can do whatever I want to do – you can please yourself."

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the Mental Capacity Act (MCA). The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The Mental Capacity Act 2005 (MCA) requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. People's care records showed their

mental capacity had been assessed for various decisions in relation to care and treatment and that DoLs applications had been made. We noted that one person was receiving 'covert' medicines [given in a hidden way] and discussed with the registered manager that this would need to be added to the authorisation from the supervisory body. They addressed this straight away.

Good

Is the service caring?

Our findings

The people we spoke with who lived in the home told us that the staff were kind, caring, polite and willing to listen, and help, if they had a problem. We were told, "hey [staff] are always friendly" and "I can always tell them what I want." A relative said, "They [staff] seem to be very caring but I am not here all the time." Local GP's told us, "The home appears safe and the residents are well looked after" and "I have found the permanent staff to be caring and professional."

People told us that friends family and friends were made welcome when they visited. We were told, "They [family] can come any time and my son takes me out as much as he can". We saw that people who lived in the home had been consulted and involved in making decisions regarding their environment and in the redecoration of their own rooms.

We asked people if they were helped to be as independent as they could be. One person told us, "At my age I do well" and another commented "I am happy with my care". One person said "They [staff] have never forced things on me up to now." People told us they had selected their wall paper, colours and coordinating soft furnishings in their room so it was how they wanted. One person told us, "The décor soothes me, I chose it myself."

Everyone we spoke with said their privacy and dignity were respected. We saw that staff knocked on people's doors and that doors to bedrooms and bathrooms were kept closed whilst support was given or when people saw their doctor.

We used the Short Observational Framework for inspection, (SOFI) to observe how people who could not easily express their views, were being supported and approached by staff. We observed several caring and appropriate interactions between staff and people living in the home especially when assisting them to move around the home or take part in activities. Some staff found this easier than others. The registered manager was addressing this through additional training

The service was developing the role of 'champions'. Champions are staff who have a specific interest in particular areas and are central in bringing best practice into a home, sharing their knowledge, acting as role models and supporting staff to provide people with good care and treatment. The home had a dignity champion who we spoke with. They were clear that champions are role models so that others can see dignity and respect of individual needs in practice and follow their lead. They spoke enthusiastically about their role and how they could influence care. They told us about the importance of "noticing things and acting upon them" For example, the champion took a person who lived in the home for a hospital appointment and noticed they were feeling very down in mood about appointment visit. They said they would rather have a day out, so they turned it into a day out and went for lunch, took a walk and visited the shops nearby.

People's preferences, cultural and spiritual needs were respected. Religious services were held on a monthly basis and people could have visits from their own ministers or priests when they wanted One person told us,

"If I wanted to go to church I am sure they would take me." The registered manager told us they would support anyone to maintain and follow their faith and beliefs.

Advocacy services were accessible should people need this help and support. Information leaflets on display in the reception area for people and families if they wanted information on this. The registered manager was able to give us a recent example of where the advocacy service had been used by one person who had no close family to support them. This helped to make sure that people's interests could be represented and they could use appropriate external services to act on their behalf if they wanted this.

Good

Is the service responsive?

Our findings

The people we spoke with who lived in the home said they knew how to make a complaint and would feel comfortable doing so. We were told "I would just talk to my nurse, but I don't like to complain" and "I can complain to the doctor or sister." Relatives we asked told us they had no concerns at present to complain about and if they did they would " just knock on the office door and speak to the manager or deputy." The service had a complaints procedure in place and this was displayed within the home and in the service's statement of purpose. Records demonstrated complaints were investigated and action taken to improve if necessary.

A list of organised activities for the month was on the notice board that included musical events, a trip out, singers, crafts quizzes, bingo and games. There were armchair exercises and seated dance sessions to help aid mobility and to socialise. One person told us, "I am aware [of the activities] and sometimes join in". On the day of the inspection there was a hairdresser available in the afternoon if people wanted to see them and dominoes were being played. One person told us "I cannot join in with the activities but I do like to listen to the singers". A new activities coordinator is due to start in post soon and there were plans to develop better use of the outside garden areas, with potential for an outdoor gardening space and shed for activities and relaxation.

We saw that an assessment of needs had been done before a person came to live at Swarthdale and this continued on admission. These assessments covered people's physical, psychological, emotional and social needs. There was a system of review so people's progress and changes were recognised and monitored. Care plans were based upon the individual needs of people and had information about people's personal likes and dislikes and the important people in their lives. A comment from a local GP we asked was that "They [management] are responsive to any problems that are picked up and we liaise with them well in person and via email if they have any problems."

We noted that there was little written evidence in the care plans about how people or their representatives/families had been involved in or influenced care planning. People did say they made their own choices, "I am allowed to do what I want". We recommend that the service seek advice and guidance from a reputable source, about ways of supporting people to be more involved, if they wanted to, in decisions about their care, treatment and support and evidence it clearly in their care planning.

The registered manager was implementing a new electronic care planning system that incorporated monitoring and assessment tools. This would allow 'real time' documentation of care treatment and support through a lap top computer and hand held devices for care staff. It was expected staff would be to record in 'real time' people's care, treatment and involvement and reduce the duplication of care records.

The deputy manager was the end of life lead for the home. A local GP told us, how they worked closely with them on end of life care and of the deputy's involvement in their palliative care meetings Training records showed that staff had received training on supporting people at the end of life. The home had completed the 'Six Steps' palliative care programme and worked with and took advice from a local hospice. This

programme aimed to enhance end of life care through organisational change and supporting staff to develop their roles in end of life care. We saw that people had been supported to remain in the home where possible as they moved towards end of life. This allowed people to remain comfortable in their familiar surroundings and be supported by familiar staff.

Good

Is the service well-led?

Our findings

The home had an experienced registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The registered manager and deputy manager were knowledgeable and familiar about the needs of the people they supported. They were clear about their priorities when it came to using the resources they had available to them and to try to develop the service, within their budgets, to improve the quality of life, in a practical sense, of the people who lived there. The registered manager and deputy manager attend the Cumbria Registered Managers Network that supports managers to access advice and information and share best practice, in order to support and promote their leadership roles and drive improvements in services. A local GP we contacted told us that the management team had "A very professional attitude."

Systems were being used to assess the quality of the service provided in the home. Audits were undertaken to assess compliance with internal procedures and against the regulations. This programme included audits on medication procedures and stocks, care plans, safeguarding and infection control. We noted some discrepancies in the way some 'do not attempt cardio pulmonary resuscitation (DNACPR) forms had been completed and an audit was started to check all these documents.

However, we found that the registered providers did not record how they checked on quality when they visited the service or sought the views of the people who lived there when they had visited. We recommend that the registered providers take advice and formally undertake quality assurance monitoring and include the people who lived there in the process.

Registration regulations require registered providers to notify CQC of significant incidents that occur within the home, including injuries to people. During the inspection we found an incident involving an injury that had not been notified to CQC. The registered manager had sent notifications about all other incidents but they had failed to do so on that one occasion. Failure to notify us about the one incident was explained to us by the management team as a genuine mistake and the registered manager learnt from this to help prevent such an oversight in future.

We saw that people and their relatives had been asked for their views in satisfaction surveys and there were meetings within the home for those living there and staff. People who lived in the home and their relatives/representatives could make suggestions or comment anonymously if they preferred using the suggestion box.

As part of putting in place a new electronic care planning system and assessment tools the registered manager was reviewing and updating the home's policies and procedures to reflect changes in the systems being used, in legislation and in current good practice. The manager had prioritised procedures to update that had been affected by the changes such as medication to make sure they were appropriate. This

transition from a paper based system to an electronic one reflecting new systems of working required a significant amount of time and effort from the management team to complete. If this task is to be done promptly and correctly it is unrealistic and unsafe to expect this considerable task be done by the registered manager in addition to their existing daily management workload. We recommend that the registered providers seek guidance about the safe management of major change and the importance of dedicated time to achieve change.