Hillside Commercial Limited

Mead Lodge Residential Care

Inspection report

Mead Lodge
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Norwich
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Tel: 01603279261

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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

This inspection took place on 28 September 2016 and was unannounced.

Mead Lodge is a care home service without nursing for older people and those living with dementia. It accommodates up to 24 people. At the time of our visit, there were 24 people living in the home, all of whom were living with dementia.

Staff knew what to look for that might suggest people were at risk of harm or abuse. They understood their obligation to report any concerns. They had received up to date training in this area. Recruitment processes also contributed to protecting people from the risk of harm or abuse, and there were enough staff to meet people's needs safely.

People's records contained detailed risk assessments relating to the individual. These included risks associated with using equipment to support people to move, pressure areas, falls and risks associated with people's physical and mental health. They contained clear guidance for staff on how best to mitigate risks. The environment in which people lived was kept maintained with the appropriate checks in place.

People received sufficient amounts to eat and drink, with assistance from staff when needed. The food was freshly cooked in the home and people were given a good choice every mealtime.

People had timely access to healthcare and were supported to see health care professionals if they required. Staff knew people well, and reassured them effectively when needed. Staff were caring, patient and compassionate towards the people and their families. They also had a good understanding of dementia care.

Staff asked people for consent before delivering care, and when people lacked capacity to make decisions, they were made in people's best interests. People were supported to do things as they preferred, such as get up and go to bed when they wished, and were encouraged to make choices where they could.

People were supported to engage in activities which followed their interests, and staff responded to individual needs. The care plans also contained details about people's lives, so that staff knew about them. Staff also responded to changing health needs in a timely manner, so that people received the support they needed.

There was good leadership in place, and staff felt well supported. The registered manager was approachable for families and people living in the home. There were many audits in place to check that systems were running effectively, and pick up where improvements were needed. Actions were then taken to make suggested improvements.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People were supported by staff who knew how to look for, and report concerns. Thorough risk assessments were in place to provide staff with guidance on keeping people safe.

People's medicines were managed safely and administered as prescribed.

There were enough staff to keep people safe, and they were recruited in a way that contributed to protecting people from the risk of harm.

Is the service effective?

Good

The service was effective.

Staff were trained in areas relevant to their role, and received support and supervision so they could support people competently.

People received a good choice of nutritious homemade meals and support to eat and drink enough.

The staff sought consent before delivering care where they could, and made decisions in people's best interests where they did not have capacity to consent.

Is the service caring?

Good

The service was caring.

People were supported by staff who were compassionate, patient and caring.

Staff respected people's dignity and privacy.

People were supported to maintain close relationships with their loved ones, who were involved with their care.

Is the service responsive?

Good

The service was responsive.

Staff supported people in a way that took into account their individual needs and preferences.

People were supported to follow their interests and participate in activity, and people knew how to raise any concerns.

Is the service well-led?

Good

The service was well-led.

There was good leadership in place and staff found management supportive.

There were many systems in place to assess, monitor and improve the service, such as surveys and audits.

Mead Lodge Residential Care

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.

The inspection was carried out by two inspectors. This was an unannounced inspection.

Before the inspection, we reviewed the information available to us about the home, such as the notifications that they had sent us. A notification is information about important events which the provider is required to send us by law. The provider had also completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection, we spoke with four regular visitors and three people who lived in the home. We spoke with five members of staff in the home. The staff we spoke with included the registered manager who had been in post several years, the deputy manager, two senior care workers, a kitchen assistant, cook, and two care assistants. We also spoke with the two directors of the company.

We looked at care records and risk assessments for three people who lived at the home and checked all medicine administration records. We reviewed a sample of other risk assessments and health and safety records relating to the home. We looked at staff training records and reviewed information on how the quality of the service was monitored and managed.

Good

Is the service safe?

Our findings

Visiting relatives that we spoke with all said they felt people were safe living in the home. All the staff we spoke with had received recent safeguarding training. Staff were able to give examples of what constituted abuse and who they would report this to. They said that they would feel confident to report poor practice if they had any concerns regarding staff conduct. The registered manager gave us an example of action they had taken following an incidence of misconduct. We found they had acted on this appropriately, and put in place further training for staff in safeguarding. We found that there were systems in place to protect people from harm.

There were thorough risk assessments in place which helped to protect people from harm. These included risk of falling, with actions taken following falls. We saw one risk assessment where someone was at risk of falling from their bed, and it was clear what steps were taken to mitigate this risk. This had included lowering the bed, and putting a pressure mat down on the floor for if the person were to fall from their bed, so staff would be immediately alerted. As the bed was lowered, the person was at less risk of injury from falling out. We could also see that bed rails had been considered but deemed unsafe with regard to this person's care. This showed us that staff considered and managed risks appropriately.

Any incidents and accidents had been recorded and action taken where possible to further mitigate risks of accidents happening again. The deputy manager analysed falls on a monthly basis so that any trends would be found. People who fell twice or more over the course of a month were referred to the community falls team. Other risk assessments carried out included those associated with using lifting equipment with people, and risks associated with people's mental and physical health.

There were risks assessments in place for people who were at risk of developing a pressure ulcer, and specialist equipment in place, such as air mattresses, when needed. Staff had an understanding of any concerns around people's skin integrity and took action on these. They swiftly reported if anyone had any red areas on people's skin and supported people to reposition if they were cared for in bed. We saw that one person in the home had a pressure area, and this was also tended to by district nurses, and staff followed their recommendations to monitor the person's skin.

There were enough staff to keep people safe. The registered manager had recently organised an additional member of staff to cover afternoons as some people required additional support from carers following recent poor health. In cases of staff sickness and annual leave, the home's own staff provided cover where possible. Where it was not possible, agency staff covered these shifts. The registered manager told us that they worked with a couple of agencies, and usually had the same staff revisit which helped to keep people safe as they were familiar with their needs. Staff told us that agency staff were not expected to work alone with someone. This meant as far as possible, the people were looked after by consistent staff who knew them. We looked at the staff rota and saw that numbers were consistent with what the registered manager had told us. We saw that staff were available for people when they needed, and that they responded to people quickly.

There were systems in place to check that staff were safe to work with people before they were employed. We spoke with some new staff who confirmed that they had given references, and not been allowed to start work in the home until their criminal records checks had been returned. These were reflected in recruitment records we looked at. Staff were also subject to a six month probation period. This meant that they could be assessed during this time to check whether they were working to the required standard.

We looked at other records relating to the safety of the premises. We saw that the appropriate fire checks and training for staff had been carried out, and an associated risk assessment in place. The registered manager told us that all electrical appliances in the home were checked to ensure they were safe to use. The checking and servicing of the lifting equipment, such as hoists and stair lift, was in place and had been carried out as expected. There were other checks in place relating to water safety, and mitigating the risk of legionella.

People had call bells in place in their rooms, which they could use to call for staff when they needed them. We found that there were no call bells within communal areas and we discussed this with the registered manager. There was a risk that if someone needed to call for help they would not be able to easily. The registered manager told us that staff were allocated to communal areas throughout the day in case people needed them, and to spend time with people. They also said that they would consider installing call bells in these areas for extra safety. We did see that during our visit, staff were around in all the communal areas of the home in case someone needed them, and to chat with people.

Medicines were stored securely and administered and managed safely. Staff were trained in management of medicines. One staff member who was a new senior carer, told us about how they had been supported to administer medicines, through shadowing and observation to assess their competency before doing this alone. They had then had their competencies signed off by the deputy manager. We checked all of the medicines administration records (MARs) and saw that medicines had been administered as prescribed and signed for by staff. We also checked a sample of the blister packets that they were dispensed from, and found that they had been given correctly. We checked a sample of boxed medicines, and found that these were dated and stored appropriately, and were being given correctly. We checked the records relating to medicines which carried a higher risk, and required two members of staff to administer and sign for them. We found that this had been completed safely, and that the balances tallied with what had been given.

Each MAR had a front page on which any allergies were highlighted, and people's photographs were on them. This meant that there was lower risk of staff giving anyone the wrong medicine. The first page recorded people's preferences of how they took their medicines. Some people had 'as required' medicines, which had been recorded and signed for appropriately, and documented on a separate sheet as well as the MAR. The senior carer told us that this was helpful to put down the time the medicine was given, therefore mitigating risk of medicines being taken too close together. They told us about how they would know if extra pain relief was required for people who had problems with their communication. This included information about different people's signs of being in pain if they were unable to verbalise it. There was additional guidance about this within some people's care records.

Good

Is the service effective?

Our findings

All of the people and relatives we spoke with, without exception, said that staff were competent in their role. One relative told us, "I can't fault [staff]." Another visitor told us how the staff in the home had helped their relative become much better in terms of their health, following a period of poor health prior to coming to live in the home. They said that staff had supported their relative to put on weight and walk again. The support people received from staff to recover was effective, as well as the care staff provided to people living with dementia. All of the visitors we spoke with reflected this.

All of the staff we spoke with told us that they participated in regular supervision. This is a meeting with a senior member of staff or management, in which staff can raise any concerns, discuss on-going training and their role. They said they felt supported and that they could go to a member of senior staff or management for support if they needed it any time. The registered manager told us about the supervisions that staff had during the induction period. New staff also had regular supervision during their probation period, where they would discuss their development within their role. A new staff member told us that the team had been very supportive to them during their learning. Staff also had yearly appraisals in place, to review their progress within their role.

We spoke with staff who were new to the service, and they told us about their inductions. These consisted of shadowing a more experienced member of staff until they were confident to work on their own. They told us that they had competencies in all areas of their role signed off before they started working alone. One member of care staff who had been working in the home for several months told us that the deputy manager had observed them delivering care and checked their competencies.

Staff told us about the training they had received, which included manual handling, first aid and health and safety. They had also received training in dementia care and end of life care. One member of staff told us how this had helped them in their approach to people, increasing their understanding and empathy. The deputy manager explained that the training was all classroom based, so that staff had the opportunity to discuss it face to face with the trainer.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act 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.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS).

We saw that where appropriate, mental capacity assessment had been carried out. They were thorough, documenting whether people required support to make decisions, lacked capacity, or had capacity, and the

assessment covered many different decisions. They acknowledged what decisions people could make, with or without support, including whether people could agree to get dressed, take their medicines, eat a meal and go out. Staff were also able to tell us about different people's capacity. They followed the principles of the MCA, and asked for consent from people wherever they could. Where people lacked capacity to make decisions, they were always made in people's best interests.

The registered manager was awaiting DoLS authorisations for some people living in the home. We found that where people were deprived of their liberty for safety reasons, this was always done with the least restrictive option.

A visiting relative told us, "The food is excellent." Another visitor also said the food was very good, adding, "They take the trouble to present it nicely." We observed the lunchtime period and saw that people were eating enthusiastically and engaged with staff and each other during the meal. Staff sat and ate with people which made the support given unobtrusive and also made the mealtime experience more enjoyable with lots of chatting

People chose at the mealtime what they wanted, and had second helpings if they wished. Staff told us, and we saw during the visit, that people had a good choice of freshly cooked food. Where visitors bought extra food and drink in for people, staff supported people to have them when they wished.

We spoke with kitchen staff during our visit. They were also trained as care staff and they could tell us about people's preferences and any dietary needs, and understood who required assistance to eat. Staff provided support where people needed, for them to eat their meals. They allowed people to take as much time as they needed and provided encouragement when appropriate. Kitchen staff prepared soft meals for people who required them, and we saw that these were presented nicely.

People also received enough to drink throughout the day. Where people required thickened drinks due to swallowing difficulties, kitchen and care staff knew how to use the thickener safely. There was guidance in place where staff required it. Where people required specialist cups to drinks out of, these were supplied.

People had timely access to healthcare when they needed it. One relative confirmed an example, "The GP was called as soon as needed and [staff] responded very quickly." We saw in records that people received specialist support to promote their continence, and involvement with the dementia team, and a chiropodist. We also saw that people had extra support from the district nurses when they needed.

Good

Is the service caring?

Our findings

People were supported to maintain close relationships with their loved ones. A relative we spoke with said, "[Staff] always make me feel very welcome. Very caring, very thoughtful. I can visit any time." They went on to say that staff were very supportive towards them during a difficult time of their relative living with dementia, adding, "They go out of their way." All of the visitors we spoke with confirmed this. They were invited to stay for lunch whenever they wished. Another relative said that the consistency of staff was helpful, saying, "You see the same faces all the time." All of the visitors we spoke with told us that staff were very patient.

We observed staff always taking opportunities to interact with people, whether delivering care or simply walking by someone. One visitor told us that their relative liked to spend time in the registered manager's office, and that this was accepted and supported. We could see that staff communicated well with people, adapting to the needs of each person. An example if this was when someone became distressed, care staff were very patient and reassuring towards them, and this helped the person to remain calm.

We saw during people's interactions with staff that they knew people well. The staff we spoke with were able to tell us in detail about people, and what they liked. Many of the staff we spoke with had been working at the home for several years, so they had become very familiar with people living there. A relative told us they felt that it was very helpful to their relative who was living with dementia, to see the same people.

A relative we spoke with said that they felt staff were very respectful of privacy, "Every time they come in, they always knock on the door, even if it's open." One member of staff explained how they approached people by being happy and polite, and getting down to people's eye level in order to talk with them. They also explained how they supported people to maintain their privacy and dignity, by talking to them during personal care and remaining sensitive to their feelings. We saw many warm and reassuring interactions between people and staff during our visit. We also saw that staff called people by their preferred names.

People were supported to be as independent as possible within the home, walking around and being where they wanted. Staff also told us they encouraged people to participate in personal care as much as they could to maintain their independence.

Without exception, all of the relatives we spoke with said that they were involved in their relative's care, from planning through reviewing. They also said that staff always kept them up to date on any events or changes regarding their relative, and consulted them about any concerns about people.

Good

Is the service responsive?

Our findings

Staff told us that people chose when to get up and go to bed. People were also able to choose when they wanted to have a bath. Staff we spoke with told us they had a flexible approach, and that if someone did not want a bath, they would offer assistance at another time the same day. Staff gave us an example of one person who they had supported to have four baths in the previous week, as this was their request. One member of staff also gave us an example of someone who did not always like to have their main meal at lunch time, so was able to have it in the evening. We saw during our visit that people had the freedom to be wherever they wanted within the premises, in the home or garden.

Staff were responsive to each individual's needs. They gave us one example of someone who liked to take food and put it away in their room. They allowed the person to do this, as it made them feel more comfortable. The staff had suitable arrangements in place to remove it later. They also told us about the reasons for it, giving us information about the person's history which explained why they liked to do this. Other people preferred to sit on the floor rather than a chair, and this was respected by staff.

People had been assessed thoroughly before coming into the home to ensure that the home could meet their needs. A relative we spoke with confirmed this, saying, "[Registered manager] came to the hospital to discuss [relative], and about what [relative] needs." Another relative we spoke with said, "Every month a senior member of staff talks me through the care plan." Two relatives we spoke with confirmed that they had monthly discussions with a senior care worker about the care plan, and could look at it any time they wanted to. They had consulted family members who knew people well, about end of life care for people, and details of their preferences were recorded. All of the relatives said that they were kept well-informed of their relative's well-being, and it was documented in people's care records, what details their families wanted to be told about.

The care records contained detailed information about people's needs and preferences, and guidance for staff on how best to deliver appropriate care to people. There were records of people's life histories which included their interests, past employment and family information, as well as any spiritual requirements. New staff said they found the care records useful to find out about people living in the home, so they knew what to talk to people about. The care records related to people's physical needs, as well as communication, personal care and night care. They were also very detailed with preferences of whether people would like their door kept open, and how many pillows people preferred.

Care records contained detail about how to support people who became anxious or distressed, as well as how to support specific health needs. There were some people who behaved in a way that staff and other people could find challenging. We saw clear plans for how staff should reassure people in the care records, and we saw that staff interacted in a way that was responsive to the person's individual feelings and behaviour.

The care records were reviewed monthly, and kept up to date with people's changing needs. One member of staff we spoke with said that they had consulted care plans regularly to see where people's needs had

changed.

The home was responsive to working with people living with dementia. The registered manager told us about several adaptations they had made to the environment, creating brighter coloured walls so that people could orientate themselves. They told us this had helped some people to find their way around the home. They had also introduced red toilet seats, as well as pictures on the door, to aid people's vision and understanding. This increased some people's independence in using the toilet. The home also had different coloured doors to people's rooms, which looked like front doors. This helped people to recognise their own room.

The deputy manager told us that the home had recently increased staffing in the afternoons due to changing needs of the people living there. This had provided more time for staff to assist people, as well as provide time to support activities with people. One relative said, "They're always sitting with people, doing things."

Staff supported people to follow interests and engage with hobbies and activities. They had a weekly timetable of activities they would do, however they told us this was flexible depending on what people wanted to do. Activities included playing board games, pampering, reminiscence and crafts. We saw pictures up in the home of people enjoying themselves at a summer party recently held at the home. There was also some visiting entertainment such as singers. The staff spent time with people chatting in the afternoons. There was one person there who liked to carry around dolls, and staff ensured that the dolls were available for the person. Staff also told us about other people's preferences and hobbies, such as one person who liked books and would enjoy talking about them with staff. Staff had also started developing a reminiscence box, with some items of interest for people to look at, such as a camera and typewriter.

The visitors we spoke with said that they knew how to make a complaint or raise any concerns. One said that whenever they had anything at all to bring up, it was acted upon straight away. The home had received no formal complaints, and people had access to the complaints procedure if they required.

Good

Is the service well-led?

Our findings

People were familiar with the registered manager and we could see that they responded positively to them when they were walking around the home. All the visitors we spoke with knew who the registered manager was and said they found them approachable, helpful and supportive. Visitors we spoke with confirmed that they were asked for feedback on the home, including the environment as well as their relative's care. There were also quarterly meetings for people living in the home, which allowed the opportunity for staff to discuss the running home with them. Although there were people who had difficulties communicating, we found that wherever possible, they were empowered to give their views. An example of this was that the maintenance staff had painted a few different options of colour on the wall in the dining room, so that staff could ask people what they preferred.

The staff that we talked with during our visit spoke highly of their management team. They confirmed that the deputy manager and registered manager helped staff in delivering care when they needed extra help. One member of staff said that management were, "Brilliant at supporting us [staff]."

There was good leadership evident within the home. The registered manager operated an 'open door' policy where people, staff and families could go and approach them whenever they required.
The registered manager told us that they carried out spot checks, and had done so recently during the night shift. They said that they had found that staff were carrying out their role as they should have been. The registered manager had taken appropriate action when needed, for example following any misconduct of staff, and we could see that any concerns were taken seriously. Where there had been events that require a notification to the local authority or CQC, the registered manager had made these.

The registered manager said they were supported by the directors of the company, who came every week to visit the home and provide support and discuss on-going ideas for improvement. We spoke with the directors and they felt confident in the registered manager, and stated that they were always open and honest with them. They also said that they were proud of the homely, friendly atmosphere in the home.

The deputy manager had engaged with various external trainers, such as the dementia coaching programme, which helped them to remain up to date with current best practice. They then disseminated this knowledge through further in house training.

There were meetings in place for the night staff and seniors, as well as general staff meetings which were held quarterly. This provided an opportunity for staff to share information and any updates or concerns. The registered manager told us about a recent staff survey they had carried out, which was followed by a discussion group where staff made decisions about their supervisions. As they felt that they were well supported, they felt that bi-monthly supervisions were too frequent so they changed this to do five during the year instead.

There were many systems in place for assessing, monitoring and improving the service. We looked at management audits which covered care plans, existing checks, safeguarding incidents, supervisions and

training. We saw that any aspects of this which required action, were documented and staff took action. The deputy manager carried out medicines audits monthly, and we could see any actions arising which were also displayed in the medicines room. There were also audits of accidents and incidents which picked up any trends in accidents. We could see that these picked up any gaps or problems so that they were acted upon.