Inspection Report

We are the regulator: *Our job is to check whether hospitals, care homes and care services are meeting essential standards.*

St Wilfrid's Hall Nursing Home

Foundry Lane, Halton On Lune, Lancaster, LA2 6LT

Tel: 01524811229

Date of Inspection: 06 August 2013

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We inspected the following standards as part of a routine inspection. This is what we found:

Consent to care and treatment	✓ Met this standard
Care and welfare of people who use services	✓ Met this standard
Meeting nutritional needs	✓ Met this standard
Management of medicines	✓ Met this standard
Assessing and monitoring the quality of service provision	✓ Met this standard

Details about this location

Registered Provider	Latham Lodge Limited
Registered Manager	Mr. Alasdair Swan
Overview of the service	St Wilfrid's Nursing Home is situated in the small village of Halton-on-Lune, just north of Lancaster. The home has many historic features and is set in its own extensive grounds. Accommodation is provided on the ground and first floors. There are three lounges, a separate dining room, plus additional seating areas in the hall and on the first floor landing. The bedrooms all have a wash basin, with the majority having en-suite facility of a toilet and hand wash basin.
Type of service	Care home service with nursing
Regulated activities	Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury

Contents

When you read this report, you may find it useful to read the sections towards the back called 'About CQC inspections' and 'How we define our judgements'.

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Summary of this inspection

Why we carried out this inspection

This was a routine inspection to check that essential standards of quality and safety referred to on the front page were being met. We sometimes describe this as a scheduled inspection.

This was an unannounced inspection.

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 6 August 2013, observed how people were being cared for and checked how people were cared for at each stage of their treatment and care. We talked with people who use the service, talked with carers and / or family members, talked with staff and reviewed information sent to us by other authorities.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

What people told us and what we found

People told us what it was like to live at St Wilfrid's Hall Nursing Home and described how they were treated by staff and their involvement in making choices and decisions about their care. People also told us about the quality and choice of food and drink available and how they made their views known about the quality of care delivered. This was because the inspection focused on these important topics along with the management of medicines within the home.

People spoke positively of the care they received and described staff as, "Compassionate, kind and caring". One relative told us, "The staff are brilliant and helpful, not only to **** but to me as well. They really care about people nothing is too much trouble no matter how busy they are". One person living at the home said, "I really do like it here, I only came for two weeks but I have never been home since. Alasdair (Registered Manager) came to see me and chatted about it and what went on and I said I was staying for no longer than two weeks. It's a good home I never thought I would like it to be truthful".

Another person said that staff listened to what he was saying and acted on what he said. We were also told that the meals served were well cooked with plenty of variety with one person saying, "The cook or another member of staff comes in every morning and asks me what I want for breakfast and dinner. Most of the things I eat and enjoy but if I didn't want what was on the menu, I would have something else.

You can see our judgements on the front page of this report.

More information about the provider

Please see our website www.cqc.org.uk for more information, including our most recent judgements against the essential standards. You can contact us using the telephone number on the back of the report if you have additional questions.

There is a glossary at the back of this report which has definitions for words and phrases we use in the report.

Our judgements for each standard inspected

Consent to care and treatment ✓ Met this standard

Before people are given any examination, care, treatment or support, they should be asked if they agree to it

Our judgement

The provider was meeting this standard.

Before people received any care or treatment they were asked for their consent and the provider acted in accordance with their wishes

Reasons for our judgement

During the course of the visit we spoke individually with three people living at St Wilfred's Hall and four relatives who were visiting. We also spoke briefly with a small number of other people in a communal area of the home. However the conversation with some of these people was sometimes limited. This was because of the effects of their dementia related illness. Individual discussion also took place with the registered manager, a qualified nurse, a member of the care staff team, the chef on duty and the activities coordinator. This helped us to gain a balanced overview of the quality of care provided by staff at the home.

People who we were able to speak with us told us that they had full confidence in the staff team. They also told us that staff listened to what they had to say and wherever possible, acted on what was said. People understood that they could refuse the level of care that staff may consider would be of benefit to them. However nobody we spoke with ever had. We were told by one person, "They know what they are doing and I am happy with that".

The people we spoke with confirmed that they were given sufficient explanation and enough time to think about their consent decisions. The qualified nurse we spoke with explained that when people were able to give valid consent to the level of care and support proposed, they were always enabled and encouraged to do so. If the person was seen to be unable to do this, systems were in place to ensure their best interests were considered and met. This often included discussion with family members, the person's G.P. or other medical staff and/or other significant people. This helped to ensure an outcome that was in the best interest of the individual.

Information held within the care records seen, showed that people had given their written consent to decisions made. This included the individual person's plan of care. We were told that if the person had capacity, the content of the plan of care was always verbally discussed with the individual and agreed, before they were asked to sign the document. This was confirmed by a person spoken with. By signing the document, the individual

confirmed their understanding and agreement to the content. We saw in one instance that a family member had signed the document on behalf of her mother who had only limited capacity.

We also saw completed preferred priorities of care forms. these detailed the wishes of the person, including where they would like to be cared for in any given set of circumstances. This showed respect for the individual and provided clear guidance and instruction regarding the personal preferences of the person.

We also saw that people had given their written consent to a variety of other important issues such as, their self-medication risk assessment form. If the person agreed with the assessment, they had been asked to sign and date the document. The member of staff undertaking the assessment also took ownership of the information by signing and dating the document. This helped to protect people's rights.

Records showed that people had been asked about their wishes for end of life care and funeral arrangements. Although some people had been very clear in expressing their wishes, we saw that others had refused to discuss any such arrangements. This had been respected.

Care and welfare of people who use services ✓ Met this standard

People should get safe and appropriate care that meets their needs and supports their rights

Our judgement

The provider was meeting this standard.

People experienced care, treatment and support that met their needs and protected their rights.

Reasons for our judgement

The needs of people wishing to move into the home had been carefully assessed before a decision had been made to arrange admission. This ensured that the staff team were able to provide the level of care and support required by each individual. Information had also been gathered from family members and other professionals involved with the individual. This helped to ensure that a clear picture of assessed needs and requirements was known.

One relative told us, "We had looked at a number of homes but I really wanted ***** to come here. At first there was no vacancy so he came in for respite care, but now a decision had been made that he is going to stay. We are very impressed. Whatever we ask for such as ***** spending time in the garden, this is also accommodated".

Following admission to the home a care plan had been drawn up based on the needs identified during the pre-admission assessment. This included risk assessments in areas such as pressure care, falling moving and handling and nutrition. Staff spoken with had a good understanding of what people needed.

We looked at the care plans of four people living at the home and found them in general to be well written and informative documents. This provided staff with clear guidance about the health, personal and social care needs of each individual.

However the provider may find it useful to note that in one of the care plans we looked at in respect of a more recently admitted person, the care plan had only been partially completed. This meant that staff did not have a comprehensive written account of the holistic needs and requirements of this person. Whilst the registered manager agreed that the care plan should have been completed in full, by not doing so there was potential for an inconsistent approach in the delivery of care.

The plans of care we looked at had been reviewed on a regular basis and if required with the individual concerned or their relative. Any change of circumstances had been clearly recorded and the care plan updated to reflect current needs. This meant that staff always had the most up to date information, so that the most appropriate level of care could be

delivered.

It was clear that the home had sought advice from a range of external professionals, so that people's health care needs were being fully met in a timely manner. A number of staff had either completed or were completing an end of life palliative care course. A member of staff spoken with explained that this extended course had provided greater insight and professional guidance and support with regard to best practice. These principles had been adopted within the home for the benefit of the people that lived there.

Social histories had been recorded within three of the four care files seen. This included important family relationships, people's hobbies and interests and any needs associated with individual spirituality. Records showed that people were encouraged and supported to maintain their interests whilst living at the home.

Since the last inspection improvements had been made to the range of social care activities offered. This was an area that people living at the home had previously identified as something that could be improved. Recently a new activities coordinator had been appointed. Discussion with this person confirmed that different activities had been introduced. This included spending one to one time with people and also various group activities. The care coordinator stated that she was eager to extend her skills in providing appropriate activities for people with a more advanced dementia. This was to ensure that the specific needs of this group of people were not neglected. The activities coordinator was confident that appropriate training would be provided.

Meeting nutritional needs ✓ Met this standard

Food and drink should meet people's individual dietary needs

Our judgement

The provider was meeting this standard.

People were protected from the risks of inadequate nutrition and dehydration.

Reasons for our judgement

We saw evidence to demonstrate that people were protected from the risks of inadequate nutrition and dehydration. The nutrition and hydration care plans we examined, were informative and gave good guidance for staff to follow. These included care plans for people with varying and complex health needs. Each care plan identified the person's dietary needs, their likes and dislikes of foods and any special diet they required.

We noted that a malnutrition universal screening tool (MUST) was used to identify peoples' risk of inadequate nutrition or hydration. For people who were identified as at risk, a food and fluid intake chart was available detailing the amount of food and drink taken during each day. People who were at risk had their weight recorded weekly. We saw evidence of GP involvement when there was concern and requests for a dietician to guide and advise. All care plans and risk assessments relating to nutrition were regularly reviewed. This ensured that up to date information was always available.

We observed a small group of three people in the dining room over the lunchtime period using the short observational framework for inspection (SOFI). There was a calm atmosphere during this midday meal period. We observed that people were not rushed and were supported and encouraged to eat a healthy and nutritious meal. One person told us that she was asked each day for her choice from the menu of the day prior to main meals being served. However we also saw that staff asked people to confirm their choice at the time the meal was served. This meant that people could either reaffirm their previously chosen meal or make a different choice. This was particularly important for people with dementia who may not have remembered their previous choice or those who may have had difficulty in expressing their dietary preferences. This helped to ensure that people were provided with foods they enjoyed at every meal.

The food appeared appetising and well presented. For people on pureed diets, the chef confirmed that food was pureed separately to ensure it looked appetising. This also made sure that people could taste the different elements of the meal.

There was a good system in place to ensure that any specific dietary requirements such as diabetic meals were known by the chef and catered for. The chef was made aware of any dietary requirements by the nurse in charge on admission of a person and also following any review of dietary needs.

We observed specialist diets were provided for people in respect of specific medical conditions. People living at the home were all of a very similar religious, ethnic and cultural background. We did not observe any difficulties regarding food or drink requirements in respect of religious or culture purposes. Discussion with the cook confirmed that a specific diet in relation to religious or cultural need could be catered for. This ensured that appropriate foods were always served and that people had an adequate nutritional food intake.

Management of medicines ✓ Met this standard

People should be given the medicines they need when they need them, and in a safe way

Our judgement

The provider was meeting this standard.

People were protected against the risks associated with medicines because the provider had appropriate arrangement in place to manage medicines.

Reasons for our judgement

We saw that medication was securely stored in a locked medication trolley and locked metal cabinets attached to a wall. There was also a locked medication fridge in use. Daily temperature checks were recorded. The medication room was kept locked when not in use.

Only qualified nurses administered medication. The company had recently introduced a computer system for the ordering, administration and disposal of medication. This was supplied in conjunction with a dispensing pharmacy based in Bristol. Although some teething problems had been experienced and some staff were currently less confident about using the computer handset, the system did have real potential to significantly reduce the risk of human error. All staff with responsibility for the administration of medication had received training in the use of the new system.

Each person with responsibility for the administration of medication had a personal password and a unique pin number. From this information the computer hand set recorded and identified which member of staff that was undertaking that specific drug round.

Each person living at the home also had a unique identifier. Once this was activated, information on the hand set identified all the medication that had been prescribed for that person. The information provided on the hand set also included a photograph of the person to aid identification. Any known allergies were also noted along with any medication that was self-administered. When a specific medication was due to be administered the information changed colour. The colour also changed when the medication had been given. This provided clear information to guide and instruct staff.

Each medication container or bottle was provided with a bar scanning code. This identified the type of medication, the dosage required and the name of the person the medication had been prescribed for. The medication container was scanned when the medication was due. If any error had been made in respect of the person or the time the medication should be administered this was clearly highlight in red prior to any medication being administered. This helped to protect people.

If the system detected that medication had not been given to a person at the time due, there was provision to record the reason why. For example if a medication had been refused such as PRN medication not required, or if the person was out of the building or in hospital. If there had been a change in the dose of a prescribed medication the system prompted the person administrating the medication to ask another person to check and witness the change of dose and confirm by scanning their unique details. Only then was the dose change updated.

We were told that at the end of each drug administration round the computer system automatically synchronised to ensure the information it provided remained current. The system also aided stock control by identifying the amount of medication prescribed, the amount already administered, the amount left and the next due date for reordering. However staff at the home still collected the new prescriptions from the G.P. and checked that the medication was correct prior to faxing the new prescriptions to the supplying pharmacist. The required medication was usually delivered within about 24 hours. If medication was required immediately this was dispensed by a local pharmacy. This ensured that people received their medication as soon as possible.

We saw that there was provision for people to administer their own prescribed medication within a risk assessment framework. This helped to keep people safe whilst ensuring people were not prevented from maintaining their independence. People that we spoke with had no concerns about the medication practice in the home and confirmed that they received their medication at the time prescribed.

Assessing and monitoring the quality of service provision ✓ Met this standard

The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care

Our judgement

The provider was meeting this standard.

The provider had an effective system to regularly assess and monitor the quality of the service that people received

Reasons for our judgement

We spoke with the registered manager about quality monitoring systems at the home. St Wilfrid's Hall Nursing Home had developed a range of systems, so that the quality of the service provided could be closely monitored. This helped to ensure that any shortfall was quickly identified and addressed.

There was a system in place for reviewing the support received by each person. This included a regular formal review of each person's care plan, to ensure the level of care and support provided continued to meet current needs. When necessary the care plan was amended to reflect any changing needs. This meant that staff always had up to date information so that people received the level of care and support they required.

The dispensing pharmacist that supplied the computerised medication system produced a daily audit of medication practices within the home taken from the computer records of the previous day. Detailed outcomes were provided to the registered manager. This meant that medication practices had been tracked and monitored so that action could be quickly taken to address any deficit.

Questionnaires were periodically distributed to users of the service, their relatives, staff and other stakeholders. During our visit we looked at the collated outcome of the most recent relative surveys. This questionnaire covered a wide range of questions. Outcomes were all highly scored. We were told by the registered manager that if an outcome scored less that 80% an action plan was developed. The action plan(s) were left in a public area of the home so that people using the service, relatives, staff and other stakeholders knew the action to be taken to address the shortfall. Any action required was discussed with senior staff at the heads of department meetings and a further action plan developed targeted for a specific department to address any outstanding recommendations. We were given a good example of action taken to address concerns expressed that resulted in a new activities coordinator being appointed and a wider range of targeted activities being introduced.

Staff meetings, resident meeting and staff supervision arrangements were in place

meaning that systems were in place for people to have their say and influence change.

About CQC inspections

We are the regulator of health and social care in England.

All providers of regulated health and social care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The essential standards are described in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. We regulate against these standards, which we sometimes describe as "government standards".

We carry out unannounced inspections of all care homes, acute hospitals and domiciliary care services in England at least once a year to judge whether or not the essential standards are being met. We carry out inspections of other services less often. All of our inspections are unannounced unless there is a good reason to let the provider know we are coming.

There are 16 essential standards that relate most directly to the quality and safety of care and these are grouped into five key areas. When we inspect we could check all or part of any of the 16 standards at any time depending on the individual circumstances of the service. Because of this we often check different standards at different times.

When we inspect, we always visit and we do things like observe how people are cared for, and we talk to people who use the service, to their carers and to staff. We also review information we have gathered about the provider, check the service's records and check whether the right systems and processes are in place.

We focus on whether or not the provider is meeting the standards and we are guided by whether people are experiencing the outcomes they should be able to expect when the standards are being met. By outcomes we mean the impact care has on the health, safety and welfare of people who use the service, and the experience they have whilst receiving it.

Our inspectors judge if any action is required by the provider of the service to improve the standard of care being provided. Where providers are non-compliant with the regulations, we take enforcement action against them. If we require a service to take action, or if we take enforcement action, we re-inspect it before its next routine inspection was due. This could mean we re-inspect a service several times in one year. We also might decide to re-inspect a service if new concerns emerge about it before the next routine inspection.

In between inspections we continually monitor information we have about providers. The information comes from the public, the provider, other organisations, and from care workers.

You can tell us about your experience of this provider on our website.

How we define our judgements

The following pages show our findings and regulatory judgement for each essential standard or part of the standard that we inspected. Our judgements are based on the ongoing review and analysis of the information gathered by CQC about this provider and the evidence collected during this inspection.

We reach one of the following judgements for each essential standard inspected.

✓ **Met this standard**	This means that the standard was being met in that the provider was compliant with the regulation. If we find that standards were met, we take no regulatory action but we may make comments that may be useful to the provider and to the public about minor improvements that could be made.
✖ **Action needed**	This means that the standard was not being met in that the provider was non-compliant with the regulation. We may have set a compliance action requiring the provider to produce a report setting out how and by when changes will be made to make sure they comply with the standard. We monitor the implementation of action plans in these reports and, if necessary, take further action. We may have identified a breach of a regulation which is more serious, and we will make sure action is taken. We will report on this when it is complete.
✖ **Enforcement action taken**	If the breach of the regulation was more serious, or there have been several or continual breaches, we have a range of actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers include issuing a warning notice; restricting or suspending the services a provider can offer, or the number of people it can care for; issuing fines and formal cautions; in extreme cases, cancelling a provider or managers registration or prosecuting a manager or provider. These enforcement powers are set out in law and mean that we can take swift, targeted action where services are failing people.

How we define our judgements (continued)

Where we find non-compliance with a regulation (or part of a regulation), we state which part of the regulation has been breached. Only where there is non compliance with one or more of Regulations 9-24 of the Regulated Activity Regulations, will our report include a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation). This could be a minor, moderate or major impact.

Minor impact - people who use the service experienced poor care that had an impact on their health, safety or welfare or there was a risk of this happening. The impact was not significant and the matter could be managed or resolved quickly.

Moderate impact - people who use the service experienced poor care that had a significant effect on their health, safety or welfare or there was a risk of this happening. The matter may need to be resolved quickly.

Major impact - people who use the service experienced poor care that had a serious current or long term impact on their health, safety and welfare, or there was a risk of this happening. The matter needs to be resolved quickly

We decide the most appropriate action to take to ensure that the necessary changes are made. We always follow up to check whether action has been taken to meet the standards.

Glossary of terms we use in this report

Essential standard

The essential standards of quality and safety are described in our *Guidance about compliance: Essential standards of quality and safety*. They consist of a significant number of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. These regulations describe the essential standards of quality and safety that people who use health and adult social care services have a right to expect. A full list of the standards can be found within the *Guidance about compliance*. The 16 essential standards are:

Respecting and involving people who use services - Outcome 1 (Regulation 17)
Consent to care and treatment - Outcome 2 (Regulation 18)
Care and welfare of people who use services - Outcome 4 (Regulation 9)
Meeting Nutritional Needs - Outcome 5 (Regulation 14)
Cooperating with other providers - Outcome 6 (Regulation 24)
Safeguarding people who use services from abuse - Outcome 7 (Regulation 11)
Cleanliness and infection control - Outcome 8 (Regulation 12)
Management of medicines - Outcome 9 (Regulation 13)
Safety and suitability of premises - Outcome 10 (Regulation 15)
Safety, availability and suitability of equipment - Outcome 11 (Regulation 16)
Requirements relating to workers - Outcome 12 (Regulation 21)
Staffing - Outcome 13 (Regulation 22)
Supporting Staff - Outcome 14 (Regulation 23)
Assessing and monitoring the quality of service provision - Outcome 16 (Regulation 10)
Complaints - Outcome 17 (Regulation 19)
Records - Outcome 21 (Regulation 20)

Regulated activity

These are prescribed activities related to care and treatment that require registration with CQC. These are set out in legislation, and reflect the services provided.

Glossary of terms we use in this report (continued)

(Registered) Provider

There are several legal terms relating to the providers of services. These include registered person, service provider and registered manager. The term 'provider' means anyone with a legal responsibility for ensuring that the requirements of the law are carried out. On our website we often refer to providers as a 'service'.

Regulations

We regulate against the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009.

Responsive inspection

This is carried out at any time in relation to identified concerns.

Routine inspection

This is planned and could occur at any time. We sometimes describe this as a scheduled inspection.

Themed inspection

This is targeted to look at specific standards, sectors or types of care.

Contact us

Phone:	03000 616161
Email:	enquiries@cqc.org.uk
Write to us at:	Care Quality Commission Citygate Gallowgate Newcastle upon Tyne NE1 4PA
Website:	www.cqc.org.uk

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