Latham Lodge Limited

Latham Lodge Nursing and Residential Care Home

Inspection report

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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

Latham Lodge Nursing and Residential Care Home offers accommodation with nursing care for up to 40 people, including those who are living with dementia.

The inspection was unannounced and was carried out on 7 and 9 September 2016.

There was a registered manager in place at the home. A registered manager is a person who has registered with the Care Quality Commission to manage the home. 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 home is run.

People told us they felt the home was safe. Staff had received safeguarding training and were able to demonstrate an understanding of the provider's safeguarding policy and explain the action they would take if they identified any concerns.

The risks relating to people's health and welfare were assessed and these were recorded along with actions identified to reduce those risks in the least restrictive way. They were personalised and provided sufficient information to allow staff to protect people whilst promoting their independence.

People were supported by staff who had received an induction into the home and appropriate training, professional development and supervision to enable them to meet people's individual needs. There were enough staff to respond to and meet people's needs.

There were suitable systems in place to ensure the safe storage and administration of medicines. Medicines were administered by staff who had received appropriate training and assessments. People were supported to access healthcare services when they needed them.

Staff followed legislation designed to protect people's rights and ensure decisions were the least restrictive and made in their best interests.

Staff developed caring and positive relationships with people, were sensitive to their individual choices and treated them with dignity and respect.

People were supported to have enough to eat and drink. Mealtimes were a social event and staff supported people in a patient and friendly manner.

The service was responsive to people's needs and staff listened to what people said. Staff were prompt to raise issues about people's health and people were referred to health professionals when needed. People were confident they could raise concerns or complaints and that these would be dealt with.

People and, when appropriate, their families or other representatives were involved in discussions about their care planning. People were encouraged to provide feedback on the service provided both informally and through an annual questionnaire.

Staff felt supported by the management team to raise any issues or concerns. The quality of the care and treatment people experienced was monitored and action taken to promote people's safety and welfare. Accidents and incidents were monitored, analysed and remedial actions identified to reduce the risk of reoccurrence.

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.

Individual risks to people had been assessed and action taken to minimise the likelihood of harm in the least restrictive way.

People received their medicines at the right time and in the right way to meet their needs.

People and their families felt the home was safe and staff were aware of their responsibilities to safeguard people.

There were enough staff to meet people's needs and recruitment practices ensured that all appropriate checks had been completed.

Is the service effective?

Good

The service was effective.

Staff sought verbal consent from people before providing care and followed legislation designed to protect people's rights.

People were supported to have enough to eat and drink. They had access to health professionals and other specialists if they needed them.

Staff received an appropriate induction and on-going training to enable them to meet the needs of people using the service.

Is the service caring?

Good

The service was caring.

Staff developed caring and positive relationships with people and treated them with dignity and respect.

Staff understood the importance of respecting people's choices and their privacy.

The service supported people and their families to express their views and be involved in making decisions about their care and

support.

Is the service responsive?

Good

The service was responsive.

The service was responsive to people's needs and any concerns they had.

Care plans and activities were personalised and focused on individual needs and preferences.

The registered manager involved people and their representatives in planning care and had a process in place to deal with any complaints or concerns.

Is the service well-led?

Good

The service was well-led.

The registered manager adopted an open and inclusive style of leadership. Staff understood their roles and responsibilities and there were clear lines of accountability within the service.

People, their families and staff had opportunities to feedback their views about the home and quality of the service being provided.

The quality of the care and treatment people experienced was monitored and action taken to promote people's safety and welfare.

Latham Lodge Nursing and Residential Care 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 checked 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 unannounced and was carried out on 7 and 9 September 2016 by one inspector accompanied by a specialist advisor and an expert by experience. The specialist advisor had clinical and practical experience and knowledge of best practice relating to the care of older people and those living with dementia. The expert by experience had personal experience of working in and caring for someone who uses this type of care service.

Before the inspection, the provider 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 the improvements they plan to make. We reviewed the information in the PIR, along with other information that we held about the service including previous inspection reports and notifications. A notification is information about important events which the service is required to send us by law.

We spoke with 14 people using the service and three relatives/visitors. We observed care and support being delivered in communal areas of the home to help us understand the experience of people who could not talk with us. We spoke with five members of the care staff, the activities co-ordinator, chef, a nurse, the deputy manager and the registered manager. We also received feedback about the service from a community care professional.

We looked at a range of documents including seven people's care records, risk assessments and medicine charts, staff recruitment, duty and training records. We also looked at information regarding the arrangements for managing complaints and monitoring the quality of the service provided within the home.

The home was last inspected in July 2013 when no issues were identified.

Good

Is the service safe?

Our findings

People said they felt safe. A person told us "I feel safe here. That's part of it. I used to keep checking the doors and windows at my house". Relatives said they liked that they were given the code number for the front door. One said this gave them peace of mind as it indicated the service was always accessible and "No one has anything to hide". The other relative said there was "Very easy access, but it's secure". They said the code had been changed since their last visit and they were aware of the new code.

Staff had a good understanding of how to keep people safe and their responsibilities for reporting accidents, incidents or concerns. They knew how to report any suspicion of abuse to the management team and external agencies, such as the local authority safeguarding team, so that people in their care were protected and their rights upheld. Policies were in place in relation to safeguarding and whistleblowing procedures and these were accessible to all staff. Records showed and staff confirmed they had received training in safeguarding adults as part of their training and this was regularly updated.

Risks to people had been identified, assessed and actions had been taken to minimise the risks, such as the risks of people falling, becoming malnourished or developing pressure sores. This information was recorded in each person's care records and updated regularly with any changes to the level of risk or changes to health. Staff were aware of the risk assessment and management plans in place for people. Staff acknowledged that some risks to health and wellbeing needed to be accepted and taken, in order to promote and not limit people's freedom and independence.

People were supported by sufficient staff with the right skills and knowledge to meet their assessed needs. Staffing levels were kept under review and additional staff could be used if people's needs changed. Staff confirmed there were enough staff on duty and were able to respond to people quickly. A member of staff said regular agency staff were used as much as possible, mostly during the night shift which was the most difficult to cover. Another member of staff told us the service was in the process of recruiting staff to replace those who had left. They said staff were very flexible about covering shifts at short notice.

The rota was planned 12 weeks in advance. The registered manager used a dependency rating tool as a guide in reviewing staffing levels on a monthly basis. Additional staffing had been agreed by the senior operations director. There were two nurses and six or seven care staff on duty in the mornings. A minimum of one nurse in the afternoon was supported by five care staff. One nurse and three care staff were on duty at night. In addition to the registered manager, nursing and care staff, there was a full time activities person, two chefs and two administrators, a maintenance person and a housekeeping team.

Five new care staff had been recruited and staffing would increase by a care worker per day shift plus a new twilight shift once staff inductions were completed. The registered manager had been able to recruit over the staffing budget due to having a number of staff on maternity leave. The registered manager said "The company are very supportive regarding staffing".

The provider had a system in place to assess the suitability and character of staff before they commenced

employment. Records included interview notes and previous employment references. Staff were required to undergo a Disclosure and Barring Service (DBS) check. DBS checks enable employers to make safer recruitment decisions by identifying candidates who may be unsuitable to work with adults who may be at risk. Records were on file showing that checks were also undertaken to ensure that nursing staff were correctly registered with the Nursing and Midwifery Council (NMC). All nurses and midwives who practise in the UK must be on the NMC register.

There were appropriate plans in case of an emergency occurring. Personal evacuation and escape plans had been completed for each person, detailing the specific support each person required to evacuate the building in the event of an emergency. A grab box in the reception area contained useful phone numbers, a list of GPs, and contingency plans.

Thorough systems were in place to help ensure people's medicines were ordered, stored, administered or disposed of safely. There were detailed individual support plans in relation to people's medicines. For example, clear guidelines were in place that helped staff to understand when 'as required' (PRN) medicines should be given. A controlled drugs (CD) cabinet and logbook was in use and the records were completed in line with the relevant procedures. There were no gaps in the medicine administration records (MAR), which were signed after each medicine was successfully dispensed. Records were in use for when people took medicines out with them when going out for the day.

Medicines were all labelled including the dates when opened. Medicines trolleys were clean and attached securely to the wall when not in use. There was a cleaning schedule for the medicines fridge and the fridge and medicines room temperatures were recorded daily.

There were robust processes and records demonstrating the nursing staff sought advice and clarification from the GP and pharmacist and ensured clear instruction was documented and followed. For example, a letter on one person's file highlighted which medicine on the MAR could be crushed, which could be given in liquid form and which was in dispersible form, due to the person having swallowing issues. A letter on another person's file informed staff what to do regarding increasing the person's insulin if required and under what circumstances and what dosage.

Records showed the registered manager conducted her own observational checks and medicines audit on a monthly basis. The pharmacy also carried out audits and observations every six months. Where areas were identified as requiring attention the registered manager had created and implemented clear action plans. A relative said "The schedule with medication is very strict, they know what mother needs. They are very efficient and diligent".

The registered manager was aware of their responsibilities in relation to infection control. An annual infection control statement was written and the registered manager was aware of what needed to be reported. There was a cleaning schedule in place for staff to follow and records showing checks took place. The home environment was clean and we observed that staff were aware of infection control procedures. Protective clothing was available and in use by staff. The training record showed that staff received training in infection prevention and control.

Good

Is the service effective?

Our findings

People told us they were happy at the home, they said they liked the staff and many classed the meals as "excellent". Relatives were also very positive about the service.

A community care professional told us staff were "Equipped with many qualities. They remain professional and courteous to residents, relatives and visiting professionals. I have found them to be very knowledgeable of all the residents needs and they are diligent to raise any concerns during their shift to the nurse in charge. There appears to be supportive structure to the team and they are led by very experienced team leaders / senior carers. To the best of my knowledge they are supported with their professional development and have an initial Induction programme".

This was further confirmed through talking with staff and looking at training and supervision records. Staff completed computer based training in a variety of subjects and were assessed on their knowledge and understanding following the training. Staff told us they also received face to face group training in some subjects including safeguarding people. The service had an in-house moving and handling trainer. A nurse confirmed they received regular training and told us staff were given supernumerary time for learning and development if required. The deputy manager told us there was a lot of training available. They had recently attended training about a medical procedure, which they found very helpful and would now be able to utilise in the home.

The provider had a system to record the training staff had completed and to identify when training needed to be repeated. This included essential training, such as medicines training, safeguarding adults, fire safety and moving & handling. Staff were able to access further training such as dementia awareness and were supported to undertake a vocational qualification in care. Staff told us the training helped them to understand and meet people's needs. One member of staff told us they had enjoyed doing their vocational qualification in care and spoke enthusiastically about a presentation they had given to the staff group about dementia.

New staff completed an induction that included shadowing experienced staff on a supernumerary basis. The provider had introduced the new national Care Certificate, which sets out common induction standards for health and social care staff. There was also a 'buddy' system in place to support new staff in putting training into practice. A recently recruited member of staff told us their induction was thorough and the managers and staff team were supportive. They said "I can always ask questions".

Staff received regular supervision and an annual appraisal. Supervision and appraisal provide opportunities for management to meet with staff, give feedback on their performance, identify any concerns, offer support, assurances and identify learning opportunities to help them develop. Staff said they felt supported by the management team and senior staff. There was an open door policy and they could raise any concerns straight away.

Staff had received training in the Mental Capacity Act 2005 (MCA). The 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. The deputy manager demonstrated a good understanding of mental capacity and best interest decision making. A community care professional confirmed the registered manager worked with them to support the needs and protect the rights of people who lacked mental capacity.

Staff showed an understanding of the principles of the MCA in relation to people they were supporting. Before providing care, they sought consent from people and gave them time to respond. Staff were aware that some people had capacity to make decisions, while others may require more support in relation to bigger decisions that may need to be made. They said they would report any concerns about a person's capacity to make particular decisions to one of the management team. Another member of staff spoke of the importance of "Taking time and allowing people to make choices. There are ways of communicating".

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 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. DoLS applications had been authorised for three people. One person's authorisation had included a condition that the service had complied with.

People said they had enough to eat and drink and they enjoyed the meals and the variety provided. Their comments included: "They feed you very well. You get lots of choice". "The food is excellent. For breakfast I can have anything I want. There are always a couple of choices at supper time and at dinner time". "They are very nice meals, always nice meals"; and "I like home cooking, you get variety". A relative said "The menu is very good, varied and nutritionally balanced".

We observed staff assisting people to eat in the dining room. Staff were patient and did not hurry people. Visitors were invited to share a meal with their relatives or friends, making it a social event. The dining area was clean, well-presented and included daily menus on all of the tables. The menu was also displayed in the main entrance in both written and pictorial versions. Staff provided meals for some people in their rooms and asked them what assistance they needed, for example help with eating or having the food cut up for them.

People's support plans included nutritional assessments and details of their dietary requirements and support needs. Staff demonstrated knowledge of which people were on soft, fortified, or other special diets and records also contained this information. There was a list of people who required assistance at meal times, which was signed by staff each meal to record that assistance had been given. The chef had a list of people who were on special diets, such as soft diets, and information describing what such diets consisted of and any related assessed needs. The chef told us communication between care and kitchen staff was good and any changes affecting a person's diet, appetite or weight were relayed effectively.

The service had taken part in a six week pilot study that looked at ways of increasing and improving the variety of food for people with swallowing difficulties. We saw examples of cake and biscuits made in a way that looked appetising while not presenting a choking risk. The chef had received training in relation to this and also about allergens and had relevant information on file.

The service had developed a robust and effective process for weight monitoring, which included

communicating with staff throughout the home and external professionals. This process ensured people's weights were not only taken and recorded but that any changes were clearly identified, acted on and subsequently reviewed.

Records showed staff contacted community health and social care professionals in relation to concerns about people's health. People had access to a range of services including chiropody, dentists and opticians. A community care professional told us the service had supported people "With all their physical and mental health needs, demonstrating in depth knowledge of the conditions and care required. They have managed their day to day care, keeping both the GP and myself informed of changes". We saw examples of care plans containing detailed information about people's health including how medical conditions had arisen, how they were managed, symptoms that staff should be aware of and how best to support the person. Staff demonstrated a good working knowledge of people's care plans and needs and the procedures to follow.

Good

Is the service caring?

Our findings

People told us they were happy with the care they received. Their comments included: "Everyone is so kind. They are being so nice. I've got a very nice room"; and "The staff are all nice and friendly, when they come in, we have a laugh". Another person told us "There is good care at night, I dream and get restless and the staff are very good. Everyone is very kind here, a very happy crowd". A relative said "Staff are friendly and informative, they give lots of information about how gran is feeling and what she is up to. They take an interest in the person, as a person". They added "I love them to bits".

A community care professional told us "Latham Lodge provides exceptional care from the foundations upwards. I have never witnessed any behaviours or practices that have raised concerns".

We observed that staff were kind, caring and friendly in their approaches to people's care. There was a good rapport between staff and the people they supported with lots of smiles and laughter. A member of staff told us "It's a lovely place to work. There's never a day when I don't want to come in to work. I feel I make a difference even if it's just making someone smile. We're a good team". They said they felt all staff across all shifts worked together and added "I think I'm fortunate to work here".

The service supported people to express their views and be involved in making decisions about their care and support. Each person had named members of staff assigned to them as key workers. Key working is a system where a member of care staff takes special responsibility for supporting and enabling a person. The aim of this system is to maximise the involvement and help to build relationships between people using the service, their families and staff. A person told us "The staff are nice. Some are my keyworkers and one is my nurse. I've got two keyworkers. I get on with them very well". People were also involved in the running of the service through residents and relatives meetings with the registered manager and other staff including the chef and activities coordinator.

The relationships between staff and people receiving support demonstrated dignity and respect. The care staff were kind and courteous and we observed they knocked on doors before entering people's rooms. People received personal care in the privacy of their bedrooms. Staff gave examples of respecting people's privacy and dignity, for example keeping a person covered as much as possible while assisting them to wash.

Care plans and associated records were written in a way that promoted dignity and respect. For example, people's summary care plans stated the name by which they liked to be addressed and we observed staff addressed each person by their preferred name. Staff spoke in a caring way about people. For example, one care worker said "If you can get someone to smile or do something they can't usually do, that makes my day". They told us they felt it was important to "Look after people the same way you'd like to be looked after yourself? It's about the respect". Another member of staff said they felt staff were good at treating people with respect and told us this formed part of the induction training.

Care plans included people's likes and dislikes and their family and friends were involved in recording this

information, where appropriate. Visitors were welcome and were supported to stay for lunch and share activities with people. Near the reception area was a separate kitchenette for visitors and staff with tea, coffee and biscuits provided. This provided a sense of welcome and inclusion. People were supported to keep in contact with friends and families. Social events were also held to involve families in the service.

People's end of life care wishes and any advance decisions were also discussed and documented in their care plans. Do not attempt cardio-pulmonary resuscitation (DNACPR) decisions were recorded where appropriate. The registered manager told us that where end of life care was needed, the service sought advice from specialist palliative care nurses. Emotional support was provided to relatives and visitors at these times.

Good

Is the service responsive?

Our findings

Overall, people were positive about the service and felt staff were responsive to their needs.

Some people expressed concern about staff response times to the call bell during busy periods, such as mealtimes. A call bell system was in place and the registered manager kept a record of when response times were spot checked. The response times were mostly between one to five minutes. The registered manager was aware of the issues with the call bell system. They explained that the system was very old and often could not be heard by staff when they were in people's rooms. Following the inspection visit the registered manager confirmed that the planned new system was now in place. The new system included handsets for staff to log when calls for assistance were answered and a monitor screen in the office.

A personalised approach to responding to people's needs was evident in the service. Before people moved into the home they and their families or representatives participated in an assessment of their needs to ensure the service was suitable for them. Involving people in the assessment and subsequent reviews helped to make sure that care was planned around people's individual care preferences. Following this initial assessment, personalised care plans were developed that provided guidance about how each person would like to receive their care and support, including their preferred routines of care, how they communicated their needs and the name they preferred staff to use.

Records showed care plans were kept under review and, where necessary, external health and social care professionals were referred to as part of the response to people's changing needs. People and/or their relatives/representatives were involved in reviews according to each person's wishes or best interests decision. Through talking with people and the staff and through observation, it was evident that staff were aware of people's care needs and acted accordingly.

Care plans provided a good level of detail to assist staff in supporting people with their care needs. These included information on particular conditions relevant to the person. Nursing staff were knowledgeable about wound management processes and procedures, including what to do if a pressure area was identified.

There was an activities board in the main entrance, illustrating activities on offer for the week and highlighting whether they incorporated emotional, sensory, physical, cognitive or social elements. The home had an activities area that was well used. We saw people's artwork on walls, reading materials and blankets for outdoor activities if required. We observed the activities co-ordinator working with a group of people and engaging them in a number of one-to-one activites. Individual records showed what recreational and social activities each person had taken part in, on either a group or one to one basis. These included, for example, card and board games, reminiscence and group discussions, music and films.

A person told us they liked Elvis Presley and was impressed that the service booked an Elvis impersonator to perform at the home. We also saw photographs of people enjoying a visit from a miniature horse, provided as a therapeutic activity. One person told us staff had introduced them to a creative colouring activity, which

the person really enjoyed and had continued to do. Another person spoke about activities they enjoyed and said the activities coordinator was "Very good".

People told us they would feel comfortable raising any concerns or complaints. There was a system and procedure in place to record and respond to any concerns or complaints about the service. The complaints record log showed that one complaint had been received within the past year and demonstrated that the registered manager had listened and taken action. The complaint had been investigated and the outcome recorded in a timely manner in line with the procedure.

Staff understood people's needs well and demonstrated how they would be able to tell if a person was not happy about something, which meant that people would be supported to express any concerns. There was a white board in the reception area for people to write comments on. Above the board was displayed the key standards the service should be meeting, as a prompt for people who wished to give feedback. There were records showing the management team acted on the feedback received.

Good

Is the service well-led?

Our findings

The service worked in partnership with community professionals to help ensure people received the care they needed. A community care professional told us "The current manager appears very supportive, mindful and fair with her staff". They also said "I have high regard for the staff working and managing this service" and "This home has strived to maintain a professional service and high standards whilst providing a homely, supportive environment for their residents….. and still smile".

The registered manager was promoting an open and inclusive culture within the service. They had an open door policy for people living in the home, staff and relatives. The registered manager carried out 'walk arounds' in the mornings and evenings, which provided opportunities to talk with people, and they facilitated relatives and residents meetings every three months. An annual survey took place, most recently in March 2016. A report and action plan had been written in response to themes raised by the survey results. For example, making sure that relatives were aware of information that was available about the service. The registered manager had started a monthly newsletter, which provided another way of keeping people and their relatives informed about what happened in the service.

The registered manager told us they encouraged staff to be open so that the service could learn from any mistakes. Staff told us they were able to speak openly and raise any concerns at meetings. We saw detailed minutes were kept of staff and management meetings. A nurse said they enjoyed working at the home and that staff were "All treated the same". They told us the management team were supportive. There had been a lot of changes including the implementation of new paperwork from the head office. They said the home environment needed improvement but the management were addressing this and things were changing and getting better. The deputy manager said the regional manager was very supportive and was a regular face at the home. They said "Support is always there". They said they had a good working relationship with the registered manager and regularly met with them to share information throughout the shift.

Staff were aware of the values and aims of the service and demonstrated this by promoting people's rights, independence and quality of life. There were clear lines of accountability within the service with each shift having a clearly designated member of staff in charge. One member of staff was a designated dignity champion and another took a lead role in infection prevention and control. There were processes in place to enable the registered manager to account for the actions, behaviours and performance of staff, and the registered manager told us how she had implemented the procedures when necessary. The registered manager said they felt well supported in their role by the organisation's senior managers. They said their line manager was "Very hands on. They all are".

Regular audits of the quality and safety of the service took place and were recorded. For example, there were audits of care plans, medicines, infection prevention and control and equipment. The provider carried out quarterly health and safety audits and action plans were developed and completed if required. The organisation had a quality assurance department and unannounced visits took place at approximately six month intervals. The service had recently had such a visit and the registered manager was awaiting the report. A regional manager also carried out monthly visits, which included talking with people living at the

home and with staff. A report was produced following each visit and any identified actions were followed up at the next visit. There was a clinical governance process to monitor accidents and incidents, complaints, safeguarding, wound care and infection prevention and control. Risk assessments for the home environment were on file and regularly reviewed.

Records showed that investigations were undertaken following incidents and that appropriate actions were taken in response. For example, following a medicines error the staff involved received further training and a competency assessment and spot checks were introduced. The registered manager had demonstrated an awareness of the duty of candour and followed the relevant company policy and procedure. The duty of candour regulation sets out some specific requirements that providers must follow when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information and an apology when things go wrong.