Methodist Homes

Riverview Lodge

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

Our inspection of Riverview Lodge took place on 16 and 30 March 2016. This was an unannounced inspection.

At our previous inspection of Riverview Lodge in May 2014 we found that the home was meeting the requirements of the outcomes that we assessed. These were: Respecting and involving people who use services; care and welfare of people who use services; cleanliness and infection control; requirements relating to workers; assessing and monitoring the quality of service provision.

Riverview Lodge is a care home situated in Kingsbury. The home is registered to provide care to up to 36 older people living in three units. At the time of our inspection there were 35 people living at the home, many of whom were living with dementia.

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

People who lived at the home told us that they felt safe, and this was confirmed by family members whom we spoke with.

People were protected from the risk of abuse. Staff members had received training in safeguarding, and were able to demonstrate their understanding of what this meant for the people they were supporting. They were also knowledgeable about their role in ensuring that people were safe and that concerns were reported appropriately.

Medicines at the home were well managed. People's medicines were stored, managed and given to them appropriately. Records of medicines were well maintained.

Staff at the home supported people in a caring and respectful way, and responded promptly to meet their needs and requests. There were enough staff members on duty to meet the physical and other needs of people living at the home. People who remained in their rooms for part of the day were regularly checked on.

Staff who worked at the home received regular relevant training and were knowledgeable about their roles and responsibilities. Appropriate checks took place as part of the recruitment process to ensure that staff were suitable for the work that they would be undertaking. All staff members received regular supervision from a manager, and those whom we spoke with told us that they felt well supported.

The home was meeting the requirements of The Mental Capacity Act 2005 (MCA). Assessments of capacity

had been undertaken and applications for Deprivation of Liberty Safeguards (DoLS) had been made to the relevant local authority. Staff members had received training in MCA and DoLS, and those we spoke with were able to describe their roles and responsibilities in relation to supporting people who lacked capacity to make decisions.

People's nutritional needs were well met. Meals were nutritionally balanced and met individual health and cultural requirements as outlined in people's care plans. Alternatives were offered where required, and drinks and snacks were offered to people throughout the day. People's food and liquid intake was recorded and monitored.

Care plans and risk assessments were person centred and provided guidance for staff about how they should work with people to meet their needs. Daily records of people's care were well maintained and effective systems were in place to share information between outgoing and incoming staff at shift changes.

The home provided a range of individual and group activities for people to participate in throughout the week. Staff members engaged people supportively in participation in activities. People's cultural and religious needs were supported.

People and their family members that we spoke with knew how to complain.

Care documentation showed that people's health needs were regularly reviewed. The home liaised with health professionals to ensure that people received the support that they needed.

There were systems in place to review and monitor the quality of the service, and we saw that action plans had been put in place and addressed where there were concerns. Policies and procedures were up to date and staff members were required to sign that they had read and understood any new or amended ones.

People who used the service, their relatives and staff members spoke positively about the management of the home.

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. Risk assessments were clearly linked to guidance in people's care plans how to manage identified risks.

Staff we spoke with understood the principles of safeguarding vulnerable adults, how to recognise the signs of abuse, and what to do if they had any concerns.

Medicines were well managed and recorded.

Is the service effective?

Good

The service was effective. The requirements of The Mental Capacity Act 2005 and Deprivation of Liberty Safeguards 2007 had been met.

Staff members received the training and support they required to carry out their duties effectively.

People were supported to maintain good health and to access health services when they needed them.

People chose their meals and were provided with the support they needed to eat and drink.

Is the service caring?

Good

The service was caring. People who used the service and their family members told us that they were satisfied with the care provided by staff. We observed that staff members respected people's privacy and dignity.

Staff members spoke positively about the people whom they supported, and we observed that interactions between staff members and people who used the service were caring and respectful.

People's religious and cultural needs were respected and supported.

Is the service responsive?

Good

The service was responsive. People and their relatives told that their needs were addressed by staff.

Care plans were up to date and person centred and included guidance for staff to support them in meeting people's needs.

People were able to participate in of individual and group activities.

The service had a complaints procedure and people knew how to make a complaint.

Is the service well-led?

Good

The service was well-led. There were systems in place to monitor the quality of the service and we saw that these were evaluated with improvements made where required.

The registered manager demonstrated leadership and accountability. She was approachable and available to people who used the service, staff members and visitors.

Staff members told us that they felt well supported by the manager. People and family members of people who used the service felt that the home was well managed.

The registered manager had a good working relationship with health and social care professionals and organisations.

Riverview Lodge

Detailed findings

Background to this inspection

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

This inspection took place on 16 and 30 March 2016, and was unannounced. The manager was away from the home at our first visit on 16 March, so we returned on 30 March to complete our inspection. The inspection team comprised of two inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

During our inspection we spoke with eleven people who lived at Riverview Lodge and two family members. We also spoke with four care staff, the cook, the maintenance officer, the activities co-ordinator, the deputy manager and the registered manager.

We spent time observing care and support being delivered in the main communal areas. We looked at records, which included seven care records, six staff records and records relating to the management of the 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 improvements they plan to make. We reviewed the information included in the PIR along with other information we held about the home.

Good

Is the service safe?

Our findings

People told us that they felt safe. People knew who to speak to if they had a concern about their welfare. We were told that the staff "are really supportive," and, "I do feel happy and content here." A family member told us that, "[my relative] wasn't happy at home. We are lucky to have found a place that really suits them."

People's risk assessments were personalised and had been completed for a selection of areas including people's behaviour, medicines, falls, pressure ulcers, infection control and moving and handling. We saw that these were up to date and had been reviewed on a regular basis. Risk management plans were included in people's care plans and we saw that these had been cross-referenced to the relevant risk assessment. Behavioural risk assessments included guidance for staff around providing positive approaches to supporting people. During our inspection we saw that staff had updated the risk assessment and care plan for a person who had recently been discharged from hospital. This showed us that suitable arrangements were in place to protect people from risk.

There was an up to date policy on safeguarding that included contact details for the local authority. Staff members that we spoke with demonstrated that they understood the principles of safeguarding, and how they would respond to and report suspicions and concerns that a person may be at risk of abuse. We saw evidence that training in safeguarding had been received by all staff members. We looked at the safeguarding records for the home which showed that safeguarding concerns had been appropriately managed.

Medicines were stored, managed and recorded appropriately, and administered to people safely. An up to date medicines policy which included procedures for the safe handling of medicines was available to staff. Staff administering medicines had received training in administration of medicines. Guidance was in place for people who received PRN (as required) medicines. Appropriate records and guidance were in place for a person who needed to take their medicine covertly. These showed that a GP, a pharmacist, staff and the person's next of kin had been involved in the best interest decision made in relation to this. Weekly monitoring of medicines took place and we saw that 'spot checks' were also undertaken. We were told that an audit of medicines took place on a quarterly basis and we were able to see records that showed that this was the case. Staff members administering medicines were also responsible for checking medicines and records. A recent medicines error had been very quickly identified and appropriate action had been taken to ensure that the person was safe. An action plan had been put in place to reduce the likelihood of error in the future.

Staff members that we spoke with did not always demonstrate that they knew what specific medicines were prescribed for. We discussed this with the registered manager who told us that they would arrange a session to increase staff awareness of the medicines that people used.

Staffing rotas showed that between 8am and 8pm there were always two care workers and one senior care worker on duty on each floor, supported by the registered manager and deputy manager. Between 8pm and 8am, a waking night care worker was available on each floor. In addition the home had an activity co-

ordinator, catering staff and domestic workers. The staff members that we spoke with told us that they considered that there were enough staff members of shift at any time to meet people's needs.

We also observed that people received care and support when they required. We saw staff that staff members respond promptly to ensure that people were provided with the assistance they needed. There were enough staff to support people to take part in activities. During our inspection we saw that there were enough staff members on shift to meet the needs of people using the service.

The six staff records we looked at showed that appropriate recruitment and selection processes had been carried out to ensure that staff were suitable for their role in supporting people who used the service. These included checks of references relating to previous employment and of criminal records.

Staff members were seen wearing disposable aprons and gloves when supporting people with their care. We also observed that catering and domestic staff used appropriate protective clothing. Anti-bacterial hand rub was located in several areas of the home to minimise the risk of spread of infection. Guidance for good hand washing was displayed in bathrooms. Soap and paper towels were accessible in bathrooms.

Checks of equipment were carried out. Moving and handling equipment, such as hoists and the home's lift were inspected and serviced regularly in accordance with the Lifting Operations and Lifting Equipment Regulations (LOLER) 1998.

Temperatures of fridges and freezers, hot water temperatures and the storage of medicines were monitored closely.

Fire action guidance was displayed and fire equipment had been regularly serviced. Fire drills were carried out quarterly and we noted that these included and included drills during the night. Emergency evacuation plans were in place for individuals. Accident and incident records were well maintained and showed that appropriate actions to address concerns had been put in place. The provider maintained an out of hours emergency contact service and staff we spoke with were aware of this.

The records demonstrated that actions had been taken to reduce health and safety risks to people. Regular health and safety checks and audits took place, and outstanding actions were promptly dealt with. The home had a maintenance officer, and we saw that maintenance issues had been reported immediately and dealt with in a timely manner.

Good

Is the service effective?

Our findings

People that we spoke with were positive about the support that they received from staff members. One person said, "I am content here, more than content. I've a gorgeous room and if I'm feeling off-colour staff will bring me my food but that does not happen often. The cook makes roast dinners just like my Mum did. And there is always fruit in bowls" .Another person said, "I wouldn't stay here if I didn't like it."

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 and hospitals 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.

The care records showed that assessments relating to people's capacity to make decisions had been undertaken and that these followed the code of practice associated with The Mental Capacity Act 2005 (MCA). Care plans provided information for staff about how they should support people to make decisions. We saw copies of applications to the relevant local authority team in relation to Deprivation of Liberty Safeguard (DoLS) regarding restrictions in place for people who were under continuous supervision and unable to leave the home unaccompanied due to risk associated with lack of capacity to make decisions.

Training in MCA and DoLS had been provided to all staff at the home and the staff members that we spoke with demonstrated that they were aware of the requirements of the MCA and understood their roles and responsibilities in relation to this.

Guidance contained within the MCA code of practice was used to support best interest decision making in respect of covert medicines and use of bedrails for people unable to make these decisions for themselves. The bedrails assessments for the two people who required them indicated that other less restrictive options had been explored. The registered manager told us that low profiling beds, 'crash mats' and falls alarms had been considered, but were not considered safe due to people's mobility and frailty

People were asked for their consent with regards to care planning and risk assessment and this was recorded in their care plan. Where people were unable to record consent, the home asked family members or other representatives to support any such decisions, and this was recorded.

Training records for staff members showed that new staff members received induction training that met the requirements of the Care Certificate for staff working in social care services. We saw evidence that core

training was refreshed on a regular basis The training programme included additional training sessions, for example, dementia awareness, positive behavioural approaches and end of life care. The home's training matrix showed when training had been received, or was due, for each staff member. This was reviewed on a weekly basis, and we saw that training had been booked for staff members requiring refresher training. This showed that staff had been provided with the skills and knowledge they required to support people effectively.

Staff members that we spoke with told us that they received the support that they needed to undertake their duties effectively. One staff member said, "There is always someone I can talk to." The records that we viewed showed that staff had received supervision from a manager on a regular basis and that annual performance appraisals had taken place during the past year. We also saw that staff meetings took place on a monthly basis and that these were well attended. The minutes of recent staff meetings showed that there was a focus on the care needs of people who used the service, and of how this care was delivered and recorded. The registered manager held additional meetings for night staff who were unable to attend meetings during the daytime, and for domestic staff at the home.

People's health care needs were met and monitored. Records showed that people regularly received health checks. They had access to a range of health professionals including; GPs, dieticians, opticians, chiropodists, psychiatrists, and dentists. They also attended hospital appointments.

The home's physical environment was suitable for the needs of the people who lived there. People told us they were happy with their bedrooms and the layout of the home. People were able to use a lift to move between floors and there were hand rails on each corridor to aid mobility. The garden was accessible for wheelchair users. The registered manager told us about changes they were making to the service to provide a more dementia friendly environment. We saw that signs were on bathroom doors and that a room had been recently refurbished in a 'retro' style. This was not yet fully in use during our inspection but the registered manager told us that it was to be used for reminiscence activities.

People's individual dietary and nutritional needs were met. The weekly menu was displayed on the walls in the dining area, and daily menus were on each table. There were at least two choices provided for each meal and, where people did not want what was on the menu we saw that they were offered alternatives. When food was delivered to people at the table, we observed that staff checked with them if the dish was what they wanted. Special diets and individual preferences were catered for. We spoke with the cook who showed us daily eating plans for people with requirements or wishes that were not met by the homes regular menus. One person sometimes refused to eat the food that was regularly prepared for them, and the cook described how alternatives were offered and prepared.

People told us they enjoyed the meals. Fresh fruit and other food items were available for snacks. People were offered hot and cold drinks throughout the day. Prescribed nutritional supplements were available to people with poor appetites. People's nutritional needs were assessed and monitored, and guidance for staff members on supporting people with dietary needs and poor appetites were contained within care plans. The care records showed that people's daily food and fluid intake was recorded and monitored, and any concerns were raised and passed on appropriately. Where there were concerns about weight loss or poor food or fluid intake we saw that relevant professionals, such as a GP or dietician were consulted and guidance developed for staff.

Good

Is the service caring?

Our findings

People and their family members told us that staff members were caring. Comments included, "The staff are lovely," and, "staff are so kind fetching me books. I like frightening thrillers and they get them for me." A family member told us, "They have taken such good care of [my relative]." People also told us that they had the opportunity to express their views and that staff listened to them.

We saw that staff members interacted with people in a positive and respectful manner. We observed staff initiating conversations with people and chatting to them with them when providing support. During the first day of our inspection when there was a St Patrick's Day party taking place, we observed a staff member sit with a person who did not wish to participate in the activity. They chatted in a gentle and positive way about topics of the person's choice, and offered to bring them drinks and snacks from the party if they wished. We also saw a staff member painting the nails of three women who were using the service and engaging with them in lively conversation whilst doing so. One person showed us her nails and pointed at the staff member with a smile.

People were supported to maintain the relationships that they wanted to have with friends, family and others important to them. The family members that we spoke with who were visiting the home spoke positively about the approach of staff members. The registered manager told us that where people's partners and other family members visited, staff members were encouraged to ensure that they had privacy. We asked about the home's approach to supporting people's sexuality. The registered manager told us that she had discussed this with staff members at a team meeting. She told us that she believed that staff members would support people and their significant others with positivity and discretion.

We observed that where people required personal support, this was provided in a timely and dignified manner. Some people chose to spend time in their rooms. We saw that staff members checked on their welfare regularly and asked them about any needs or wishes in relation to care and support.

Staff members spoke positively about the people whom they supported. One told us, "I haven't been here that long but I really enjoy spending time with the residents."

Family members that we spoke expressed satisfaction with the information and contact that they received from the home.

People's care plans included information about preferences in relation to communication needs and preferences in relation to delivery of personal care. Care documentation also included assessment and guidance about promoting people's independence.

Care plans included information about people's cultural and spiritual needs. People's care plans included information about their histories, interests and faiths. The staff members that we spoke with were knowledgeable about people's individual cultural needs and interests. The home had a designated chaplain who visited regularly and a priest from another faith group visited weekly to provide pastoral care.

Care plans also recorded information about peoples' end of life preferences and needs. This included information about whether or not people wished to remain at the home or be admitted to hospital, along with information about how they would like to be supported. Some end of life plans had not been completed. The registered manager told us that this was a difficult subject for some people to discuss and the home's approach was to build up a picture gently and in their own time, involving family members where appropriate. The activities co-ordinator told us that special attention was paid to people at the end of life and that staff spent time reading to them, chatting with them and supporting their family members. Staff had received training in end of life support. One person was receiving palliative care, and the staff worked in partnership with palliative care nurses who visited the home regularly.

Good

Is the service responsive?

Our findings

One person who used the service told us that everyone had a key worker. They said, "Key workers are very important to each of us. They get to know us and speak up for us. We can tell them things."

The registered manager told us that, before any new person moved to the home, she assessed the individual care and support needs of the person to determine if the service was able to meet their needs.

Care plans were up to date and person centred, and contained guidance for staff in relation to meeting people's identified needs. The care plans were detailed and included information about, for example, people's histories and personal interests, communication, health support, behaviours, mobility and dietary needs. The plans included guidance for staff on how they should support people to meet their individual needs, and were linked to their risk assessments where appropriate. Care plans were updated immediately where there was a change in people's needs. We saw that staff had promptly updated a plan for a person who had recently been discharged from hospital. Staff members were required to sign to show that they had read any new or revised plan and we saw that a record of this was maintained.

Staff maintained detailed care notes for each person. These included information about activities, behaviours, health issues and any monitoring that was taking place for the person and were read by incoming staff members at the start of each shift. Records of food and drink taken were maintained in people's files. Medical appointments and visits by health professionals were recorded along with the outcome for each. Important information was passed on to incoming staff members at a 'handover' at the beginning and end of each shift. Each person had a nominated key worker who was responsible for ensuring that care plans were updated. People knew who their key worker was and told us that they met with them regularly.

A wide range of activities took place at the home. On the first day of our inspection we observed a St Patricks Day party with live musicians, drinks and food. The majority of people at the home and visiting relatives joined the party and we saw that many people joined in with singing and dancing. This had replaced the regular weekly film show, and we noted that the posters about this had not been removed even though the posters for the party were placed next to them. We discussed the fact that this could be confusing for some people, and we saw that the posters about the film were immediately taken down. When we returned to complete our inspection, a film of a musical was showing in one of the lounges and this was well attended. Other activities included reminiscence activities, regular visits from a 'pet therapy' provider, music therapy, quizzes and exercise. At our second visit we saw that some chicks had been purchased and were told that the some people really enjoyed watching them grow. We observed a person accompanied by a staff member coming into the room to look at the chicks. The home was a member of NAPA [National Activity Provider's Association], a charity supporting meaningful activities for older people. The activities co-ordinator was working towards a NAPA qualification in activities support in adult social care.

The home had its own hairdressing salon and a hairdresser visited regularly. On the second day of our inspection we met the hairdresser and three people who were having their hair done. There was a friendly

and chatty atmosphere in the salon. One person told us, "I love having my hair done." The registered manager told us that a reflexologist had recently started working at the home one day each week. She told us that people who had received this therapy had enjoyed it, but that it was too early to assess longer term benefits as the reflexologist has only been coming for three weeks.

Two people were able to go out unaccompanied. We were told outings were regularly arranged for other people, for example, shopping trips and visits to places of interest and we saw records of these activities. A small shop had been set up in the reception area. The registered manager told us that this was designed to enable people to purchase small everyday items such as toiletries and confectionary without having to wait for a staff member to accompany them to the shops.

Monthly residents meetings took place on each unit. We looked at the notes of the most recent meetings and saw that people had been asked for their views about changes within the home and involved in discussions about planning activities and menus.

We saw that there was a complaints procedure which was available in an easy read format. People who lived at the home told us that they were able to complain. One person said, "I always say how I feel. It's asking properly that gets things done." We looked at the complaints log and saw that complaints had been addressed quickly and to people's satisfaction.

Good

Is the service well-led?

Our findings

The registered manager was supported by a deputy manager who had been recently appointed. Senior care workers were responsible for each unit, and were supported by the manager and deputy.

We reviewed the policies and procedures. These were up to date and reflected good practice guidance. There was a process in place to ensure that staff members were required to sign when they had read the policies.

The staff members that we spoke with told us that they felt that the manager was supportive and approachable. Family members told us they felt that the home was well managed. We saw that the manager and deputy manager spent time on the units and communicated positively with both people who used the service, their visitors and the members of staff who were on shift.

Staff members spoke positively about the management team and the support that they received. A care worker told us, "This is a good place. We are getting experience at a well-run and happy home." Staff members told us that the manager and deputy manager spent time with people who used the service, and would be involved with care where required. We saw evidence of this during our inspection.

There were systems in place to monitor the quality of service and we saw recorded evidence of these. We saw that quarterly health and safety monitoring took place, along with six monthly audits of systems and practices in relation to care. Food safety audits took place on a six monthly basis, and an annual infection control audit had been undertaken during the past year. We saw monthly monitoring records of care plans, medicines, falls, infection, and people's weights. Each of the monitoring records contained information indicating reasons for any concern, along with action plans with timescales for completion. We saw that appropriate actions had been put in place and addressed in a timely manner. The provider also undertook an annual compliance assessment of the home. The most recent was carried out in June 2015. We could see that actions arising from this assessment had been promptly addressed.

Regular monitoring of incidents, accidents and 'near misses' had also taken place and the provider had promptly submitted notifications to CQC where required.

Satisfaction surveys took place annually. The most recent survey of the views of people who lived at the home and their family members had been analysed and showed high satisfaction rates. Where issues had been raised, actions had been taken to address these. For example, a concern that clothes had not always been returned from the laundry had been addressed by labelling all items of clothing.

Minutes of staff team meetings showed that information and concerns arising from quality monitoring activities were regularly discussed. The registered manager told us that urgent information was communicated to staff immediately, and the staff members that we spoke with confirmed that this was the case.

Records showed the registered manager worked well with partners such as health and social care professionals to provide people with the service they required. Information regarding appointments, meetings and visits with such professionals were recorded in people's care files.