Nathu Limited

Nene Lodge Retirement Home

Inspection report

224 Bridge Road
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Spalding
Lincolnshire
PE12 9SG

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Date of inspection visit:
08 November 2022
09 November 2022

Date of publication:
01 December 2022

Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Nene Lodge Retirement Home is registered to provide accommodation and support for up to 52 older people. At the time of our inspection, there were 28 people living at the service.

People's experience of using this service and what we found
Guidance for staff about how to meet people's individual care needs and mitigate known risks, had not been consistently reviewed, kept up to date or made available.

The provider used a dependency tool to determine staffing levels required. However, this did not consider the layout of the building and the staff rota showed occasions when care staff levels were below what was expected.
People spoke positively about the service they received and highly of the management and staff team. However, examples were given of long wait times for calls for assistance and how staff were constantly busy and lacked time to spend with people.

Medicines management did not consistently follow expected best practice guidance. However, no person had come to harm.

The service was found to be clean and hygienic. Staff had access to personal protective equipment. Clinical waste was not disposed of as required. We discussed this with the provider who agreed to take action.

People's experience of visiting arrangements differed, with some people raising concerns about restrictions. The provider confirmed there were no restrictions and agreed to notify people and visitors of this.

Systems and processes that monitored quality and safety were not fully effective. Audits and checks were not always recorded to confirm checks had been completed and what the outcome was. This impacted on opportunities to continually develop and improve the service.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). At the time of the inspection, no person had a DoLS. However, we were concerned a DoLS was required for a person and asked the provider to submit an application.

Following the recent pandemic, resident and relative meetings had stopped. However, the provider was planning to introduce these again. People and relatives were confident they could raise any issues or concerns with the management team. Quality assurance procedures included an annual feedback survey for people and relatives to share their experience.

Safeguarding information was available to people. Staff had received training and understood their role and responsibility to protect people from abuse and avoidable harm.

Staff were positive about working at the service and the support they received. Visiting professionals gave positive feedback about their experience of working with staff to support people in their ongoing care needs.

For more details, please see the full report which is on the Care Quality Commission website at www.cqc.org.uk

Rating at last inspection
The last rating for the service was good (published 21 February 2020).

Why we inspected
We received concerns in relation risk management and staffing levels. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating. The overall rating for the service has changed good to requires improvement based on the findings of this inspection.

We have found evidence that the provider needs to make improvements. Please see the safe and well-led sections of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Nene Lodge Retirement Home on our website at www.cqc.org.uk.

We have identified two breaches in relation to the provider's governance systems and processes and staffing at this inspection.

Please see the action we have told the provider to take at the end of this report.

Follow Up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our safe findings below.

Nene Lodge Retirement Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

Inspection team
One inspector and an Expert by Experience completed the inspection. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Nene Lodge Retirement Home is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Nene Lodge Retirement Home is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

At the time of our inspection there was a registered manager in post.

Notice of inspection
The inspection was unannounced.

What we did before the inspection
We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service.

During the inspection
We spoke with 6 people who used the service and 2 relatives for their experience of the service. We also observed staff interaction with people to help us understand people's experience. We sought feedback from staff and spoke with the registered manager, the provider, assistant manager, 2 care workers, cook and relief cook and 2 domestic staff. We spoke with 3 visiting health care professionals.

We reviewed the care records of 5 people and multiple people's medicine records. We reviewed 3 staff files and a variety of records relating to the management of the service, including policies and procedures, audits and checks, staff deployment, dependency tool, meeting records and staff training.

Requires Improvement

Is the service safe?

Our findings

Safe
Safe – this means we looked for evidence that people were protected from abuse and avoidable harm. At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement.

This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Staffing and recruitment
● People raised concerns about staff deployment and having to wait for assistance. One person said, "Sometimes you do have to wait for help. There have been a couple of times when I have pressed the bell 3 times to get help. They [staff] tell me they are understaffed and busy." Another person said, "If I need the toilet, I have to ring the bell for help. I can wait, 5, 10, 15 minutes and I have had a couple of accidents when they haven't come in time. That isn't very nice for me." These examples show staff deployment had a negative impact on people.
● The provider used a dependency tool to calculate staffing levels required. However, this did not consider the size and layout of the building. Non care staff supported people during drinks and mealtimes but had not completed refresher training the provider expected staff to complete. This increased the risk that people were supported by staff not trained and competent to meet their care needs.
● The provider's dependency tool assessed 3 care staff were required for an evening shift. The staff rota for October 2022 showed examples of 5 occasions when 2 staff were allocated to work an evening shift. The registered manager told us the provider would have been on site. The staff rota showed a further 6 occasions when the provider was rostered to be the third care staff. This was a concern as whilst they assisted care staff with non-care tasks, they were unable to fulfil the role of a care worker.

The provider had failed to consistently deploy sufficient numbers of suitable qualified, competent and skilled staff. This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider had safe staff recruitment procedures. This included, Disclosure and Barring Service (DBS) checks, this provides information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions. Staff received opportunities to discuss their work.

Using medicines safely
● Medicines management did not consistently follow best practice guidance. Whilst staff had completed relevant training. They had not had their competency assessed. It is important to assess and monitor staff practice to ensure it is safe.
● Handwritten entries on Medicine Administration Records (MAR) did not have a second staff signature to ensure transcribing was correct. A body map was not used to record and monitor patch (pain relief

medicine) rotation. The importance of rotation is to reduce the risk of skin irritation. However, staff assured us the patch was rotated but not recorded.
● Medicines prescribed 'when required' did not record the reason for administration. This is important for monitoring purposes. One person had a missing staff signature for the 1 November 2022 which had not been picked up. Another person's prescribed medicine was not recorded on their MAR and a PRN protocol was in place to guide staff on safe administration. The registered manager took action to address this.
● People were positive about how their medicines were managed. One person said, "I take a lot of things, but I know what it is all for. I always get it on time." Another person said, "I don't have to worry about it. They come and give it to me. I am on my usual stuff."

Assessing risk, safety monitoring and management
● Guidance for staff about how to meet people's individual care needs lacked detail in places. Care plans and risk assessments had not consistently been updated. We saw examples of where records had not been reviewed since April 2022 despite people's needs or risks having changed. Staff showed a good understanding of people's individual needs and this was confirmed in feedback from external health care professionals. We therefore concluded this was a recording issue. We discussed this with the management team who agreed to review care records.
● Where people had specific health conditions, staff did not always have guidance of how this impacted the person and their care and support needs. However, we saw some examples of NHS Information fact sheets relating to some health conditions provided for staff to support their knowledge.
● Health and safety checks were completed on the environment, premises, equipment, including fire and risks associated with legionella. The registered manager also completed daily walk around checks. However, these checks were not always recorded. We noted wardrobes were not fixed to walls which was a potential safety hazard. The patio area was raised as a concern by a relative due to it being uneven and a potential trip hazard. The outdoor smoking area was also raised by a person as a concern in relation to its position. We discussed these concerns with the management team who agreed to review and take action.

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 MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)

● We found the service was not consistently working within the principles of the MCA. For example, we identified a person required a DoLS application submitting. We discussed this with the registered manager, and they agreed to complete this as a priority. The registered manager told us they would arrange further refresher training to further upskill all staff's understanding.

Learning lessons when things go wrong
● The registered manager analysed falls and incidents and considered themes and patterns to support any learning and required action to mitigate further risks. However, we were not sufficiently assured all reasonable action had always been taken to mitigate risks from occurring again.
● We were aware of an incident that had occurred in September 2022 that put a person at risk. The management team had not reviewed the person's risk assessment or taken any other action to mitigate the

risk, apart from informing staff to increase observations. However, this guidance was not recorded and there was no records to confirm additional monitoring was being completed.
● Falls analysis did not consider if the person had used their call bell, or if the call bell was within reach. People told us when they had experienced a fall, this was sometimes due to them being unable to reach the buzzer to call for assistance. We also observed, buzzers were not always in each reach for people. We discussed this with the management team who agreed to follow this up.

Systems and processes to safeguard people from the risk of abuse
● The provider had systems and processes to support people to remain safe as far as possible. This included people having information about how to report a safeguarding concern. People spoke positively about feeling safe. A person said, "I feel safe here. All the people that live here are peaceful people and don't bother me." Another person said, "It is quiet here. The staff come and check on me and make sure I am okay."
● Staff had received safeguarding training and had access to the provider's policy and procedure to support them. This included the providers whistle blowing policy. Staff confirmed they would use this procedure to report any safeguarding concerns.
● Staff understood their role and responsibilities to keep people safe. A staff member said, "Any unexplained bruising, a change in a person's usual behaviour may be a sign of abuse and I would report it."

Preventing and controlling infection
● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises. However, we identified clinical waste was not being disposed of via clinical waste bags. The provider agreed to review their practice.
● We were assured that the provider's infection prevention and control policy was up to date. However, we identified COVID-19 needed adding to the list of infections that required to be reported on. The provider had reported outbreaks as required this was a recording issue.
● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was supporting people living at the service to minimise the spread of infection.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was responding effectively to risks and signs of infection.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.

Visiting in care homes
● We received a mixed feedback about people's experience of visiting arrangements. Some people reported there were some restrictions and others not. The registered manager assured us there were no visiting restrictions. We asked them to contact people to confirm visiting arrangements, and they shared this information with us. This information confirmed there were no restrictions in place.

Requires Improvement

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At our last inspection we rated this key question good. At this inspection the rating for this key question has changed to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- The provider's systems and processes to assess, monitor and review quality and safety had some shortfalls. Guidance for staff about how to provide safe care and mitigate risks was either not consistently detailed, missing or was not reflective of people's current needs. Whilst staff were aware of people's needs, there was ongoing recruitment to fill 5 care staff vacancies. A lack of up to date and detailed guidance for new and current staff, raised the risk or people receiving inconsistent, safe and effective care.
- Governance audits and checks had not identified the concerns found during this inspection. Staff deployment had not been sufficiently assessed and monitored to ensure sufficient, trained and competent staff were available to meet people's needs. Whilst people were positive about living at the service, repeated concerns were raised about staffing levels and the impact this had on them.
- Medicines audits and checks were not sufficiently robust or recorded. Shortfalls identified during this inspection and reported in the key question of safe, had not been identified by internal checks.
- The management team had failed to recognise a person required a DoLS application submitting to the local authority for assessment. Without a DoLS authorisation a person may have been subject to restrictions without legal authority.
- The provider regularly attended the service but did not complete any audits and checks to assure governance, systems and processes were accurate and up to date. There was no improvement plan to continually improve the service.
- Health and safety audits and checks were not fully effective. From speaking with the management team and reviewing records, there was a lack of formal recording procedures to show how all areas of health and safety was monitored. The management team assured us checks were completed but acknowledged these were not always recorded. This lack of transparency and accountability impacted on management oversight and opportunities for learning.
- Incident analysis was completed monthly. From reviewing this information, it was not always clear of actions taken to mitigate further risks and how lessons learnt had been shared with staff.

The provider had failed to consistently assess, monitor and mitigate risks and to maintain accurate records. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good

outcomes for people
● Care staff had a positive approach and we observed positive, caring and compassionate care. However, we observed some examples of a lack of dignity such as a staff member not knocking on a person's bedroom door before entering. During lunchtime a staff member did not gain people's consent before putting clothes protectors on, gravy was poured without asking people if they wanted it. A staff member stood and assisted a person to eat a couple of mouthfuls of food then left and returned. We shared this information with the management team who agreed to follow up with staff.
● People spoke positively about living at the service. A person said, "It is very homely and friendly. I am very happy, and it is nice and quiet which I like." Another person said, "There is a warmth here and people seem to work as a team. It is like you are part of a big family."
● Staff were positive about working at the service. A staff member said, "All the staff work extremely hard, we have a common goal to provide the best care we can. The quality of care and safety is never compromised. We just need more staff." Another staff member said, "Staff morale most of the time is good, I enjoy working here, the management team are all very supportive."

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
● The registered manager was aware of their responsibility to be open and honest when things went wrong. They were open and honest during the inspection and about the challenges they were experiencing in recruiting staff and the impact this had. They were aware documentation had some shortfalls but said their priority was to ensure people needs came first.
● People spoke highly of the registered manager and provider's approach, leadership and communication. A person said, "[Name] is a really good manager. They will always listen to you. The home seems to run itself and that is a sign that the home is well managed." Another person said, "The manager is very friendly and will always help you, they do a good job and they will always listen to you. They seem to organise people well."
● The registered manager understood information sharing requirements. They had sent notifications to the Care Quality Commission as required by law.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● People felt involved and informed by staff. Resident and relative meetings had not yet been reintroduced following the pandemic. The registered manager told us they would be doing this. However, people told us they had regular contact with the registered manager and felt involved and consulted. A person said, "We have had some resident meetings, but we can get things done by just talking at any time. You just speak to any of the staff. The manager and owner will always make time for you."
● People received opportunities to share their experience by a feedback survey. We reviewed feedback received in 2021 and saw this was consistently positive. The registered manager told us they were aware they were due to repeat this opportunity again for people and had plans to do this. □
● Staff told us they received opportunities to discuss their work and development needs. Whilst staff meetings had not happened, staff attended daily handover meetings and used a communication book as an additional method to exchange information.

Working in partnership with others
● Feedback from three external visiting professionals was consistently positive. This included staff making appropriate and timely referrals. Staff following any recommendations made and being organised and supportive during visits.
● People were positive about staff working with external health care professionals. This was confirmed by a

person who said, "If you are unwell, they [staff] will get the doctor or an ambulance. They will come to your room to see how you are."

● Care records confirmed how staff worked with external agencies in people's ongoing care needs.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to have robust systems and processes to assess, monitor and review quality and safety. Records had not been kept up to date or were accurate. Regulation 17 (1) (2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to consistently deploy sufficient, qualified and competent staff to meet people's individual care needs and safety. Regulation 18 (1)