Lynn of Lorne Care Home
Care Home Service

Benderloch
Oban
PA37 1QW

Telephone: 01631 720278

Type of inspection: Unannounced
Inspection completed on: 15 December 2016

Service provided by:
McKenzie Care Homes Ltd

Service provider number:
SP2011011754

Care service number:
CS2011305842

About the service

Lynn of Lorne is a registered care home. The provider is McKenzie Care Homes Ltd.

The home is situated in the village of Benderloch near Oban. The service was registered on 3 April 2012 to provide 24 hour care to 62 older people. Four places were available for short breaks or respite care.

The building is divided into four care units, two on each floor. Access to the first floor is by lift or stairs. Each unit has a lounge/dining area. All bedrooms are single rooms with en-suite toilet. Bathroom and shower facilities were available on each floor but one shower room was out of order and problems persist with water pressure affecting use of these facilities.

The home has car parking and gardens with seated areas.

The service's philosophy states "to provide care and support for you, consistent with your care needs, whilst supporting you to live as independently as possible."

What people told us

We spoke with five service users who all told us they were content and had no issues or concerns.

We spoke with two relatives who gave the following comments:
"It's much fresher since the new manager took over I feel things are cleaner."
"Things are fine, it's just the staffing - they keep changing and the manager's new too."

Self assessment

The manager submitted a self assessment as requested by the Care Inspectorate. This set out how the service rated itself against the quality themes and standards and identified areas for development. This was comprehensive and gave detailed accounts of strengths as well as areas for improvement.

From this inspection we graded this service as:

Quality of care and support	3 - Adequate
Quality of environment	3 - Adequate
Quality of staffing	2 - Weak
Quality of management and leadership	2 - Weak

Quality of care and support

Findings from the inspection

There were many service users and relatives that were satisfied with the service. We saw this through the cards and letters of appreciation sent by relatives. Some relatives' and residents' meetings had taken place. This helped to give people a chance to feedback on the quality of the care experience.

Staff were very busy and at times this could affect care outcomes for service users.

We observed a mealtime in Greenwood unit. There were long waits between courses and some service users could not be given the encouragement and support needed due to the way the mealtime was organised. Staff told us five service users needed full assistance and the remainder needed support and encouragement with meals but there were only three members of staff available. This meant the mealtime experience was affected and some service users may not have been provided with sufficient support with their meals. We discussed the benefits of a mealtime plan to allocate staff to assist those who needed full assistance first before serving the main meal. (See recommendation 1.)

Staff told us at times service users have to wait for assistance to go to the toilet or receive help with the management of incontinence. Staff also told us supervision of service users at risk of falling was sometimes very difficult.

During our visit a service user with dementia was in pain with unknown cause and was transferred out of bed whilst in pain. This caused the service user distress. Although medical attention was sought for this service user we could not see any record of a full body check or pain assessment being carried out. (See requirement 1).

The issue above was highlighted in a letter of serious concern to the service on 16 December 2016 an action plan has been supplied to address some of the issues raised with regards to falls management, incident reporting and use of pain assessment tools.

We observed a service user with reduced swallowing function partially choking for a short period of time. The staff responded to this appropriately. However, there was no risk assessment in place for choking and at times he was left for very short periods of time unsupervised with food in front of him. (See recommendation 1).

The issue above was also highlighted in the letter of serious concern. Actions were started in relation to:
- staff training in use of emergency buzzer.
- full care planning and risk assessment format being reviewed and staff training planned.
- mealtime experience audits have been commenced.

The personal plans written to support service users' care were mostly quite detailed and up-to- date. Development was ongoing to ensure personal preferences were recorded.

Six monthly personal plan reviews involving the service user and/or their representative had not been taking place. This system had not been kept up-to-date due to management changes. (See requirement 2).

Medication records were satisfactory but improvements could be made. The front sheets did not have special instructions to identify allergies or swallowing issues. A small number of service users had medication disguised in food or drink (covert) medication. There was no written instruction from the pharmacist to agree the method of disguise and this was not recorded clearly enough in care plans or in the medication folder.

The service had not agreed the use of homely remedies with GP.'s and these were not available to service users. This meant prescriptions had to be raised for medications available over the counter such as simple linctus and paracetomol. This should be reviewed to enable an agreed list of homely remedies to be used within agreed policy and protocols. (See recommendation 2).

A recent audit by the supplying pharmacy showed improvements were being made to medicine management and there were no concerns noted.

Requirements

Number of requirements: 2

1. The service provider must ensure appropriate action is taken in the event of service users with dementia exhibiting pain of unknown cause. This must include:
- carrying out an assessment in order to determine the cause.
- recording changes to demeanour and actions taken.
- use of incident records and escalation of reporting.
- consider other methods of relieving pain and providing comfort.

This is in order to comply with SSI 2011/ 210 Regulation 4(1)(a) Welfare of users.
Timescale by 31 January 2017.

2. The service provider must ensure personal plans of service users are reviewed every 6 months using a process which involves the service user and/or their representative.

This is in order to comply with SSI 2011/ 210 Regulation 5(2)(b) Personal Plans.
Timescale by 31 March 2017.

Recommendations

Number of recommendations: 2

1. The service provider should improve the organisation and support provided to service users at mealtimes. This should involve:

- an improved mealtime plan should be prepared for each unit to set out the type of diet, special instructions and support needed by each service user and the appropriate allocation of staff made to provide either one-to-one or group support. The mealtime should be staggered so that appropriate supports can be provided depending on the number of staff available.

- If a service user is at risk of choking a swallowing risk assessment should be put in place to highlight this risk and consider levels of supervision and support required.

- the service should consider the use of nutrition champion to support food fortification for service users losing weight and to lead and support staff in following best practice.

- regular audits of mealtimes should be carried out to identify learning points and to ensure the best support and experience possible.

National Care Standards for care homes for older people, Standard 13.9 Eating Well.

2. The service provider should ensure medication records and practices improve as follows:

- review the use of photo front sheets to ensure these are securely put together and clearly record any special instructions such as allergies, swallow changes or covert medications.

- review any service user who has covert medication to ensure there are written instructions available from the pharmacist for each medication to be disguised and it is clear what the agreed method of disguise is. The number of medications for disguise should be clearly identified on the medication administration record for staff to see easily. Covert medications should be reviewed regularly and the practice kept to an absolute minimum.

- an agreement should be made as to the use of homely remedies.

- valuable items must not be stored in the controlled drug cupboard. These should be removed and stored appropriately in the office safe or returned to families.

- the tracking of medication using the quantity in and number count down should be checked regularly for any inaccuracy.

National Care Standards for care homes for older people, Standard 15.6, 15.9, 15.11 - Keeping Well - Medication.

Grade: 3 - adequate

Quality of environment

Findings from the inspection

We walked round each of the care units. All areas were observed to be clean and tidy.

Efforts had been made to decorate rooms for Christmas and there was a pleasant atmosphere.

There were long standing issues affecting the bathrooms and shower rooms. Staff told us the water pressure meant use of baths and showers was problematic. This was particularly first thing in the morning. (See requirement 1.)

The bathrooms viewed were not homely, needed repairs and some contained items which should be stored elsewhere such as mattresses, wheelchairs and walking aids. One had a missing toilet seat. One had no lock. One shower room was out of use and needed repairs. A shower chair was noted to be dirty, the seat canvas had not been cleaned and was badly stained. (See requirement 2).

We noted that there was a free standing heater in a room and many of the wall fixed heaters had sharp edges and wires which hung loose. These health and safety issues were not well identified and we could not see risk assessments in place or action plans to address these issues. (See requirement 3).

Some furnishings, door and corridor edges were damaged. The environment had not been sufficiently adapted to suit older people with dementia. (See recommendation 1).

Issues raised in this section of the report have been subject to a specific condition of registration (condition 3) which was not met.

A serious concern letter highlighted the need for immediate action following this inspection.

Action taken included:
- plumber visited the home and work is on-going to fix the leak in Greenwood shower room.
- shower in Rowan unit has been improved.

Requirements

Number of requirements: 3

1. The service provider must improve the availability of hot water in order to be able to run a bath or shower at any time this is needed.

This is in order to comply with SSI 2011/ 210 Regulation 10(2)(a)(b)(d) Fitness of Premises.

Timescale by 31 January 2017.

2. The service provider must improve bathrooms and shower rooms to ensure they are well maintained and homely.

This is in order to comply with SSI 2011/ 210 Regulation 10(2)(a)(b)(d) Fitness of Premises.

Timescale by 31 March 2017.

3. The service provider must ensure essential health and safety checks are carried out and action plans produced to rectify any issues identified. This must include:

- risk assessments for free standing heaters
- a review of wall fixed heaters to ensure safe use and a replacement plan.

This is in order to comply with SSI 2011/ 210 Regulation 10(2)(a)(b)(c)(d) Fitness of Premises.

Timescale by 28 February 2017.

Recommendations

Number of recommendations: 1

1. The environment should be audited and plans put in place to address:

- maintenance issues,
- furnishings which need replacement and
- improvements to ensure a more "dementia friendly" environment.

National Care Standards for care homes for older people, Standard 4 - Your Environment.

Grade: 3 - adequate

Quality of staffing

Findings from the inspection

We were told that agency use at the service had reduced and staffing was more stable than it had been in recent months. Changes had been made to staff deployment and this was being constantly reviewed by the manager.

The staffing schedule which is a condition of registration sets out the minimum staffing numbers and skill mix. This was not being met on a regular basis in terms of both numbers and skill mix. Staff told us they often worked short and often there was only one nurse. (See requirement 1).

Nurses and some senior carers were trained to administer medications. These staff told us they spent most of their time doing medication rounds. This left little time for other nursing duties, supervision of staff and development of best practice. Some senior carers were yet to complete medication training. This could help alleviate some of these pressures. However, review of staff roles to ensure clearer clinical and shift leadership would also be beneficial. (See recommendation 1).

Staff told us there was distrust between staff groups such as day-staff and night-staff. This could lead to a lack of team work.

We noted two staff members who were not registered appropriately with the Scottish Social Services Council (SSSC). (See requirement 2).

Staff supervision and appraisal systems were not fully developed or being used to best effect. The allocation of staff to lead on clinical developments such as nutrition, falls or dementia had been disrupted by staff changes. (See recommendation 2).

The care home was involved in a Scotland wide programme in helping to reduce pressure ulcers and improve practices.

Overall, there had been a lot of staff changes and each unit lacked a clear unit leader. Staff shortage was blamed on last minute call offs by staff. The effect being that cover was often difficult to arrange. Ways of reducing absence and ensuring cover should be put in place. (See recommendation 3).

Requirements

Number of requirements: 2

1. The service provider must comply with the staffing schedule set by the Care Inspectorate which is a condition of registration.

This is in order to comply with SSI 2011/ 210 Regulation 15(a) and Condition 2 of registration certificate.

Timescale by 31 January 2017.

2. The service provider must ensure nursing and care staff are registered appropriately for the role they perform.

This is in order to comply with SSI 2011/ 210 Regulation 9(2)(c) Fitness of employees.

Timescale by 31 January 2017

Recommendations

Number of recommendations: 3

1. The service provider should review staff roles (nurses, senior care assistants and care assistants) to ensure there is clear clinical and shift leadership and support for best practice to be developed.

National Care Standards for care homes for older people, Standard 5.4 Management and staffing arrangements.

2. The service provider should introduce appropriate supervision and appraisal systems that help to support staff in the roles they are being asked to perform. This should also help to drive improvement by considering leadership and additional responsibilities such as "champion" roles. For example, in nutrition, falls and dementia care.

National Care Standards for care homes for older people, Standard 5.3 Management and Staffing Arrangements.

3. The service provider should look at ways to ensure staff cover is always maintained by:

- encourage staff to provide as much notice as possible of any staff absence.
- remind staff of their codes of practice and responsibilities to adhere to these.
- ensure whenever a call off call is taken a clear protocol is available for staff to follow.
- records should be kept on a daily basis of actions taken.

National Care Standards for care homes for older people, Standard 5.7 Management and Staffing Arrangements.

Grade: 2 - weak

Quality of management and leadership

Findings from the inspection

There was positive feedback on the effect the new manager was having on the running of the home. However, there were management weaknesses which result from poor external support, lack of systems and lack of a full management team.

We saw a basic weekly report which gave numbers of admissions, discharges and so on. There were no measures of quality of care used to inform the weekly report.

There was no effective quality assurance framework in operation. There was an overall lack of audit of care or checking of how standards and systems were being used. For example, six monthly reviews and personal plan audits were not being carried out. Maintenance records had not been checked to show a manager overview.

There had been some recent relatives and residents' meetings which gave some feedback on the care experience. This could be developed further to ensure individual feedback is obtained and linked to the six monthly review process.

The manager had not been given a comprehensive induction into the home manager role and there were no recent supervision records to show the manager was being well supported. This was often done by phone and there was a lack of direct external support provided.

There was no depute manager and no allocated unit managers to provide clear leadership within the home and to ensure appropriate back up in the manager's absence.

Although dependency calculations were made these were inaccurate. This meant it was not possible to see if staffing was sufficient. A new calculation was made and this showed staffing was within the average zone. However, this did not take into account the quality of the service or the environment and we could not see if staff absence was also taken into account. See staffing section for requirement made.

The manager frequently worked "on the floor" due to staff shortages. This meant the home was lacking in management support and systems were not being kept up-to-date.

Notifications had not been made to the Care Inspectorate about significant issues. This was discussed with the manager and copies of the notification guidance was supplied.

Overall, management structures both external to the home and within the home need improvements. This should be reviewed to consider structure, roles and staffing compliments. Quality assurance systems need review and improvement. (See recommendation 1).

In order to be able to track progress with actions to be taken a service improvement plan should be put in place. (See recommendation 2).

A letter of serious concern was issued to the service on 16 December 2016 and the management team have started to carry out the following:

- A full review of accident and incident reporting and record keeping, with training sessions for staff, in particular nurses who may be in charge of the home in the manager's absence.

- A memo was sent to staff with the procedure to follow in the event of an incident/accident.

- A full accident and incident audit, analysis and action planning system will be introduced to allow necessary action to be taken to support residents.

- recruitment for a depute manager and/or unit managers.

Requirements

Number of requirements: 0

Recommendations

Number of recommendations: 2

1. The service provider should review management structure both externally and internally to the service. This should include a review of roles and responsibilities, staffing structure and quality assurance systems.

National Care Standards for care homes for older people, Standard 5 Management and staffing arrangements.

2. The service provider should use an overall service improvement plan to track and show progress in response to actions to be taken. Actions will result from regulatory reports, internal audit and results of investigations such as complaints, accidents or incidents.

National Care Standards for care homes for older people, Standard 5 Management and staffing arrangements.

Grade: 2 - weak

What the service has done to meet any requirements we made at or since the last inspection

Previous requirements

Requirement 1

The provider must ensure a system is in place for the applying of knowledge in practice being explored more fully in regular one-to-one supervision and staff appraisals.
a. The provider must ensure that management support includes the monitoring and development of staff professional development and practice. Clear systems must be documented to evidence the competence of staff on completion of training and in ongoing practice.

This requirement was made on 14 July 2015.

Action taken on previous requirement
Some supervision sessions were taking place. Staff appraisals were still to be put in place. Staff competence and systems to assess this were still being developed. We have commented on this is the staffing section of this report. Further recommendations have been made. A requirement has been made in relation to staffing.

Met - outwith timescales

Requirement 2

The provider must be able to evidence that people who use the service have a good quality of life. This must reflect service users' interests, needs and beliefs. The provider must ensure that there is sufficient staff support available to undertaken assessments that assist service users to fulfil their potential and aspirations. Documentation must contain clear goals and outcomes when planning and delivering Care Plans. This is still ongoing and reported in the body of this report.

This requirement was made on 14 July 2015.

Action taken on previous requirement
Care outcomes were at times being affected by the quality of staffing. We have made a separate requirement in relation to staffing in this report.

Documentation is an ongoing area for development. We have made a separate requirement in this report regarding the 6 monthly review of personal plans.

Met - outwith timescales

Requirement 3

The provider must ensure staffing levels, staff skills and abilities are at all times appropriate to meet the health and welfare of people who use the service
In order to achieve this provider must:

- undertake a full analysis of service users' dependency level of needs to determine the level of staffing required and identify where possible that if a service users' needs fluctuate this is taken into consideration.

- ensure that care staffing levels are deployed on each shift to fully meet the needs of service users; where increased support is required, for example if a service user is ill or requires end of life care there should be appropriate staffing levels to provide this.

- ensure that service users' needs are not compromised by care staff also undertaking other duties.

- review staff deployment for service users in relation to the layout of the building over a 24 hour basis, ensuring that supervision of service users is provided in sitting rooms and that service users can retire to bed when they wish.

- ensure service user dependency levels are regularly updated and regular audits completed to monitor compliance of staffing levels and staff deployment in the home.

This is to meet the following requirement:
The Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011, No 210: Regulation 15(a)(b) - to make proper provision of sufficient staff.

This requirement was made on 30 November 2016.

Action taken on previous requirement
The manager had started to analyse dependency levels to help determine staffing needs. However, there were problems with the use of the dependency tool and this was inaccurate.

Changes had been made to staffing deployment and a daily allocation sheet was in use to allocate staff to where they were most needed.

Staffing was still being affected by last minute call offs by staff. This has been commented on in the staffing section of this inspection report and a new requirement has been made.

Not met

What the service has done to meet any recommendations we made at or since the last inspection

Previous recommendations

Recommendation 1

During the first week in the home and at least every six months after that service users will receive a full assessment of all their health care needs and staff will record all assessments and reviews of their Health care needs.
National Care Standards Standard 14.3

This recommendation was made on 18 November 2016.

Action taken on previous recommendation
Personal plans included recognition of health needs. New service users were referred to GP.'s for assessment of health needs and other health care professionals as required.
This recommendation is met.

Recommendation 2

Activities and outings should be organised and take place on a regular basis and give the resident the choice whether to participate or not.
National Care Standards Statement 17 .1

This recommendation was made on 18 November 2016.

Action taken on previous recommendation
There were two staff who were allocated as activity organisers. There was evidence of regular activities taking place. The development of activities to be more suitable for older people with dementia was an ongoing area for development.
This recommendation is met.

Recommendation 3

The residents can expect that the rooms and corridors are kept in good decorative order and that the home and furnishings are well maintained.
National Care Standards Standard 4.8

This recommendation was made on 18 November 2016.

Action taken on previous recommendation
There were many issues identified with the environment in this inspection. See environment section.
Requirements and further recommendations have been made.

Recommendation 4

Agency staff should receive pertinent information to enable them to safely and caringly carry out their required tasks.
National Care Standard 5.

This recommendation was made on 18 November 2016.

Action taken on previous recommendation

The use of agency staff had dropped. We spoke with one regular agency staff member who told us there was good handover information and communication had improved recently at the service.
This recommendation is met.

Recommendation 5

50% of staff should be trained to at least SVQ2 level.
National Care Standards Standard 5 Management and staffing arrangements.

This recommendation was made on 18 November 2016.

Action taken on previous recommendation

Information relating to the percentage of nursing and care staff with qualifications was seen. Out of 48 staff 24 had qualifications.
This recommendation is met.

Recommendation 6

The provider should review the domestic tasks that night care staff undertake. This is to ensure that service users have the opportunity to sleep undisturbed from noise and care staff are available to respond to their needs.
National Care Standards Standard 4 and Standard 6.

This recommendation was made on 30 November 2016.

Action taken on previous recommendation

The manager had reviewed staff duties and there were no reports of noise disturbance at night.
This recommendation is met.

Recommendation 7

The provider should ensure that :
- they have systems in place to communicate effectively with service users families and their representatives.
- staff are aware of their responsibility to do so.
- staff know how to respond appropriately when answering phone calls made to the care home.

National Care Standards Care Homes for Older People Standard 6 Support Arrangements.

This recommendation was made on 21 September 2016.

Action taken on previous recommendation

The manager had taken steps to ensure regular communication with families especially those who live a distance away. This included e-mails, telephone calls and supply of the newsletter.
This recommendation is met.

Recommendation 8

The provider should ensure that all areas of a person's needs are assessed and when required obtain specialist advice such as an Occupational Therapist to ascertain how they can be met
National Care Standards Care homes for Older People Standard 6 Support Arrangements.

This recommendation was made on 21 September 2016.

Action taken on previous recommendation

We were told there had been regular contact with health care professionals including the occupational therapist in order to assess and obtain specialist advice.
This recommendation is met.

Recommendation 9

The provider should ensure that where a service user has an identified skin condition and a skin care plan is in place it should be fully implemented.

The provider should also:
- Ensure that the skin care plan is updated with all of the assessed areas of needs.
- Where creams are prescribed and topical charts used, these are fully completed and topical applications recorded as per the medication administration sheet.
- Where a service user requires support with types of clothing, blankets and environment to, for example reduce heat, this is included in the skin care plan and staff ensure the service user is supported at all times to achieve this.
- Where a service user requires support to maintain their dignity due to partly removing clothing there is full support by staff to ensure this is provided.
- The provider should on a regular basis audit the skin care plan to ensure all staff are compliant and the skin care plan continues to be effective.

National Care Standards Care homes for Older People Standard 14 Keeping well Health care Standard 5 Management and Staffing arrangements.

This recommendation was made on 21 September 2016.

Action taken on previous recommendation

We saw that there were records kept of cream applications using the "responsibility folder". This included a topical medication administration record which was completed by care staff who had additional training. Skin care plans were in use. No specific issues were noted in relation to skin care. Staff had attended recent training and this remains an ongoing area for development. The use of clinical leads or "champions" is commented on in this inspection report. See staffing section.
This recommendation is met.

Complaints

Please see Care Inspectorate website (www.careinspectorate.com) for details of complaints about the service which have been upheld.

There were two complaints made to the Care Inspectorate which were upheld. Requirements and recommendations were made in the complaint reports and these have been followed up as a part of this inspection.

Enforcement

No enforcement action has been taken against this care service since the last inspection.

Inspection and grading history

Date	Type	Gradings	
29 Aug 2016	Unannounced	Care and support Environment Staffing Management and leadership	3 - Adequate 3 - Adequate 3 - Adequate 3 - Adequate
8 Dec 2015	Unannounced	Care and support Environment Staffing Management and leadership	Not assessed Not assessed Not assessed Not assessed
14 Jul 2015	Unannounced	Care and support Environment Staffing Management and leadership	3 - Adequate 4 - Good 3 - Adequate 3 - Adequate
31 Oct 2014	Unannounced	Care and support Environment Staffing Management and leadership	2 - Weak 2 - Weak 3 - Adequate 2 - Weak
22 May 2014	Unannounced	Care and support Environment Staffing Management and leadership	2 - Weak 3 - Adequate 3 - Adequate 2 - Weak
16 Jan 2014	Unannounced	Care and support Environment	4 - Good 4 - Good

Date	Type	Gradings	
		Staffing Management and leadership	4 - Good 4 - Good
17 Jun 2013	Unannounced	Care and support Environment Staffing Management and leadership	4 - Good 3 - Adequate Not assessed Not assessed
4 Feb 2013	Unannounced	Care and support Environment Staffing Management and leadership	Not assessed 2 - Weak 3 - Adequate Not assessed
19 Jun 2012	Unannounced	Care and support Environment Staffing Management and leadership	3 - Adequate 2 - Weak Not assessed 3 - Adequate

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