Mrs Christine Lyte

Caythorpe Residential Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement
Is the service safe?	Requires Improvement
Is the service effective?	Requires Improvement
Is the service caring?	Good
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Overall summary

Caythorpe Residential Home provides accommodation for up to 14 people who need personal care. The service provides care for older people, some of whom live with dementia.

There were 14 people living in the service at the time of our inspection.

This was an unannounced inspection carried out on 17 February 2015. There was a registered manager who was also registered as being the provider of the service. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are a 'registered person'. Registered persons have a legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. In this report we refer to the registered manager as being 'the registered person'.

The Care Quality Commission is required by law to monitor how a provider applies the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS)

Summary of findings

and to report on what we find. DoLS are in place to protect people where they do not have capacity to make decisions and where it is considered necessary to restrict their freedom in some way. This is usually to protect themselves. At the time of our inspection one person was being deprived of their liberty and records showed that this was being done in a lawful way.

We found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because there were not always enough staff to ensure that people promptly received all of the care they needed. In addition, the registered person had not protected people against the risks of inappropriate or unsafe care by regularly assessing and monitoring the quality of the service provided. We also found a breach of the Care Quality Commission (Registration) Regulations 2009. This was because the registered person had not notified us about all incidents that had affected the wellbeing of people who lived in the service. You can see what action we told the registered person to take at the back of the full version of this report.

There were not always enough staff on duty to ensure that people promptly received all of the care they needed. The registered person had not notified the Disclosure and Barring Service that a former member of staff might need to be barred from working in health and social care provision. Some of the arrangements in place to protect people from risks to their health and safety were not robust. Staff knew how to recognise and report any concerns so that people were kept safe from harm. People's medicines were safely managed. Background checks had been completed before new staff were appointed.

People had not been consistently helped to eat and drink enough to stay well. Staff had been supported to assist people in the right way including people who lived with dementia and who could become distressed. Staff had ensured that people had received all of the healthcare assistance they needed. People's rights were protected because the Mental Capacity Act 2005 Code of Practice and the Deprivation of Liberty Safeguards were followed when decisions were made on their behalf.

People were treated with kindness, compassion and respect. Staff recognised people's right to privacy and promoted their dignity. Staff managed private information about people in a confidential way.

People had not been fully consulted about all of the care they wanted to receive. They had not been assisted to obtain the services of a hairstylist. People were not always offered the opportunity to pursue their interests and hobbies. People had received all of the practical assistance they needed including people who lived with dementia and who had special communication needs. In addition, people had been supported to celebrate diversity by fulfilling their spiritual needs. There was a system for handling and resolving complaints.

Quality checks had not been consistently effective. People had not been fully consulted about the development of the service. The registered person had not developed extensive links with the local community. People had not benefited from staff being involved in local and national good practice initiatives. The service was run in an open and inclusive way that encouraged staff to speak out if they had any concerns.

Summary of findings

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 consistently safe.

There were not enough staff on duty to give people the care they needed.

People had not always been helped to stay safe by managing risks to their health and safety.

Concerns about a former member of staff had not been reported to the national barring service.

Staff knew how to recognise and report any concerns in order to keep people safe from harm.

Medicines were managed safely.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People were not reliably helped to eat and drink enough to stay well.

Some parts of the accommodation did not effectively meet people's individual needs.

People had received all the medical attention they needed.

Staff had been supported to provide the right care including reassuring people when they became distressed.

People's rights were protected because the Mental Capacity Act 2005 Code of practice and the Deprivation of Liberty Safeguards were followed when decisions were made on their behalf.

Is the service caring?

Good

The service was caring.

Staff were caring, kind and compassionate.

They recognised people's right to privacy and promoted people's dignity.

Private information about people who lived in the service was kept confidential.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People had not been fully consulted about all of the care and other services which they wanted to receive.

People had been supported to celebrate diversity by fulfilling their spiritual needs.

Summary of findings

People had not always been supported to pursue their hobbies and interests.

Staff had provided people with the practical care they needed including people who lived with dementia and who had special communication needs.

There was a system to receive and handle complaints.

Is the service well-led?

Quality checks had not reliably ensured that people always received the care and had the facilities they needed.

People had not been effectively asked for their opinions of the service so that their views could be taken into account.

The registered person had not developed extensive links with the local community.

People had not benefited from the registered person taking part in local and national good-practice initiatives.

The registered person knew the service well and ensured that staff were supported.

Requires Improvement

Caythorpe Residential Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection 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.

We visited the service on 17 February 2015. The inspection team consisted of an inspector and an expert by experience. An expert by experience is a person who has personal experience of using services or caring for someone who requires this type of service.

During the inspection we spoke with nine people who lived in the service, four care workers, the chef and the registered person. We observed care and support in communal areas, spoke with people in private and looked at the care records for five people. We also looked at records that related to how the service was managed including staffing, training and health and safety. After the inspection visit we spoke with three relatives.

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

Before our inspection we reviewed the information we held about the service. We reviewed notifications of incidents that the provider is required by law to send us. In addition, we contacted local commissioners of the service and a representative of a local primary healthcare team who supported some people who lived in the service. We did this to obtain their views about how well the service was meeting people's needs.

Requires Improvement

Is the service safe?

Our findings

The registered person had not taken appropriate steps to ensure that there were sufficient staff employed to provide people with the care they needed. People who lived in the service and their relatives said that the service was not adequately staffed. A person who lived in the service said, "The staff are far too rushed in the afternoon. They've got to help people in their bedrooms, people in the lounges, sort out the tea time meal and on top of that do all of the medicines. It's not do-able." A healthcare professional said that they considered staff often to be rushed in the afternoon and that this resulted in some people not promptly receiving all of the care they needed.

During the afternoon when we were in the service the number of care workers on duty was in line with the provision that the registered person said was necessary. However, we found that this level of staff cover was not enough to enable people to promptly receive all of the care they needed. Two people who were said to need regular support were receiving care in their bedrooms. However, when we observed their bedrooms for a period of half an hour staff did not visit them. At the end of this period we visited both of these people and found that they needed assistance. One person had dropped their cup of tea and could not reach it. The other person was sitting uncomfortably because an item of clothing had become displaced.

Shortly after this we observed three people who were seated in the main lounge. For most of the time no staff were present because they were assisting people elsewhere. Nearly all of the people sat without any interaction and were passive. Towards the end of the time two people rose to their feet and walked about the room in circles without any apparent purpose. Both were unstable and were at risk of falling. Another person was distressed[HL1] and called out for staff to assist them to use the bathroom. During this time we heard the call bell sound on two occasions which indicated that people in other parts of the service wanted assistance. On both occasions the call bell sounded for longer than the response time that the registered person considered to be acceptable.

We noted that one person who lived with reduced capacity had not always been supported in the right way. Shortly before our inspection, this had resulted in the person leaving the service on their own in the evening when it had not been safe for them to do so. Although staff had been reminded about the need to closely monitor this person's whereabouts this was not always possible because there were not enough staff. For example, we saw that the person was distressed when seated in the lounge but that no staff were present to respond and provide reassurance.

These shortfalls had reduced the registered person's ability to ensure that people promptly received all of the care they needed.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered person had taken steps to ensure that only appropriate people were employed to work in the service. This involved completing background checks before staff were appointed. This process included checking that staff did not have criminal convictions and had not been guilty of professional misconduct. In addition, other checks involved obtaining references from previous employers. These measures helped to ensure that new staff could demonstrate their previous good conduct which made them safe to work in the service.

However, we noted that the registered person had been concerned about the conduct of a former member of staff. This was because the person had not always acted in the best interests of people who lived in the service and may have been unkind and harmful in their approach. We found that the registered person had not correctly responded to this situation because they had not notified the Disclosure and Barring Service so that other employers could be alerted to the concerns that had been raised. This shortfall had reduced the registered person's ability to ensure that people who use health and social care services were safeguarded from harm.

However, records did show that staff had completed training in how to keep people safe from abuse. In addition, staff said that they had been provided with relevant guidance. We found that staff knew how to recognise and report a situation that could result in people experiencing harm so they could take action to keep people safe.

Staff had identified possible risks to each person's safety and had taken action to promote their wellbeing. For example, people had been provided with soft cushions and mattresses that helped to reduce pressure on their skin. Staff had also taken action to reduce the risk of people

Requires Improvement

Is the service safe?

having accidents. For example, people had been provided with equipment to help prevent them having falls. This included people benefitting from using walking frames, raised toilet seats and bannister rails. Some people had rails fitted to the side of their bed so that they could be comfortable and not have to worry about rolling out of bed. Each person had a personal emergency evacuation plan to ensure that staff knew how best to assist them should they need to quickly leave the building.

There were reliable arrangements for ordering, storing, administering and disposing of medicines. We saw that there was a sufficient supply of medicines and they were stored securely. Senior staff who administered medicines had received training and we noted that they correctly followed the provider's written guidance to make sure that people were given the right medicines at the right times. People were confident in the way staff managed their medicines. A person said, "The staff do my tablets for me so I don't get them muddled up. I'm quite happy with that."

Requires Improvement

Is the service effective?

Our findings

Some of the arrangements used to ensure that people who were at risk of not having enough nutrition and hydration and who needed extra help were not robust. People's body weight had not been measured as frequently as the registered person considered to be necessary. In addition, some of the weights that had been taken had not been recorded correctly. These shortfalls made it more difficult for staff to notice any changes that might need to be referred to a doctor.

Two people were considered to be at risk of not drinking enough to promote their good health. Although staff had correctly recorded how much the people were drinking each day they had not been given clear guidance about how much they should drink. Some staff were not familiar with all of the signs to indicate that someone was at risk of becoming dehydrated. In addition, there was no clear system to guide staff about what action to take if they became concerned that a person was not having enough hydration.

Although other care records for the people concerned did not indicate they had experienced any direct harm the oversights had increased the risk of them not eating and drinking enough.

People said that staff were reliable and had their best interests at heart. A person said, "All of the staff know me and I'm quite happy because they seem to work together as one team. They don't pull in different directions and they want what's right for us."

Staff had periodically met with the registered person to review their work and to plan for their professional development. Care workers had been supported to obtain a nationally recognised qualification in care. In addition, records showed that staff had received training in key subjects including how to support people who lived with dementia and who could become distressed. The registered person said that this was necessary to confirm that staff were competent to care for people in the right way. Staff said they had received training and were confident they had the knowledge and skills they needed. For example, staff knew how to effectively help people who had reduced mobility and who were at risk of falling. In addition, they knew about first aid and infection control.

Staff were able to effectively support people who lived with dementia and who could become distressed. We saw that when a person who lived with dementia became distressed, staff followed the guidance described in the person's care plan and reassured them. They noticed that the person was upset because they had become confused about where they were in the building and wanted to go back to the main lounge. The staff member helped them to walk back to the lounge and along the way explained how the rooms they were going through led back to the lounge. After this was done the person was seen to be calm and smiling. The staff member knew how to identify and effectively respond to the person's needs and wishes.

People said that they received the support they required to see their doctor. Some people who lived in the service had more complex needs and required support from specialist health services. A relative said, "I'm reassured that the staff always call the doctor straight away if my mother is not well." A healthcare professional said that staff promptly alerted them if someone was not well and in general followed any treatment advice they were given.

Some parts of the accommodation were not adapted, designed and decorated to meet people's individual needs. Two shared use toilets did not have locks on the doors and so could not be used fully in private. One of the toilet seats was incorrectly fitted and slid to the side when someone was seated on it. A radiator guard located in a main corridor area was not secured to the wall and came loose if any pressure was placed on it. In some communal and private areas carpets were stained and had a stale odour. These shortfalls reduced the registered person's ability to ensure that people received care in a homely, comfortable and safe setting.

The registered person and senior staff were knowledgeable about the Mental Capacity Act 2005 (MCA). This had enabled them to protect the rights of people who were not able to make or to communicate their own decisions. Care records showed that the principles of the MCA had been used when assessing people's ability to make particular decisions. For example, the registered person had identified that some people who lived in the service needed extra help to make important decisions about their care due to living with dementia.

When a person had someone to support them in relation to important decisions this was recorded in their care plan.

Requires Improvement

Is the service effective?

Records we saw demonstrated that the person's ability to make decisions had been assessed and that people who knew them well had been consulted. This had been done so that decisions were made in the person's best interests.

There were arrangements to ensure that if a person did not have anyone to support them they would be assisted to make major decisions by an Independent Mental Capacity Act Advocate (IMCA). IMCAs support and represent people who do not have family or friends to advocate for them at times when important decisions are being made about their health or social care.

The registered person was knowledgeable about the Deprivation of Liberty Safeguards. We noted that they had sought advice from the local authority to ensure the service did not place unlawful restrictions on people who lived there.

Good

Is the service caring?

Our findings

People and their relatives were positive about the quality of care provided in the service and we did not receive any critical comments. A person said, "The staff do a lot for me from first thing until bed time. And I choose my own bedtime." A person who had special communication needs smiled and pointed towards a passing member of staff and then held their hand in an appreciative way.

We saw that people were treated with respect and in a caring and kind way. Staff were friendly, patient and discreet when providing support to people. We saw that staff took the time to speak with people as they supported them. We observed a lot of positive interactions and saw that these supported people's wellbeing. For example, we saw a person being assisted to find some sweets that they had dropped down the back of their chair. The member of staff then helped the person choose a particular flavour before helping unwrap the sweet.

Staff were knowledgeable about the care people required and the things that were important to them in their lives. They assumed that people had the ability to make their own decisions about their daily lives and gave people choices in a way they could understand. They also gave people the time to express their wishes and respected the decisions they made. For example, a person described how staff assisted them to choose their clothes each morning so that they could co-ordinate colours.

Relatives told us that they were free to visit the service whenever they wished. A relative said, "I call regularly to the service and staff always make me feel welcome. In general, they're pretty good about keeping in touch with me in between my visits so I know how things are going for my mother."

Some people who could not easily express their wishes did not have family or friends to support them to make decisions about their care. The service had links to local advocacy services to support these people if they required assistance. Advocates are people who are independent of the service and who support people to make and communicate their wishes.

Staff recognised the importance of not intruding into people's private space. Most people had their own bedroom. People who shared a bedroom were provided with privacy screens so they could be on their own if they wanted. Bedrooms were laid out as bed sitting areas which meant that people could relax and enjoy their own company if they did not want to use the communal lounges. Staff knocked on the doors to private areas before entering and ensured doors to bedrooms and toilets were closed when people were receiving personal care. People could speak with relatives and meet with health and social care professionals in the privacy of their bedroom if they wanted to do so.

Written records that contained private information were stored securely and computer records were password protected. Staff understood the importance of respecting confidential information. They only disclosed it to people such as health and social care professionals on a need to know basis.

People received their mail unopened. Staff only assisted them to deal with correspondence if they had been asked to do so. People could choose to have a private telephone installed in their bedroom. However, the service did not have a payphone. This meant that people had to ask if they could use the service's business telephone if they wanted to make or receive a call. A person said, "I don't ask for the telephone really because staff need it and so I just wait for my daughter to come in."

Requires Improvement

Is the service responsive?

Our findings

The registered person said that each person's care plan was regularly reviewed. This was done to make sure that they accurately reflected people's changing preferences and needs so that staff had the information they needed to care for people in the right way. However, we found that the care plans were not written in a user-friendly way and so people were not fully supported to access the information they contained. None of the four people we asked were aware that they had an individual care plan. This shortfall had reduced people's ability to be fully involved in planning, reviewing and assessing the care they received.

We noted that people had not been supported to have their hair cut and styled. Three people said that they had asked on a number of occasions for a hairdresser to call to the service but that the registered person had not made the necessary arrangements. A person said, "I think it's terrible that I've not had my hair done for two months. It's not good enough that if we ask for something basic like that we don't get what we want. I hate my hair looking dishevelled like it does now." Another person said, "My hair has never been left so long."

Staff had not fully supported people to pursue their interests and hobbies. There was an activities manager present in the service for three days a week. Records showed that she engaged people in a wide range of small group and individual activities that included people who were often cared for in their bedroom. However, the activities manager was not present in the service on the day of our inspection. We spent most of the day in the service and we did not see any activities taking place. We noted that most people spent time on their own. Although some people watched television most people sat in their armchairs without anything in particular to do. A person said, 'When the activities aren't being done the day seems very long indeed. There's not much to do other than watch television and try to fill up time between meal times. I think we should have an activity every day."

People had not been supported to regularly access community resources. We were told that people had last been invited to visit a local place of interest more than a year before the date of our inspection. We noted that no visits had been planned and staff did not anticipate that any would take place. Some people told us they were happy with the arrangements in the service but other people wanted to have more support to pursue interests and hobbies. One of them said, "I would like to go out a bit more when the weather's nice. I don't think it's good to stay in all the time like most of us do."

The service celebrated equality and diversity by acknowledging people's individuality when care was provided. This included people being supported to meet their spiritual needs by attending acts of worship.

People said that staff provided them with all of the practical everyday assistance they needed. This included support with a wide range of everyday tasks such as washing and dressing, using the bathroom and getting about safely. In addition, staff regularly checked on people during the night to make sure they were comfortable and safe in bed. A person said, "I like to be independent but at the same time I do like staff checking on me at night because it makes me feel safe." Records and our observations confirmed that people were receiving all the practical assistance they needed.

Staff said that they had received training to assist them to care for people with special communication needs. They were confident that they could communicate with and effectively support people who lived with dementia. We saw that staff knew how to relate to people who expressed themselves using short phrases, words and gestures. For example, we observed how a person who had special communication needs frowned and tussled their hair. A member of staff understood that they wanted to be assisted to return to their bedroom. They then accompanied the person back to their bedroom and we saw the person to be smiling and relaxed.

People said that they were provided with a choice of meals that reflected their preferences. We saw that people had a choice of dish at each meal time. In addition, records showed that the chef prepared alternative meals for people who asked for something different. We were present when people had lunch and noted the meal time to be a pleasant occasion. Some people received individual assistance to eat their meal. People commented positively on how the chef regularly asked them how they liked their meals and asked them to suggest changes to the menu. A person said, "I have no complaints at all about the food it's great." Another person who had special communication needs pointed towards the kitchen and gave a 'thumbs-up' sign.

Requires Improvement

Is the service responsive?

The registered person had a formal procedure for receiving and handling concerns. Each person had received a copy of procedure when they moved into the service. People said they would be confident speaking to the registered person if they had a complaint or concern about the care provided. A person said, “Apart from the hairdressing situation which hasn’t been sorted out, everything else we ask for does seem to get dealt with, quickly and pleasantly.” A relative said, “I have seen the complaints procedure but I’ve never bothered much about it. If I have a problem it gets sorted without any fuss.”

Requires Improvement

Is the service well-led?

Our findings

Although there were systems to assess the quality of the service we found that these were not always effective. The systems had not ensured that people were protected against some key risks to their wellbeing and safety. We found problems in a number of areas that had not been identified before our inspection. These included shortfalls in planning, delivering and evaluating some of the care that people needed to protect them against the risks of not eating and drinking enough. In addition to these issues, we found that problems relating to staffing, the accommodation and responding to people's preferences had not been effectively resolved.

We also noted that the registered person had not properly assessed the adequacy of the fire safety system. This oversight had contributed to some fire safety checks not being completed on time. These checks were necessary to safeguard people from the risk of fire. Together, these shortfalls in the auditing process increased the risk that people would not reliably receive all of the care they needed in a safe setting.

These shortfalls had reduced the registered person's ability to ensure that people safely received all of the care they needed.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered person had not informed the Care Quality Commission about two significant events that had occurred in the service. This had resulted in the Commission not being in a position to seek assurances that people who lived in the service were safely receiving all of the care they needed.

This shortfall meant that the registered person had not complied with a condition of their registration.

This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

Although staff consulted with people informally, other arrangements to enable stakeholders to contribute to the development of the service were not well developed. The registered person said that there were regular 'residents' meetings' when people discussed their home and suggested improvements. However, records of the last meeting could not be found. No one could clearly recall what had been said and there was no other evidence to show if any suggested improvements had been acted upon.

People said that they knew the registered person well and that they were helpful. During our inspection visit we saw the registered person talking with people who lived in the service and with staff. They had a good knowledge of the personal care each person was receiving. They also knew about points of detail such as which members of staff were on duty on any particular day. This level of knowledge helped them to manage the service and provide leadership for staff.

Staff were provided with the leadership they needed to develop good team working practices. These arrangements helped to ensure that people consistently received the care they needed. There was a named person in charge of each shift. During the evenings, nights and weekends there was always a senior member of staff on call if staff needed advice. There were handover meetings at the beginning and end of each shift so that staff could review each person's care. In addition, there were periodic staff meetings at which staff could discuss their roles and suggest improvements to further develop effective team working. These measures all helped to ensure that staff were well led so that they could care for people in a responsive and effective way. A relative said, "I'm very confident that the service is well run. The staff seem to get on well together and I like seeing the manager around the place and in charge."

There was an open and inclusive approach to running the service. Staff said that they were well supported by the registered person. They were confident that they could speak to the registered person if they had any concerns about another staff member. Staff said that positive leadership in the service reassured them that they would be listened to and that action would be taken if they raised any concerns about poor practice. A staff member said, "It's always been made absolutely clear that the residents come first here and that we have a duty to say something if we're concerned."

However, the registered person had not provided all of the leadership necessary to engage the service fully with the local community. For example, arrangements had not been made for local community services agencies to become involved in supporting and developing the service. In

Requires Improvement

Is the service well-led?

addition, the registered person had not subscribed to any national good practice initiatives sponsored by recognised professional bodies. For example, good practice guidance relating to supporting people who live with dementia had not been used to identify possible improvements in the service. These shortfalls reduced the service's ability to ensure that people benefited from care that was based upon recognised best practice and current research.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing The registered person had not taken appropriate steps to ensure that at all times there were sufficient numbers of staff employed for the purposes of carrying on the regulated activity. Regulation 18 (1) HSCA 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
	Regulation 17 HSCA (RA) Regulations 2014 Good governance The registered person had not protected people who lived in the service against the risks of inappropriate or unsafe care by regularly assessing and monitoring the quality of the service provided. Regulation 17 (1) (2) (a) (b) HSCA 2008 (Regulated Activities).

Regulated activity	Regulation
	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents The registered person had not notified the Care Quality Commission of all incidents that had affected the wellbeing of people who lived in the service. Regulation 18 (c) (f) Care Quality Commission (Registration) Regulations 2009.