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Lockermarsh Residential Home

Inspection report

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Date of inspection visit:
22 June 2022

Date of publication:
04 August 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
Lockermarsh is a residential care home providing personal care for up to 24 people. At the time of our inspection there were 17 people using the service. Some people were living with dementia.

People's experience of using this service and what we found
Risks were not always managed to ensure people's needs were met. Although we found no evidence people were harmed, the documentation in place did not always detail how to meet people's needs safely.

The registered manager had a system in place to monitor incidents and completed an analysis to identify trends and patterns. However, this did not always show what action had been taken to minimise future incidents. The provider's systems did not always evidence that people received their medicines as prescribed.

Staff we spoke with told us they were recruited safely, and pre-employment checks were carried out prior to them commencing work at the service. From our observations and speaking with staff, we found there were enough staff available to assist people to meet their needs.

The home was not always clean, and staff did not always wear appropriate personal protective equipment (PPE). PPE was available at several points throughout the home.

Staff confirmed they received safeguarding training and knew what actions to take if they suspected abuse. As part of this inspection we raised a safeguarding concern to the local authority.

The provider had systems in place to monitor the quality of the service. This process had not always identified issues we found on inspection. Where issues had been noted as a result of internal audits taking place, actions to rectify them had not been completed in a timely way.

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

Rating at last inspection
The last rating for this service was good (published 18 February 2021).

Why we inspected
We received concerns in relation to infection control, personal care and staffing. 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 from 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 see what action we have asked the provider to take at the end of this full report.

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

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 well-Led findings below.

Lockermarsh Residential 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.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

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

Service and service type
Lockermarsh 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. Lockermarsh 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
This inspection was unannounced.

What we did before inspection
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. 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 used all this information to plan our inspection.

During the inspection
We spoke with three people who used the service and four relatives about their experience of the care provided. We spoke with five members of staff including the registered manager and care workers. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We reviewed a range of records. This included two people's care records and multiple medication records. We looked at a variety of records relating to the management of the service.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records.

Requires Improvement

Is the service safe?

Our findings

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.

Assessing risk, safety monitoring and management

- Risks were not always managed to ensure people's needs were met safely.
- Although we found no evidence people were harmed, the documentation in place did not always detail how to meet people's needs safely. For example, one person was at risk of developing pressure areas, but had no risk assessment in place. Another person used a hoist to transfer, but there was no information available about the size, type or loop configuration to use. We raised this with the registered manager who added this information to people's care documentation.

Using medicines safely

- Medication systems were in place for staff to follow. This was an electronic system which staff told us they didn't feel comfortable using it. The system did not always tally with the stock of medicines. We raised these issues with the registered manager who informed us they had oversight of the medication records and told us this was a recording issue.
- Medicine records did not always evidence that people had received their medicines as prescribed. For example, one person had not received their medicine because the controlled drugs register was full. This was reported to safeguarding.
- Some people were prescribed medicines on an as and when required basis, known as PRN. We found no PRN protocols in place to guide staff when medicines should be administered. Following our inspection, the registered manager told us PRN protocols were in place in a separate file, however, staff on site did not know they existed.

Preventing and controlling infection

- We were not assured that the provider was promoting safety through the layout and hygiene practices of the premises. We found areas of the home required a deep clean. Some seating and bedding required either a deep clean or replacing. Following our visit, the registered manager took action to address this.
- We were not assured that the provider was using personal protective equipment effectively and safely. Some staff were not constantly wearing face masks.

Risks relating to the welfare of people were not always effectively managed. The provider had failed to ensure safe management of medicines. The provider had failed to ensure infection, prevention and control policies and procedures were always followed. This was a breach of regulation 12 (safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Visiting in care homes

● The provider was facilitating visits for people living at the home.

Systems and processes to safeguard people from the risk of abuse
● The provider had a safeguarding policy and staff confirmed they received training in protecting people from the risk of abuse.
● However, following our inspection we raised a safeguarding concern with the local authority which had not previously been reported by the provider. This meant the provider's internal procedures were not always effective.

Learning lessons when things go wrong
● The registered manager had a system in place to record and collate information regarding accidents and incidents. The analysis stated that notifications to safeguarding were made where necessary, however, no action was recorded as to what the home had done to mitigate other incidents.

Staffing and recruitment
● Staff confirmed they had pre-employment checks carried out prior to them commencing in employment for the company.
● Staff also confirmed they received an induction which included shadowing experienced care staff.
● During our inspection we found there were enough staff available to support people in a timely way.

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 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.

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

- The provider did not promote a positive culture and people were not supported to achieve good outcomes. Staff assisted people in a kind and caring way, however, there were several times when people were left alone and had nothing to occupy them.
- Confidential information was left unattended and personal information was written on a notice board in the dining room in view of everyone. The registered manager told us this would be removed.

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

- On the day of our inspection the registered manager was not available. Although senior care staff were on duty, they had no access to management documentation and the staff team were not clear about some aspects of their role.
- We asked to look at personal emergency evacuation plans, and PRN protocols and the staff team told us these were not in place. Following the inspection, the registered manager told us these were in place. This showed the processes in place were not always effective and staff were not given all the relevant information to carry out their role.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- Relatives told us communication was poor. One relative said, "I don't know if it's the key worker, the staff or the management but there is just a lack of communication full stop." Another relative said, "When we phone, we don't get a lot out of them. It feels like they are too busy to speak to us. We might get a '[relative] had a good day' but they don't go into any detail about things. It feels like they can't wait to get off the phone."
- A staff satisfaction survey dated April 2022 stated a staff member didn't feel involved in what was going on at Emyvale Care. They felt the senior management team were approachable, but did not feel career opportunities were available, and the manager had not discussed plans for the future with them. There was no evidence to show what actions had been taken as a result of this feedback.

Continuous learning and improving care

- Systems in place to monitor the service were not robust and did not always identify and address issues.

We identified some concerns around infection control, risks and medication management. These issues had not been previously addressed.

● An electronic system had replaced a paper based medication system, the new system required embedding in to practice.

● There was a lack of provider oversight which had failed to determine a decline in standards.

We identified a lack of person centred care, leadership, engagement and ineffective management systems. This was a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Relatives we spoke with told us they were happy with the care their family member received.
One relative said, "Nothing worries me at Lockermarsh with regard to the care of [relative], I've certainly never been unhappy with the care that they provide." Another relative said, "The way the home care for [relative] gives me peace of mind. With everything else going on it is a big weight off my mind knowing [relative] is being well cared for and well looked after."

Working in partnership with others

● The home worked with other agencies such as the local authority and healthcare professionals.

● Recommendations and advice from healthcare professionals were followed. This helped to make sure the care and support provided was up to date with current practice.

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 12 HSCA RA Regulations 2014 Safe care and treatment Risks relating to the welfare of people were not always effectively managed, the provider had failed to ensure safe management of medicines and the provider had failed to ensure infection, prevention and control policies and procedures were always followed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance We identified a lack of person centred care, leadership, engagement and ineffective management systems.