Mrs Christine Lyte

Caythorpe Residential Home

Inspection report

77 High Street
Caythorpe
Lincolnshire
NG32 3DP
Tel: 01400 272552
Website:

Date of inspection visit: 24 July 2015
Date of publication: 24/08/2015

Ratings

Overall rating for this service	Requires improvement
Is the service safe?	**Requires improvement**
Is the service well-led?	**Requires improvement**

Overall summary

We carried out an unannounced comprehensive inspection of this service on 17 February 2015 and found that there were three breaches of legal requirements. The service was not consistently safe. This was because the registered person had not ensured that at all times there were sufficient numbers of staff available to meet people's needs for care. In addition to this, the service was not consistently well led. This was because the registered person did not operate reliable systems to monitor the quality of the service provided so that any shortfalls could quickly be corrected. We also noted that the registered person had not always notified us about significant events that had occurred in the service that the law says we need to be told about.

We completed an unannounced focused inspection carried out on 24 July 2015. This inspection was undertaken to make sure that improvements had been made and that the breach of legal requirements had been addressed.

This report only covers our findings in relation to this topic. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Caythorpe Residential Home on our website at www.cqc.org.uk.

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.

Summary of findings

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'.

At this inspection we found that the registered person had followed their action plan that they had told us would be completed by 31 May 2015. This action plan had enabled the registered person to meet legal requirements.

We found that the registered person had reviewed the way staff completed their work at busy times of the day and had extended the provision for additional staff to be on duty when necessary. This had been done to ensure that people's care needs could be promptly met. These care needs included making sure that people with reduced mobility were helped to avoid having falls and near misses. In addition, we noted that the increased flexibility in staffing arrangements had better enabled people who mostly received care in their bedroom to have the attention they needed.

We also found that the registered person had regularly completed more robust quality checks including determining how many staff needed to be on duty. These checks also involved evaluating particular parts of the care that people received to ensure that it met their needs and wishes. This measure included making sure that some people received extra assistance to eat and drink enough. Other new checks had focused on ensuring that people were supported to express their individuality and to pursue their interests.

We noted that quality checks had also been completed to assure the adequacy of the accommodation including making sure that people enjoyed a suitable level of fire safety protection. However, further improvements were still needed. This was because the checks had not resulted in action being taken to address some of the defects in the accommodation we noted during our previous inspection.

We found that the registered person had notified us about any significant events that had occurred in the service. This had assisted us to determine if the service was responding to people's needs in an effective way.

Together, the improvements that had been made had strengthened the registered person's ability to ensure that people received safe and consistent care that met their needs.

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 

Action had been taken to improve how people were kept people safe. This involved making revised arrangements to ensure there were enough staff available to meet people's needs for care.

This meant that the registered person was now meeting legal requirements.

While improvements had been made we have not revised the rating for this key question. This is because we require a longer term track record of consistent good practice in order to improve the rating to 'Good'.

We will review our rating for 'safe' at the next comprehensive inspection.

Is the service well-led?

Requires improvement 

Action had been taken to improve the way in which the service

was managed and led because the registered person had regularly completed more robust quality checks. These had helped to ensure people reliably and safely received all of the care they needed. However, further improvements were still needed in order to ensure that defects in the accommodation were quickly addressed.

The registered person had notified us about significant events that had occurred. This had been done so that we could establish that people had been kept safe.

The improvements that had been made meant that the registered person was now meeting legal requirements.

While improvements had been made we have not revised the rating for this key question. This is because we require a longer term track record of consistent good practice in order to improve the rating to 'Good'.

We will review our rating for 'well-led' at the next comprehensive inspection.

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 registered person was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008.

We completed an unannounced focused inspection of Caythorpe Residential Home on 24 July 2015. This inspection was undertaken to check that improvements to meet legal requirements planned by the registered person after our comprehensive inspection on 17 February 2015 had been made.

We inspected the service against two of the five questions we ask about services: Is the service safe and is it well led? This was because the service was not meeting legal requirements in relation to these questions.

Before our inspection we reviewed the information we held about the service. We reviewed notifications of incidents that the registered person had sent us since the last inspection. In addition, we contacted local commissioners of the service to obtain their views about how well the service was meeting people's needs.

The inspection team consisted of a single inspector.

During the inspection we spoke with six people who lived in the service. We also spoke with a care worker, senior care worker, activities coordinator, chef and the registered person's administrator. We observed care being provided in communal areas that were used by people who experienced reduced mobility. We also looked at the care records for three people two of whom needed extra assistance to ensure that they had enough to eat and drink. In addition, we examined records that related to how many staff were on duty at different times of the day. We checked records that showed how the accommodation was being maintained including the fire safety system. We established what significant events had occurred in the service since our last inspection and how they had been managed by the registered person.

Requires improvement

Is the service safe?

Our findings

At our comprehensive inspection on 17 February 2015 we found that the registered person had not ensured that there were always enough staff on duty to respond when people needed assistance. We saw examples of staff having to help more than one person at the same time. This had led to people not receiving the individual attention they needed to walk safely about their home. We also noted that insufficient staff had resulted in people who chose to be cared for in their bedroom not always receiving the assistance they needed and wanted.

This was a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 that corresponds to Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found that the registered person had followed the action plan they had prepared. The improvements they had introduced had met the requirements of Regulation 18 we have described above.

We found that the registered person had re-assessed how many staff were needed to meet people's care needs including those who received some or all of their care when in their bedroom. This had resulted in changes being made to the way in which some tasks were completed that had enabled staff to use their time in a more flexible way. For example, ancillary tasks such as managing laundry could be put back for night staff to undertake if day staff were too busy. In addition, the registered person was in the process of making arrangements for an extra member of staff to be available during busy times of the day.

We saw that there were enough staff on duty at the time of our inspection. This was because people received all of the practical assistance they needed. When people used the call bell to ask for assistance staff responded promptly. Staff were present in the communal areas and so were able to promptly assist people who were in these spaces when they asked for help. We observed two people who received care in their bedroom. We noted that staff regularly called on them to check how they were and to offer any assistance they needed. For example, one person had not used their call bell but informed a member of staff who called to their bedroom that they wanted to be assisted to use the toilet. The member of staff provided this help and did not leave the room until they had made sure that the person was comfortable.

Records showed that the number of staff on duty during the week preceding our inspection matched the level of staff cover which the registered person said was necessary. People who lived in the service and staff said that there were enough staff on duty to meet people's care needs. A person said, "The staff are very kind to us all and they give us all the help we need. Although there have been a lot of changes in the staff team, the best ones have stayed and they get on well together as a team."

The improvements to staffing arrangements made by the registered person had ensured that there were sufficient staff to reliably and promptly provide people with the care they needed.

Requires improvement

Is the service well-led?

Our findings

At our comprehensive inspection on 17 February 2015 we found that the registered person had not regularly completed robust quality checks. These checks were necessary to ensure that people reliably and safely received all of the care they needed. As a result of this situation, problems in the running of the service had not been quickly identified and resolved. These shortfalls included the support provided for people who experience reduced mobility or who were at risk of not eating and drinking enough. There had also been oversights in ensuring that people could have regular consultations with a hair stylist and were enabled to pursue their hobbies and interests. In addition to this, there had been shortfalls in the maintenance of the accommodation. We also noted that quality checks had not effectively ensured that fire safety equipment and procedures provided people with a high level of fire safety protection.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 that corresponds to Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found that the registered person had followed most of the action plan they had prepared. The improvements they had introduced had met the requirements of Regulation 17 we have described above.

The registered person had regularly completed more effective quality checks to make sure that people were reliably receiving all of the care and facilities they needed. These checks included making sure that care was being consistently provided in the right way. This included consistently supporting people who were at risk of not eating and drinking enough to promote their good health. In addition to this, action had been taken to enable people to have regular consultations with a hairstylist. We also found that checks had resulted in people being offered the opportunity to engage in a wider range of social activities.

Records showed that more rigorous checks had been completed to ensure that the accommodation provided a safe and accessible setting within which people could receive care. For example, a loose toilet seat that slid when used had been repaired and was safe to use. Another example involved two communal toilets that did not have lockable doors and so could not be fully used in private. However, further improvements in quality checks were still needed because other defects had not been addressed. One of these involved the need to repair a radiator guard that was loose and moved when people touched it to help balance themselves.

Records showed that quality checks had been completed to ensure that fire safety equipment remained in good working order. This helped to ensure that people were provided with a high level of protection from the risks of fire.

At our comprehensive inspection on 17 February 2015 we found that the registered person had not notified us about significant events that had occurred in the service. The law requires registered persons to tell us about events that could place people at increased risk of not receiving the care they need.

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

At this inspection we found that the registered person had followed the action plan they had prepared. The improvements they had introduced had met the requirements of Regulation 10 we have described above.

We found that the registered person had introduced more robust arrangements to ensure that we are told about the occurrence of significant events. This had enabled us to see what steps had been taken to keep people safe and to promote their wellbeing. For example, our records showed that we had been informed about a recent incident when a medicine had been incorrectly administered. The information we received explained how the mistake had occurred and what steps had been taken to manage the risk including seeking medical advice.

Improvements in the arrangements used to notify us about important events meant that the registered person had complied with the law and had given us the information we needed to be confident that people were being kept safe.