Mr Harbansh Rana and Mrs Sudha Devi Rana

Flora Lodge

Inspection Report

21-23 Glenfield Road East
Leicester
LE3 5QW
Tel: 0116 253 0279

Date of inspection visit: 30 April and 1 May 2014
Date of publication: 14/11/2014

Contents

Summary of findings

Overall summary

Flora Lodge provides care and support for twelve people with mental health needs and has a registered manager in post. We met eight people who used the service during our inspection and asked them about their experiences of the service.

We found people were protected from the risk of abuse as effective systems were in place and staff understood what action to take to protect people. However the behaviour of some staff at times was not respectful of people's sensibilities, emotional well-being and dignity. Although everybody we spoke with felt safe living at the home, we were concerned that the attitude and behaviour of some staff may have at times undermined this. .

There was also limited understanding and implementation of the Mental Capacity Act and Deprivation of Liberty Safeguards. Risk assessments were in place but we found them to be inadequate. People received their medication as prescribed but overall the management of medicines did not protect people from the associated risks.

There were systems in place that monitored the quality of service and the delivery of care and support however, this had not been fully effective in identifying concerns with risk assessments, care planning or staff interactions with people and had therefore not lead to the necessary improvements. The service had not met CQC requirements to notify us about all the events they are required to inform us about by law.

Care plans recorded people's wishes and preferences but did not always provide detail about how staff should meet people's needs. We found that people's health had been monitored and guidance from health professionals had been sought when appropriate.

We spoke with staff and found they had received appropriate training, supervision and support to enable them to provide effective care to people. There were sufficient numbers of staff to ensure the safe and effective delivery of care. We observed the staff team treating people with kindness and the manager, in particular, had developed good relationships with the people who used the service. Comments from people living in the home included: "I love it here", "The food here is good," and "The manager is very approachable".

Records showed that people's views, wishes, preferences and concerns were sought, listened and responded to.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of this report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Risk assessments were in place in relation to people's health or behaviour. However, these were inadequate and did not provide proper guidance for staff to follow to ensure risks were minimised. In some cases the risks to people had not been recognised by the service. This meant there had been a breach of Regulation 9 of the Health and Social Care Act 2008.

There were no policies or procedures in place in relation to the Mental Capacity Act 2005 or the Deprivation of Liberty Safeguards. Staff had not received any training in these areas and had limited understanding of how this legislation may impact the people who used the service. This meant that people's human and legal rights may not have been upheld. This meant there had been a breach of Regulation 18 of the Health and Social Care Act 2008.

However people were not always protected against the risks associated with medicines. This was because there were inadequate arrangements in place for the storage of medicines and the storage of controlled drugs in particular. In addition, the management of controlled drugs did not follow relevant regulations and guidance. There was insufficient guidance in place for staff in relation to people's medication. This meant there had been a breach of Regulation 13 of the Health and Social Care Act 2008.

We found that people were protected from the risk of abuse because the service had effective systems in place to ensure allegations of abuse were reported and responded to. Staff we spoke with had received training about the safeguarding of vulnerable adults and were clear about their responsibilities. People living at the home told us they felt safe and comfortable with the staff team. However we were concerned that some aspects of the behaviour of some staff may not have always been appropriate or professional and may potentially undermine this.

Are services effective?

People we spoke with were satisfied with the service and felt their needs were met.

Care plans were individualised and contained information in relation to people's personal preferences, needs, wishes and routines. We found that people's care was delivered in a way that reflected this information. People's care plans could be improved and developed further so that they reflected how staff should support people to meet their needs.

Summary of findings

People were supported to maintain good health by on-going monitoring and referrals to appropriate health professionals when necessary. The service had forged good relationships with a variety of health professionals. When people declined medical advice they had been given relevant information about the impact of this decision and their choice was respected. People we spoke with felt they were well supported with maintaining good health.

Staff had had received relevant and appropriate training, support and supervision.

Are services caring?

Most people we spoke with were positive about the staff team and felt they were treated with dignity and respect. However, two people told us that staff sometimes shouted. The manager investigated this during our inspection and found that whilst staff had not been shouting at people, they may have been shouting or raising their voices within people's hearing. We concluded that some staff may not have fully appreciated how their behaviour may impact on people who used the service.

Our observations during our visit were that staff treated people with respect and kindness. However, we noted that most staff interactions were focused on tasks rather than on the people using the service. The manager of the service demonstrated a rapport with people and interacted with them in a positive and considerate way. The staff team delivering care to people did not always demonstrate the same approach and improvements could be made in this area.

There were policies and procedures in place to ensure people's privacy, dignity and human rights were respected. However, not all staff had received training in these areas and these values had not always been embedded into practice.

Are services responsive to people's needs?

Consideration had been given to supporting people to engage in meaningful activities and the service promoted people's independence and community involvement. This could be improved upon by ensuring all staff were proactive in continuing to offer opportunities to people who did not always want to participate.

Care plans and records demonstrated people's involvement in the delivery of their care and support and in the running of the service. Staff gathered people's views in a number of ways including questionnaires, residents meetings and through key worker

Summary of findings

engagement. We saw that the service responded to people's changing needs and wishes. Improvements could be made by ensuring people had the opportunity to be involved in their care planning in a more appealing way.

The service had an appropriate complaints policy and responded to concerns and complaints effectively. People felt confident raising a concern and all were confident that they would be listened to.

Are services well-led?

There were systems in place that monitored the quality of service however, this had not been fully effective in identifying concerns with risk assessments, care planning or staff interactions with people and had therefore not lead to the necessary improvements.

The service had been organised to meet the needs of the people who used it. There were clear systems in place to ensure that people were effectively communicated with and listened to despite their needs and difficulties.

Staff felt that the service was well-managed and had confidence in the registered manager. There was a stable staff team that had been supported to receive training and development that would enable them to meet people's needs. The manager had ensured there were enough staff on duty at all times to provide effective and appropriate care and this was kept under review.

The service had not met CQC requirements to notify us all the events they are required to by law. This meant there had been a breach of Regulation 18 of the Health and Social Care Act 2008.

Summary of findings

What people who use the service and those that matter to them say

We met eight people who used the service over the two days of our inspection. People spoke positively about the service and the support they received. Comments included: “I feel this place is safer than where I was before”, “I feel treated with dignity and respect”, “Staff always listen to what I have to say” and “If I had a problem I would talk to the manager, she is very approachable”.

People looked comfortable in their surroundings and were free to spend their time as they wished. Some people went into the community to visit friends or participate in activities they enjoyed such as working at an allotment. Other people preferred to spend time at the home in communal areas or their bedrooms. A few people told us they would have liked more activities at the home and we spoke with the manager about this.

Everybody we spoke with felt that the staff and the manager listened to them and took into account their views. People told us about residents meetings where they had the opportunity to talk about things that mattered to them.

People were happy with the care and support they received and we observed staff responding to people’s requests during our inspection. People told us they were supported with their health needs and that staff accompanied them to the GP, dentist or on hospital appointments.

We found that people’s friends and family were welcome at the home and staff supported and encouraged these relationships.

Two people told us about instances where some of the staff team had shouted. The manager investigated this during our inspection.

Flora Lodge

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 was meeting the regulations associated with the Health and Social Care Act 2008 and to pilot a new inspection process under Wave 1.

Before our inspection we reviewed the information we held about the home and asked the provider to complete an information return. We used this to help us decide what areas to focus on during our inspection.

We visited the home on 30 April and 1 May 2014. We met eight of the twelve people who lived at the home and observed daily life in the home. We looked at all areas of the building including communal areas and, with permission, some people's bedrooms.

The inspection team consisted of an inspector and an expert by experience who had experience of services for people with mental health needs.

We spoke with the registered manager and all care workers on duty at the time of our visit. We looked at a number of records including people's personal records, staff records and records in relation to the management of the home.

Are services safe?

Our findings

As part of our inspection we looked at a number of risk assessments in relation to people's behaviour, health and the environment. We found that risk assessments did not effectively record the potential risks and action that should be taken to minimise the risk. For example, some people's care plans showed they may experience suicidal thoughts or display inappropriate behaviours. The corresponding risk assessments did not contain enough detail to support staff in recognising and responding to these risks. In some cases, the risks to people had not been recognised by the service at all and so there were no risk assessments in place. Therefore, the planning and delivery of people's care may not have always ensured their welfare and safety. This meant there had been a breach of Regulation 9 of the Health and Social Care Act 2008. The action we have asked the provider to take can be found at the back of this report.

We found there were no policies or procedures in place in relation to the Mental Capacity Act 2005 (MCA) or the Deprivation of Liberty Safeguards (DoLS). Staff we spoke with had a limited understanding of this legislation and how it might have impacted on the people they supported. There was no clear system in place for obtaining people's consent to their care and support and where people lacked the capacity to consent, we could see no evidence that the service had established, or acted in accordance with the best interests of the person. This meant that the service had not followed key principles of the MCA and so may not have ensured people's rights were upheld. This meant there had been a breach of Regulation 18 of the Health and Social care Act 2008. The action we have asked the provider to take can be found at the back of this report.

We also found there had been no DoLS applications submitted and no DoLS training undertaken which meant that staff had not been trained to understand when an application should be submitted and how to submit one. This meant that people's legal and human rights may not have been upheld by the service due to a lack of staff training and awareness. In one person's care plan we found evidence of restrictions and monitoring which may have amounted to a deprivation of that person's liberty. We spoke with the registered manager about this and they agreed to consult with the relevant authority immediately.

We looked to see if the arrangements for the management of people's medication was safe. We found that people were getting their medicines as prescribed and that staff that were responsible for the administration of medication had completed appropriate training. We found that some people were administering their own medicines and the service had systems in place to ensure they could do this safely.

However, we found that storage of medicines was not adequate. Medication had been locked in a medication trolley but the trolley was stored in the office which was left unlocked throughout the day. In addition we found that controlled drugs had been stored alongside other medicines and not in accordance with relevant regulations and guidance for the storage of controlled drugs. Although the service had a controlled drugs book, this was not bound and entries had been crossed out. Furthermore, the service required two staff members to sign for the administration of controlled drugs and this had not been consistently happening. This again meant the service had not adhered to relevant regulations and guidance relating to the management of controlled drugs.People's personal records contained a list of medication they had been prescribed. However, there was no guidance for staff on how and when to give this medication or what it was being given for. There were also no risk assessments in place in relation to people's medication and no evidence the service had adequately assessed people's medication requirements and the risks associated with them giving people their medication. In addition, some people were prescribed medication on an 'as and when required' basis. We found there were no protocols or plans in place which detailed under what circumstances these medicines should be administered. This meant that people were not being protected against the risks associated with medicines due to the lack of information and guidance available for staff to ensure medicines were being handled and administered safely. We considered that these issues meant there had been a breach of Regulation 13 of the Health and Social Care Act 2008. The action we have asked the provider to take can be found at the back of this report.

We met eight people who used the service across the two days of our inspection. People said they felt safe living at the home and were treated well and were involved in decisions being made about their care and support. People's comments included, "I feel that this place is safer than where I was before", "I can't complain about the home, it's the best I've been in", "I love it here" and "I trust the staff here". However, we were concerned that some

Are services safe?

aspects of staff behaviour may not have been appropriate or professional. One person living in the home told us that a member of staff had shouted within people's hearing when the boiler would not work and another staff member shouted at their dog which they sometimes brought into the home. While people did not report that they felt unsafe as a result of this behaviour we considered that it was highly disrespectful.

The service had an up to date safeguarding policy and procedure which was in line with national guidance about how to safeguard vulnerable adults. We also found that the registered manager had recently completed a 'train the trainer' course in safeguarding adults which would enable them to provide on-going training for the staff team. All staff told us they had received training about how to protect people from the risk of abuse and records we looked at confirmed this. Staff knew about the signs of abuse and were able to tell us the action they would take to safeguard people. For example, one staff member told us they, "Keep their eyes open" and are vigilant to possible abuse and another staff member said they looked out for changes in people's behaviour or for any unexplained bruising.

In addition, we found that the manager was aware of local procedures for reporting abuse and relevant contact numbers were displayed in the office. People who used the service had been given information about safeguarding and they all had contact numbers of the relevant authorities on their bedroom doors. We also found that people had been spoken with about abuse and had been informed how to raise concerns in residents meetings. The manager had spent time speaking with people about these issues on an individual basis. This meant that the risk of abuse was reduced because the service had systems in place to safeguard those they supported.

Records showed that staff had recorded any incidents or accidents that had happened in the home. These included incidents involving behavioural challenges. We looked at examples of these and found that staff had responded effectively and consistently with minimal intervention.

Are services effective?

(for example, treatment is effective)

Our findings

We met eight people who used the service across the two days of our inspection. Everybody we spoke with told us their care and support needs were being met by the service. Comments included: "We get looked after very well here", "Staff understand my needs" and "I have a good relationship with all the staff". People told us they were able to come and go from the home as they wished and told us about that staff supported them when requested.

During our inspection we observed staff responding to individual requests and supporting people to carry out activities they enjoyed, such as gardening. We observed that people could choose how to spend their time. Staff we spoke with understood the importance of asking people how they would like their support to be provided and acting in accordance with their wishes.

We looked at the care plans and records of five people who used the service. We found that people's needs had been assessed and that people's views about what was important to them had been included. Care plans were individual to the person and contained sections regarding people's needs in relation to their personal care, mobility, cultural and social needs amongst others. However, people's care plans should be improved and developed so that they reflected how staff should support people to meet their needs. For example, one person's care plan stated they needed support to cook independently and that they needed to be encouraged to eat healthily but their care plan contained no guidance about how staff should do this. Staff we spoke with gave conflicting accounts of the support and guidance they provided in these areas.

Care and support was delivered in a way that respected people's choices and preferences. We saw evidence of this happening during our visit and care plans reflected people's personal preferences, routines and wishes. Although no one using the service had advocacy support at the time of our inspection, we found that the manager had made arrangements for an advocate to visit the home regularly in the future.

Records showed that people had been supported to maintain good health, had access to appropriate healthcare support and that their health had been monitored. For example, we found that one person had developed an additional health condition and the service had supported the person to attend hospital appointments and liaised with the relevant healthcare professionals. Most people had care plans in place which documented the support they required in relation to specific medical issues and their mental health. However, we noted that one person did not have a plan in place about how to manage their diabetes which we drew to the manager's attention during our visit.

Staff had supported people to attend medical appointments when necessary and we observed staff taking action to book a doctor's appointment for one person on the day of our inspection. Records showed that medical appointments and information had been recorded. We saw evidence that people had been supported to attend the GP on a six monthly basis for a health review and had been supported with their eligibility for national screening programmes. Where people had chosen not to attend appointments or screening tests we saw that staff had spoken with them about the risks involved and provided relevant information but respected their wishes to opt out. Everybody we spoke with as part of our inspection told us they had received support to see the doctor, dentist and optician and we saw that the service had developed good links with people's psychiatric services.

Staff we spoke with were able to tell us about the needs of people who used the service and what people's likes and dislikes, personal preferences and individual needs were. Staff told us they had been supported to develop the skills required to be able to meet the needs of people who used the service. Records we looked at supported this and showed that staff had been provided with training in topics such as behaviour that challenges others, medication administration and mental health awareness. The manager told us about training courses that were booked for the staff team, however, it was difficult to tell if there were gaps in people's training or if there training was up to date as no training record had been completed to show the courses staff had completed.

We found that staff also received regular support through staff supervisions, team meetings and observations of staff practice and interactions. This meant that staff had been supported to deliver effective care that met people's needs.

Are services caring?

Our findings

Two people told us about occasions where staff members had shouted: "Sometimes staff shout, it's just the way it is". We raised this with the manager who investigated these concerns during our inspection. The manager told us staff had not shouted at people who used the service but within their hearing. This meant that these staff members had not always taken into account how their actions and behaviour might impact on the well-being of people who used the service. We were concerned that staff behaviour was not always professional, appropriate and respectful of the people who lived at the home. Other people told us: "I get on well with the staff here", "My keyworker is very good with me", "I very much feel treated with dignity and respect" and "Staff treat me alright".

During our inspection we observed that staff treated people with kindness, dignity and respect. We found that the manager, in particular, had a good rapport with people who used the service and was very empathic and engaged in their communications with people. However, interactions of the staff team as a whole with people who used the service however were not as positive, engaging or empathetic. We noted communication was usually initiated by people using the service requesting help or asking for support rather than by staff. Staff did respond to these requests and interactions in a positive manner.

Some staff were able to give us examples of how they respected people's dignity and privacy and acted in accordance with people's wishes. For example, one person told us, "People are well looked after and cared for, they can do anything they want. Staff are sympathetic". However, other staff struggled to give answers about how they improved people's quality of life and told us they were, "Expected to be a saint". We considered this meant that staff understanding of dignity in care had not been fully embedded into practice.

The service had a 'charter for rights' and a copy of this was included in people's care plans. The charter had a clear set of values about promoting respect and choice. There were also policies and procedures in place to ensure people's privacy, dignity and human rights were respected. Some staff had received training in these areas but most had not. However, we could see limited evidence that the charter and relevant policies had been truly embedded into staff practice at the home and this impacted onto the culture of the service.

We found that care was individualised and centred on each person and the staff team knew of people's preferences and individual needs. The manager, in particular, was proactive in their approach and sensitive to changes in people's well-being. Throughout both days of our inspection we observed people seeking support from the manager and them responding in a caring and thoughtful manner.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

We spoke with eight people who used the service across the two days of our inspection. People told us they had the individual support they needed and felt they were listened to and responded to. One person told us, "Staff always listen to what I have to say". People also told us their family members and friends were encouraged to visit and were always made welcome.

During our inspection we noted that some people were involved in activities that were important and relevant to them and others were content to carry out their personal routines within the home. For example, some people attended a gardening project, others went out independently to visit friends or carry out their shopping and others spent time chatting in the outside courtyard. A few people told us there were not many activities happening within the home. One person said, "We have no activities here; we just watch telly and listen to music." Other people told us about suggestions the staff team had made for activities they might enjoy but told us they had then decided they did not wish to participate. The manager told us about the difficulties they had in engaging some of the people who used the service in meaningful activities. We saw evidence of some of the suggestions that had been made to people about activities or events they might enjoy but saw that people had subsequently declined these.

Records we looked at showed that people had been encouraged to use community facilities and regularly went to the leisure centre, shops, local pubs and cafés. The staff team told us about how they supported people to carry out activities they enjoyed and knew about individual people's interests. People who used the service had been encouraged and supported to maintain and develop relationships with their family and other people who were important to them and records we looked at reflected this. We found that staff were aware of people's religious and cultural needs and provided support to people when required. One person told us, "The staff respect my faith and encourage me to go to church".

We looked at the records and care plans for five people who used the service and found they had been encouraged to make their views known about their care and support. Care plans reflected people's diverse needs and took into account people's needs, wishes and preferences.

We found that people and their representatives had been asked for their views about the service and their care through the use of regular surveys and questionnaires. The results of these were positive and had been collated and shared with people who used the service. In addition people had chosen a key worker from the staff team who regularly evaluated how people's care and support was being delivered.

However, we found that people we spoke with were not always familiar with what was written in their care plan and had not signed it to say it was understood. For example people said: "I don't think I have a care plan" and "I have no idea about my care plan". We spoke to the registered manager about this who explained that people who used the service had been asked to review their care plans and declined. Presenting the information to people in a more accessible and innovative format and ensuring key workers were more proactive in their approaches to supporting people.

We found that the service held regular residents meetings. People we spoke with told us that meetings were held monthly to discuss issues and obtain feedback. People felt their views were listened to and acted upon. Records of these meetings showed that people were encouraged to talk about issues reflecting the quality of service, for example the meals prepared, health and safety issues and activities that were taking place. People who had not attended the meeting had also been asked for their feedback. Wherever possible we found the service responded to people's requests. This demonstrated that the staff team were actively listening to people and being proactive in asking people for their views.

The service had an appropriate complaints policy in place. The manager recorded all complaints and concerns the service received. We looked at a copy of the complaints log and found that concerns and complaints had been appropriately responded to within a timely manner. People we spoke with felt comfortable raising a concern or complaint, for example one person said: "I feel comfortable raising concerns with the manager".

Are services well-led?

Our findings

We found the manager had implemented a quality assurance system to ensure the risks to people were being assessed, monitored and responded to. These included regular checks of the environment, reviews of care plans and risk assessments and analysis of accidents and incidents. We found however, that the manager had not identified the issues that we found in relation to risk assessments and care planning. We also found that concerns about the storage and administration of medication had not been identified through the manager's quality assurance checks.

The service had a number of policies and procedures in place to ensure people's safety and the quality of service provided. However, some of these policies referred to legislation and organisations no longer in place. In addition, there was no business continuity plan in place to deal with foreseeable emergencies which may have affected the smooth running of the service.

We spoke with the registered manager and found they promoted a service that was shaped by the needs of the people using it. We were told the service aimed to support people to live their lives as they wished and to support them through periods of mental ill health. Our observations showed that the manager was proactive and motivated in their approach to achieving these aims but this was less apparent with the staff team. Leadership had not developed a consistently positive culture in the service as a whole. Staff were clear about their responsibilities but we observed they were task focused and reactive in their approach to supporting people.

The staff we spoke with felt the service had good leadership in place and staff said they would have no concerns about speaking to the manager if they wanted to raise issues about the delivery of care or running of the home. We found the staff team had regular team meetings where they were encouraged to be involved in the development of the service and we found staff to be well supported.

We found there were sufficient numbers of staff on duty to meet the needs of people who used the service at all times. However, the cleaning and cooking tasks at the home took staff away from being able to interact with people, particularly during the morning. On the second day of our inspection the manager told us they had agreement from the provider to employ a cleaner at the service. This would allow a member of staff to be able to spend more time with people to encourage and support their development.

We found that the service had a stable staff team and that staff were experienced and had a good understanding of people's needs. The manager ensured that staff had received on-going training, supervision and appraisals to support them in their roles. Staff confirmed they felt well supported in their role and were positive about the management of the service. Staff also knew about the service's whistleblowing policy and said they would be comfortable raising any concerns they had with the manager of the service.

The service had not met CQC requirements to notify us all the events they are required to by law. We found there had been an allegation of abuse which we had not been informed about. Although the local authority had been notified as the lead body responsible for investigating such allegations, the CQC had not been made aware of this incident. This meant there had been a breach of Regulation 18 of the Health and Social Care Act 2008. The action we have asked the provider to take can be found at the back of this report.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment. How the regulation was not being met: Suitable arrangements were not in place for establishing and acting in accordance with the best interests of people who may lack capacity to consent. Regulation 18 (1) (b) (2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of service users. How the regulation was not being met: The planning and delivery of people's care did not ensure their safety and welfare due to inadequate risk assessments. Regulation 9 (1) (b) (ii)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines. How the regulation was not being met: People were not protected from the risks associated with medicines because appropriate arrangements were not in place for the safe keeping, dispensing and safe administration of medicines. Regulation 13.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA 2008 (Registration) Regulations 2010 Notifications of other incidents.

This section is primarily information for the provider

Compliance actions

How the regulation was not being met: The service had not notified the commission of an incident as required by law. Regulation 18 (1) (e)