1st Care (UK) Limited

Leen Valley Care 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?	Good
Is the service well-led?	Requires Improvement

Overall summary

We inspected the service on 17 March 2015. The inspection was unannounced. Leen Valley Care Home is registered to accommodate up to 36 people. On the day of our inspection 18 people were using the service.

The service did not have a registered manager in place at the time of our inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons.' Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

When we last inspected the service on 25 September 2014 we found there were improvements needed in relation to how care was planned for people with diabetes and end of life care. The provider sent us an action plan telling us they would make these

Summary of findings

improvements by 12 November 2014. We found at this inspection that this had not been completed and the provider had not made all of the improvements in line with their action plan.

People felt safe in the service but we found the provider had not always shared information with the local authority when they should. This meant the systems in place to protect people from the risk of abuse were not effective.

Medicines were not always managed safely and staffing levels were not matched to the needs of people who used the service to ensure they received care and support when they needed it.

People were supported by staff who had not been given the training to provide safe and appropriate care and support. People were not always protected by the Mental Capacity Act 2005. People were supported to eat and drink enough.

The acting manager told us that they had considered the requirements of the Deprivation of Liberty Safeguards and assessed that applications were not needed at this point but there were systems in place to ensure the appropriate assessments would take place if the need arose.

Referrals were made to health care professionals for additional support or guidance if people's health changed. However people who had a health related illness did not always have an appropriate care plan in place informing staff how to monitor the risk and how to respond if the person became unwell.

People were treated with dignity and respect and had their choices acted on. We saw staff were kind and caring when supporting people.

People enjoyed the activities and social stimulation they were offered. People also knew who to speak with if they had any concerns they wished to raise and they felt these would be taken seriously.

People were involved in giving their views on how the service was run through the systems used to monitor the quality of the service. Audits had been completed that resulted in recognising some improvements needed in the service. However a lack of oversight in relation to areas of monitoring safe systems had resulted in a decline in the service.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. 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.

Is the service safe?
The service was not consistently safe.

People felt safe but the systems in place to protect people from harm were not being adhered to in relation to recognising and responding to allegations or incidents.

People received their medication as prescribed but medicines were not managed safely.

There were not always enough staff to provide care and support to people when they needed it.

Requires Improvement

Is the service effective?
The service was not consistently effective.

People were supported by staff who had not received appropriate training.

Referrals were made to health care professionals for additional support or guidance if people's health changed. However people who had a health related illness did not always have an appropriate care plan in place informing staff how to monitor the risk and how to respond if the person became unwell.

Requires Improvement

Is the service caring?
The service was caring.

People were treated with kindness and respect.

People were encouraged to make choices in relation to their care and involved in planning their care.

Good

Is the service responsive?
The service was responsive.

People were involved in planning their care and were supported to pursue their interests and hobbies.

People felt comfortable to approach the acting manager with any issues and complaints were acted on.

Good

Is the service well-led?
The service was not consistently well led.

The systems in place to monitor the quality of the service were not effective.

The management team were approachable and sought the views of people who used the service, their relatives and staff.

Requires Improvement

Leen Valley Care 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 inspected the service on 17 March 2015. This was an unannounced inspection. The inspection team consisted of two inspectors 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.

Prior to our inspection we reviewed information we held about the service. This included previous inspection reports, information received and statutory notifications. A notification is information about important events which the provider is required to send us by law. We contacted commissioners (who fund the care for some people) of the service and asked them for their views. Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

During our inspection we spoke with eight people using the service, four relatives, the acting manager, the cook, four members of care staff and the registered provider. We observed the way in which staff supported people in the communal areas of the service. We looked at the care plans of six people and any associated daily records. We looked at staff training records as well as a range of other records relating to the running of the service, such as audits, maintenance records and medication administration records.

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.

Requires Improvement

Is the service safe?

Our findings

People felt safe in the service. One person said, "I feel safer here than I did in my own home" and another said, "It feels like one big family here." One relative told us they were very happy with the service and said, "We feel as though [relation] is safe here." The service had closed circuit television (CCTV) operating in all of the communal areas of the service. This was so that people could be monitored and the acting manager could see what was happening in these areas at any time. One person told us the cameras had assisted them one night as they had taken a wrong turning in the service and staff had seen this on the CCTV system and quickly assisted them.

However, people could not be assured that incidents would be responded to appropriately. Staff had received training in protecting people from the risk of abuse. The acting manager and staff we spoke with had a good knowledge of how to recognise and respond to allegations or incidents of abuse. They understood the process for reporting concerns and escalating them to external agencies if needed. However we saw there had been incidents in the service which should have been shared with the local authority's safeguarding team. These related to concerns raised about a relative about the impact one person's behaviour was having on other people and an incident which happened when staff were supporting a person with a piece of equipment.

There had also been a recent incident in relation to missing medicines. Although the provider had completed a thorough internal investigation of this, the incident should have been notified to the police, in line with the provider's policy, but this was not done until we asked the provider to do so.

We found that 1st Care (UK) Limited had not protected people against the risk of abuse. This was in breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People did not feel there were always enough staff working in the service. One person said, "There are things I would like help with, like dressing in the morning sometimes but I don't like to ask the staff as I don't want to be a bother and they already have enough on their plate." Another person said, "Staff here are very good, but they are always so busy. They never have time for a chat." One relative told us, "There are just not enough of them (staff)."

We asked two members of care staff if they felt there were enough staff on duty to enable them to provide people with the level of care described in their care plans. Both members of staff said they were always busy but thought there were sufficient staff on duty to support people and meet their needs.

In the afternoon we found the atmosphere was not as relaxed as it was in the morning and the staff were rushed and busy. We observed the only two staff on duty were assisting one person who needed two staff to support them, which meant there were no staff available to provide any support to the other 17 people.

Three people who used the service required two staff to assist them with any care and with only two staff on duty this would mean other people were frequently left without staff to support them. Some people reported not wanting to ask for help as staff were too busy. One person said, "I have used the bell once and a carer came and told me that they would come back as they were busy, but I had to call again as they never came." We also observed a person ask for a drink and staff told them they would get one "in a minute" but the person did not get a drink.

We saw that two people were at risk of falls and their falls prevention care plan stated that staff should observe them when they were mobilising to minimise the risk of them falling. During our visit we saw one of these people stood up alone and then fell. There were not any staff in the area as they were assisting other people .This meant systems in place to minimise the risk of people falling were not effective as there were not enough staff available to provide the monitoring as detailed in people's care plans.

We found that 1st Care (UK) Limited had not protected people against the risk of not receiving care and support when they needed it. This was in breach of regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Risks to individuals were recognised and assessed and staff had access to information about how to manage the risks. However we found this was not effective in managing the

Requires Improvement

Is the service safe?

risks in relation to falls prevention. Where people were at risk of falling there were care plans in place giving staff guidance on how they should support the person such as having pressure mats in their rooms which alerted the staff to them being out of bed during the night. We observed these pressure mats were in place and records showed these were being used appropriately. However we found that two of these people were still having falls on a regular basis. One person had fallen six times this year and another had fallen seven times this year. This showed systems for managing this risk were not effective and people were at risk of further falls.

We saw there were risk assessments in place for people in other areas of daily living such as nutrition and emergency situations, for example fire evacuation. These contained guidance for staff on how to minimise the risks and ensure the wellbeing of people.

The acting manager had recently re-introduced a medicines audit as required by the provider's policy for the management of medicines. We saw this audit had identified medicines which had gone missing. Not all of the missing medicines identified in the audit had been found which meant there was a risk the medicine could be consumed by someone it was not intended for. The Health and Social Care Act 2008 requires all providers to handle medicines safely, securely and appropriately. The regulations also require providers to ensure medicines are prescribed and given safely. We found that although written procedures were in place for investigating adverse events, incidents and errors or for sharing concerns about mishandling, these had not always been followed.

Staff who supported people with their medicines had not had their competency assessed and staff we spoke with were not aware of the procedures which should be followed for reporting drug errors.

We found that 1st Care (UK) Limited did not have systems in place to ensure the safe management of medicines. This was in breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service effective?

Our findings

At our inspection in September 2014 we found that improvements were needed in relation to monitoring healthcare in relation to diabetes. During this inspection we found that not all of the required improvements had been made and the monitoring of people with diabetes mellitus was not always managed appropriately.

We saw one person with diabetes had a care plan in place to guide staff in how to monitor and respond to this. However a second person had a care plan in place which instructed staff to monitor the person's blood sugar levels. We saw this had been monitored until November 2014 and then no further monitoring had taken place. There was a lack of guidance in the care plan informing staff what signs and symptoms this person may display if their blood sugar was too high or low. This meant that should the person's condition deteriorate staff may not recognise this.

We found the principals of the MCA were not consistently applied. For example one person had a health condition and records showed the person sometimes refused to let staff support them with this. A MCA assessment had not been considered to determine if the person had the capacity to understand the risks and to make a decision in their best interest if they did not have capacity.

People had been consulted about the CCTV in the service and the people who had the capacity to understand they were being filmed, had signed consent forms. Where people did not have the capacity, relatives had been asked to sign on their behalf. However MCA assessments had not been completed to show this decision had been made in people's best interest. This meant people's rights under the MCA were not always being upheld.

The manager had an understanding of the Mental Capacity Act 2005 (MCA) and described how they supported people to make their own decisions. However there had not been a recognition that people's capacity to consent to the CCTV. We found some but not all staff we spoke with had a good understanding of the MCA. One member of staff told us they had attended a course approximately two years ago which had given them a good understanding of the assessment process and how decisions were made in a person's best interest. Another member of staff was not familiar with the requirements of the act and told us this was an area where they required further training. The MCA is in place to protect people who lack capacity to make certain decisions because of illness or disability.

We found that 1st Care (UK) Limited did not have systems in place to ensure people were protected under the Mental Capacity Act 2005. This was in breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People felt they were supported to make decisions about their care and support and could decide what they did with their day. One person said, "If it gets too noisy or I don't like what is on TV, then I know I can go to my own room." We observed a health professional visited another person and this person did not want to go out of the lounge area to talk to the health professional. Staff asked the person for their consent to talk to the health professional in the lounge and the person gave consent to this.

People felt supported by staff who had the knowledge and skills to provide effective care and support. People were very complimentary of the staff and their ability to care effectively for them. One person told us, "I am very happy here. The girls know what they are doing and look after me well." One relative said, "I can't fault the care Mum gets."

However we found that training staff should be given in relation to safeguarding adults and moving and handling was out of date and staff had not been given refresher training to make sure they were up to date with current safe practice. The acting manager told us they had already booked this and we saw evidence of this booking.

We observed staff using a piece of equipment to assist a person with their mobility. The person was not able to stand very well and so the equipment used was not appropriate for this person to be supported safely. We saw from records that there had already been an incident with this person when using this equipment previously. This meant staff may not have the knowledge and skills to recognise this equipment may not be safe and so the person was placed at risk of falling whilst using this equipment. There had not been a request made for the

Is the service effective?

occupational therapist to assess whether this equipment was the right equipment to use to transfer this person and we asked the acting manager to make this referral on the day of our visit.

People had been supported by staff who had not been kept up to date with the skills, knowledge and support they needed to care for people safely. We asked staff if they felt they received the training they needed to enable them to carry out their role effectively. One member of staff told us they had received some training but were not up to date with all the training they needed for their role. One member of staff said they had received a supervision session with the new acting manager and had discussed their training and development needs. The other member of staff said that supervision and appraisal had slipped but these were now booked in for them to attend and discuss their training needs. The acting manager told us they recognised some training and support given to staff had slipped and this was being addressed with supervisions and training booked. We saw evidence of these bookings.

The acting manager displayed a good understanding of the Deprivation of Liberty Safeguarding (DoLS) and told us there was no one who currently used the service who required an application for a DoLS. DoLS protects the rights of people by ensuring that if there are restrictions on their freedom these are assessed by professionals who are trained to decide if the restriction is needed. We saw the acting manager had applied these principles recently when a relative had requested specialist equipment for their relation. The acting manager had felt this had not been the least restrictive way of keeping the person safe and so had moved the person to another bedroom and this had resulted in the desired outcome for the person without restricting them with the equipment.

People were supported to eat and drink enough to help keep them healthy. People we spoke with told us that the food was good and that they were given plenty to eat. One person said, “The food is very plain but good and I am full up all the while.” Another person said, “I enjoy the food here, I have a good appetite and I get plenty to eat.”

We observed the lunch time meal and we saw people were given good sized portions of food which looked appetising and nutritious. The food had been cooked from fresh ingredients, including vegetables, in the kitchen. Where people had been assessed as needing a special diet the cook was aware of this and the special diets were catered for, for example soft diets. Staff were available to give support to people who needed assistance with their meal.

We saw nutritional assessments were completed and where a risk of weight loss or gain had been identified, appropriate steps were taken to support the person with this. For example one person had some unplanned weight loss and staff had sought advice from the person’s GP and were now weighing the person weekly and putting extra calories in their meal. We saw this had been effective and the person’s weigh was now more stable.

Where people were at risk of developing a pressure ulcer or had developed an ulcer staff had sought appropriate advice from the district nursing team and had obtained specialist equipment to help manage the risk. We saw from the care records of one person who had a current pressure ulcer that there was a plan in place informing staff how to minimise the risk of the ulcer deteriorating and the person developing a further pressure ulcer. We saw staff were following advice from the visiting district nurses such as supporting the person with repositioning and using specialist pressure relieving equipment as detailed in the care plan. We saw this care was effective with the ulcer making progress with healing.

We spoke with a visiting healthcare professional who told us staff called them to request a visit if they had concerns about a person’s health.

We saw that where health professionals had given guidance on supporting people with specific needs, this information had been added to the person’s care plan and the guidance was being followed by staff. For example one person had been assessed by the Speech and Language Therapist team (SALT) and they had recommended the person be given a soft diet and supported with their meals. We observed this happened in practice on the day of our visit.

Good

Is the service caring?

Our findings

People told us that staff were kind and caring. One person told us, “I love it here. They (staff) are kind.” Another said, “The bit I like best about being here is being looked after so well.”

People were treated with kindness and compassion by staff. We saw one person who became distressed and a member of staff responded to this straight away and reassured the person. The person was much calmer when the staff member had reassured them. Another member of staff was very gentle with a person who kept asking, “How much is that going to cost me?” The staff member was very patient and said, “It’s ok, it’s all covered, and you don’t need to pay anything extra.” This clearly relieved the person’s anxiety.

People’s preferences were known and respected by staff. For example we saw one person’s care plan detailed the person liked their drink in a specific way and we saw staff respect this preference. People told us their preferences were respected such as they could have a bath or shower when they preferred.

People felt they were able to choose what they did and how they spent their day. One person we spoke with told us, “I love the freedom of being here and the ability to do as I like, sit with others and talk or be by myself in my room.”

Independence was promoted in the service and we saw examples of staff supporting people with this. We saw two people had been given specialist crockery to enable them to eat independently and we saw this was effective.

We saw there had been building work carried out since our last inspection to create an extra lounge so that people had a choice of where to spend their time. The provider said they were also having talks about creating a further lounge area on the second floor of the service.

The acting manager told us that no one was currently using an advocate. Advocates are trained professionals who support, enable and empower people to speak up. Following our visit the provider arranged for an advocate to visit the service to inform people of their role and how they could support them if people wished to use this service.

People we spoke with told us that staff respected their privacy and dignity. We observed staff respecting people’s privacy and dignity when supporting them. For example speaking to people discreetly about matters of a personal nature and knocking or bedroom doors and waiting for an answer prior to entering. Staff we spoke with understood the need to respect people’s dignity for example when providing personal care. One member of staff told us about the importance of talking to the person to check they were happy with the care being provided. Another member of staff described how they supported people to be involved in tasks such as getting dressed, to support the person’s independence and dignity.

Good

Is the service responsive?

Our findings

People told us they felt they were supported to have a say in how they were supported and care plans we reviewed reflected this. People had access to their care records and we saw that people who used the service and their relatives, where appropriate, had been consulted about how they were supported and if they were happy with the way they were cared for in recent care reviews. This meant people were involved in planning their own care and support.

One person told us they enjoyed being outdoors and was encouraged by staff to go into the garden when it was warmer. They told us staff had asked them if they would like to do some gardening to brighten things up out there. The person told us, "Staff create things for us to do." Another person told us they were an, "Avid knitter" and had been encouraged to knit for another relative's baby granddaughter which made them, "Feel really good." They described other items they were going to knit and another service user joined in the conversation and requested an item be knitted for them. This showed people's individual hobbies were recognised and they were supported to continue with these.

There was an activities co-ordinator employed at the service, for a period of two hours in the afternoon. We saw there was a notice advising that there would be, 'Gentle Exercise at 10.30am each day', although this did not happen on the day we visited. When the activity organiser arrived in the afternoon they engaged a small group of people in a card game and played dominoes with an individual. People enjoyed these activities.

People felt they could speak with any of the staff and tell them if they were unhappy with the service. They told us they did not currently have any concerns but would feel comfortable telling the staff if they did. One person said they would speak with care staff if they had concerns and said, "If it's not their job, they (care staff) will ask someone else."

People could be assured their concerns would be responded to. There was a complaints procedure for staff to follow should a concern be raised. Staff we spoke with told us they would direct anyone who was unhappy with the service to the acting manager. One member of staff said they were aware there was a complaints policy and the manager and owner always took complaints seriously. We saw there had been three complaints raised and these had been recorded and addressed. However the previous manager had not recorded whether people had been satisfied with the response to the complaints so we were unable to assess this.

Requires Improvement

Is the service well-led?

Our findings

There was not a registered manager in post as they had recently left the service. A new acting manager had been recruited and had applied to us to become registered. The new acting manager understood their role and responsibilities and told us they knew there were improvements to make and they were working hard with the provider to make the improvements. People were clear about who the new acting manager was and felt they could approach them if they wanted to talk to them.

The provider spent time in the service speaking with people about the care they received and records showed people were reporting they were happy with the care they received. The provider also spent time speaking with relatives and staff during these visits. However we found there had been deterioration in the quality of the service people received during recent months and this had not been recognised by the provider for some time.

The last time we inspected the service we asked the provider to make some improvements to improve the assessing, planning and monitoring of people with diabetes. We found at this inspection that the improvements had been made to the one person's care plan where we had found shortfalls. However the provider had not ensured this was improved across the service to other people with the same condition. This meant the provider was not using the learning from this across the service in order to improve the care people received.

We found training and support for staff had slipped and incidents had not been dealt with appropriately. There had not been a structure in place for the provider to quality check the work being undertaken by the previous manager this had resulted in systems to provide safe and effective care declining. The provider agreed that the system for monitoring the service had not been effective and they had now put systems in place to ensure this did not happen again, for example a senior manager was working in the service on a regular basis overseeing the delivery of care.

We saw the provider had been auditing any accidents and falls on a monthly basis. However this had not lead to a recognition that some people were falling on a regular basis and steps were not taken to address why this was and if further preventative measures were needed. This resulted in some people continuing to have falls.

We saw that there were incidents which had occurred in the service which should have been shared with the local authority and had not been. There was no clear oversight of the incidents as these were recorded in people's care plans and there was no analysis of incidents happening in the service, to ensure these had been responded to appropriately and shared with the relevant bodies such as the local authority, the police and CQC.

We found that 1st Care (UK) Limited did not have effective systems in place to assess and monitor the quality of the service. This was in breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw audits had been carried out in the service such as environmental checks, infection control audits and meal quality audits. There were also checks made on equipment such as bed rails and specialist mattresses. These audits had been effective in continuous improvements and we found the environment and equipment to be safe and the service to be clean.

People were given the opportunity to have a say in what they thought about the quality of the service they received. We saw a satisfaction survey had been sent to people who used the service in June 2014 and the responses to these were mainly positive. People were also supported to attend meetings to give their views of the service and their relatives and friends were also invited to these. We saw the record of the most recent meeting and saw that there was positive engagement during the meeting with people and their relatives being encouraged to give their views.

People who used the service and their relatives told us they felt things had improved under the new ownership. They told us they felt well cared for and very happy in the service and relatives told us they felt their relations were cared for well by staff. One person said, "I can't fault it."

We observed people who used the service and staff who worked together to create a relaxed and welcoming atmosphere. There was a friendly banter between staff and people who used the service, who spoke openly and warmly to each other. We saw staff supporting each other and working well as a team.

Requires Improvement

Is the service well-led?

We saw there were greeting cards around the service with messages of thanks from relatives of people who used the service. The comments were complimentary of the care people had received.

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 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment Effective systems were not being effectively operated to ensure service users were protected from abuse. Regulation 13 (1) (2)(3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent Service users were not protected under the Mental Capacity Act 2005. Regulation 11(3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing Effective systems were not in place to ensure a sufficient number of staff were deployed at the service. Regulation 18(1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance Effective systems were not in place to assess, monitor and improve the service. Regulation 17(1) (2)(a)(b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

This section is primarily information for the provider

Action we have told the provider to take

Systems did not ensure the proper and safe management of medicines. Regulation 12 (1) (2)(g)

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.