Lawton Rise Care Home Limited

Lawton Rise 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?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This unannounced inspection took place on 13 December 2017. At our previous inspection in March 2015 we found no concerns and rated the service as 'outstanding'. At this inspection we found that the service was not consistently safe, effective, caring, responsive or well led. We found two breaches of the Health and Social Care Regulations (Regulated Activities) Regulations 2014.

Lawton Rise is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Lawton Rise accommodates 62 people living with dementia across four separate units, each of which have separate adapted facilities. At the time of the inspection 62 people were using the service.

There was a new manager in post who was in the process of registering with us. 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.

There were insufficient numbers of staff available to meet people's needs and reduce risks of harm and people's medicines were not always managed and administered safely.

Staff did not always follow national guidance in delivering care that met people's needs in an effective way. The provider was not following the principles of the MCA and ensuring that when people lacked the mental capacity to agree to their care they were supported to do so in their best interests.

The building and environment required improvement to meet people's needs in relation to their dementia. We have made a recommendation to offer staff further training in dementia care.

Staff had limited time to spend with people at mealtimes to ensure it was a dignified dining experience and people did not always receive personalise that met their individual needs and preferences due to a lack of available staff and routines.

The provider had a complaints procedure, however some relatives did not feel able to raise their concerns.

People had not always been consulted with about changes to their care routines and some relatives and some staff felt that the manager was not approachable.

People were safeguarded from the risk of abuse and lessons were learned following incidents that had resulted in harm.

Infection control procedures were followed to prevent the spread of infection.

People were supported and encouraged to engage in hobbies and entertainment and offered social stimulation.

People's wishes were gained as to how they wished to be cared for at the end of their life and people and their relatives were involved in their care planning and treated with dignity and respect.

People's right to privacy was upheld and respected.

People's needs were assessed and when their needs changed or they became unwell the appropriate health care support was gained in a timely manner.

People who used the service received a holistic service and were supported by staff who were trained and effective in their roles.

People were supported to eat and drink sufficient amounts to remain healthy.

The provider recognised the needs to improve the quality of care for people and was implementing new systems to bring about the improvements in a timely manner.

Staff worked alongside other agencies to ensure that a holistic approach was taken to people's care.

Audits and analysis of accidents and incidents were effective as lessons were learned and the quality of care was improved when concerns were raised.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

There were insufficient numbers of staff available to meet people's needs and reduce risks of harm.

People's medicines were not always managed and administered safely.

People were safeguarded from the risk of abuse and lessons were learned following incidents that had resulted in harm.

Infection control procedures were followed to prevent the spread of infection.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff did not always follow national guidance in delivering care that met people's needs in an effective way. The provider was not following the principles of the MCA and ensuring that when people lacked the mental capacity to agree to their care they were supported to do so in their best interests.

The building and environment required improvement to meet people's needs in relation to their dementia.

People's needs were assessed and when their needs changed or they became unwell the appropriate health care support was gained in a timely manner.

People who used the service received a holistic service and were supported by staff who were trained and effective in their roles.

People were supported to eat and drink sufficient amounts to remain healthy.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Staff had limited time to spend with people at mealtimes to ensure it was a dignified dining experience.

People and their relatives were involved in their care planning and treated with dignity and respect.

People's right to privacy was upheld and respected.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People did not always receive personalise that met their individual needs and preferences due to a lack of available staff and routines.

The provider had a complaints procedure, however some relatives did not feel able to raise their concerns.

People were supported and encouraged to engage in hobbies and entertainment and offered social stimulation.

People's wishes were gained as to how they wished to be cared for at the end of their life.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

People had not always been consulted with about changes to their care routines. Some relatives and some staff felt that the manager was not approachable.

The provider recognised the needs to improve the quality of care for people and was implementing new systems to bring about the improvements in a timely manner.

Staff worked alongside other agencies to ensure that a holistic approach was taken to people's care.

Audits and analysis of accidents and incidents were effective as lessons were learned and the quality of care was improved when concerns were raised.

Lawton Rise 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 checked 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.

This inspection took place on13 December 2017 and was unannounced. The inspection team comprised of two inspectors, a specialist nurse advisor and 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.

We used information the provider sent us in the Provider Information Return to help us with our planning. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We looked at notifications the provider is required to send us.

We spoke with two people who used the service and eight relatives. We spoke with two nurses and seven care staff and the cook. We spoke with the manager and two area managers. We spoke with a visiting health care professional.

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 looked at six people's care records. We looked at the way medicines were managed and the systems the provider had in place to monitor and improve the quality of service. We looked at staff rotas, training records and two staff recruitment files.

Requires Improvement

Is the service safe?

Our findings

At our previous inspection we found no concerns in the safety of the service. At this inspection we found that people were not always receiving safe care due a lack of available staff.

Staff told us and we saw that there were insufficient staff members to meet people's needs in a safe and timely way. In one unit we saw that all the people who resided there required two members of staff to support them due to them not being able to mobilise. A member of staff was allocated to supervise and support people to eat breakfast and this left one member of staff to support people to get up whilst the nurse administered the medication. The member of staff supporting people to get up and dressed had to wait for a member of staff to be available from the other adjoining unit and this meant that some people had to have their breakfast in bed whilst waiting. A nurse told us that staff went on their breaks at 10.30am whether people had been supported to get up or not and this delayed people getting the support they needed. Two members of staff told us that they had supported people to wash and change on the bed alone as they felt guilty making people wait. This would put people at risk as they had mobility problems and required moving using safe moving and handling techniques which would require two staff members.

One staff member in another unit told us: "Last week we only had two staff in here and [Person's name] requires one to one staff support. We did raise this with the management at the time. It can be very difficult even when we have three staff. It's ok if [Person's name] is asleep as we can help with other people but when staff are helping people in their rooms, we don't have spare staff in the lounge to help other people". We observed that this was the case on the day of the inspection as we saw that staff member providing one to one support to the person who required it and was trying to support them to have a drink. Two other people were becoming anxious in the same area and there was potential for an incident of challenging behaviour. We saw that the staff member was trying to diffuse the situation whilst maintaining the one to one support. The lack of available staff meant that people were at risk of harm as there were insufficient staff to support people when they became anxious.

A relative told us: "I have been asked to 'watch' the lounge whilst staff go off and support people; I shouldn't have to do that should I? I'm here to visit my relative". A member of staff told us that the day before the inspection there had been an incident where one person had assaulted another person and the staff member had left the one to one support and go and assist. This had left the person at risk as they were not receiving their required one to one staff that they had been assessed as needing.

A further member of staff told us that people did not always have their care needs met due to a lack of available staff. They told us and we saw that several people had risk assessments and needed repositioning to prevent their skin from getting sore and developing pressure ulcers. We found that two people had not been repositioned as required. A member of staff told us: "We feel like we are rushing, we reposition people as often as we can, I'm always worried people are going to fall when left alone". This meant that these people were at risk of sore skin and pressure areas as their risk assessments were not being followed and the risk of harm were not being minimised.

In another unit we saw that some people were still waiting to be supported to eat their meals at 13.45. These people were all living with dementia and needed staff to help them eat and drink. A member of staff in this unit told us: "The last person to get out of bed wasn't until 12.45 as we are so busy". This meant that these people were not having their care needs met in a timely manner.

Two relatives told us that three people in an upstairs unit had missed the planned activity by 45 minutes as it was due to start at 2.00pm, however staff had not been able to bring them down until 2.45pm due to there not being enough staff to support them down at the desired time. This meant that people were missing out on opportunities for social activities due to a lack of available staff.

The manager informed us that the staffing levels haven't reduced since they had been at the service. However the staff had previously not been allocated to give the one to one support as required, so they had ensured that this was now in place. This had meant that the general staffing levels had reduced for the other people who used the service. They told us they were in the process of recruiting new staff members and looking at changing senior staff job roles to give support to the nursing staff. This meant that there were insufficient numbers of staff to keep people safe.

These issues were a breach of Regulation 18 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked to see if medicines were being managed safely. Some people were prescribed 'as required' (PRN) medicine for pain or anxiety/agitation. We found that there were no instructions for staff to know when people may require the medicine and most people at the service would be unable to ask for when they needed it. We saw several people were being administered anti-anxiety 'PRN' medicine and there was no recorded justification for the use of this medicine. We saw two people were regularly being administered this medicine and there had been no review to ensure that this was being given appropriately. This put these people at risk of being administered medicine they did not require.

We checked a sample of stock of medicine and found that the balance of medicine did not match the amount recorded as being available. This meant the provider could not be sure that all people had their medicines as required.

These issues were a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The manager and staff had received training and knew what to do if they suspected someone who used the service had been abused. Incidents of assault between people who used the service were recorded and reported to the local authority for further investigation. We saw that safeguarding incidents had been acted upon and reported according to the local authority safeguarding procedures.

We saw that following accidents and incidents there was an investigation into how they had occurred. The provider conducted a root cause analysis (RCA) for serious incidents that had resulted in harm and we saw that action was taken to reduce the risk of the incident occurring again. For example, one person had fallen out of a chair and injured themselves. A RCA had been completed and the outcome was that a new more suitable chair was purchased for the person. This meant that lessons were learned following incidents to minimise the risk of them occurring again.

We looked at how the service prevented the spread of infection and we saw that staff followed infection control procedures when going about their tasks. We saw that staff used gloves and that there was

antibacterial gel throughout the building. Infection control procedures were followed when laundering people's soiled laundry and the building was clean and hygienic throughout.

Requires Improvement

Is the service effective?

Our findings

At our previous inspection we had no concerns in the effectiveness of the service. At this inspection we found that the effectiveness of the service required improvement.

The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People who used the service were living with dementia and required support to consent to their care and treatment at the service. One person had a do not attempt resuscitation order (DNAR) which had been signed by a member of the nursing staff at the service as being in agreement of the order. The decision to have a DNAR should be made by the clinician, for example the person's GP, the person themselves if able in consultation with family members. We also saw that a member of staff had contacted people's relatives to ask them to consent to their relatives having the flu jab. This decision should be made in the persons best interest by the person prescribing the flu jab, for example, the Doctor as one adult cannot consent to the care and treatment of another unless they had lasting power of attorney for health and welfare and there was no evidence that this was the case. This meant that the principles of the MCA were not being consistently followed to ensure that people who lacked the mental capacity to make decisions were supported to do so safely.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We saw that the provider followed the MCA in relation to people who were unable to consent to being at the service and other restrictions that were in place. People had DoLS authorisations and applications to restrict people legally had been made to the local safeguarding authority. This meant people were being protected from being unlawfully restricted of their liberty.

People mostly told us they liked the food they were offered and we saw that there was food available to meet people's individual needs, such as soft and diabetic diets. A relative told us: "My relative has soft meat and does enjoy the food. Particularly in summer they get plenty of drinks and encouragement.'' Another relative told us: "I arrived one day to find my relative covered in chocolate custard. The staff know they love chocolate. My relative was really enjoying themselves. The staff helped to clean them up as soon as they had finished". We saw when people lost weight or experienced difficulty in eating that health care advice was sought to ensure people maintained a healthy weight and diet. A relative told us: "The staff adapt when my relative is tired to finger foods to encourage them to eat as they have lost some weight". This showed that people's nutritional needs were being met.

Some people who used the service at times became anxious and unsettled and this resulted in them becoming aggressive towards others. We saw that not all these people had comprehensive care plans to be able to support staff to care for them at these times. For example we saw staff had recorded that one person

had been hitting staff, however there was no care plan to inform staff how to support this person at these times and maintain their safety. We saw that although staff recorded incidents of challenging behaviour the records would not have helped in identifying any triggers to people's behaviour. We recommend that as a service aiming to be a dementia specialist, training would be valuable to ensure that staff are fully aware of how and why records of incidents might be effective in assisting care and of what information needs to be recorded.

The building had been adapted to meet the physical needs of people who used the service. We saw there were grab rails and flat services for people to be able to mobilise safely throughout independently. The manager had made some changes to some people's living areas to create space and meaningful interactions for people. The service would benefit from being adapted to meet the needs of people living with dementia to support them to orientate to time and place and offer stimulation. The manager told us there were plans to adapt the building to ensure that it met the needs of people living with dementia. The provider was in the process of completing 'The Kings Fund environmental assessment tool'. The tool is designed to support clinical and care staff, managers to become more dementia friendly.

People were supported by staff who were trained and competent in their roles. Staff received on-going training and personal development from a line manager. Relatives we spoke with told us that they felt that staff knew how to care for people effectively. A person who used the service told us: "The staff know what to do from what I have seen". A relative told us: "Yes the staff know what they're doing. I know they get training for example in handling of people and other training".

When people became unwell or their health care needs changed we saw that the appropriate health care advice was sought in a timely manner. People had access to their Doctor and referrals to other health professionals such as speech and language therapists were made to support people to remain healthy. Staff at the service worked with other agencies to offer a holistic approach to people's care. Each person was having a full review and assessment of their care which included all the health and social care professionals and relatives who were involved in the person's life.

Requires Improvement

Is the service caring?

Our findings

People and their relatives were mostly involved in the planning of their care. However, some relatives told us that they had not been informed of some changes which had taken place since the new manager had been in post. We discussed this with the manager and area manager who recognised that they had not consulted with some relatives and had offered them an apology. The area manager told us that they had instructed that changes had been made swiftly to enhance the quality of life for people. There were planned resident and relatives meetings and everyone who used the service was having a full review of their care which would involve people and their relatives. One relative confirmed that they had attended a review, they told us: "I have been involved in my relative's care plan. We had a review about two weeks ago and I've signed it". Another relative told us: "The staff always keep me up to date, I get a phone call if my relative has a knock or a bruise''.

We observed people's care and found that although the staff were kind and caring in their interactions they had little time to offer meaningful time with people especially during mealtimes. During breakfast in one lounge we observed one member of staff supporting seven people to eat and drink one at a time as they all required full support. The staff member went from one person to the next whilst other staff were supporting other people to get up. A member of staff told us: "We feel like we are rushing people, we have no time". The breakfast experience lacked a pleasant meaningful feel as it was task led and people had to wait and watch whilst other people were supported. At lunchtime we observed that there were too few staff available to support people to eat and drink in a timely way. In one lounge several people had to wait up to an hour and a half to be supported to eat and drink whilst staff supported other people. These people were left watching and waiting or sleeping whilst mealtime proceeded. This did not demonstrate a dignified and respectful approach to mealtimes.

People and their relatives told us that staff treated them well. One person who used the service told us: "The staff treat me nicely". A relative told us: "Carers have always got a smile for you, and my relative is loved. Sociability costs nothing. The staff always have time for me too. They think about me which makes visiting easier. I'm not just sat in a corner. I regularly see carers acting kindly to residents". Another relative told us: "'All the Staff are lovely. They chat and take their time. I'm never made to feel like a spare part. They recognise my needs too. You can feel the affection as the staff care for my relative. One example of how much the staff care was my relative's birthday. I arrived and their door was covered in balloons. They didn't know I was coming. I live a long way off so have no regular day. They did it for my relative and all the staff sang happy birthday. It meant the world to me. This kind of care is part of their everyday experience.'' This showed that people and their relatives were treated kindly and respected.

People's right to privacy was respected. One person told us: "The staff always knock before coming in my room". We saw one person who due to their dementia had limited inhibitions and at times exposed themselves to other people. We saw that the staff had devised a way of protecting the person's dignity by using a privacy screen when the person had taken to undressing. This demonstrated that staff were supporting this person to maintain their dignity and ensuring their privacy.

Requires Improvement

Is the service responsive?

Our findings

At our previous inspection we had no concerns in the responsiveness of the service. At this inspection we found that this area required improvement.

We observed people's care and found that people were not always receiving personalised care due to a lack of available staff and routine. We saw that people had care plans and that their preferences were recorded, for example in relation to what time they would like to get up or go to bed. However we found that routines were in place which meant that care was not always designed around people's individual needs. For example, some people had to wait to be supported to get up in the morning due to a lack of staff. Consideration to staff going on their breaks had not been made to ensure that people's individual needs were met first.

The provider had a complaints procedure and we saw that if a formal complaint was made this was dealt with according to the procedure. However some relatives told us they did not feel able to raise concerns with the manager and they felt that they had not been kept informed of the changes in the service. We discussed this with the manager and area manager who recognised that more needed to be done to ensure people felt able to raise concerns.

People's care was in the process of being reviewed with people and their relatives. We spoke with a visiting health professional who was facilitating the reviews. They told us: "Every family member I have seen has been very positive about the environment and person-centred care provided. Staff communication has been friendly and I have been informed of any changes to people's needs". A relative told us: I've not long signed my relatives care plan. I'm impressed with the daily recordings of what happens in every aspect of their life here. I like the booklets all about the Resident. I've seen them adding in to it if they like a particular food.''

Staff knew people well and knew their needs and preferences and responded to changes to people's care. A relative told us: "When my relative was assessed for some liquidised food it was put in place straight away". A member of staff told us how they treated people as an individual. They told us: "I like the saying, 'My bubble, My rules'. It's about getting to know people and respecting how they want to live their life".

People were offered opportunities to engage in activities. The activity staff designed the activity programme around the individual needs of people. There were group activities including external entertainment and there were one to one activities with people who required more intensive interaction. We observed one activity coordinator sitting and just chatting with people about their life. People enjoyed this time and we saw they responded to the staff member fondly. We saw that the staff member also recognised when people had had enough and was able to withdraw the support before the person became anxious.

People were cared for at the end of their life. There was no one receiving end of life care at the time of the inspection however we saw that people had an end of life plan which documented how they chose to be cared for when the time came. Trained staff recognised when people were coming to the end of their life and referred them in a timely way to an end of life team who would coordinate the care including any

medication the person may require.

Requires Improvement

Is the service well-led?

Our findings

At the previous inspection we had no concerns in how the service was led. At this inspection we found that this area required improvement.

There was a new manager in post who was in the process of registering with us. Prior to this inspection we had received information of concern about the management of the service. We spoke with some people's relatives and staff who told us that they found that the manager was not approachable and had made changes without consulting with people. A relative told us: "I think the changes will be good but they've gone about it the wrong way". We discussed these concerns with the manager and area manager who informed us that the provider had wanted the manager to make changes quickly to ensure the safety and welfare of people who used the service. They recognised that this may not have been managed as sensitively as it could have been and they were working on building relationships with relatives and staff through regular meetings, a human resources clinic and having an open door policy. The manager told us that they had offered some relatives an apology as they had not been informed of some changes made to their relative's environment.

We fed back our concerns in relation to the staffing levels and the management of medicines and both the management and staff were responsive to our findings. A nurse immediately started to record when and why people were being administered 'PRN' medication. The area manager and manager told us that they would take our feedback, speak to staff and complete their own observations into the staffing requirements throughout the service.

The provider had recognised the need to improve the service and had a clear vision of where it needed to be. The manager was implementing new systems and ways of working which would potentially improve the quality of the service. Senior staff were undertaking medication training and although some staff and relatives were resistant to this, the benefits would be that the nursing staff would be able to spend more time carrying out clinical duties. The manager told us that this would also benefit the senior staff's personal development and help with career progression.

Every person was being fully assessed and their care reviewed. This was to ensure that people were receiving the right care and to identify any areas for improvement. People and their relatives were invited to attend the reviews and there were planned relative and resident meeting. The area manager told us they planned to implement a relative's support group as they recognised that relatives needed support too and this support often came from other relatives.

There was a range of audits and accident and incident analysis which took place and we saw that action was taken to improve when areas of concern were identified. For example, we saw the 'night audit' had identified that the service required more staff during the evening to support people living with dementia who often became anxious at these times. A 'twilight' member of staff had been put in place and this had proved successful. The area manager told us that following our feedback on the breakfast experience that they would also look into having more staff over the mealtimes.

The provider worked in partnership with other agencies and was following national guidance in improving the service. For example, they had plans in place to improve the environment using the 'Kings Fund tool' which would improve the quality of service for people living with dementia.

The manager and provider knew their requirements in relation to their registration with us (CQC). We had been informed of significant events through the submission of notifications.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People's medicines were not managed safely.

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.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing There were insufficient staff to meet people's needs in a safe and timely manner.

The enforcement action we took:

We served the provider with a warning notice.