Aegis Residential Care Homes Limited

Ladydale Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	Good
Is the service effective?	Requires Improvement
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

We carried out an unannounced comprehensive inspection of this service on 31 January 2017 and breaches of legal requirements were found. After the comprehensive inspection, the provider wrote to us to say what they would do to meet legal requirements in relation to the breaches.

We undertook this focused inspection to check that they had followed their plan and to confirm that they now met legal requirements. This report only covers our findings in relation to those requirements. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Ladydale Care Home on our website at www.cqc.org.uk. We found that improvements had been made in relation to all four previous breaches, so those regulations were no longer being breached.

The inspection took place on 10 May 2017 and was unannounced. Ladydale Care Home is a residential home for up to 54 people who have a variety of support needs, such as people with a physical disability, those with dementia or people who have a learning difficulty. There were 34 people living at the service at the time of the inspection.

There was a Registered Manager in post 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.

The principles of the Mental Capacity Act 2005 (MCA) were not always followed. Conditions for Deprivation of Liberty Safeguards (DoLS) were not always being followed. Mental capacity assessments were not always carried out to help determine if people had capacity to make decisions and evidence of Lasting Power of Attorney (LPOA) was not always in place.

Audits were now being carried out and whilst some had been effective, some actions had not yet been completed and further work was required to ensure the improvements continued and that all plans were updated to reflect that people had care and support that protected their wellbeing.

People told us they felt safe and their relatives confirmed they felt their loved ones were safe in the home. We found staff understood risks to peoples safety. For example, there were detailed plans in place to help people who needed support of they became agitated so that staff could effectively support them and action was taken to ensure people's health and wellbeing was being protected. Medicines were being managed safely, however further improvements were required to staff training for topical medicine administration and guidance for staff on as required medicines. People, relatives and staff told they felt there were enough staff and our observations confirmed this. Safe recruitment practices were in place and staff had appropriate checks prior to starting work to ensure they were suitable to work with people who use the service.

Plans were also in place for people who needed support to maintain their skin integrity and for those at risk of falls. We could see appropriate analysis and action had been taken following a person falling to try and reduce the risk of another fall occurring.

Up to date plans were in place for staff to follow in the event of an emergency evacuation of the home.

People were protected from abuse by staff who understood the different types of abuse, how to recognise it and to report it if they suspected someone was being abused. We saw appropriate safeguarding referrals had been made.

People were complimentary about the food and were supported to have food and drinks of their choice that were appropriate for their needs. People had access to other health professionals in order to maintain their health and wellbeing.

Staff and relatives knew who the registered manager was and felt able to go to them with queries. The manager was proactive in seeking and encouraging feedback from people and relatives, in the form of meetings and surveys, and this feedback was acted upon. Staff also felt supported and that they could approach the registered manager.

The registered manager had also been submitting notifications about the service, which they are required to do.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People and relatives told us the home felt safe.

There were sufficient numbers of appropriately recruited staff to support people.

Medicines were managed safely although we recommend PRN protocols are adopted for all appropriate medicines.

People were protected from abuse by staff who understood their responsibilities and safeguarding referrals were made.

Plans were in place for people who needed support with their behaviours that others may find challenging, skin integrity and falls.

Is the service effective?

Requires Improvement

We could not improve the rating for effective from requires improvement because to do so requires consistent good practice over time. We will check this during our next planned comprehensive inspection.

The principles of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards were not always being followed. One person was sometimes being deprived of their liberty. Capacity assessments were not always carried out and Lasting Power of Attorney's were not always checked. Work was in progress to improve this.

Staff were trained however we recommend staff who apply topical medicines would benefit from medicines training.

People had a choice of food and their preferences and needs were catered for.

People had access to health care services and were supported by staff where required.

Is the service well-led?

Requires Improvement

We could not improve the rating for well-led from requires improvement because to do so requires consistent good practice over time. We will check this during our next planned comprehensive inspection.

Action had not always been taken to rectify issues when they had been identified in audits and some files needed updating. Work was in progress to improve this.

People were encouraged to give feedback about their care and feedback was acted upon if improvements were required.

People, relatives and staff all felt supported by the manager and felt they were approachable.

Ladydale 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 undertook an unannounced focused inspection of Ladydale Care Home on 10 May 2017. This inspection was done to check that improvements to meet legal requirements planned by the provider after our inspection on 31 January 2017 had been made. The team inspected the service against three of the five questions we ask about services: is the service safe, is the service effective and is the service well-led? This is because the service was not meeting some legal requirements.

The inspection was carried out by two inspectors. 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 carried out a lunchtime observation to see how people were supported during meals in order to help us understand people's mealtime experiences.

We looked at information we held about the service including statutory notifications submitted. Statutory notifications include information about important events which the provider is required to send us by law. We also asked commissioners and Healthwatch if they had any information they wanted to share with us about the service. Healthwatch is an organisation that gathers information from people and relatives who use services and provides feedback to commissioners and regulators (like the CQC) about those services.

We spoke with six people who use the service, two relatives, five members of staff that supported people, the registered manager, the assistant manager, the provider, one of the domestic staff and one visiting professional that had contact with the people who use the service. We also made observations in communal areas. We reviewed the care plans and other care records (such as medicine records) for seven people who use the service. We also looked at management records such as quality audits. We looked at recruitment files and training records for two members of staff.

Good

Is the service safe?

Our findings

At the last four inspections we found the provider was not adequately assessing or managing the risks to people's safety and welfare. This was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We found that risks to people's safety and well-being had not always been consistently assessed or reviewed. Risk assessments relating to how staff supported people in the event of an evacuation of the home were not up to date. People who needed assistance with behaviours that others may find challenging however there were not always plans for staff to follow to support them. Medicines were not always available. Staff did not always have appropriate recruitment checks prior to starting working in the service. At this inspection we found the service was no longer in breach of this Regulation.

Medicines were managed safely. We observed staff administering medicines and they were kind and encouraging and they explained what the medicine was to people. Records of stock levels matched the amounts available and were stored appropriately. Medication Administration Records (MARs) contained instructions for staff to follow and were being completed by staff. Some medicine is applied or taken as and when required, called 'PRN medicine'. Protocols should be in place for staff to follow so they can identify when a person should take their medicine and what the guidance is around taking that particular PRN medicine. We found some people did not have guidance in place for staff when the medicine was, although we did see some evidence of this for some people We recommend the service look to ensure that all appropriate medicines have a PRN protocol in place as some people may not be able to tell staff if they needed their PRN medicine as they lacked capacity.

People were supported by sufficient staff to keep people safe. One relative told us, "My relative needs two staff to move and they always receive that support" and they went on to say, "The staffing at night used to be a big issue but it seems ok now." Staff told gave us positive feedback about staffing. A member of staff told us, "The staffing is enough, it has improved." We observed that people did not have to wait long for support, for example one person asked for a drink and the member of staff got it for them straight away. The registered manager explained they used a dependency tool and also took into account the layout of the building when deciding how many staff were required. This meant the provider had sufficient staff to protect people's health safety and wellbeing were being protected.

The service followed safe recruitment practices. Staff files we viewed included application forms, records of interview and appropriate references. Records showed that checks had been made with the Disclosure and Barring Service (criminal records check) to make sure people were suitable to work with people who used the service. This meant that people were supported by staff who were suitable to work with the people who used the service.

People were supported to manage risks to their safety. One relative we spoke with said, "My relative has been prone to pressure sores but now they have got better." Staff were able to describe the support people needed to maintain their skin integrity. One member of staff said, "[Person's name] has a cushion, we stand them up every four hours, they have a mattress and has cream applied to help pressure areas." Records

gave detailed plans for managing risks and we saw that staff were following plans in place which included input from other health professionals. This meant people were supported to maintain their skin integrity.

In another example, where people needed extra support when they became agitated or distressed staff were able to tell us how they supported people and there were detailed plans for staff to follow should a person become agitated. We found the registered manager had reviewed incidents of agitation to identify steps to prevent further episodes. For example, one person's incident reviews resulted in a referral to another health professional to support the person. This meant people were supported to become less distressed during periods of behaviour that others may find challenging and it protected their safety and wellbeing.

In a further example, where people were at risk of falls appropriate plans were in place to reduce the likelihood of a person falling. For example, one person had fallen and an investigation had taken place as to why the person fell and action had been taken to carry out a medicines review and put a falls senor mat in place. We reviewed risk assessments relating to how staff supported people in the event of an evacuation of the home. We saw the guidance reflected people's current needs and matched the care plan. This meant people were protected in the event of an evacuation as staff had appropriate plans to refer to. This showed us people were supported to manage risks to their safety.

People told us they felt safe. One person said, "I feel as safe as houses, there are staff here and they are all lovely." A relative we spoke with said, "The staff try to keep my relative safe." Staff knew the different types of abuse, how to recognise potential abuse and what to do if they suspected someone was being abused. One member of staff said, "I would have no hesitation to report any concerns, but I have never seen anything here." Another member of staff told us, "I wouldn't have any problems with reporting something." We saw appropriate referrals to the local safeguarding authority had been made. This meant people were protected from abuse and improper treatment.

Requires Improvement

Is the service effective?

Our findings

At our last four inspections, we found that the requirements of the Mental Capacity Act 2005 (MCA) were not always followed or met. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, we found although some improvements had been made so that the service was no longer in breach of Regulation 11, further action was required to ensure people were protected by the appropriate implementation of the MCA. At the last inspection the service was found to be in breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, we found although some improvements had been made so that the service was no longer in breach of Regulation 13, further action was required to ensure people were not being deprived of their liberty.

The MCA 2005 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 can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). In order for staff to know whether a person no longer has their capacity and whether a DoLS referral is appropriate, a mental capacity assessment should be carried out to help them determine the type of decisions a person can make. Multiple referrals had been made, however people did not always have capacity assessments in place. The service was going through reviewing people in order to ensure they had appropriate capacity assessments in place. Therefore it was not always possible to determine how the service established that a DoLS referral was required and whether the person had capacity to decide about where they chose to live in some instances. This meant that although some appropriate applications had been made, people who had a DoLS application in place had not been assessed sufficiently.

Once a DoLS referral has been considered by the local safeguarding authority there can be conditions placed upon the agreement to ensure that people are not inappropriately restricted. We saw that one person had a condition on their DoLS agreement which meant they had to be offered the opportunity to leave the home at least once per week and for this to be recorded. However the home were not consistently offering this opportunity and there were no records. Once this was discussed with the registered manager and management team a plan was put in place for them to start consistently offering the person this opportunity, in line with the condition. This meant the home were not consistently complying with a DoLS condition and the person was sometimes being restricted.

A person who has Lasting Power Of Attorney (LPOA) for health and welfare has the legal right to make decisions and sign agreement on behalf of someone who has lost their capacity to make their own decisions. We saw evidence that LPOA had been considered by the service and saw some evidence of LPOAs in people's files. However, in some instances, copies or evidence that a LPOA was in place were not available so it could not be verified whether representatives had the right to make decisions on people's behalf. This

meant people were not always protected as people who may not have had the legal right to make decisions had been recorded as able to make these decisions. The service explained this was a work in progress and they were in the process of liaising with some relatives or representatives for this information where appropriate.

Relatives told us their loved ones were offered choices and we saw staff offering choices and checking consent. People's choices were also respected by the home. One relative we spoke with said, "It's my relative's choice not to have drinks that are appropriate to their needs. The staff ask what my relative wants and they try to accommodate their likes and dislikes" and they went on to say, "Staff checking consent is a lot more evident." We observed staff offering choice, for example one person asked where they could sit and the staff member told them, "You can sit wherever you like." We saw that the home had documented the person choice not to have drinks that were appropriate to their needs as they had the capacity to choose and a risk assessment was in place for staff to follow. We saw staff following this risk assessment in order to ensure they respected the person's choice.

People received support from staff that had the skills and knowledge to support them effectively. Staff told us they had received training regarding the MCA and DoLS. One member of staff explained DoLS were, "for people who have not got capacity and ensuring best interest decisions. Things like locked doors can be a restriction" and "about keeping people safe." Staff told us they had the training when they started working at the home, and were supported to refresh their training, which was both online and some face-to-face and we saw records to confirm this. A member of staff who was relatively new to the role said, "I spent a lot of time shadowing. I'd not worked in care before and the manager explained everything to me." One of the domestic staff told us, "I've had lots of training and I'm getting on alright." If people needed support to stand up or move, we saw staff using the appropriate techniques to do this. However, a member of staff told us that they assisted people with their topical creams however they had not had formal medicines training. We found that people were receiving their medicines as prescribed however we recommend that all care staff involved in the application of topical medicines are given appropriate training.

Staff felt supported in their role to effectively care for people. There were a mixture of group supervisions, individual supervisions and appraisals which we saw were documented. One member of staff said, "I've just done my appraisal, I can ask things about the people living here and how better to support them" and went on to say, "Everything you want for people, you can ask for." Another member of staff said, "The level of support is really, really good." This meant staff felt they had the support they needed to work effectively and to continue to care for people.

People were supported to maintain their nutritional intake and people told us they were happy with the food and they got to choose what they had. One person we spoke with said, "I've not been anywhere with this much choice. Even restaurants don't have this much choice." Another person told us that they had chosen their breakfast that morning. We observed people at lunch time having food appropriate for their dietary needs, and the food was well presented and staff explained what the food was to people. For example, it was in one person's nutritional plan that they could feed themselves but they may need assistance after a while due to becoming tired. The person's relative we spoke with said, "My relative's eating a lot more now as they are getting assistance." When we asked staff about the person's needs at meal times and what they told us matched the plan and we observed staff leaving the person to feed themselves then coming to them after a little while and supporting them to eat after checking the person's consent. We observed staff offering a range of drinks throughout the day. This meant people were offered a choice of food and had food and drink appropriate to their needs and in a way suitable for them.

We saw that other health professionals had been involved with people's care when necessary. We spoke

with a visiting health professional and they said, "I feel the home make appropriate referrals to us and if they are ever not sure of something they ring and ask us." We saw records involving Community Psychiatric Nurses, GPs, opticians, chiropodists and Speech and Language Therapists (SaLT). People were weighed regularly in order to check they remained healthy and were not unintentionally losing weight. One person had lost weight and this had been identified and a referral made to the GP. This meant people were being supported to access other health professionals to help maintain their wellbeing.

Requires Improvement

Is the service well-led?

Our findings

At our last four inspections, we found that effective systems were not in place to assess, monitor and improve quality and manage risks to people's health and wellbeing. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, we found some improvements had been made so that the service was no longer in breach, however some further action was required so that people were fully protected by effective systems to ensure accurate records were up to date for staff to follow.

We saw audit systems were in place and whilst many were effective and had identified some issues, action had not always been taken to remedy issues that had been found. For example, one person had skin integrity needs and whilst there were multiple plans in place, the information was not easy to follow as it was not consistently recorded within the skin integrity plan. We saw evidence that this had been identified in an audit, however action had not yet been taken to consolidate the plans into a clear plan for staff to follow. Another person was being supported to manage their diabetes and staff would check the person's blood sugar levels. There was generic guidance available for staff to follow however the range the blood sugar should be for that particular person was not documented within the person's care plan and what action staff should take should the person's blood sugar be outside of their healthy range. It had also been identified that some mental capacity assessments had not been carried out so it was not possible to determine how the service had decided it was appropriate to apply for a DoLS. One person was not having their DoLS condition complied with so they were being unlawfully restricted. Although some steps had been taken to start carrying out assessments, more work was required to get all the appropriate people reviewed and assessed.

We did also see some examples of effective auditing, such as that of incidents. We saw the registered manager had acted upon feedback from the previous inspection and records were put in place to support staff in the event of an emergency evacuation of the home. Also, that following care plan audits it had been identified one person did not have a positive behaviour support plan and we saw that this had now been put in place. As well as the registered manager carrying out regular audits, the provider would checks the audits carried out by the registered manager to ensure they were effective. For example, one audit had identified that further analysis was required if people had lost weight and we saw that the registered manager put this in place. This meant that although some audits had been effective, more work was required to continue the improvements and ensure all plans were reviewed to ensure people had care and support that protected their wellbeing.
We found a 'post-fall protocol' had been introduced which was to ensure appropriate action had been taken to protect people. A monthly analysis of falls within the home had taken place, and the number of falls occurring each month had gradually declined over a four month period. If people needed equipment to help them move around the home, we saw people and staff using this equipment and it matched what was recorded in people's plans. If people had been admitted to hospital, when they returned to the home their support needs had been reviewed to check if there had been any changes.

People, relatives and staff told us they found the registered manager approachable and felt supported. A

relative told us, "The home has definitely improved. The manager is approachable; they are a very good manager. They make a lot of effort." Another relative we spoke with said, "The new manager is approachable, has got things going and changed things." A member of staff said, "The manager is good at their job but is approachable." Another member of staff told us, "There is a better management structure now." We observed friendly and positive interactions between people and the registered manager. It was clear the new registered manager had started to get to know people well since starting in their role. This meant people, relatives and staff could approach the manager f they felt they needed to.

We saw there was a proactive approach to encouraging people to provide their opinion about their care. We saw surveys had been carried out and the registered manager had responded to the feedback with a 'You Said, We Did' document so people and relatives could see what action had been taken. One item of feedback was about the garden being improved. There were regular residents meetings being held where feedback about the home could be discussed. One of the meetings addressed the idea of making improvements to the home and what people would like. We saw that feedback had been acted upon and the garden was in the process of being improved with planters and the hair dressers room had been recently redecorated. New furniture and carpets had been replaced in some part of the home and there were plans for future improvements. We saw recorded that people had requested a more varied menu and particularly wanted more roast chicken dinners. We saw that roast chicken was being served on the day of our visit. Another meeting had discussed the idea of adding signs to people's bedroom doors so that people would know when they wanted privacy. We saw that following this discussion, individualised signs had been added to people's door. We also saw staff meetings took place and various topics were discussed such as staff conduct. For example, one meeting discussed with staff the need to ask people first whether they wanted their food to be cut up before staff do it. A meeting also discussed the need for staff to spend more meaningful time with people, rather than just carrying out tasks. We observed staff doing both of these things, which shows that team discussions had been effective.

Staff were also being encouraged to contribute to the improvement of the service. One member of staff we spoke with told us, "We want our home to be the best home." Other meetings with staff were held called 'flash' meetings which looked at different areas of learning each meeting, some of the topics discussed were general and applicable to all people, whereas some areas of development were tailored to the specific needs of the people living in the home. For example, some people needed support with their behaviour which others may find challenging and we saw 'flash' meetings had taken place to discuss those people's needs. Following a comment on a survey completed by a person living in the home, one of the 'flash' meetings was about a particular condition which some people in the home had, in order to extend staff understanding. Other meetings were based around the skills of some of the staff already working there so they could share their knowledge, for example one member of staff had experience of working with people with learning difficulties and the registered manager had a plan for them to conduct one of the 'flash' meetings. The registered manager also did regular checks when walking around the home and would informally speak to people about their opinions to check people were satisfied and conducted observations on staff. This meant the registered manager was proactively seeking out feedback, encouraging people to contribute if they wanted to and acted upon feedback to try and make improvements.

The registered manager submitted notifications to the CQC about incidents that they are required to send us by law.