Mrs Christine Lyte

Caythorpe Residential Home

Inspection report

77 High Street
Caythorpe
Grantham
Lincolnshire
NG32 3DP

Tel: 01400272552

Date of inspection visit:
23 August 2016

Date of publication:
30 September 2016

Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This was an unannounced inspection carried out on 23 August 2016.

Caythorpe Residential Home can provide accommodation and personal care for 14 older people and people who live with dementia. There were 14 people living in the service at the time of our inspection.

The provider of the service was a sole trader. This meant that the person who was the sole trader acted as both the provider of the service and the registered manager. In this report we refer to this individual as being, 'the registered person'. The registered person has a legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We carried out an unannounced comprehensive inspection of this service on 27 April 2016 and found that there were three breaches of legal requirements. We found that people were not consistently receiving safe care. This was because medicines were not being safely managed and, people were not fully protected from the risk of accidents. In addition, people were not consistently helped to reduce the risk of acquiring infections. A further shortfall we noted was that the system used to recruit staff was not robust. We also found that quality checks had not been completed in the right way to identify and quickly resolve problems in the running of the service.

After our inspection of 27 April 2016 the registered person wrote to us to say what improvements they intended to make in order to meet the legal requirements in relation to the breaches. They said that all of the problems we noted would be addressed so that people consistently received safe care. The registered person said that all of the necessary improvements would be completed by 31 June 2016.

This report only covers our findings in relation to the action taken by the registered person to meet the breaches of legal requirements. You can read the report from our last comprehensive inspection by selecting the 'all reports' link for Mrs Christine Lyte on our website at www.cqc.org.uk

At this inspection, we found that the registered person had introduced most of the improvements that were necessary to ensure that people safely and reliably benefited from receiving safe care. This meant that the relevant legal requirements had been met. However, a small number of further improvements still needed to be made to ensure that the service continued to reliably care for people in the right way.

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 registered person had improved the arrangements in place to ensure that people received safe care. This included making sure that medicines were managed safely and by better protecting people from avoidable risks to their health and safety. However, further steps still needed to be taken to address remaining defects in the accommodation that could result in people having avoidable accidents.

The registered person had made suitable arrangements to recruit staff. These included obtaining suitable background checks to ensure that applicants could demonstrate their previous good conduct and were suitable people to be employed to work in the service.

We have not revised the rating for this key question, to improve the rating to 'Good'. This is because we need to be sure that the registered person will address some remaining shortfalls in the arrangements made to enable people to benefit from receiving safe care. In addition, we need to be confident that the registered person will continue to operate robust arrangements when recruiting new staff.

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

Is the service well-led?

Requires Improvement

The registered person had introduced a number of the quality checks that were necessary to ensure that people reliably received the care they needed. However, further improvements in the completion of quality checks were needed to ensure that some remaining oversights in the running of the service were effectively addressed.

We have not revised the rating for this key question, to improve the rating to 'Good'. This is because we need to be sure that the registered person will fully establish and will maintain the robust quality checks that are needed to underpin the operation of the service.

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

Caythorpe Residential Home

Detailed findings

Background to this inspection

We undertook a focused inspection of Caythorpe Residential Home on 23 August 2016 to follow up on three breaches of legal requirements we had identified at our comprehensive inspection on 27 April 2016. This inspection was completed to check that the registered person had made the improvements necessary to ensure that people who lived in the service reliably benefited from receiving safe care that met their needs and wishes.

Our inspection was unannounced and the inspection team consisted of a single inspector.

We inspected the service against two of the five questions we ask about services: is the service safe and well-led? This was because at our earlier inspection the registered person was not meeting legal requirements in relation to these sections.

During our inspection we spoke with four people who lived in the service. We also spoke with two care workers, a senior care worker and the registered person. We observed care that was provided in communal areas and looked at the care records for three people living in the service. In addition, we looked at records that related to how the service was managed including staff recruitment, training and quality assurance.

After the inspection visit we spoke by telephone with three relatives. We did this so that they could tell us their views about how well the service was meeting people's needs and wishes.

Requires Improvement

Is the service safe?

Our findings

At our inspection on 27 April 2016 we found that there was a breach of Regulation 12 (2) (a) (b) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We noted that some of the arrangements in the service did not enable people to consistently benefit from receiving safe care. This was because there were shortfalls in the management of medicines and in the support provided for people who were at risk of developing sore skin. In addition, there were shortfalls in the arrangements used to prevent avoidable accidents and to protect people from acquiring infections.

After the inspection the registered person wrote to us to say that action had been taken to address all these problems. They said that the necessary improvements would be fully completed by 31 June 2016.

At our inspection on 27 April 2016 we found that there had been a number of occasions when records did not confirm that people had been consistently helped to use medicines in accordance with their doctors' recommendations. We also found that suitable checks were not being regularly made to ensure that medicines were stored at the correct temperature. This is necessary if they are to have their full therapeutic effect. In addition, we noted that reliable arrangements had not been made to ensure that a medicine remained within its 'use by' date. We also found that another medicine had not been returned to the pharmacy when no longer in use. This oversight had increased the risk that the medicines in question might be offered in error to someone for whom it had not been prescribed.

At the present inspection we found that medicines were safely stored and managed and that they were disposed of in the correct way. We examined records that described the medicines that had been dispensed to three people during the week preceding our inspection visit. We found that all of the medicines had been dispensed in accordance with the doctors' instructions and that this process had been properly recorded. We also found that regular checks had been completed to ensure that medicines were stored at the correct temperature and that new checks had made sure that medicines were only used within their 'use by' date. Other new quality checks had ensured that medicines had promptly been returned to the pharmacy when no longer in use.

At our inspection on 27 April 2016 we found that there had been a number of occasions when a person had not been suitably assisted to regularly change position when resting in bed. This shortfall had increased the risk that they would develop sore skin.

At the present inspection we found that people were being correctly assisted to change position so that there was less risk of them developing sore skin. A relative commented on this saying, "I have seen staff assisting my family member to regularly move from side to side when in bed and in their armchair so that they don't get sore and they're gentle when doing it."

At our inspection on 27 April 2016 we found that there were a number of defects in the accommodation and in the use of equipment that increased the risk of people having accidents. These defects included some floors having sloping and uneven surfaces. In addition, we noted that a cover over some electrical

equipment was loose. The cover which was used by some people as a bannister rail, readily moved when any pressure was applied to it. We saw several people living in the service losing their balance when holding the cover because they expected it to be secure. A further problem we noted concerned a ramp that led into a bedroom. The device was not fixed to the floor, was loose and had a hole in its surface. These defects increased the risk that someone stepping on the structure would trip and fall.

In addition to these problems, some of the windows on the first floor were not fitted with safely latches as recommended in national guidance. As a result they could be opened wide enough to create the risk of people falling. Another problem was the way in which a person had been supported to be comfortable and safe in bed. Records showed that the person had been provided with bed rails but that a full assessment had not been completed to ensure that these were safe to use by the person concerned.

At the present inspection we found that the cover used as a bannister rail had been fixed to the wall and provided a firm surface for people to hold. We also found that suitable steps had been taken to ensure that people were only offered the opportunity to have rails fitted to their bed when it was safe to do so.

At our inspection on 27 April 2016 we found that some of the arrangements used to protect people from acquiring infections were not robust. Some communal and private rooms did not have a fresh atmosphere and a toilet seat in a communal bathroom was not clean. Other problems included the shelves and the floor in the medicines store room not being clean and hygienic.

At our present inspection we found that improvements had been made to the way in which suitable standards of hygiene were promoted so that people were suitably protected from the risk of acquiring avoidable infections. We visited a number of communal rooms and were invited to see three private rooms. In each case we found the rooms to be clean and to have a fresh atmosphere. We also noted that the toilet seat we had previously found to not be clean had been replaced and the new item was in a hygienic condition. In addition, we found that new clean flooring and shelves had been installed in the medicines room enabling staff to handle medicines in hygienic conditions. A relative speaking about standards of cleanliness in the service said, "Overall the place is quite clean. It's lived in and olde worlde and so it always appears a bit ramshackle but at the same time it's well kept."

The various improvements we have described meant that the relevant legal requirement had been met. However, we found that further improvements still needed to be made to ensure that people consistently received safe care.

Although we found that most windows in bedrooms located on the first floor had been fitted with suitable safety devices, two windows did not have latches. As a result there was an increased risk that people would not always open them in a safe way. Although the windows were relatively difficult to reach the oversight had increased the risk of people not being safe when opening them. The registered person said that in both bedrooms completely new windows with safely latches built into them were due to be installed in the near future. They also said that in the mean-time they would complete a robust assessment of the risk of injury resulting from the use of the current windows. This was so that suitable steps could be taken to keep people safe.

We found that one of the potential trip hazards caused by sloping and uneven flooring had been addressed by displaying a sign that alerted people to the problem. However, another location that had a similar problem had not been managed by displaying a sign or by some other means. We also noted that the trip hazard created by the ramp leading into a bedroom had not been addressed in that it remained loose and did not have an even surface. We raised these matters with the registered person who assured us that the

oversights would be addressed immediately.

At our inspection on 27 April 2016 we found that there was a breach of Regulation 19 (3) (Schedule 3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We found that records did not confirm that suitable recruitment checks had been completed for two members of staff. Although no concerns had been raised about the conduct of the staff concerned since their appointment, the oversight had reduced the registered person's ability to ensure that only suitable people were employed to work in the service.

After the inspection the registered person wrote to us to say that action had been taken to address this problem. They said that the necessary improvements would be fully completed by 31 June 2016.

At the present inspection we looked at the recruitment checks that had been completed for two members of staff and found that in each case the necessary assurances had been received. These included obtaining references and clearances from the Disclosure and Barring Service. These checks had enabled the registered person to obtain assurances about the previous good conduct of the staff concerned and establish their suitability for employment in the service.

These improvements meant that the relevant legal requirement had been met.

Requires Improvement

Is the service well-led?

Our findings

At our inspection on 27 April 2016 we found that there was a breach of Regulation 17 (b) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the registered person had not completed sufficiently robust quality checks to enable them to quickly resolve shortfalls in the care and facilities provided in the service. These included the problems we have already reviewed in our report relating to the management of medicines, protecting people from avoidable risks to their health and safety, shortfalls in maintaining good standards of hygiene and oversights in the completion of suitable recruitment checks.

In addition to these issues, at our inspection on 27 April 2016 we also noted that the lack of robust quality checks had led to a number of other problems not being quickly identified and resolved. These included shortfalls in the training and guidance provided for staff. In turn, this was related to some staff not having all of the knowledge and skills they needed. An example of this was some staff not being confident about how best to help people who were at risk of not eating and drinking enough to maintain their good health. In addition, we noted that mistakes had been made in the support provided to people who were at risk of not having enough nutrition and hydration. The people concerned had not always been reliably assisted to monitor their body weight. Also, checks had not been consistently completed of how much they were eating and drinking each day so that any concerns could quickly be brought to the attention of a healthcare professional.

We also noted at our earlier inspection that suitable steps had not been taken to ensure that people only received care that respected their legal rights. This was because the registered person had not correctly sought authorisations from the local authority to enable staff to restrict three people's freedom when this was necessary to keep them safe. People can only be deprived of their liberty in order to receive care and treatment when this is in their best interests and legally authorised under the Mental Capacity Act 2005. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

Other problems we noted at our earlier inspection that had not been addressed by the registered person's quality checks, involved shortfalls in the support provided for people who lived with dementia and mistakes in the secure management of confidential information. We also found that people had not been fully supported to meet their spiritual needs and to enjoy social activities. In addition, some fire safety checks were overdue and not all parts of the accommodation had been kept comfortably warm. A further shortfall involved the way in which accidents had been recorded and analysed. This was because documents did not clearly demonstrate that the registered person and staff had investigated how accidents had occurred so that effective action could be taken to help prevent them from happening again.

All of these shortfalls had resulted from the registered person not robustly monitoring and evaluating the arrangements used to ensure that people were safely provided with the assistance they needed. After the inspection the registered person wrote to us and said that they had strengthened the way in which quality checks were completed. This was so that the people could be reassured that they would reliably benefit

from receiving safe care. The registered person said that all of these improvements would be fully completed by 31 June 2016.

At the present inspection we found that the registered person had introduced new and more robust quality checks. We saw that as a result of this development a number of improvements had been made to the provision that was available in the service. These improvements included staff being given sufficient training and guidance to acquire the competencies they needed. In addition, people who were at risk of not eating and drinking enough were being assisted in the right way. This included there being robust systems to make sure that people were offered the opportunity to monitor their body weight. In addition, we saw that checks were being completed to ensure that people were having enough nutrition and hydration. A person speaking about this remarked, "The staff do keep an eye on what I'm having to eat and drink and they especially encourage me to drink a bit more when it's warm weather."

We also noted that as a result of better quality checks suitable safeguards had been put in place to ensure that people only received care that respected their legal rights. These included the registered person promptly seeking the necessary authorisations so that people's legal rights were protected when it was necessary to deprive them of their liberty in order to keep them safe. A further improvement was the way in which people who lived with dementia were reassured when they became distressed. We saw that staff had been provided with the guidance they needed and so were able to consistently support the people concerned.

Another improvement resulting from the registered person's greater focus on quality management involved the way in which confidential information was stored. We found that a new lockable facility had been provided so that records could be kept securely when they were not in use.

We also noted that people were more satisfied with the arrangements that had been made to support them to meet their spiritual needs. They said that the registered person had consulted with them about this matter and had offered to make the arrangements necessary for them to attend a religious service. People who lived in the service also told us that they were pleased with the varied range of social activities that had been made available for them to enjoy. One of them said, "When the activities lady isn't on duty the care workers usually find time now to help us with some activities and it's quite jolly in the lounge with most of us joining in." We also noted that the registered person was completing more regular checks to ensure that there was sufficient heating to ensure that people could use their bedrooms in comfort during the day.

Records showed that fire safety checks had been completed in the correct way. In addition, the registered person said that new checks would be completed as soon as the weather turned cooler to ensure that all areas of the accommodation were heated sufficiently. We also found that accidents were being recorded and analysed in greater detail so that effective steps could quickly be taken to reduce the risk of the same thing happening again. An example of this involved suitable arrangements having been made to provide additional support for someone who had experienced falls when they had attempted to walk without assistance. We saw that staff had been given updated guidance about how best to help the person and were correctly providing support by regularly checking if they wanted help to get up from their armchair.

The various improvements we have described meant that the relevant legal requirement had been met.

However, we noted that further improvements still needed to be made in the way some quality checks were completed. This was because they had not always clearly highlighted the limited number of problems we have noted in this report that increased the risk of people having avoidable accidents.