Aegis Residential Care Homes Limited

Ladydale Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

We carried out an unannounced comprehensive inspection of this service on 23 June 2016. At that inspection, we identified a number of Regulatory breaches and we told the provider that immediate improvements were needed to ensure people consistently received care that was safe, effective and well-led. The service was rated as 'inadequate' and was placed into 'special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

We undertook this focused inspection on the 14 July 2016 to check that the required immediate improvements had been made. 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.

At this inspection, we found the required improvements had not been made. Breaches of Regulations were still present and the service was again rated as 'inadequate'. As a result of this, the service will remain in special measures.

The service is registered to provide accommodation and personal care for up to 54 people. People who use the service may have a physical disability, a learning disability and/or mental health needs, such as dementia. At the time of our inspection 47 people were using the service.

The home had a registered manager. However, they were absent from the service at the time of this 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 and associated Regulations about how the service is run. An interim manager was in place during the registered manager's absence. Staff told us they felt more supported in the absence of the registered manager.

At this inspection, we found that the provider did not have effective systems in place to assess, monitor and improve the quality of care. This meant that poor care was not being identified and rectified by the registered manager or provider.

Risks to people's health, safety and wellbeing were not consistently identified, managed and reviewed and people did not always receive their planned care. Medicines were not managed safely.

People were not always protected from the risk of abuse because suspected abuse was not always identified or reported as required.

Safety incidents were not always analysed and responded to effectively, which meant the risk of further incidents was not always reduced. There were not always enough suitably skilled staff available to keep people safe and meet people's individual care needs.

The requirements of the Mental Capacity Act 2005 were not always followed to ensure people had the ability to make decisions about their care. One person who was unable to consistently make decisions about their care was at times being potentially unlawfully deprived of their liberty.

We found staff did not always have the knowledge and skills required to meet people's individual care needs and keep people safe. People's health was not effectively monitored and managed to promote their health and wellbeing. Prompt referrals to health and social care professionals were not always made in response to changes in people's needs or behaviours.

The provider did not always notify us of reportable incidents and events as required.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe. Risks to people's health and wellbeing were not consistently identified, managed and reviewed.

Equipment and medicines were not always managed safely and there were not always enough staff to keep people safe and meet peoples care needs in a prompt manner.

People were not consistently protected from the risk of abuse as suspected abuse was not always reported as required.

Is the service effective?

Inadequate

The service was not effective. People's health needs were not effectively monitored and managed and, prompt referrals to health care professionals were not always made when people's needs changed. Staff did not always have the knowledge and skills needed to meet people's needs effectively.

The requirements of the Mental Capacity Act 2005 were not always followed. This meant we could not be assured that people could consent to their care.

The requirements of the Deprivation of Liberty Safeguards (DoLS) were not always followed and people were potentially not always being lawfully deprived of their liberty.

Is the service well-led?

Inadequate

The service was not well led. The provider did not have effective systems in place to consistently assess, monitor and improve the quality of care.

Effective systems were not in place to monitor safety incidents, so action was not always taken to reduce the risk of further harm occurring.

The provider did not always notify us of reportable incidents and events that occurred at the service.

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 was 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 14 July 2016. This inspection was completed to identify if improvements had been made and sustained since our last inspection that took place on 23 June 2016. We inspected the service against three of the five questions we ask about services: is the service safe, effective and well-led? This was because our previous inspection had identified that immediate improvements were needed in these three areas to protect people from risks to their health, safety and wellbeing. Our inspection team consisted of three inspectors.

We checked the information we held about the service and provider. This included the notifications that the provider had sent to us about incidents at the service and information we had received from the public. We used this information to formulate our inspection plan. We also used the action plan the provider sent to us following our last inspection provider's to inform our inspection. In addition to this we liaised with representatives from the local authority to discuss the concerns they had with quality and safety at this service.

We spoke with eight people who used the service, a visiting health care professional and six members of care staff. We did this to gain people's views about the care and to check that standards of care were being met. We also spoke with the regional manager, a manager who worked at another service owned by the provider who was supporting the management team and a consultant the provider had employed to manage the service whilst the registered manager was absent.

We spent time observing how people received care and support in communal areas and we looked at the care records of 13 people to see if their records were accurate and up to date. We also looked at records relating to the management of the service. These included audits, staff rotas and training records.

Following our inspection we shared our findings and concerns with the local authority. We did this because

we continued to have significant concerns about people's health, safety and wellbeing.

Inadequate

Is the service safe?

Our findings

At our last inspection, we found that improvements were needed to ensure that risks to people's safety and welfare were consistently assessed, monitored and managed. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, we found the required improvements had not been made and people continued to receive or be at risk of receiving unsafe care.

We found that risks to people's safety as a result of people's behaviours were still not always assessed and planned for. For example, one person who used the service frequently displayed episodes of verbal and physical aggression towards other people who used the service and staff. The risks associated with these behaviours had not been assessed or planned for as no risk assessments or care plans referring to these behaviours were contained in their care records. Care records showed that staff did not effectively manage this person's behaviours effectively as their behaviours frequently reoccurred.

We found that effective and prompt action was still not taken to identify and manage people's risk of falling. For example, since our last inspection, two people's care records showed that they had fallen. These falls had not triggered any reviews of their risk of falling again which meant no action was taken to protect them from the risk of further falls and sustaining injuries associated with falling.

Where risks to people's safety had been recognised and planned for, we found that care was still not always delivered in accordance with their agreed care plan. For example, one person's care records showed that staff needed to check on them every 15 minutes to ensure their safety. Records showed and staff told us they were not completing these checks. One staff member said, "I think we stopped doing them because you said they didn't mean anything". This meant that this person's care plan was not being followed as planned to promote their safety.

We saw that equipment at the home was still not effectively checked or maintained to ensure it was safe for use. For example, at our last inspection we found three commodes were unsafe for use as they did not have non slip ferrules at their bases to prevent the commode from moving or causing injury if the commodes were to move. Following our last inspection, the provider told us the commodes were all safe for use. However, at this inspection, we saw two commodes that remained unsafe for use due to missing non slip ferrules.

We found that effective systems were still not in place to ensure people's medicines were managed safely. At this inspection, we saw medicines being administered to people in an unsafe manner. People were given their medicines in a pot by a staff member who then walked away and signed to say people had taken their medicines without checking that this was the case. We found a tablet on the floor and reported this to the staff member responsible for administering medicines. However, because people had not been observed taking their medicines, the staff member was unable to identify what tablet this was and who should have taken it. This meant the staff member could not identify who had not taken their medicine as prescribed. We also saw medicines that had past their expiry date were still located in the medicines trolley. This meant

people were at risk of receiving unsafe medicines.

We saw that people did not always receive their medicines as prescribed as their medicines were not always readily available for use. For example, one person did not receive one of their prescribed medicines for four days as it was not in stock at the service. We also found that people did not always receive their medicines in accordance with their care plans. For example, the information one staff member gave us about when and where they applied one person's cream did not match the information in the person's care records. This meant the person did not receive their medicines in accordance with their care plan.

We found that people who were responsible for the storage and administration of their own medicines, were not protected from the risks associated with self-administration of medicines. For example, one person who was responsible for storing and administering their own medicines was often confused and their ability to self administer their medicines safely had not been recently assessed. Accurate records continued to not be maintained to ensure the provider could account for all the medicines at the home. This meant people could not always be assured that they had received their medicines as prescribed.

The above evidence demonstrates that effective systems were not in place to ensure people consistently received their care in a safe manner. This was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection, we found that people were not consistently protected from the risk of abuse or avoidable harm. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, we found the required improvements had not been made and people continued to be at risk of abuse and avoidable harm.

Some staff still did not understand their responsibility in identifying, recording and reporting suspected abuse. We found at least 10 incidents of alleged verbal abuse that had not been discussed with or reported to the local authorities safeguarding team in accordance with local and national guidance. There was also no evidence to show that these incidents had been reported to the management team or provider by the staff. Some staff told us these incidents could not be abuse as it was the result of one person's 'normal behaviours'. This showed that staff did not recognise what constitutes abuse. Because the incidents had not been reported by the staff, no action had been taken to prevent further incidents of suspected verbal abuse from occurring. This meant people were not protected from the risk of on-going incidents of suspected abuse. This was a continued breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection, we found that staff were not always available to keep people safe or meet people's care needs and preferences. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, we found the required improvements had not been made and people were still not receiving prompt care and support when they needed it.

People continued to tell us that they did not always receive their care and support in a timely manner. For example, one person told us how they often had to wait for assistance to access the toilet. The delay in receiving this assistance had on occasions led to them being incontinent of urine. They said, "I wear a pad now which I never used to have to in case I have to wait" and, "I have had to wet my pad because I waited which just isn't nice". We also saw and staff told us they were not always available to provide people with the care they needed when they needed it. For example, we saw that one person did not receive the support they needed to eat their meal in accordance with their care plan. This meant the person struggled to eat their lunch time meal over a two hour period.

Records showed that changes in people's needs did not trigger a review of their dependency levels or a review of the staffing numbers required to meet their needs in a timely manner. For example, one person's care records showed and staff confirmed that their physical health had recently significantly deteriorated. This person had gone from being independently mobile to requiring the use of a hoist at times. Their care records showed their dependency level had not been reviewed in response to this change in their needs. This meant the provider had not formally recognised that this person's dependency level had changed and we could not be assured that there were enough staff available to consistently meet this person's needs in a safe and prompt manner.

Recent staff meeting minutes showed that the provider had agreed to increase the staffing numbers in response to feedback from the staff. However, staff rotas showed and we saw that the actual staffing numbers had not promptly increased in response to identifying that more staff were needed. This meant the need to increase staffing numbers was not being immediately addressed to promote people's health, safety and wellbeing.

The above evidence shows that staff were not always effectively deployed to ensure people's needs were consistently met in a timely manner. This was a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service effective?

Our findings

At our last inspection, we found that people's health needs were not effectively monitored and managed to promote people's wellbeing. This was an additional breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, we found the required improvements had not been made and people's health needs continued to not be effectively monitored and managed.

At our last inspection, we fed back concerns that people's weight was not being effectively monitored or managed. A person we had identified as losing a significant amount of weight had continued to lose more weight since our last inspection. Staff told us this weight loss should have triggered a referral to a GP, but they confirmed this referral had not been made. This showed that weight loss was still not being acted upon to ensure people's health and wellbeing was promoted.

We saw that people continued to not always get the support they needed to eat and drink. We observed one person struggling to eat their lunch over a two hour period. This person's care plan stated they needed support from staff to eat, but we saw and staff confirmed that they were busy completing other tasks to provide this person with the support they required.

We found that people's risk of dehydration was still not being effectively monitored or managed. People whose care plans stated they needed their fluid intake to be monitored did not receive this planned monitoring. This was because people's daily intake was not being calculated by the staff.

We found that prompt referrals to health and social care professionals were still not always made in response to peoples' changing needs. For example, one person's care records showed and staff confirmed that their physical health had significantly deteriorated in the three weeks leading up to this inspection. This person had gone from being independently mobile to requiring the use of a hoist at times. A referral to a physiotherapist was only made on the day of this inspection; 20 days after their needs had changed. This showed professional advice was not always sought promptly when people's needs changed.

The above evidence shows that people's health needs were not effectively monitored and managed to promote people's wellbeing. This was an additional and continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection, we found that the staff did not always have the knowledge and skills to meet people's needs effectively and safely. This was an additional breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, we found the required improvements had not been made and people remained at risk of receiving unsuitable or unsafe care as a result of this.

Staff training records still showed significant gaps in training. For example, training records showed that 11 care staff had not received safeguarding training or their training had expired. The training records also showed that the registered manager's safeguarding training had expired in May 2015. We also saw that incidents of suspected abuse were not being consistently identified and reported in accordance with local

and national guidance. This showed that staff did not always receive the training they needed to ensure people's safety and wellbeing and service users were at risk of harm because of this. This was an additional and continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection, 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 the required improvements had not been made.

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 make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. Although staff were able to tell us the basic principles of the Act, people's care records showed these principles were not always followed. For example, we saw, care records showed and staff confirmed that one person who self-administered their medicines was confused at times. This confusion could affect their ability to make decisions about their care. This person's ability to make the decision to self-administer their medicines had not been formally assessed to ensure they understood the risks associated with this. This meant the requirements of the MCA had not been followed to identify if the person could consent to this element of their care. This was a continued breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection, we found that people were at times being deprived of their liberty in an unlawful manner. This was an additional breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, we found the required improvements had not been made and people continued to be or were at risk of being unlawfully deprived of their liberty.

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 Mental Capacity Act 2005. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). At our last inspection we identified one person who was at times restricted to move freely around the home. Staff told us the person did not always have the ability to make decisions about their care, so they prevented them from accessing all; areas of the home freely to keep them safe. Staff confirmed a DoLS referral had not been made which meant the person was at times possibly being unlawfully deprived of their liberty. At this this inspection, we saw this continued to be the case and no DoLS application had been made. This meant the person continued to be potentially unlawfully deprived of their liberty at times. This was an additional breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

At our last inspection, 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 the required improvements had not been made.

The information contained in people's care records was still not being effectively monitored or analysed by the provider to ensure people's needs were being managed effectively. For example, they had not identified that plans were not in place to help staff manage one person's behaviours that challenged. They had also not identified that incidents relating to behaviours that challenged, such as, suspected verbal abuse were not being appropriately reported.

The provider had still not identified that people were not always receiving their planned care. For example, people who needed their fluid intake monitoring were not always receiving this monitoring as their daily fluid intakes were not totalled. This showed that effective systems were not in place to ensure the quality of care was consistently assessed, monitored and improved.

Effective action had still not been taken in response to concerns identified through medicines audits. For example, the medicines audit completed in May 2016 identified bottled medicines were not always labelled with an opening date. It is important to label the date of opening so that people can be assured that their medicines are safe to use if they are time limited. At our last inspection we found three bottles of medicines that were time limited had not been dated to show when the bottles had been opened. At this inspection, we found another opened and undated bottle of time limited medicine. This showed the concerns identified through audit had not been effectively addressed and people could not be assured that their medicines were safe.

Effective systems were still not in place to ensure equipment was safe to use despite the provider's action plan stating this issue had now been resolved. At this inspection we found two commodes that were unsafe. This showed the checks in place to monitor the safety of equipment remained ineffective.

Quality monitoring checks were still not identifying that safety incidents were still not always appropriately reported, investigated or managed to prevent further incidents from occurring. Accurate records relating to safety incidents were not maintained. For example, one person's care records showed they had recently been verbally abusive towards other service users on at least 10 occasions. However, care records only recorded the names of the people affected by this person's behaviours for one of the 10 incidents. This meant we could not identify which people had been subject to verbal abuse during the other nine incidents. As a result of this, retrospective safeguarding referrals could not be made to protect the people who had been exposed to this abuse. Also, action was still not being taken after people fell to prevent further falls from occurring. This showed that risks to people's health, safety and wellbeing were not being effectively managed by the provider in order to improve people's care.

At our last inspection, we found that the risks associated with staff living in rooms next to people who used the service had not been assessed. Following that inspection, the provider and regional manager told us this risk assessment should have been completed by the registered manager to ensure any risks posed to people were managed. At this inspection, the provider still could not evidence that these risks had been assessed and planned for. This showed the provider had not been responsive to our feedback in order to ensure people's health, safety and wellbeing was consistently promoted.

Effective systems were still not in place to ensure the staff had the knowledge and skills required to meet people's needs and keep people safe. For example, there were significant gaps in the staffs' safeguarding training which placed people at risk of receiving unsafe care. An effective system was still not in place to ensure staff were deployed effectively to meet people's needs in a safe and timely manner. For example, when the provider had identified that an increase in staff numbers was needed, this was not immediately acted upon to promote people's safety and wellbeing.

The above evidence shows effective systems were not in place to assess, monitor and improve quality and manage risks to people's health and wellbeing. This was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection, we found the provider did not inform us of notifiable events as required under our registration Regulations. This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009. At this inspection, we found the required improvements had not been made. The provider had failed to notify us of at least 10 incidents of alleged abuse as required under our registration Regulations. This was a continued breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

The registered manager had been absent from the service since our last inspection on 23 June 2016. The regional manager and an interim manager were managing the service in the registered manager's absence. Staff told us they felt more supported since the registered manager had been absent from the service. They told us the management team who were leading the service in the registered manger's absence were listening to their feedback and they believed they would make changes to improve people's care. One staff member said, "Since the manager's not been here, things have started to get better. Everyone seems more organised and they seem to be listening more". Another staff member said, "The staff are smiling more now and I feel more supported".