Royal Mencap Society

Royal Mencap Society - 22 Lamberts (Daisy)

Inspection report

22 Lamberts
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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
22 Lamberts (Daisy) is a residential care home providing personal care and support to up to five people. The service provides support to people with a learning disability, autistic people, as well as support for people's mental and, or physical healthcare needs. At the time of our inspection there were five people living at the service.

People's experience of using this service and what we found
We expect health and social care providers to guarantee autistic people and people with a learning disability choices, dignity, independence and good access to local communities that most people take for granted. Right support, right care, right culture is the statutory guidance which supports CQC to make assessments and judgements about services providing support to people with a learning disability and, or autistic people.

The service was not able to demonstrate how they were meeting some of the underpinning principles of Right support, right care, right culture.

Right support: The standards of care provided, did not support people to have choice and control over their own care and lifestyles. This was compounded by the level of staff available to meet people's assessed needs, and corresponding limitations on access to the community. The overall condition of the premises needed to be addressed, to ensure people lived in a clean and comfortable environment.

Right care: Care records did not demonstrate people were involved in the development of these documents, or that their individual wishes and preferences were consistently reflected. People's dignity, privacy and human rights were not being upheld, particularly in relation to the implementation of the Mental Capacity Act (2005). People were not always supported to have maximum choice and control of their lives. Staff did not always support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice. Gaps in staff training and competency checks did not ensure staff had the necessary skills, knowledge and expertise to safely meet people's needs.

Right culture: There was a lack of leadership within the service, due to there being no registered manager. The provider team representatives visited the service to carry out audits and checks. Inspection findings highlighted the provider's audit findings were not being addressed. This did not ensure improvements to the quality of people's care or the condition of the care environment were made. People were not being empowered to lead meaningful lives, or to be part of their local community.

Rating at last inspection and update
This service was registered at this location on 10 December 2020 and this is the first inspection.

Why we inspected
The inspection was prompted in part due to concerns received about the safe running of the service, in

relation to medicines management, staffing levels and training to meet people's assessed needs and risks. A decision was made for us to inspect and examine those risks.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

You can see what action we have asked the provider to take at the end of this full report.

We have found evidence that the provider needs to make improvements. Please see the Safe, Effective, Caring, Responsive and Well-led sections of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for 22 Lamberts (Daisy) on our website at www.cqc.org.uk.

Enforcement and Recommendations
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and will take further action if needed.

We have identified breaches in relation to safe care and treatment, including the management of infection such as COVID-19, staffing, good governance and oversight of the service at this inspection.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the 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.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not safe. Details are in our safe findings below.	**Inadequate**
Is the service effective? The service was not always effective. Details are in our effective findings below.	**Requires Improvement**
Is the service caring? The service was not always caring. Details are in our caring findings below.	**Requires Improvement**
Is the service responsive? The service was not always responsive. Details are in our responsive findings below.	**Requires Improvement**
Is the service well-led? The service was not well-led. Details are in our well-Led findings below.	**Inadequate**

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Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

Inspection team
On day one, there were two CQC inspectors. On day two, there was a CQC medicines inspector. Another inspector also completed some of the telephone calls to staff and people's relatives.

Service and service type
22 Lamberts (Daisy) is a 'care home'. People in care homes receive accommodation and nursing and, or personal care as a single package under one contractual agreement dependent on their registration with us. 22 Lamberts (Daisy) is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

At the time of our inspection there was not a registered manager in post.

Notice of inspection
This inspection was unannounced. Inspection activity started on 28 March 2022 and we visited the service on 28 March and 5 April 2022.

What we did before the inspection
We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We also liaised with the local authority to source feedback. We used all this information to plan our inspection.

During the inspection
We spoke with one person who used the service and observed care being provided in communal areas. We spoke with five members of staff including the provider representatives and two members of care staff.

We reviewed a range of records, including two people's care records and five medication records. We looked at staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We spoke with one member of care staff and one person's relative about their experience of the care provided by telephone. We provided final inspection feedback to the provider team on 20 April 2022.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

This is the first inspection of this newly registered service. This key question has been rated Inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management; Preventing and controlling infection

- We were not assured that the provider was meeting shielding and social distancing rules. There was limited space within communal areas and adjustments to the layout of seating had not been made to support social distancing. People needed to use shared bathroom facilitates as ensuite toilets were being used for storage purposes.
- We were not assured that the provider was using personal protective equipment (PPE) effectively and safely. We observed a member of the management team moving between services without changing their PPE, with a known COVID-19 outbreak at one of the other locations on the same site. Staff were not wearing clothes bare below the elbow when providing personal care and were not able to don and doff PPE safely due to the lack of bins in place.
- We were not assured that the provider was promoting safety throughout. The layout of communal areas did not support social distancing. Damaged surfaces and poor cleanliness impacted on the standards of hygiene within the care environment. There were gaps in cleaning records.
- We were not assured that the provider was ensuring infection outbreaks could be effectively prevented or managed. There were poor infection, prevention, control practices in place, and government guidance was not being followed. Infection control audits were identifying risks that were not being addressed.

- Taps and sinks were found to have limescale present, which posed an infection control risk. Mops and cleaning equipment was not stored hygienically between uses.
- We found examples of where people's tooth brushes and urinal bottles were being stored unhygienically, next to each other.
- The provider was unable to demonstrate that safety checks were being consistently completed to ensure equipment was safe for staff and people to use.
- Records showed that no evacuation drills had been completed by day or night staff since 2021. A fire risk assessment completed in September 2019, only showed actions being addressed between January and March 2022, therefore placing people at known risk.
- Concerns regarding building security and people's safety was identified.

Risks relating to the health and welfare of people were not assessed and managed; including measures to mitigate infection, prevention and control. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Visiting in care homes

- One person was able to tell us about their experiences of having their relatives visit them at the service.

They confirmed that their relatives came into the building, to spend time with them, or they could sit in the garden if the weather was warm enough.

Staffing and recruitment
● Staffing numbers impacted on their ability to keep people safe and prevent the risk of harm. For example, staff were not present to monitor people eating when they were assessed as being at risk of choking.
● Two people required assistance of two staff to transfer using moving and handling equipment. One person needed regular repositioning during the day and overnight. There were not sufficient staff on each shift to safely meet people's assessed needs.
● Staffing numbers during the day, and particularly at night-time, had not been fully considered in relation to the management of emergency situations, such as needing to evacuate in the event of a fire.
● Fire risk assessments in place identified the need for use of equipment to support people to evacuate, requiring assistance of two staff. Records also showed, once evacuated, one person could not be left alone. Staffing levels, particularly at night-time did not meet this assessed risk.

Sufficient levels of staff were not in place to keep people safe during the day and overnight. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse
● The condition of the service, and areas of practice did not protect people fully from the risk of harm, or support people in line with their identified care needs as reflected in their records.
● We identified gaps in the completion of safeguarding training, and examples of where training was not being implemented into staff practice.
● Staff told us they were familiar with people's communication needs and demonstrated the ability to respond to people's needs from their body language and known gestures. However, the service relied on using agency staff at times, who would be less familiar with people's needs.
● The condition of the care environment, and concerns regarding staffing levels identified, did not demonstrate that the service could consistently keep people safe.

Learning lessons when things go wrong
● Provider level oversight of the service was not ensuring that standards of care were being maintained in the absence of a registered manager. Lessons had not been learnt from previous incidents that had happened at the service.
● The provider had identified a lack of staff meetings being held, or where held these had not been recorded. From the set of recent meeting minutes seen, these were generic, were not service specific, and contained the same information as one of their other locations on the same site.

Using medicines safely
● Arrangements were not in place to ensure people received regular medication reviews by their prescribers in line with nationally recognised guidance.
● The service had considered the risks around medicine storage; however, we found some medicines that were not stored securely at the service placing people at risk.
● Staff were trained and assessed for their competency to handle and give people their medicines safely. We saw that people received their medicines from staff who followed safe procedures.
● There was written guidance to help staff give people their medicines consistently and appropriately.
● There was a system in place to report incidents and investigate errors relating to medicines.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

This is the first inspection for this newly registered service. This key question has been rated Requires Improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
- Staffing levels impacted on the quality of individualised care people received. Staff told us that where there were low numbers on shift, or a lack of drivers, this impacted on people's abilities to access the local community and other activities.
- The provider's own audits identified that people were not regularly accessing meaningful activities in the community, and instead, were only leaving the service to attend medical appointments.
- Inspection findings, along with information gathered during the inspection did not demonstrate that the service was meeting some of the underpinning principles of Right support, right care, right culture. The provider's Right support, right care, right culture policy information contained plans going forward, not measures already in place.

Staff support: induction, training, skills and experience; Supporting people to eat and drink enough to maintain a balanced diet; Supporting people to live healthier lives, access healthcare services and support
- Staff did not consistently show implementation of their training into practice. For example, not ensuring the safe storage and use of specialist equipment to maintain its effectiveness.
- Staff told us they felt there were not enough staff on shift to enable them to provide more than the basic level of care for people.
- We observed people placed at risk, due to inadequate staffing and unable to monitor people at known risk of choking to eat safely, when they were assessed to need staff supervision.
- We observed one person repeatedly calling out to request their breakfast, saying they were "Hungry", but the two staff on shift were providing care to another person. Inspectors provided reassurances to the person in the absence of a staff member.
- Some people required specialist diets, including support with their weight and health needs. We noted that the daily menu only consisted of one option, limiting people's abilities to choose.
- People's weight was not being regularly monitored. A member of the provider's representative team told us everyone was now being weighed weekly, but there was not any clinical justification for this blanket approach.

We recommend the provider implements individualised monitoring arrangements for people's weight monitoring and maintains required weighing equipment.

Adapting service, design, decoration to meet people's needs
- The care environment did not contain signs for example to assist people to orientate to where the

bathroom, or their bedroom was located.
● People's bedrooms were personalised in their decoration and content, including meaningful items such as photographs and items of individual importance. However, the overall cleanliness, and condition of the care environment impacted on the value this placed on people's quality of life.

Ensuring consent to care and treatment in line with law and guidance; Staff working with other agencies to provide consistent, effective, timely care
The Mental Capacity Act 2005 (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 MCA 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.

In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.
● People's care records lacked consistent completion of decision specific capacity assessments; this did not demonstrate adherence with the MCA.
● Where equipment was in use which restricted a person's freedom of movement, such as bed rails and lap belts on seating, capacity assessments were not in place to demonstrate less restrictive options had been considered and discounted.
● We identified gaps in staff training relating to the MCA and DoLS. Staff were not confident about those people with a DoLS in place, or other aspects of their individual care provision, such as the level of one to one support in place.
● People's care records contained some examples of where staff had consulted with health care professionals when making decisions regarding people's medicines and other healthcare needs.
● People's care records reflected consultation with their relatives to support them when making decisions. However, there were no records to indicate if relatives held the legal powers to make these decisions.

We recommend the provider assesses and records people's wishes, needs and preferences, in line with MCA and make best interest decisions

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

This is the first inspection for this newly registered service. This key question has been rated Requires Improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity

- Staff felt unable to support people with meaningful activities and outings in the community due to low staffing levels and other expectations placed on them to cook and clean the service.
- One person told us they attended the local church regularly, and this was important to them, to be able to maintain social networks with people they had known for a long time.
- Staff we spoke with as part of the inspection process were observed to be compassionate and caring, but their abilities to provide person-centred care was being compromised by staffing levels. This was resulting in more task-based care being provided.
- People were supported to choose how they wished to decorate their bedrooms, and what clothes they wished to wear, as an expression of individuality.

Respecting and promoting people's privacy, dignity and independence

- We observed that staff spoke loudly and lacked discretion when checking to see if people wished to use the toilet. This did not protect people's privacy or dignity.
- Staff were observed to knock before entering people's bedrooms and explained what they were going to do while supporting people.
- People were encouraged by staff to complete tasks independently. For example, one person liked to take their cup to the kitchen once they were finished.

Supporting people to express their views and be involved in making decisions about their care

- Staff did their best to ensure they sourced feedback from people while providing hands on care; however from our observations, staff's time to do this was limited and under pressure.
- House meetings were meant to be in place, to support people to provide feedback on the service provided and make requests. However, these were not being held regularly to ensure people's views were sourced
- Meeting minutes for a house meeting held in April 2021, identified that people had raised concerns that there were not enough staff to meet their needs. This remained an area of serious concern as an outcome at this inspection.
- The person's relative we spoke with raised concerns regarding the standards of care and communication by the service with them. They were confident to contact the service or local authority safeguarding team if they had concerns.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

This is the first inspection for this newly registered service. This key question has been rated Requires Improvement. This meant people's needs were not always met.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them; Planning personalised care to ensure people have choice and control and to meet their needs and preferences; Meeting people's communication needs

Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

- Care records did not contain evidence of people being consistently involved in decision making relating to their care and support needs, wishes and preferences.
- Care records did contain detailed guidance for staff, to support them in their interactions with people. For example, to help them understand people's methods of communicating their thoughts and feelings.
- Use of agency staff posed a risk for those people with limited communication to ensure their needs were recognised and met. At times, from reviewing rotas, agency staff worked alone at the service, not having a familiar member of staff present to source advice or feedback from.
- Staffing levels, and whether staff could drive was found to impact on people's levels of community activity. If people required support to access the community, then staffing numbers needed to be increased to ensure those people remaining at home could also be kept safe.
- We received concerns from a person and a person's relative in relation to the lack of activities and daily stimulation available within the service.

The provider was not ensuring that people received personalised care, tailored to their individual wishes, needs and preferences. This was a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improving care quality in response to complaints or concerns

- The lack of provider level oversight, along with a lack of staff meetings, did not ensure that lessons were being learnt from complaints and concerns received from people or their families. This in turn, did not ensure standards of care provision were being improved.
- We received mixed feedback from the person's relative in the handling of concerns and acting on their feedback when given. Due to the level of concern identified during our telephone calls with relatives, we did make a referral to the local authority safeguarding team, and sourced additional assurances from the provider.

End of life care and support

- There was no one receiving end of life care at the time of our inspection.
- The provider's training matrix did not demonstrate that staff received training in the provision of end of life care, or in relation to supporting people to have discussions and make plans for their future care needs to ensure their wishes and preferences were known.

Inadequate

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

This is the first inspection for this newly registered service. This key question has been rated Inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- The service was not providing high standards of care, and was not working in line with their own values, including being "Kind to everyone," as overall standards of governance and leadership within the service were poor.
- Care was found to be task focussed rather than person-centred, and a lack of provider level oversight of the service did not ensure that people were being empowered to lead meaningful lives as part of their wider community.
- Gaps in provider level oversight of the service did not demonstrate that they had a good awareness of people's quality of life and were not ensuring in the absence of a registered manager, that standards of service provision were being maintained.
- The lack of regular staff and service user meetings did not offer opportunities to provide feedback or make suggestions on areas the service could improve.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

- The last registered manager, de-registered in May 2021, and there had been changes in manager leading up to the time of this inspection. This did not ensure that staff, people and their relatives had access to consistent leadership, or the embedding of changes in practice.
- Where quality audits and checks were completed, we identified actions not being addressed to prevent risks to people and staff. We also found discrepancies between information recorded in recent audits when compared against inspection findings.
- Poor oversight of staff training and competency checks did not ensure that the provider could be confident staff understood how to meet people's needs and individual risks.
- The records in place for the monitoring of accidents, incidents and safeguarding referrals were held in more than one document, impacting on the ability to audit for trends and themes.
- Since the last inspection, the service had been registered as a separate location. However, records continued to refer to the service under its previous name and staff worked between service locations. The provider was not running the service as a separate location.
- The quality of people's care records varied, for example we reviewed personal evacuation plans for each person living at the service, and many referred to another person's name or contained the wrong address

details. The provider's own quality checking processes were not identifying such shortfalls.
● Rather than working in isolation, the provider team needed to develop opportunities for collaborative working, and learning opportunities alongside external professionals and other stakeholders, people and their relatives.
● Accident and incident forms did reflect where relatives had been updated following an incident, however, feedback received from a person's relative did not reflect that they were always assured by the information received from the service.

Continuous learning and improving care; Working in partnership with others
● Lessons had not been learnt from the last inspection findings, or ongoing support provided by CQC and other stakeholders. This was reflected in the overall deterioration in rating, as well as breaches of regulations.
● Examples of actions taken by the provider's representatives, following initial inspection feedback, demonstrated a lack of insight into risk, particularly in relation to the management of infection, prevention and control, including COVID-19 management.
● Improvements to partnership working with people, their relatives and with staff was required to improve people's overall quality of life and to ensure going forward, improvements to the standards of personalised care and support provided.
● Maintenance contracts in place did not offer timely enough responses to address issues with the condition of the care environment. Where audits had identified equipment or areas of the service needing to be repaired, this was not addressed in a timely way to maintain people's safety.

The provider had poor governance and oversight arrangements in place to maintain standards and drive improvement at the service. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider was not ensuring people received personalised care, to ensure people lead meaningful lives. Regulation 9 (1)

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	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider did not ensure that people and the care environment were consistently kept safe, clean and well maintained. Infection, prevention and control practices needed to improve. Regulation 12 (1) (2) (a) (b) (h)

The enforcement action we took:

Warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider was not completing good quality checks and audits of the service. There were not good governance processes in place. People and their relatives were not being encouraged to give feedback on the service to drive improvement, or where feedback was given there was a lack of evidence to demonstrate this was acted upon. Regulation 17 (1) (2) (a) (b) (c) (e) (f)

The enforcement action we took:

Warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider was not making sure there were sufficient staff to be fully responsive to risks and meet people's needs, including at night time. Regulation 18 (1)

The enforcement action we took:

Warning notice