Norse Care (Services) Limited

Lydia Eva Court

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 1 and 2 November 2016 and was unannounced.

Lydia Eva Court provides residential care for up to 89 older people, some of whom may be living with dementia. At the time of our inspection there were 88 people living within the home. The accommodation is over two floors with three separate, smaller units on each floor. There are a number of communal areas throughout the home and all bedrooms have en suite facilities. The home has a number of enclosed outdoor spaces.

There was a registered manager in post. 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.

At this inspection, we found one breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This breach related to the governance of the service.

You can see what action we told the provider to take at the back of the full version of the report.

The risks to people who used the service had not consistently been identified, assessed, reviewed or managed appropriately. People who required specialist diets were also at risk of not having their nutritional needs met. This put people at risk of potential harm.

Although staff knew the needs and preferences of those they supported and delivered this in an individual manner, care plans were not always accurate, complete or person centred. Discrepancies within the care plans put people at potential risk of not receiving the appropriate care and support they needed to maintain their health and wellbeing. Documentation associated with each person's care was located in various places throughout the building and this made it difficult for staff to have a full picture of a person's health, wellbeing and care and support needs.

Fully effective systems were not in place to monitor the quality of the service and drive improvement. Although some audits had been carried out on a regular basis and were effective, others had failed to identify and rectify the issues highlighted within this report.

Procedures were in place to mitigate the risk of employing unsuitable staff and these were adhered to. These included the completion of references from previous employers and a criminal police check. The records we viewed confirmed these were in place prior to staff starting in post.
Staff received an induction, ongoing training and support in their roles.

People spoke of the caring and kind nature of the staff. They also told us there were enough of them to meet

their needs. People's dignity was maintained and their independence encouraged. Staff respected people's privacy and understood the importance of confidentiality and supporting people with making choices.

The service had processes in place to help protect people from the risk of abuse. Staff had received training in safeguarding vulnerable people. They were able to explain to us how they helped to protect, prevent, identify and report any concerns they many have. The service had made appropriate referrals to the local authority safeguarding team and records showed that the service had followed their recommendations as required.

The risks associated with the premises and working practices had been identified and managed. These had been regularly reviewed and a comprehensive schedule of regular maintenance checks was in place and completed as required. The potential negative impacts associated with adverse events such as loss of utilities or a fire had also been identified and plans put in place in the event of such incidents.

People received their medicines as the prescriber intended and the service followed good practice in regards to the administration and management of medicines. Robust auditing of the medicines management system was in place and completed on a regular basis.

The people living within the home benefited from an environment that stimulated their senses and supported them with orientation. A café area was available to relatives and visitors and people were made to feel welcome.

The CQC is required to monitor the Mental Capacity Act (MCA) 2005 Deprivation of Liberty Safeguards (DoLS) and report on what we find. The service had made appropriate referrals for consideration to legally deprive some people of their liberty and care and support was being delivered in ways that did not overly restrict people.

People received enough to eat and drink and were given choice in this. Those people that required assistance, received it at a time they needed it. The service was flexible in its approach to providing food and drink and this was available to people when they wished for it. Most people received healthcare intervention as and when required or when they requested it.

The management team was visible and approachable. People told us they saw them regularly and had confidence in them. The registered manager felt supported and encouraged by the provider.

People's feedback on the service had been sought on a regular basis and in a variety of ways. This was used to develop and improve the service. Staff told us they were encouraged to make suggestions and felt listened to. People felt comfortable in raising any concerns they may have and complaints had been fully investigated and appropriately responded to.

People told us that they would recommend the service.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

The individual risks to people had not always been identified, assessed, reviewed or adequately managed. This put people at risk of harm.

Processes were in place to reduce the risk of employing staff unsuitable to work within the home and there were enough staff to meet people's needs.

People received their medicines as prescribed. The processes the service had in place helped to reduce the risks associated with medicines management and administration.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Although people currently had their nutritional needs met, there was a risk these may not be met in the future due to lack of guidance for staff.

People benefited from receiving care and support from staff who had received training and support to assist them in their role.

The service adhered to the principles of the MCA and understood the impact this had on people and the way they supported people.

Is the service caring?

Good

The service is caring.

People spoke highly of the caring, thoughtful and compassionate approach of the staff and that it made them feel reassured and cared for.

The service had ensured that people had received all the information they needed in order to make informed decisions. People had been involved in decisions around their care and, where appropriate, their relatives had been included in this.

People had choice in how they spent their day and their independence was encouraged. Staff maintained people's dignity and understood the importance of confidentiality.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Care plans were not consistently accurate, complete or person centred. However, staff knew the needs of the people they supported and delivered this in an individual manner.

People benefited from regular interactions with staff that were warm and engaging but some people felt that there were a lack of organised activities to meet people's interests.

The service had a complaints policy in place and we saw that this had been adhered to. Complaints had been investigated, responded to and acted upon.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

The system the provider had in place to monitor the quality of the service had not been fully effective in identifying and rectifying issues.

People spoke positively of the management team and told us that they were friendly, approachable and accessible.

The people who used the service, their relatives and staff all had the opportunity to provide feedback on the service. This was used positively by the provider in developing and improving the service delivered.

Lydia Eva Court

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.

This inspection took place on 1 and 2 November 2016 and was unannounced. Five inspectors and two Experts-by-Experience carried out the first day of the inspection. An Expert-by-Experience is a person who has personal experience of using or caring for someone who uses this type of care service. The second day of inspection was carried out by two inspectors. A large inspection team was used to carry out this inspection as the home is divided into six separate units.

Before we carried out the inspection we reviewed the information we held about the service. This included statutory notifications that the provider had sent us in the last year. A statutory notification contains information about significant events that affect people's safety, which the provider is required to send to us by law. Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also contacted the local authority safeguarding team and the local authority quality assurance team for their views on the service.

During our inspection we spoke with seven people who used the service, 10 relatives, three visitors and a social care professional. We also spoke with the registered manager, the deputy manager, one cook, four team leaders and 10 care assistants. We observed care and support being provided to the people who used the service on both days.

We viewed the care records for 13 people and the medicines records for five people who used the service. We also looked at records in relation to the management of the home. These included the recruitment files for three staff members, staff training records, staff rosters, quality monitoring audits and minutes from meetings held.

Following the inspection visit, we asked the registered manager and deputy manager to send us some

additional information. This included a copy of the service's Statement of Purpose, confirmation of actions taken in relation to one person who used the service and information on the assistive technology used within the home. This information was received in full and within the timescale agreed.

Requires Improvement

Is the service safe?

Our findings

The risks to some people who used the service had not been fully identified, assessed, reviewed or managed. For one person who had experienced a number of incidents resulting in injury, the service could not demonstrate, at the time of our visit, that the risks associated with these incidents had been recorded, assessed and mitigated. Following our visit, the service submitted a risk assessment for this person. However, this assessment did not fully mitigate the identified risk as it referred to additional measures but this section was blank. At the time of our visit, this person had experienced a number of incidents in a short space of time, some of which had resulted in injury. However, the risk assessment had not been reviewed to check whether any additional measures could be taken to mitigate future risk.

The care records we viewed for this person showed that although these incidents had been recorded, they had been documented in various places. This made it difficult for staff to identify any trends in relation to the incidents, the risks associated with them and therefore take action to mitigate any future risk. On one recent occasion, the service had failed to seek medical advice after it had identified that the person had bruising to their head following one of these incidents. This put the person at risk of potential harm. When we discussed this with the registered manager, they confirmed that they would have expected staff to seek medical advice or intervention for a person who has experienced a head injury.

The registered manager was not fully aware of these incidents and they had not been recorded and assessed as part of the registered manager's management of accidents and incidents. This person had experienced seven incidents over a recent 24 hour period resulting in a number of injuries. None of these incidents had been recorded on the registered manager's accidents and incidents log sheet. This meant that the registered manager did not have all the information available in order to take appropriate action to mitigate any future risk and help protect the person from harm.

One person who used the service was at risk of choking. The service had identified this and assessed the risk. However, a review of this risk had not taken place since March 2016 and information to guide staff on how to mitigate the risk were not fully recorded. The person had experienced a choking incident in June 2016 which required both immediate and follow up medical intervention. Following this incident, the service had failed to review the risk assessment and take appropriate action to fully mitigate any risk of future occurrences.

The deputy manager told us that this person had been assessed by a SALT prior to this incident. However, the service could not produce this assessment and there was no reference to this in their care records. Although the person was receiving a soft diet and thickened fluids in order to mitigate the risk of choking, the care records did not indicate how much drink thickener was required. In addition, we could not be sure that the person was receiving the correct diet as the SALT assessment was not available. We concluded that this person was at risk of choking as the service had failed to fully review the risks associated with this.

When we discussed these concerns with the registered manager and deputy manager, they took appropriate and immediate action to mitigate the risks associated with these two individuals. This included seeking medical intervention, making referrals to healthcare professionals, updating risk assessments and

care records and providing staff with additional guidance. The service had made a healthcare referral for one of these people one day prior to our inspection visit.

All the people we spoke with told us that they felt reassured by the safety aspects of the service. One person who used the service said, "Oh yes, I feel very safe, I certainly do." Whilst one relative told us, "I feel [relative] is safe and secure here." A second relative said, "[Safety] is very, very good. There's always somebody [staff] passing, they put their head in the door all the time." We observed that the separate homes within Lydia Eva Court were secure and accessed by a swipe card. These were suitably managed and the management team had responsibility for allocating these. During our inspection, we saw that the home was secure at all times.

Processes were in place to help protect people from the risk of abuse. These included staff training, appropriate referrals to the local safeguarding team and robust records in relation to any safeguarding concerns. The staff we spoke with could describe potential symptoms that may indicate a person was being abused and what actions they would take in response. Most staff knew who they could report concerns to outside of their organisation and we saw that relevant telephone numbers for the local authority safeguarding team were on display in the home.

The risks associated with the premises, working practices and environment had been identified, assessed and reviewed with appropriate actions taken to mitigate the risks. Regular maintenance and checks were completed on the building and any relevant equipment within the building. The service had recently reviewed the risk assessment in relation to fire safety and this showed that a number of actions were needed. However, the service had identified what actions were required and had prioritised these requirements.

A business continuity plan was in place in the event of adverse incidents. This gave staff guidance and information in the event of incidents that could potentially adversely affect the service people received. The plan covered events such as burst water pipes, utilities failure and telephone system breakdown. The plan was accurate, up to date and had been reviewed on a regular basis.

Most of the people we spoke with told us that there were enough staff to meet people's needs. One person who used the service told us, "All the staff are very good. Normally they're quite quick to come and help you." Another person said, "Staff are quick mostly. If you ring your bell at night they answer quickly." A third person who used the service said, "If I pull my cord I'm seldom kept waiting." The relatives we spoke with agreed. When we asked relatives if they felt there were enough staff to meet their family member's needs, one said, "Oh good grief, yes. They do seem to cover themselves well, there's never a situation when you can't find someone." Most of the staff we spoke with also agreed that there were enough staff to meet people's individual needs.

During our inspection visit, we saw that people's needs were met in a timely manner. When we asked the registered manager how staffing levels had been calculated, they told us that these had been decided by the provider with input from them. The registered manager told us that the provider had recognised that a more formal tool was required to direct staffing levels and that one had been introduced at the beginning of October 2016. The records we viewed confirmed this.

Processes were in place to mitigate the risk of employing staff that were unsuitable to work within the service. This included requesting two references from previous employers and completing a Disclosure and Barring Service check. The three staff recruitment files we viewed confirmed these checks had taken place.

The service had processes in place to help mitigate the risks associated with the management and

administration of medicines. This ensured that people received their medicines as the prescriber had intended.

People's medicines were stored in their room with excess medicines being stored in two treatment rooms. This ensured that a person centred approach was delivered in regards to people receiving their medicines. Those care staff that administered medicines had received training in this. The competency of staff to carry out this task had been regularly assessed. During our inspection we saw that medicines were securely stored and that good practice was followed. Medicines were stored at appropriate temperatures and these were recorded on a daily basis both in people's rooms and in the two treatment rooms. Any medicines that needed to be returned to the pharmacy were also securely stored and appropriate records made.

We looked at the medicine administration record (MAR) charts and associated documentation for five people who used the service. This was to see whether these records supported the safe administration and management of medicines.

The MAR charts we viewed were accurate and legible. They had been fully completed and included relevant explanations wherever medicines had not been administered. Wherever handwritten dosage instructions were apparent, these had been checked and signed by two staff members to help reduce the risk of inaccurate transcribing. Any returned medicines were also recorded on the MAR charts. This ensured that the service was able to complete an audit of medicines as required. Stock counts were completed for each boxed medicine every time it was administered and these were accurate for those we checked. Staff had to sign a drugs round record sheet after each person had received their medicines for accountability. The team leader them completed checks to ensure people had received their medicines as prescribed before signing to say they had done so.

Medicine overview sheets were in place for each person who used the service and included a photograph to aid identification and reduce risk. These were individual to each person and included relevant information to aid staff in administering people's medicines in the way they wished. For example, these gave information on people's allergies, how people were able to communicate and their personal preferences in regards to how they liked to take their medicines.

Any medicines prescribed on an 'as required' basis had care plans in place that gave staff information to assist them in safely managing and administering the medicine. Where people were prescribed medicines with variable doses, appropriate checks and records were in place to safely manage this. Staff recorded on the MAR chart whenever topical creams were applied in most cases. However, for those people where topical cream was applied on more than four occasions per day, this was not recorded. When we discussed this with the registered manager and a team leader, they acknowledged the need for this and told us this would be rectified.

Requires Improvement

Is the service effective?

Our findings

There was a risk that people's nutritional needs would not be met. This was due to inconsistencies within people's care plans in relation to what support they required for their nutritional needs. For example, one person had been assessed by a SALT and, although this assessment was available, it was located in a separate part of the home to the person's care plan. This made it difficult for staff to refer to this assessment in order to ensure nutritional support was being delivered as recommended. In addition, this person's care plan also contained discrepancies in regards to what nutritional support they needed. For example, sections one and two of their care plan showed that the person required a pureed diet and normal fluids. However, another section of the care plan stated they required thickened fluids. We also noted that drinks thickener had been prescribed although this did not indicate how much was required. Staff knew this person's nutritional needs and we saw that these were delivered. However, these discrepancies put the person at risk as staff did not have clear and accurate guidance on what nutritional support this person required to keep them safe and well.

Although the cook knew the number of meals required in each dysphagia diet food texture, no information was available on who these people were or their individual likes, dislikes and preferences in regards to food and drink. No guidance was available to the cook on what constituted each dysphagia diet texture and they did not have copies of people's individual SALT assessments and recommendations. They were aware that some people required a diabetic diet but could not tell us the names of those people. They told us that it was the responsibility of the care staff at the point of serving to ensure that people received the correct food and fluid in order to maintain their wellbeing, including those who required a diabetic diet. However, staff had not received training in diabetes awareness and we could therefore not be sure that they had the appropriate knowledge to assist people in making suitable choices. When we discussed this with the registered manager, they told us that it was the responsibility of both the cook and the care staff to ensure people received the correct nutritional support.

We observed lunch being served in five of the six units of the home. In four out of the five units, we saw that enough staff were available to assist people and that they got the support they required. However, on one unit we noted that staff took time to realise that people didn't have the equipment they needed to eat their meals. On the same unit we saw that staff gently and kindly woke and encouraged one person to eat their meal after they had fallen asleep at the table. However, their main meal had been sat in front of them for 25 minutes and staff did not ask if the temperature was to their liking or offer to get something fresh for them.

The people who used the service enjoyed the food served and spoke positively in regards to it. One person said, "The food is glorious. Very good, yes." Another person told us, "The food is good and there are two main courses each day." The relatives we spoke with told us that their family members enjoyed the food served. One said, "The food is amazing here."

People told us that they had choice and had enough to eat and drink. They told us that they could request food and drink at any time. One person who used the service said, "If I don't fancy what's on the menu, staff change it and get me something else, it's great. If you fancy something in the afternoon, you only have to ask

and they fetch you something." Another person told us, "Staff will fetch finger food in-between meals if you want it." One relative said, "Staff are always coming round with drinks, milkshakes, biscuits…"

From the care records we viewed we saw that most people who used the service had received healthcare intervention as required or as their needs had changed. However, one person had not received the health intervention they required at a time they needed it. This put them at risk of harm. The service had failed to identify the need for a healthcare professional and had not sought the advice required to ensure the health and wellbeing of this person.

People received care and support from staff that had received an induction, support and ongoing training. The people we spoke with told us that they felt the staff had the appropriate skills and knowledge to perform their role. However, one person who used the service and one visitor had some concerns regarding the recent decision to move staff around the different units of the home. The person who used the service said, "The only thing is they're now moving the staff, when for people living with dementia they don't cope well with change." Whilst the visitor told us, "It depends on what staff are on. Some are first rate, some need more training." They went on to explain they felt this was due to a changing staff group on the unit.

When staff deployment was discussed with the registered manager, they told us that it was sometimes necessary to move staff around the different units. They told us that this was to aid flexibility within the service in order to meet people's needs. However, the registered manager told us that some staff remained permanently based within each unit to aid continuity of care.

Staff told us that they felt supported and received appropriate training in order to perform their role. Records showed they had received an induction and ongoing training that covered topics such as moving and handling, first aid, medication administration, dementia awareness, food safety and infection control. Staff had to pass a probationary period to ensure they had the skills and competency to work within the service. An evaluation of staff competency was recorded and the rationale for employing staff members recorded.

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 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 Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met.

The service had made appropriate and individual applications to the local authority for authorisation to restrict people's liberty in order to keep them safe. Some had been authorised and we noted that conditions were being met. We saw that the service worked within the principles of the MCA. This included the completion of assessments on whether people had the capacity to make a specific decision and the recording of best interests decisions as appropriate.

The registered manager had a good knowledge of the MCA and DoLS and how this affected the care and support some people received. They were able to give us examples of situations where they would consider

applying for a DoLS and they were aware of the impact on people who were under continuous supervision and monitoring. For example, the home used assistive technology to help keep people safe. However, this was used only as required and not in an overly restrictive manner.

The service had taken care to ensure that the home's environment was stimulating and supportive to those living at Lydia Eva Court. The décor was clean, bright and themed for interest. Dementia friendly signage was used throughout the home and colours were used to assist people in orientation. A number of rooms were decorated and fully furnished to help promote memories and these included a garden, music and sewing room. Walls were decorated with 3D items that were bright, tactile and themed. Items were available for people to interact with throughout the home and we saw people engaging with them. Memory boxes helped people to identify their rooms along with coloured doors and large signage. People had free access to safely enclosed outside spaces with garden furniture and items of interest.

Good

Is the service caring?

Our findings

People spoke highly of the caring nature of the staff that supported and cared for them. They spoke of staff that demonstrated respect, patience and acknowledgement of them as individuals. We asked the people who used the service if staff were kind and compassionate towards them and whether they felt valued and listened to. One person replied, "Always, all of the time." Another person said, "Oh yes, they're kind and respectful. Staff are unendingly patient." Whilst a third person described staff as, "Truly patient and kind."

People's relatives had confidence that their family members were well cared for and that the staff treated them with compassion and thoughtfulness. One told us, "Everyone speaks to you, it's a lovely feeling, very attentive, you catch a staff member's eye and they respond. I really can't speak highly enough of them." Another person's relative said, "The staff have a good rapport with [family member], both the male and female carers. It doesn't matter what age the staff are, they all treat [family member] with compassion." A third relative told us, "I can see [family member's] eyes are clear and shiny, their smile is bright. If they weren't happy, they wouldn't be smiling."

Throughout our inspection we saw that staff demonstrated a respectful and caring approach to those they supported. We saw examples where staff acted quickly to relieve people's distress or confusion. For one person who was heard to say that they didn't know where their family was and that they felt frightened because of this, we saw a staff member offer prompt reassurance. The staff member smiled and gently held the person's hand whilst offering calm and kind words that comforted the person. One person's relative described how staff kindly interacted with their family member to ensure their emotional wellbeing. They said, "The staff are really good with [family member], they take them by the hand, they agree with them. That sort of one to one, even if it's just for a few minutes, is enough to reassure them."

The knowledge staff had of those they supported assisted people to feel relaxed and accepted. Through discussions we had with staff, they demonstrated that they knew people's needs, likes, preferences and personality traits. Staff could describe what people needed to keep them well and knew their life histories and what interested them. We saw that staff interacted with people on a regular basis and talk with them about topics that interested them. We saw one staff member speaking with a person who used the service. We saw that the staff member listened to what the person had to say and showed interest in their responses. One close relative of a person who used the service gave us an example of how staff listened to people and understood what was important to them. They told us, "I once told the staff that Sunday was always our special day. The day when there was just us at home, time to ourselves. They only went and set up a table for two in the dining room for Sunday roast lunch and now I come every week and we sit and eat together, just the two of us."

One person who used the service told us, "The staff know what I need and I'm very happy." They went on to tell us that all staff knew their routine and preferences. Another person said, "The staff know me very well. I have my favourites [staff] but I get on with them all." One relative we spoke with talked of how staff knew their family member's need to feel involved and useful within the running of the home. They said that staff included the person in everyday tasks to make the person feel enabled and independent.

People told us that the service provided them with all the information they needed to make decisions both prior to moving into the home and since. One person told us, "I feel very much in control and choose what I do." Another person said, "I have all the information I need. There was only me when I came in here and I sorted everything out with the [registered] manager. Staff come and tell me what activities are going on so I don't forget."

The people who used the service and, where appropriate, their relatives, had been involved in making decisions around the care and support they wanted. One relative we spoke with said, "Oh yes, I'm totally involved and kept up to date. When [family member] was admitted all the family were involved as well." Another relative explained how they were encouraged to be part of their family member's care planning and that they were, "Constantly updated." The care plans we viewed confirmed this to be the case.

Staff maintained people's dignity and encouraged their independence. When discussing this with one person who used the service, they said, "Oh indeed, yes. Staff don't hurry you. It's just the way they are." One relative we spoke with said, "Staff do a great job in encouraging [family member]." Another relative told us, "A staff member hovers with [family member] when they're walking around to promote their independence." They went on to explain that staff encouraged their family member to be as independent as possible but were always close by just in case they needed assistance. During our visit we saw staff encouraging people to do as much for themselves as possible, particularly when mobilising around the home or when using equipment to transfer people.

People told us that they felt in control of their lives and had choice in their everyday decisions. One person who used the service said, "I feel in control. If I feel like doing something I will and if not, I don't." Another person said, "I choose what I do with my time." One relative we spoke with told us, "[Family member] is always beautifully dressed with matching clothes. They give people choice" During our inspection we observed staff offering people choice and assisting people to make decisions.

People's privacy and confidentiality was respected and maintained. We saw that staff discussed the people they supported in privacy. On no occasion during our inspection did we observe staff discussing personal matters in communal areas or where they could be overheard. The handover meetings between staff changing shift were discussed behind closed doors and we observed that this was completed with respect for those they supported.

We saw that people who visited the home were made to feel welcome and offered refreshments. People's relatives had swipe cards allocated to them to allow them to visit whenever they wished. A café area was available within the foyer of the home as well as kitchen areas in each unit for visitors to make their own refreshments if they so wished. One relative we spoke with told us, "You can come and go as you please. I've got one of those door entry cards. You can ask for tea or coffee or go make it yourself in the kitchen. I sometimes come early in the morning and one of the staff will call out 'tea or coffee?' It's kind. The staff are so good like that."

Requires Improvement

Is the service responsive?

Our findings

People mostly received the care and support they required. Staff knew people's needs and delivered the care people needed in an individual manner. However, people's care plans were not always accurate and did not always contain the most up to date information on people's needs. They were not consistently person centred. For example, we saw a number of examples where other people's names had been included in people's care plans. As care plans had been completed on a computer and then printed out in paper format, this suggested that areas of care plans had been copied from others. When we discussed this with the deputy manager and registered manager, they agreed that this was the most likely cause.

One person had a food intolerance that required them to have a food substitute which had been provided and we saw that this person was having their nutritional needs met. The food intolerance had been noted within their care plan. However, the food substitute had been noted in one part of their care plan but not in others. This posed a risk that the person may not receive the correct support in relation to this need.

For a second person we saw that their care plan stated that they spent all of their time in bed due to their ill health. However, during our inspection we observed this person in the communal areas and in the dining room having their lunch.

We saw that some care plans had sticky notes and separate notes attached to them that contained information that staff required in order to be able to support people. The information had not been transcribed into people's care plans and there was a danger the information could get lost. For example, we saw that for one person, their 'My life so far' document was blank. A sticky note attached to the care plan gave some brief information on what interested the person however it gave no guidance to staff on how to support this person in relation to their interests.

For the same person, the service had identified that they followed a particular religion. However, the care plan gave staff no guidance on how to support this person in meeting their religious beliefs. This person was unable to communicate verbally with the staff and therefore unable to tell them what support they wished for. This person had moved into the home in December 2015. There was therefore a risk that this person would not receive the support they needed.

Documents pertaining to people's care and support needs were located in various locations throughout the large home. A number of files held a variety of documents for each person and these were located in different units of the home. This increased the risk that people may not receive the care, support and treatment they required as not all information could easily be accessed and assessed in order to make appropriate and prompt decisions.

For one person who used the service whose care plan and associated documents we requested, the registered manager, deputy manager and team leader had to search for the information and documentation. Care records were found in a number of places including some documents that had been left by the fax machine in the business administrator's office. When we discussed the implications of this

with the management team, they agreed that the current system was not effective at ensuring people received prompt and appropriate care. This was due to documentation not being quickly and easily accessible for staff. This made it difficult for staff to have all the information needed to make appropriate care and support decisions or referrals to other professionals.

Out of the 13 care plans we viewed in depth during our inspection, seven contained discrepancies or incomplete information. Although the people who used the service had not come to harm as a result of this, there was the potential risk of this occurring.

People told us that they received the care and support they needed in most aspects of their lives. When we asked the people who used the service whether they were able to express their wishes in relation to the support they received they told us they did. One person said, "Most certainly", another person said, "Oh yes, the staff are very good and I'm always listened to" and, "Totally". The relatives we spoke with agreed. From the observations we made during our inspection, we saw that most people's needs were met and that staff had a good understanding of what these were.

The people who used the service were content with the level of activities and stimulation they received in regards to their social and leisure needs. When we spoke with people's relatives in relation to this, most agreed although a few thought there could be more activities taking place. Throughout our inspection we saw regular interactions with staff and the people who used the service. These were warm and engaging. We saw staff laugh, dance and sing with people and that these interactions were received with smiles and affection. The service employed a member of staff each day whose responsibility it was to arrange activities. However, for most of our time spent in the various units of the home during our inspection, we did not see many activities taking place. We did, however, observe a large amount of resources available for people to interact with such as music, games, soft toys, books and memorabilia amongst many others.

People told us that they knew how to raise any concerns that they may have and that they had confidence they would be listened to and actioned. People told us that they would not hesitate in speaking with the management team and that they found them approachable and responsive. Of all the people we spoke with, none had had a reason to complain. One relative we spoke with told us, "I'm super fussy and I feel that if I had a problem they'd resolve it." Another said, "I don't have anything bad to say about the home." A third person said, "I would raise a concern if I had to but I'm pleased with everything at the moment." A healthcare professional told us, "This is one of the few homes I've not had concerns about, an incident was dealt with very efficiently."

We saw that the complaints the home had received had been thoroughly investigated and promptly responded to.

Requires Improvement

Is the service well-led?

Our findings

The provider had an auditing system in place to monitor the quality of the service. However, it had failed to identify the issues highlighted in this report.

We requested the last three audits that the service had completed on care plans. These dated from September 2015, July 2016 and September 2016. The audits had been completed by a member of the provider's senior management team. Those completed this year audited three care plans each. Whereas the July 2016 audit had looked at one care plan on three of the six units, we noted that the most recent, carried out in September 2016, looked at three care plans on one unit only. This constituted only 3% of the total number of people living in Lydia Eva Court and, for the most recent audit, confined itself to monitoring one unit out of six. This did not give an effective overview of the quality and accuracy of the care plans within the home.

For the audit carried out in July 2016, there was no overview or analysis of the findings although action points were clearly evident. For the most recent audit, carried out in September 2016, we saw that the analysis identified that some of the care plan documentation was generic in form. It stated that the service needed to ensure that they were assessing each person's needs on an individual basis and that this needed to be demonstrated within their care plans.

The audits did not observe the care and support people received against the care plans in place for each individual. Nor did they cross reference other care and support documentation in order to get a complete picture of people's health and wellbeing and the actions the service had taken in response. This had resulted in the audit failing to identify issues relating to the risks to some people who used the service and the failure to assess and review risks promptly and take appropriate action. As the audit covered people's care plans only, it had also failed to identify the risks associated with having documentation in various locations around the home.

We noted from the minutes of a team leader meeting held in October 2016 that the registered manager had discussed errors within the auditing process. Minutes recorded that 21 documentation errors had been missed by team leaders during daily audits. These minutes also recorded that team leaders were to review the care plans they were responsible for as it had been identified that there were occasions when there was no follow through from risk assessments to daily care. In addition, a discussion was had at this meeting around the identification that not all medical information was being recorded. This demonstrated that issues had been identified with the provider's auditing process that had yet to be rectified.

The registered manager had a system in place for accidents and incidents. We saw that the analysis clearly identified trends that could contribute to accidents and incidents such as locations within the home and times of day. However, it did not take into account trends to individual people who used the service. This therefore made it ineffective at identifying contributing factors relating to individuals. We also noted that the log did not record the high number of incidents relating to one person that was often resulting in injury. The service had failed to identify these incidents as a behaviour that put the person at risk and therefore had not

taken appropriate action to mitigate future risk as a result.

The registered manager completed catering audits on a monthly basis. However, neither these, nor any other audits completed by the service, had been effective at identifying the issues relating to people's nutritional needs.

These concerns constituted a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A number of audits were in place to monitor the quality of the service delivered to those living in Lydia Eva Court. Monthly checks were completed on medicines management and these were completed comprehensively by the lead staff member for this area of the service. Actions plans were drawn up as a result and for those audits we viewed, we could see that any actions identified had been followed up appropriately. In addition, a member of the senior management team had undertaken an audit during September 2016. The medicines management system had also been audited by a pharmacist in August 2016 resulting in few actions needed. Monthly infection control audits had also been completed and were effective.

The people who used the service, their relatives and staff spoke highly of the registered manager and deputy manager. They told us they were visible, approachable and helpful. One person who used the service said, "The managers are often about. I could talk to them easily." Another person told us, "The manager's name is [name] and we often chat." One person's relative we spoke with said, "The manager is always about, checking everybody is okay." A second relative told us, "The manager is very approachable and often around." A healthcare professional told us that they found the registered manager to be, "Helpful and supportive, always accessible by telephone or email if I have any concerns."

Staff told us that they felt supported and valued in their work. They felt that the management team were approachable and encouraging. Staff felt able to make suggestions in order to improve the service and they told us that they felt listened to. Staff meetings had taken place with minutes produced. Of those we viewed, we saw that staff meetings were inclusive and informative. A staff committee was also in place that represented the staff team as a whole. They met with the registered manager every six weeks and the objective was to improve the service being delivered.

The home had a friendly, warm and welcoming atmosphere. Team work was evident and staff told us that morale was good. They described their colleagues as supportive and helpful. One staff member told us, "We help each other out."

There was a registered manager in post at the time of our inspection that had been employed by the provider for a number of years. They told us that they felt supported and saw senior management on a regular basis. They told us that they felt their line manager brought out the best in them by making them view situations from a different angle. They told us, "[Line manager] is pragmatic. They don't judge. They encourage me." The registered manager told us that the provider offered them development opportunities including training and support sessions. At the time of our inspection, the registered manager was undertaking a qualification that the provider had offered and encouraged.

The people who used the service, their relatives and staff had had the opportunity to provide feedback on the service provided. This included via regular group meetings, someone to one meetings and quality assurance surveys that were available in an accessible format. Where concerns had been identified we saw that action plans had been drawn up with timescales for completion. Individual staff were named as being

responsible for these actions to encourage accountability and improvement. From some records we viewed, we saw that improvements had been made in one particular area of the service and that these had been maintained. One relative we spoke with told us, "There are regular meetings which I go to. They're helpful for finding out about things. The manager listens to us and I'm quite happy to speak up." Another relative said, "I talk to the manager. There are also family meetings which my [family member] has come to."

All the people we spoke with during our inspection told us that they would recommend the service. They told us that they felt the service was striving for improvement and that they felt part of that. Relatives and visitors told us that they felt welcomed when they visited. One person who used the service told us, "Recommend the home? Oh yes, of course, because of the staff, the people and the place itself. We really understand each other." Another person said, "They [staff] really care about the people they look after. I would recommend the home without hesitation."

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 17 HSCA RA Regulations 2014 Good governance The provider had failed to have effective systems in place to assess, monitor and improve the quality and safety of the service. Regulation 17 (1) and (2)(a)(b)(c)(f)