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Lorraines Residential Home

Inspection report

44 School Street
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Swadlincote
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Tel: 01283211355

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Ratings

Overall rating for this service	Requires Improvement

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?	**Requires Improvement**

Summary of findings

Overall summary

We inspected this service on 19 July 2016 and it was an unannounced inspection. Our last inspection took place in April 2014 and we found no concerns with the areas we looked at. The service was registered to provide accommodation for up to 17 people. At the time of our inspection 13 people were using the service.

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.

People were not always protected from the risk of harm because there were not always enough staff in place to keep them safe. The systems to ensure that staff were safe to work with people were not fully effective. Some people were not protected from potential abuse because concerns were not reported to the local authority to ensure people who used the service were safe.

People's medicines were not managed, stored and administered in a safe way. There was no guidance in place to ensure staff understood when to give people 'as required' medicines.

The provider had not notified us about significant events within the home. There were not always systems in place to review the quality of the home and protect people. The building was not always managed and maintained to ensure that the environment did not cause a risk of harm to people.

When people were unable to consent to their care mental capacity assessments were not completed. Some people were subjected to restrictions and the provider had not identified where their support needed to be reviewed. People told us that they did not have the support they needed to pursue hobbies and interests. Their dignity and privacy was not always upheld.

People told us they enjoyed the meals and specialised diets were provided where needed. People who used the service had their healthcare needs met and saw professionals when they needed to.

Staff received training and support to do their job effectively and developed caring relationships with people. They knew people well including their life histories and preferences. Care plans were maintained and regularly reviewed and updated.

People knew who the registered manager was and staff felt supported. Complaints were investigated and action taken to make improvements where needed.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

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.
There were not sufficient staff in place to protect people from the risk of harm. Concerns about people's safety were not always reported or thoroughly investigated. The risks associated with medicines were not fully managed to protect people from harm. Risk assessments were not always in place and when they were, they were not always followed.

Is the service effective?

Requires Improvement

The service was not always effective.
People were not always able to consent to their care and no capacity assessments were carried out to determine this or to ensure decisions were made in their best interests. People enjoyed the food and specialist diets were provided where needed. Staff received an induction and training that helped them to support people. People were referred to health professionals when needed.

Is the service caring?

Requires Improvement

The service was not consistently caring.
People's dignity and privacy was not always upheld and they were not always comforted when they were distressed. Staff did know people well and when they provided support it was caring and respectful.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.
People were not provided with many opportunities to pursue interests and hobbies. The environment was not planned to support people who were living with dementia. Staff knew peoples preferences and their care needs were reviewed and recorded. Complaints were recorded and investigated.

Is the service well-led?

Requires Improvement

The service was not consistently well led.
Systems were not always in place or effective to ensure that quality improvements were made. The provider had not fulfilled their legal responsibility about notifying us of significant events

at the service. People and staff knew who the registered manger was and felt listened to.

Lorraines Residential Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014. This inspection visit took place on the 19 July 2016 and was unannounced. It was carried out by one inspector.

We checked the information we held about the service and the provider. This included notifications the provider had sent to us about significant events at the service.

On this occasion the provider was not asked to complete 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. However, we gave the registered manager the opportunity to provide us with any relevant information.

We used a range of different methods to help us understand people's experiences. We spoke with six people who lived at the home about their care and support and to the relatives of one other person to gain their views. Some people were less able to express their opinions and so we observed the care that they received in communal areas. We spoke with four care staff, the deputy manager, the registered manager, the chef, and two visiting health professionals. We looked at care records for three people to see if their records were accurate and up to date. We also looked at records relating to the management of the service including quality checks, staff recruitment files and action plans.

Inadequate

Is the service safe?

Our findings

We saw that there were not always enough staff to keep people safe from harm. One person we spoke with said, "There are two staff on in the morning and in the afternoon and they really do need three". Staff we spoke with told us that staffing levels had not been reviewed to meet people's dependency needs and these had been at the same level for many years. One member of staff we spoke with said, "It is really stressful and we can't keep an eye on the people that we should be". Another member of staff said, "In the afternoon there are only two of us and there are at least three people who need two staff to help them to move so you can see that other people will be at risk whilst we are doing that". A third said, "In the afternoons the cleaner, cook and managers go home and so not only do we have to support everyone but we also have to prepare tea and do the cleaning". We saw that a communal area did not have a member of staff for up to fifteen minutes at a time over a two hour period. There were five people in this room and they all required support to move and staff told us that none of these people would be able to use the call bell to request assistance. For example, when we asked one person who used the service how they would get staff assistance they said, "We just shout". We saw one person walked across the room unsupported and shook the walking aid in front of another person telling them to move from their seat. When we spoke with staff they told us that this person should be supported by staff to walk across a room. Records showed that the person was assessed to be at high risk of falls if they were not supported. This incident was not witnessed by staff and we had to intervene to encourage the person back to their own seat.

After lunch there were no staff in the dining area and we saw that one person attempted to assist another person to stand using a walking frame. We had to intervene and ask them to wait for staff assistance. Records we reviewed showed that the person required staff assistance to move safely. Staff told us that both people were living with dementia and were physically frail. Another person was assessed as requiring monitoring by staff following two falls which resulted in an injury. We saw that this person was not always monitored and on one occasion moved across a room using a walking aid and carrying a cup of tea. On another occasion they were alone in a corridor shaking a fire exit door. Some people were not in communal areas and spent time in their rooms. The layout of the bedrooms off corridors meant that staff would not always be able to hear if they were called from the communal area. We saw that not all of the people in their rooms were able to use a call bell to ask for assistance, and staff told us they were not always able to monitor people regularly. One person had woken and required personal assistance but by the time staff were able to attend to them they were too late and unable to support them in a dignified way.
We spoke with the registered manager about the levels of staff and they said, "We have had two hours of activity staff per week which was not enough to keep the communal areas staffed. I often spend time in the lounge to interact with people although I do work part time and doing that means that I don't get some of my other work completed".

This evidence represents a breach of Regulation 18 of the Health and Social Care Act 2008. (Regulated Activities)

People were not always protected from abuse and avoidable harm. When we asked staff about people who used the service we were told, "There have been several incidents between two people which could have

caused harm to one of the people". The staff did not recognise that this should have been reported as a safeguarding concern. One member of staff said, "It has got worse recently and I think it is because they are bored. I don't think they are in the right place". When we reviewed records we saw that these incidents had not been referred to the local authority safeguarding team. The provider had taken some action to reduce the risk of re-occurrence but we saw there were periods of time of up to 15 minutes when these people were unsupported in a communal area. We also saw that one of the actions that the provider had taken to protect one person from harm put another person at risk, and this had not been assessed or managed. This meant that the provider had not recognised this potential safeguarding concern and we did not see systems in place to protect people from harm.

This evidence represents a breach of Regulation 13 of the Health and Safety Care Act 2008. (Regulated Activities) Regulations 2014.

Medicines were not always managed to reduce the risk of harm to people. Some people were prescribed medicines for pain relief or to manage their anxiety on an 'as required' basis which is known as PRN medicine. There was no guidance for staff to know when this should be given to people, known as PRN protocols. We saw that one person had been administered PRN medicine, which was prescribed to help them reduce their anxiety, on a number of occasions. There was no record of the reasons why it had been given or the outcome for the person. One member of staff we spoke with described what signs of anxiety they would look for to administer this but they recognised that other staff may judge the situation differently. This meant that there were no measures in place to ensure these medicines were used appropriately.

The fridge that was used to store peoples' medicines had a recommended temperature range that should be maintained. Staff measured the temperature and recorded it each day. When we asked them what the temperature of the fridge should be they were unable to tell us. There was no procedure available to them to check this information. We saw that the fridge had been recorded above the recommended temperature for several days. Staff were unsure if there were any medicines stored in the fridge currently. When it was opened we saw that there was medicine for somebody who was no longer at the home and this medicine should have been disposed of. We saw some liquid medicines were opened without recording the date that this was done meaning medicines may not be in date. This demonstrated that some medicines were not stored according to manufacturer's guidance and the stock control systems used did not highlight the excess stored.

This evidence represents a breach of Regulation 12 (g) of the Health and Safety Care Act 2008. (Regulated Activities) Regulations 2014.

We saw that risks in the environment were not always managed to keep people safe from harm. We saw that some of the rooms had temperatures in excess of that recommended national guidance for example, in the dining area during meal times. Staff did not monitor the temperature or take action for people to sit elsewhere. One person's bedroom was very hot and we had to ask the registered manager to provide a fan to cool it down. We found that one radiator was warm to touch and when we asked a member of staff they said, "Even when the heating is not on we cannot get that radiator to switch off". This meant that potential risks were not always being identified and managed to ensure that the environment was at a suitable temperature for people.

The provider's recruitment procedures were not always effective in ensuring that staff who were employed could meet people's needs. We saw that the provider had not completed all of the checks needed when they employed new staff to check that they were safe to work with people. We reviewed records and saw

that references were not always obtained from the most recent employer. This meant that assessments of staff's suitability to fulfil their role were not always thorough enough because the provider did not have all of the information they required about the staff's previous performance.

Requires Improvement

Is the service effective?

Our findings

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 or themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We looked to see if the provider was working within the principles of MCA. Staff confirmed that some people living in the home lacked the capacity to make decisions about their care. When people were unable to consent we saw mental capacity assessments and best interest decisions were not completed. For example, one person we spoke with was upset about a decision that had been made to change their bedroom. There was not a capacity assessment or best interest decision to support this change. Staff we spoke with were not able to explain the process to follow when people lacked capacity. This meant that people's rights under MCA were not upheld.

This evidence represents a breach of Regulation 11 of the Health and Safety Care Act 2008. (Regulated Activities) Regulations 2014.

We saw that no DoLS applications had been made. When we spoke with the registered manager they said, "It is not something that I have had the time to fully implement but I have tried to understand it. Now that I think about it I think that the majority of the people who live here would need a DoLS application made and we will make them". This meant that some people may be being restricted of their liberty without legal authorisation.
This evidence represents a breach of Regulation 13 (5) of the Health and Safety Care Act 2008 (Regulated Activities) Regulations 2014.
Staff we spoke with told us that they received training and support to be able to do their job well. One member of staff said, "We have all sorts of training and it is really good. We recently did some on tissue viability and I am confident that I know what signs to look for to check for skin damage". The registered manager told us, "We work closely with the training company to make sure that staff have the opportunity to gain national qualifications. Me and the deputy manager are also completing our management qualifications so that we develop our skills too". This meant that staff were provided with the training that they needed to meet people's needs.

People told us that they had good meals and we saw that choices were available to them. One person said, "The food is good and if you didn't fancy it they would always make you something else". We saw that the cook made two alternative meals for one person to tempt them to eat something and they did. The cook told us, "I plan a balanced menu and use lots of fresh produce especially from local allotments and people's relatives also bring some in". Some people needed assistance to eat or drink and staff supported them in a patient, respectful manner. One person had been losing weight and with healthcare professional guidance

their food was being prepared differently. This change meant that they had recently put some weight back on. Records of food and fluid taken were maintained for some people who were nutritionally at risk. This meant that the provider ensured that people had enough to eat and drink and maintained a balanced diet.

People had their healthcare needs met. One relative we spoke with said, "They see the doctor when they need to and always let me know if they are unwell." A healthcare professional we spoke with said, "There are some very experienced staff here that are skilled at following plans to maintain people's health. There is also good staff retention. They are pro-active at managing people's conditions and will get in touch with us appropriately when they see something of concern". Records that we reviewed confirmed that people's healthcare was monitored and reviewed. This meant that people were supported to maintain good health and to access healthcare services.

Requires Improvement

Is the service caring?

Our findings

We saw that people's dignity was not always maintained. For example, one person asked other people who used the service if they were dressed correctly after attending to their personal needs in the bathroom because there were no staff available to ask. We saw that this occurred on several occasions. On another occasion, a member of staff interrupted somebody using a bathroom to collect some equipment. The member of staff was not aware that the person was in the bathroom because they did not knock before entering. We saw that staff did not always have time to show concern for people's wellbeing and respond when they were distressed. For example, we saw that one person was sitting alone in a communal room and was upset but that staff did not spend time with them to assist them because they were busy completing tasks. This meant that the provider did not always ensure that people had their privacy respected and their dignity upheld.

We saw that when staff interacted with people it was kind and respectful and they had conversations with people which included their personal histories. One relative we spoke with said, "The staff are very kind and when my relative was in hospital they were visited by staff from the home". People's rooms were decorated to personal taste with their own belongings and included family photographs.

People told us that their relatives could visit at any time. One person said, "My family call me twice a week and they can come and visit whenever they are able to". A relative said, "We drop in at all times of the day over a week and they always welcome us and other relatives too".

We saw that people had their care explained to them; one person was gently encouraged to stand by leaning on the table while the member of staff arranged their mobility aid to support them. Another person was asked and consented before they were moved to protect their skin. We heard the staff describe what they were going to do beforehand and asked people if they were happy for them to proceed.

We observed that people could make decisions about their daily routine and were encouraged to maintain their independence. For example, one person we spoke with said, "I like to spend time in my room or in the garden if it is warm and am able to go where I want to". One person's meals were organised in a distinct pattern and staff described what was on the plate so that they could eat it independently.

Requires Improvement

Is the service responsive?

Our findings

We saw people did not have many opportunities to pursue hobbies and interests. One person we spoke with said, "I don't do anything during the day". Another person said, "I sit in here all day and don't go out a lot. I do ask to but it doesn't happen". We saw that people sat for long periods of time in the communal lounge watching the television. We saw that there were no activities organised for them to participate in. The registered manager said, "We had two hours a week activities time and we did manage to get some people out then and organised some group activities. It wasn't enough though and people do need more to do".

The environment was not planned to meet the needs of people living with dementia. We saw that the décor did not assist people to orientate; for example, long corridors were all white and looked the same. Some people did not have their name or photographs on their bedroom door to help them to know which were theirs. There were no pictorial signs to identify bathrooms and toilets to assist people who were unable to interpret written signs. The carpet in the communal area was very patterned and the registered manager said, "I think it needs replacing as it could cause people living with dementia to become confused or disorientated".

Staff we spoke with did know people's needs and preferences. We saw that after lunch one person was supported to spend time in the communal area. One member of staff told us, "In the afternoon they usually like some company if they are feeling well and to spend time chatting about times gone by with their friend". Staff understood and had read people's care plans and one member of staff said, "I have checked the care plan for one person today to see how they are getting on because they have been unwell". At handover, staff discussed everybody's wellbeing and made a note of any changes which needed to be followed up or monitored. Records that we looked at showed that people had their care needs reviewed monthly and that people important to them were informed of any changes. Care plans we looked at were up to date and reflected the care that we saw provided and what staff had told us.

People and their relatives knew how to raise any concerns or complaints that they had. One person told us, "I would speak to the staff or the manager if I wasn't happy". A relative said, "I would always speak with the manager if there was a problem but all of the staff are helpful and will soon sort things out". The provider had a procedure in place to deal with complaints and we saw that any received were managed according to this. We saw that actions were taken to investigate and resolve concerns; for example, by ensuring that all staff were aware of current care plans.

Requires Improvement

Is the service well-led?

Our findings

The provider is responsible for reporting significant events that occur in the home. We had not received notifications from them relating to some specific events, which included serious injuries to people who lived at the home. This is a statutory requirement of their registration with us.

This represents a breach of Regulation 18 (2A) of the Care Quality Commission (Registration) Regulations 2009

There were not always systems in place to drive quality improvement and those that were did not always identify requirements needed. The provider had not implemented a system to determine staffing levels to meet people's needs. This was identified through an external quality review by the local authority but we saw this had not been actioned by the provider. Staff and the registered manager raised concerns about staffing levels but the provider had not increased them. This meant that the provider had not listened to internal and external feedback to review staffing levels to ensure that they were sufficient to meet people's needs and keep them safe.

Some quality audits were in place and some had recently been introduced in response to the external quality review. We saw they were not all effective in identifying where action was needed to make improvements. For example, the medicines audit had been only partly completed and had identified that actions were required to improve the management of this. These had not been implemented to manage the risk. There was not a procedure available for staff to understand why they were recording the temperature of the fridge and when to take action if needed. There was not a contingency plan in place to adapt to unexpected situations, such as very hot weather. For example, there was no guidance for staff to check room temperatures. There was not a maintenance plan or refurbishment plan in place to ensure that the environment was maintained and was safe to meet people's needs. We saw that there was a fault with the heating system which had not been repaired and meant that the building temperature was above recommended guidelines. Staff we spoke with said, "If we raise concerns about the upkeep of the home they are not dealt with". We saw that the manager worked part time and they said, "It is difficult to get all of the work done in that time, and I have had some urgent work to complete recently, such as the fire safety. The deputy manager covers some of it when I am not here but they have additional roles as well so some audits have not been done".

This evidence represents breach of Regulation 17 of the Health and Safety Care Act 2008. (Regulated Activities) Regulations 2014.

Staff we spoke with told us that the registered manager was approachable and supportive. One member of staff we spoke with said, "We get supervision but they are always around and we can talk to them anytime". Another one said, "If we have concerns about someone then the manager always listens and follows it up". People we spoke with told us that they knew the registered manager and could speak with them when they needed to. We observed the registered manager interact with people in the communal areas and saw that people who could not communicate verbally smiled and kept eye contact in recognition and responded to

questions. Some systems had been put in place to gain feedback from relatives although the registered manager said, "When we have sent questionnaires not many get returned. We do try to keep up regular contact with families though and encourage them to let us know what we can do better".

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 18 Registration Regulations 2009 Notifications of other incidents Notifications were not always sent to report important events.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent People were not always able to consent to their care and there were no capacity assessments in place to address this.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Medicines were not managed to ensure that people received safe care and treatment

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Regulation 13 (1) People were not always protected from abuse or avoidable harm. Regulation 13 (5) People were deprived of their liberty without lawful authority.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care

Regulation 17 HSCA RA Regulations 2014 Good governance

Systems in place did not effectively measure or drive improvements.

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 18 HSCA RA Regulations 2014 Staffing There were not sufficient numbers of staff deployed to meet people's needs

The enforcement action we took:

warning notice