Eldercare (Halifax) Limited

St Lukes Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 24 and 29 January 2018 and was unannounced. At our last inspection of the service on 25 October 2016 we found the service to be in breach of three regulations. These were: Regulation 9 Person centred care as we found people's preferences were not achieved and their needs were not been met. Care plans were not person-centred and did not accurately identify people's care needs.

Regulation 12 Safe care and treatment as we found PRN protocols were not in place and staff medication competency had not been assessed. Pain assessments had not been completed.

Regulation 18 Staffing as we found there were insufficient numbers of suitably qualified, competent, skilled and experienced staff deployed in the service.

Following our October 2016 inspection, the registered provider sent us an action plan detailing the changes and improvements they intended to make in respect of each of these breaches of regulation. We took this into account when planning this inspection to make sure we checked these actions had been completed. At this inspection, we found the provider had made all the required improvements and addressed all the concerns that had been highlighted last time we visited the service. The management team were also responsive to concerns we raised during our inspection.

St Lukes Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The care home accommodates up to 40 people in one adapted building. At the time of this inspection there were 20 people using the service.

The service did not have a registered manager. 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.

In September 2017, the registered provider went into administration. The administrators had employed a care company to run the home while a buyer was sought and had oversight of their management. The home manager remained in post and a regional manager for the care company employed by the administrators visited weekly. There had therefore been some changes at the home in the months preceding this inspection. Due to various factors, a number of staff had left the service since the last inspection. Recruitment for a number of posts continued, although this had been challenging due to the registered provider's administration status.

Concerns we identified about the administration of medicines at the home were responded to promptly by the management team. This was because care staff had not completed the appropriate training with regards to supporting nursing staff with the administration of controlled drugs. However, this was arranged

whilst we were onsite.

The provider did not have a policy in place regarding the Accessible Information Standard. We have made a recommendation about this.

Risks to people were assessed and recorded, and staff acted to manage identified risks safely. People were protected from the risk of abuse, because staff were aware of the types of abuse and the action to take if they had any concerns. There were systems in place to ensure people were protected from the risk of infection. The environment was tired in places and required updating. Accidents and incidents were recorded and acted on appropriately. There were safe staff recruitment practices in place.

Although appropriate numbers of staff were observed to be on duty throughout the home to meet people's needs, they had not been deployed effectively. We have made a recommendation about the deployment of staff.

There were processes in place to ensure staff new to the home were inducted into the service appropriately. The manager ensured staff received the training and supervision they needed to provide effective care. Staff were aware of the importance of seeking consent from people and demonstrated an understanding of the Mental Capacity Act 2005. Staff were also aware of the conditions under which a person may be deprived or their liberty, and acted in accordance with the Deprivation of Liberty Safeguards, to ensure people were only lawfully deprived when this was in their best interests.

People's nutritional needs and preferences were met and people had access to health and social care professionals when required.

People told us staff treated them with kindness and their privacy and dignity was respected. People were involved in day to day decisions about their care and had care plans in place which reflected their individual needs and preferences. People were supported to maintain relationships with relatives and friends. Activities were available to meet people's interests and to promote stimulation. However, feedback from people using the service suggested activities did not always meet their needs.

The service provided appropriate care and support to people at the end of their lives. People's needs were reviewed and monitored on a regular basis. People were provided with information on how to make a complaint. The service worked with health and social care professionals to ensure people's needs were met.

There were systems and processes in place to monitor and evaluate the service provided. People's views about the service were sought and considered through residents meetings and satisfaction surveys.

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 always safe.

Improvements were needed in relation to the management of medicines.

Staff were safely recruited and there were enough staff on duty to provide safe care and support for people. However, a request for support was not met in a timely manner.

We recommend the provider reviews the deployment of staff.

Staff demonstrated an understanding of the signs of abuse and neglect. They were aware of what action to take if they suspected abuse was taking place.

Is the service effective?

Good

The service was effective.

Staff worked in accordance with the Mental Capacity Act 2005.

Induction and supervision processes were in place to enable staff to receive feedback on their performance and identify further training needs.

People had access to a range of healthcare professionals as appropriate.

Is the service caring?

Good

The service was caring.

People's privacy and dignity was maintained.

Staff respected people's independence and encouraged them to do as much for themselves as they could.

Staff knew the people they were supporting well and were confident people received good care.

Is the service responsive?

Good

The service was responsive.

People had personalised care and support plans which took account of their likes, dislikes and preferences.

Staff were responsive to people's changing needs.

People's views were sought. They felt they could raise a concern if required and were confident that these would be addressed promptly.

Is the service well-led?

Requires Improvement

The service was not always well led.

The registered provider had gone into administration in October 2017. The service did not have a registered manager.

There were systems and processes in place to monitor and evaluate the service provided.

People's views about the service were sought and considered through residents meetings and satisfaction surveys.

The service worked well with health and social care professionals and made connections with people within the local community.

St Lukes Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked 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 24 and 29 January 2018 and was unannounced.

The service was inspected by one adult social care inspector on both days with the assistance of a medicines special advisor and an expert by experience on the first day. 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 expert had experience in caring for older adults.

The provider had completed a Provider Information Return (PIR). We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

When planning our inspection, we looked at the information we already held about the provider. This included any notifications they had sent us. These contain details of events and incidents the provider is required to notify us about by law, including unexpected deaths and injuries occurring to people receiving care. We reviewed information about the care home from the local authority who commission services. We reviewed information the provider had sent us about how they were going to address our concerns from the last inspection. We used this information to plan what areas we were going to focus on during our inspection visit.

During our inspection visit we spoke with seven people who used the service and three people's relatives. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We spoke with the home manager, the regional manager for the service and six members of care staff. We spoke with a GP whose practice provided services to almost all of the people using the service. We sampled three people's care plans and medicine

records of five people. We reviewed other records used by the provider to manage the service such as staff files, audits, communication records and incident records.

We also reviewed additional information the provider sent us after our inspection visit.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe living at the home. Comments included; "Yes I feel safe, the staff come when I press the buzzer if I get upset or worried. If they haven't time to talk to me then they come back later"; "Yes I feel safe living here, the staff always help me and they are very helpful here" and "Yes I do feel safe here because the staff come round checking on me every hour." Each person's room had a 24 hourly chart which showed staff checked on people hourly. These records included the time of staff visit and what the person was doing at that time. These documents were signed by the visiting member of staff.

Staff demonstrated they were aware of signs which may indicate that someone was being abused and the action to take. They knew where the provider's policies were kept and would let other agencies know if they felt issues were not being addressed. One member of staff told us, "We have safeguarding training every year." Another member of staff told us, "I've never seen any unsafe practice at this home and if I did I would report it straight away to the nurse in charge or manager."

At the last inspection, we found staffing levels in the home were not sufficient to meet people's care needs in a timely way. At this inspection we saw improvements had been made in that there were enough staff on duty, but we observed a request for assistance from one person was not responded to in a timely manner. On the first day of our visit there were six staff on duty. This included two qualified nurses. The clinical lead told us that both they and the manager often helped with care provision, not because they were always needed, but it was their way of working alongside the team. Staff we spoke with confirmed this was the case.

Staff told us they thought there were enough staff on duty and being organised was the key. One staff member said, "We have got enough staff. We are busy but we always try to make time to chat with people." Another staff member said, "If you are organised, its fine. We understand people don't like waiting but it doesn't mean we are short staffed." However, people using the service and their relatives told us they felt the home was understaffed. Comments included; "The staff here are overworked, they need more of them"; "Some days there are plenty of staff and other days there isn't. Some days I have to wait to be seen to. No the staff don't chat with me"; "The staff are very hard working here there just aren't enough of them"; and "There's not enough staff and only a small handful of good staff. They shouldn't be in the kitchen washing up they should be looking after residents." We spoke with the manager about the concerns raised and we also reviewed staff rotas. The manager told us they had flexibility with the staffing levels and could increase them when they needed to. The rotas we reviewed confirmed this.

We recommend the provider continues to review the deployment of staff within the home to ensure staff are able to respond in a timely manner to requests from people using the service.

At our last inspection, we found protocols for 'as and when' required (PRN) medicines and staff competency checks had not been completed. Pain assessments were not completed. At this inspection we found some improvements had been made. Pain assessments were now in place for people, however, they were stored in people's care records and not with their medicine charts. PRN protocols were also now in place for people

who may not be able to communicate their needs in relation to medicines. However, they did not always contain the level of detail a staff member would require to ensure medicines were administered to the person when they were required. We also found instances where records relating to the management and administration of medicines were not always completed. One person who was prescribed oxygen did not have an up to date care plan in place for this. We spoke with the clinical lead about these issues and immediate action was taken in response.

In relation to the administration of medicines, we found a gap in training for care staff who assisted the nursing staff in signing for controlled drugs. The provider policy stated that a member of care staff could assist with this but must have completed the appropriate training. This had not been done. The clinical lead took immediate action and arranged for extra nursing staff to be on duty until the training could be completed. The manager planned for the training to be facilitated within a week of our visit and staff's competency to be checked.

People were protected from harm by the prevention and control of infection. A member of domestic staff told us, "I have enough time to get around all the rooms. Staff will often do a few bits as they go, they are good like that, we all work well together". Staff received infection control and prevention training annually and we observed staff regularly using gloves and aprons when supporting people with personal care. This reduced the risk of cross infection. Toilets and bathrooms contained suitable hand washing facilities and guidance on how to prevent the spread of infection. The service had been awarded the highest rating by the local environmental health agency which meant they regarded the service as maintaining good food hygiene standards. The provider conducted regular audits to ensure these standards were maintained. We saw that the environment was tired in places and required updating. Walls were marked where they had been scuffed with equipment and a carpet in one person's room was stained. A number of upholstered chairs in the conservatory were stained. The home manager told us there was a redecoration/refurbishment programme in place which aimed to address these issues. We will check on this at our next inspection.

The manager had introduced a system to review incidents and learning when things went wrong. We saw they had updated people's care plans when they had been at risk of or suffered harm. They had also reviewed these incidents for trends. These reviews had resulted in staff taking action to reduce the risk of re-occurrence. For example, involvement from the falls team had been sought and equipment put in place to alert staff to the person's movements.

Care plans and risk assessments had been updated to reflect people's changing health needs. People had their needs assessed for areas of risk such as mobility, malnutrition, moving and handling and pressure area care. Records showed if people's health was deteriorating the person was referred to a health care professional such as the district nursing team, occupational therapist or GP.

There were systems in place to ensure the safety of the premises, including regular servicing of equipment. Up to date certificates were available for electric portable appliance testing, gas safety, fire alarms, fire extinguishers, call bell alarms and safety certificates for the lift and lifting equipment such as hoists. Risks associated with moving people in the event of an emergency in the home had been assessed. Personal Emergency Evacuation Plans (PEEPs) were in place which provided information for staff to follow on how people should be supported to evacuate in the event of an emergency. A robust business continuity plan was in place to ensure people were safe in the event of fire or other utilities breakdown such as a power failure.

We checked to see that staff were recruited safely. We looked at four staff personnel files and found there was evidence of robust recruitment procedures. The files included application forms, proof of identity and

references. There were also Disclosure and Barring Service (DBS) checks undertaken for staff in the files we looked at. A DBS check helps a service to ensure the applicant's suitability to work with vulnerable people. These checks demonstrated that staff had been recruited safely.

Good

Is the service effective?

Our findings

People using the service told us they felt staff had the required skills to provide effective care to them. Comments included, "The staff understand my needs. They know what support I need when moving around and they know how I like things to be done" and "Staff know me well and how I like to be helped. I can get on with most things and I know they are there when I need them."

Staff we spoke with told us they completed an induction when they started working at the home. They said this included all of the training which was considered mandatory. The induction also provided staff with an overview of the complaints procedure, medication management, health and safety, accidents/incidents and fire safety arrangements. This demonstrated that new staff members were supported in their role.

Staff completed a range of training to support them in their roles. We reviewed records of staff training which were held by the manager in the form of a matrix. This showed all of the training staff had attended, were due to attend and it included dates booked for refresher training. This included health and safety, fire safety, COSHH, basic first aid, equality and diversity, safe handling, infection control and dementia awareness. Staff told us they felt they were provided with the appropriate training to support people effectively. The manager responded to training requests made by staff and was aware of the knowledge and skills they needed to support people using the service.

We found evidence of staff receiving three monthly supervisions. Supervision is a one-to-one support meeting between individual staff and their line manager to review their role and responsibilities. Supervision also included feedback from colleagues and people who used the service. This system enabled the provider to monitor and support staff to provide effective care.

People's preferences and special diets, such as blended meals and any allergies, were taken into consideration. Staff completed food and fluid charts and regularly weighed each individual to monitor their health. Comments made by people using the service included; "The food is very good, tasty, plenty of it, good quality, couldn't ask for more"; "Can't grumble about the food here, it's really good and they give us plenty"; and "I think the food choices are good but not as good as where mum has come from." People were offered a variety of meal options. In addition, staff told us if someone did not want what was on the menu that day they would provide another alternative. This meant people were protected from the risks of inadequate nutrition and dehydration.

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 are called the

Deprivation of Liberty Safeguards (DoLS).

At the time of the inspection we were told six people using the service were currently subject to DoLS (Deprivation of Liberty Safeguards). Care records showed people's capacity was kept under review, with relevant assessments held within people's care plans. Where relatives had power of attorney arrangements in place to allow them to make decisions on behalf of their loved ones, the service had copies of the documents in the person's care records. We saw that where appropriate, people had given written consent with regards to staff taking responsibility for their medication and personal finances. Staff we spoke with had a good understanding of DoLS and MCA and were able to tell us under what circumstances they felt a DoLS application could be required. One staff member said, "We would always act in a person's best interests wherever possible. DoLS could be required to protect a person if they lacked capacity to make their own decisions." This showed that staff were aware of their responsibilities under this legislation.

We found the manager and staff had developed close working relationships with other healthcare professionals to maintain people's continuity of care. These included the person's GP, speech and language therapists, community and hospital specialists, dieticians, pharmacy and social workers. A staff member told us, "I report any changes to the nurse or the manager and they contact the GP or whoever else is relevant." We saw a clear process of health professional's involvement, the outcome of appointments and the review and update of the specific care plan area. This showed people using the service received additional support when required for meeting their care and treatment needs.

The adaptations and design of the home met people's needs. People had enough space to move around the home with walking aids. We observed people using walking frames and wheelchairs and they were able to move around corridors at the home. Rails and bars were installed throughout the home to provide people with something to hold on to for balance. The home was well lit and there was clear signage in place. This helped people with visual impairments or those living with dementia to orientate themselves within the home environment.

Good

Is the service caring?

Our findings

People and their relatives told us the service was caring. Comments included; "The staff here are real loves. I have a great rapport with them. They are fun and superb carers"; "They all know me well here. The staff are nice, have fun and a laugh and treat me nice. My son comes twice a week and he's happy with how I am cared for"; and "I'm happy here and the staff are so kind and caring. They always ask my visitors too if they would like a drink when they come." We also received some negative comments which included; "Some staff can't be bothered to talk to the residents, they are just robotic. One has an attitude problem, she doesn't smile, she's not pleasant" and "Some staff are caring and some aren't." We reported this feedback to the registered manager who told us they would look into this further.

During the inspection we observed many kind and caring interactions by staff members. They addressed everyone by name and spoke in a respectful manner. Their verbal and non-verbal communication and body language demonstrated kindness and consideration. We saw staff knelt down to speak to people face to face and provide them with explanations, for example, when they needed to take their medicines. Staff spoke with people as they passed by and stopped to have meaningful conversations with them. We saw staff listened to people and showed they were interested in their conversations.

People told us staff respected their dignity and privacy. They gave examples of how staff did this, "The staff always knocks on my door. They take me for lots of showers, too many really. They need to help me get dressed because of my painful arm" and "They take me to the toilet, leave me to be private then come when I call them. They are discreet."

Staff understood the importance of promoting people's independence. People were never rushed so were able to take the time they needed to perform everyday tasks. People told us that while staff promoted their independence and supported them with their personal care they did so in a respectful and gentle way. People said they were encouraged to do as much for themselves as they could which helped them maintain their independence whilst providing them with help and support where needed.

Arrangements were in place to protect people's confidentiality. Care documents were stored in a locked cupboard with only those authorised having access. Staff spoke with us in hushed voices when they were explaining people's needs to avoid being overheard ensuring that people's confidentiality and dignity was maintained. Advocacy services had been used in the past and their contact details were on display.

Good

Is the service responsive?

Our findings

Each person using the service had their own personal care plan. These contained detailed information about the support people required and how staff needed to assist them. Information within the care plans included support required, physical health, medication, mental health, finances and social interests. The care plans were reviewed on a monthly basis, or as and when there were changes to people's needs. Care plans we looked at contained person centred information about people's life history. There was additional information about any likes, dislikes and hobbies. People's preferences in relation to food and drink had also been captured so that staff knew what people wanted.

We found accurate records were maintained with regards to people using the service. For example, we saw up to date records were held in relation to when people had received a bath/shower, when bedrooms had been cleaned and their clothes washed. Daily records of people's care and support and their participation in activities were also held within care plans.

Residents and relatives meetings were held quarterly at the home. We looked at the minutes from the last residents meeting which took place in October 2017. At this meeting, topics of discussion included suggestions of what activities people might like and had recent musical entertainment been enjoyed by people. We also looked at results from an annual satisfaction survey which were sent out to people's relatives and left in the main entrance of the home for people to complete. A 'You said, we did' board was displayed in the corridor so that people could see actions taken in response to their feedback. This demonstrated people were being given the opportunity to contribute towards how the service was being run and to raise any concerns they might have.

A range of activities were on offer to people using the service. These included weekly bingo, a weekly coffee morning and chat and a weekly movie day. Every two weeks a musician visited the home and played a harp and on alternate weeks another musician visits playing a ukulele. Activities were displayed on a board on the corridor outside the lounge area, along with a 'Daily Chat' newspaper detailing news from the past. The manager told us Christmas shopping trips and outings to a Café for cream cakes had taken place. During our visit the activity observed was a staff member playing dominoes with one person and a visitor. However, feedback from relatives and people using the service were not always positive about the provision of activities. Comments included; "No there aren't any activities here. I watch television and read"; "There's not much activity going on here. I like to go into the garden in the better weather. The staff don't do any activities with us. They were going to take me out for fish and chips but the weather turned so they never did"; and "There has been a lady playing a harp in Mum's room which she enjoyed but I don't know of any other activities." We reported people's feedback to the manager. They told us they would discuss the issues raised at the next resident and relatives meeting.

Some people were unable to easily access written information due to their healthcare needs. The registered provider did not have a policy in place to provide staff with guidance on the Accessible Information Standard. The Accessible Information Standard (AIS) was introduced by the government in 2016 to make sure that people with a disability or sensory loss are given information in a way they can understand. It is

now the law for the NHS and adult social care services to comply with this standard.

We recommend the provider implements guidance for staff to follow regarding the Accessible Information Standard and also incorporate this into relevant documents within the service.

We looked at how the service managed complaints and found appropriate procedures were in place, with information displayed in the reception area of the home informing people of the process to follow. The home had received four complaints since our last inspection. We looked at how these had been investigated and responded to and saw it was in line with the policy in place. People we spoke with told us they were aware of who to speak with if they were unhappy with the service they received. We received a number of negative comments about issues relating to the laundering of people's clothes. We reported these concerns to the manager who told us they would take action to address people's concerns.

Requires Improvement

Is the service well-led?

Our findings

The home was last inspected in October 2016. In September 2017 the registered provider went into administration and a different care company had been employed by the administrators to oversee the home until it could be sold. The manager of the home had remained in post but had not applied to be registered with CQC. A regional manager for the care company employed by the administrators was overseeing management of the home and visited weekly.

The regional manager provided us with a range of quality audits they had completed since October 2017. However, we found they lacked detail, were repetitive and did not include action plans to resolve issues identified. In addition, they did not correspond with the range of audits and action plan the manager had in place for the service.

Staff told us the regional manager visited the home but did not engage with them. They also told us things were difficult for them at the moment regarding the potential sale of the service and they did not always feel supported by the care company employed by the administrators. We spoke with the manager of the home who told us it was a very challenging time for them and the service. They said staff were 'pulling together' and continued to do their best despite the uncertainty they faced.

The manager carried out a wide range of regular audits and documented their findings and any actions taken. These included checks in key areas of care delivery such as: health and safety, food and fluid, care records and medication. Where shortfalls had been identified action had been taken, demonstrating the results of audits helped reduce the risks to people and staff and helped the home to continuously monitor and improve.

Services providing regulated activities have a statutory duty to report certain incidents and accidents to the Care Quality Commission (CQC). We checked the records at the home and found that incidents had been recorded and reported to CQC correctly.

Without exception, feedback we received about the manager was positive. This was in relation to support they were providing to staff and the pace with which they responded to issues and concerns raised by staff and people using the service. Staff told us they found the manager approachable and that their door was always open. Comments made by people and their relatives included; "Yes the manager is approachable she often comes in for a chat" and "The manager is good, she gets things done." Staff told us, "She (the manager) is great. She rolls her sleeves up and helps us out, no questions asked" and "I have always been able to go to her if needed. She is a lovely lady who genuinely cares about this home."

We saw there were effective lines of communication within the home providing staff with the opportunity to meet and communicate on a regular basis. Records showed that the manager held regular meetings with staff to discuss the running of the service. We observed a daily handover meeting held in which discussions around people's needs and conditions took place and how best staff could meet and manage them. Minutes of other staff meetings held showed that topics discussed included care plans and records, staff training,

safeguarding and managing behaviours.

The service continued to work in partnership with other organisations and professionals to make sure they were following current practice, providing a quality service and the people in their care were safe. These organisations and professionals included social services, healthcare professionals including General Practitioners and district nurses. We spoke with a visiting professional who told us the service provided at the home was good, and that staff were very conscientious. They told us, "Communication is key. When we come in to the home the staff have everything ready for us. Staff are very good and I think people receive a good standard of care."

There were systems in place to ensure the provider sought the views of people using the service and their relatives on the service they received through regular residents and relatives meetings. Quarterly satisfaction surveys were also carried out. The manager showed us results from the most recent surveys carried out in January 2018, May and September 2017. These showed a range of positive comments had been received from people which included, 'I cannot single one staff out because all staff have been friendly and respectful" and "All staff are extremely helpful and friendly."