

Country Court Care Homes 2 Limited

Lyle House

Inspection report

207 Arabella Drive
London
SW15 5LH

Date of inspection visit:
21 December 2016

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20 January 2017

Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

Good 

Is the service effective?

Requires Improvement 

Is the service responsive?

Good 

Summary of findings

Overall summary

We carried out an unannounced comprehensive inspection of this service on 22 March 2016. Some breaches of legal requirements were found. After the inspection, the provider wrote to us to say what they would do to meet the legal requirements in relation to safe care and treatment, consent and good governance.

We undertook this focussed inspection to check that they had followed their plan and to confirm that they now met the legal requirements in relation to the breaches found. This report only covers our findings in relation to those requirements. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Lyle House on our website at www.cqc.org.uk.

The service had a manager in post who was in the process of submitting their application to become the 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.

Lyle House provides residential care for up to 45 older people. The home is arranged over three floors and accommodates some people with a diagnosis of dementia. At the time of the inspection, there were 43 people using the service.

At our previous inspection we found that some risk assessments were not completed properly and some did not include an associated care plan. Some care plan reviews did not always reflect changes to people's support needs. We also found that consent to care and treatment was not always clearly documented.

At this inspection, we found that improvements had been made in all of these areas.

Risk assessments and associated records, such as care plans and monitoring records were in place which helped to identify and manage risks to people. Referrals were made to health care professionals if extra support was needed.

The provider was meeting the requirements of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). The provider sought authorisation if restrictions were in place to keep people from coming to harm. We found that some care workers were not familiar with the Act and its uses and the manager told us that this would be addressed in team meetings and supervision.

Excess controlled drugs were recorded correctly and stored securely.

Care plans included life and social histories and personal preferences records were completed for people to ensure that staff were responsive to people's individual needs.

Where people's support needs had changed, these were reflected in risk assessments and care plan reviews.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

We found that action had been taken to improve the safety of the service.

Risks management plans were in place where people had been identified at high risk.

Excess controlled drugs to be returned were recorded and stored appropriately.

Good 

Is the service effective?

We found that action had been taken to improve the effectiveness of the service.

People who were unable to consent had their rights protected.

Staff understanding of the Mental Capacity Act 2005 (MCA) was variable.

We could not improve the rating for effective from requires improvement because to do so requires consistent good practice over time. We will check this during our next planned comprehensive inspection.

Requires Improvement 

Is the service responsive?

We found that action had been taken to improve the responsiveness of the service.

Care plans reflected people's individual needs and were updated regularly.

Good 

Lyle House

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.

We undertook this unannounced focussed inspection on 21 December 2016.

This inspection was carried out to check that improvements to meet legal requirements planned by the provider after our inspection on 22 March 2016 had been made. We inspected the service against three of the five questions we ask about services: is the service safe? is the service effective? and is the service responsive? This is because the service was not meeting some legal requirements.

The inspection was carried out by one inspector.

Before we visited the service we checked the information that we held about it, including notifications sent to us informing us of significant events that occurred at the service.

During our inspection we spoke with two people using the service and four staff members, including the manager and three care workers. We looked at five care plans.

Is the service safe?

Our findings

At our previous inspection which took place on 22 March 2016, we found people were not always protected from avoidable harm as not all risks were adequately mitigated. Risk assessments were not completed properly and some did not include an associated care plan. We also found that excess controlled drugs were not documented in the controlled drugs recording book.

At this inspection we found that some improvements had been made. The provider was now meeting the regulation.

In one care record for a person who was at risk of falling, there was an occupational therapist (OT) moving and handling risk assessment and plan which provided staff with the correct way in which they were to be transferred. This included the number of care workers, the type and size of the hoist and sling. We checked the person's room and the correct equipment was in place and guidelines were also available in the room so that staff could access them easily to ensure that the person was supported to move safely.

Staff we spoke with were familiar with the moving and handling techniques to be used for each person and knew how people's needs had changed. Training records showed that the majority of staff had received this training. They told us, "[Person] used to move freely before but recently [the person] has gone down, [their] mobility is not good" and "We have to use a hoist now, we have had training on it."

Plans were in place to manage risks associated with moving and handling. There were moving and positioning risk assessments and falls risk assessments in place that had been reviewed recently. There were care plans in place where people were identified at risk and these included an expected goal. These were reviewed as and when people's needs changed, for example after the OT had made a recommendation. Fall observation records were in place which were fully completed and included observation of people and specified time intervals after the fall and what action had been taken.

Waterlow assessments to assess skin integrity for the risk of pressure sores were completed monthly, those that were identified as being at high risk had a care plan in place which included actions that staff needed to take to manage the risk to help prevent pressure sores from developing.

We checked the controlled drugs recording book and saw that accurate records were maintained in respect of excess controlled drugs that were to be returned. These were stored securely.

Is the service effective?

Our findings

At our previous inspection which took place on 22 March 2016, we found people's rights may not have been protected as the provider did not always seek consent for care and support from the relevant person. We found that consent to care and treatment was not always clearly documented.

At this inspection we found that improvements had been made. The provider was now meeting the regulation.

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).

One person using the service that we spoke with told us they went into town every day. They said they caught the bus and went to see their family. Staff we spoke with were aware that this person was not to be restricted from leaving the service and should be supported to maintain their independence and make choices about where they wanted to go during the day.

Care workers were able to tell us which people were had a DoLS authorisation in place. One care worker told us, "[Person] knows the code and is able to move around freely." Another said, "[Person] is not able to leave, it's because of their safety they would not be safe on their own." However, they were less certain about the purpose of the MCA and its use although training records confirmed they had received training in this area. We spoke with the manager about this who acknowledged this shortfall and said they would try and reinforce staff knowledge and understanding during team and one to one meetings to ensure that staff understood their responsibilities.

DoLS guidelines were on display in the communal areas of the home for easy reference for staff to check.

Mental capacity assessments were done and best interests meetings were held to ensure that appropriate decisions were made where people did not have the capacity to make a specific decision related to their care. During these meetings decisions were made on their behalf in consultation with staff and next of kin. If restrictions were needed to keep people safe, the provider sought legal authorisation for these through DoLS. The manager told us that 31 people living at the service had a DoLS authorisation in place or applications had been submitted to the local authority for a DoLS authorisation.

Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) records were in place for people. Where people did not have capacity to understand these decisions this was clearly recorded and there was evidence that the decision was based on a clinical decision and in consultation with next of kin where appropriate.

Consent forms were signed by people using the service or a family member where appropriate if they did not have capacity to give consent for a number of areas including having their photograph taken, going out on trips and administering medicines.

Although we found that concerns had been addressed, work was still in progress and sufficient time had not passed to assure us that these improvements could be sustained. Therefore we have been unable to change the rating for this question. A further inspection will be planned to check if improvements have been sustained.

Is the service responsive?

Our findings

At our previous inspection which took place on 22 March 2016, we found care records were not always fully completed or up to date which meant that people were at risk of not having their needs met. We found that not all personal preference forms were complete, life aspiration forms were incomplete and external Multi-Disciplinary Team (MDT) advice was not used to develop and/or update care-plans.

At this inspection we found that improvements had been made. The provider was now meeting the regulation.

Personal preferences records were completed providing details of how people preferred to be cared for in relation to personal hygiene, oral care, nutrition, communication, and other areas. This helped to ensure that people's individual needs were met.

People's life history and social history were also recorded which meant that staff had access to more person centred information to assist them in responding to people's needs effectively. Care workers we spoke with told us about the people they key worked and were familiar with their likes and dislikes, the type of activities they enjoyed and how they liked to be supported.

We saw examples where people's care needs had changed and advice sought from external professionals such as occupational therapists (OT). Care plans were updated to reflect the new information and care workers were also familiar with these.

Care workers also completed daily care monitoring charts detailing the personal care tasks that people had been supported with which provided other staff employed by the provider and external health care professionals with access to accurate information about how people's needs and wishes were met.