Care Quality Commission

Lonsdale Midlands Limited

189d Walmley Road

Inspection report

189d Walmley Road, Walmley, Sutton Coldfield B76 1PX
Tel: 0121 313 0879
Website: www.

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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?	Requires Improvement
Is the service responsive?	Requires Improvement
Is the service well-led?	Inadequate

Overall summary

Our inspection took place on the 23 December 2014 and 12 January 2015. Both days were unannounced so no one knew we would be inspecting. We last inspected the home in April 2014. At that inspection we found that the provider was not meeting the regulations in relation to the care and welfare of people who use services. Following our April 2014 inspection the provider sent us an action plan telling us about the improvements they were going to make to information in people's care records and to the arrangements for assessing the quality of the service. During this inspection we found that further improvements were still required and additional regulations were not been met.

Walmley Road is registered to provide accommodation and personal care to a maximum of four people. On the day of our inspection four people lived at the home. All of the people living there had complex needs including autism.

A manager was registered with us as required by law. 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 the legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Summary of findings

We found that staffing levels did not always ensure that people's needs were met in the way that they wanted them to be. We identified a breach in the law concerning this. You can see what action we told the provider to take at the back of the full version of this report.

There were systems in place to minimise the risk of abuse. Staff we spoke with understood that they had a responsibility to take action to protect people from the risk of harm. However, the provider had not ensured that learning from events had taken place.

We found that action was not always taken following incidents and accidents to ensure people's safety and minimise reoccurrence.

The requirements of the Deprivation of Liberty Safeguards (DoLS) is a legal framework that may need to be applied to people in care settings who lack capacity and may need to be deprived of their liberty in their own best interest to protect them from harm or injury. We found that steps had been taken by the manager to meet the requirements of this legislation.

We saw that people received their medication on time and that medication was stored safely.

We found that staff training had not always been effective in ensuring staff had all the skills and knowledge they needed to provide safe and appropriate care to people.

People received the drink and food they needed to reduce the risk of dehydration and poor health. However, arrangements in place did not ensure people's independence was promoted effectively during meal times.

The arrangements in place for listening and learning from concerns did not ensure that these were effective.

We found the overall quality monitoring processes required improvement to ensure that the service was run in the best interest of the people who lived there. We identified a breach in the law concerning this. You can see what action we told the provider to take at the back of the full version of this report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was not safe.

Arrangements in place did not ensure that safe staffing levels would be provided.

Arrangements were in place to prevent people being placed at risk of harm of abuse but these were not robust and had not ensured that learning had taken place.

People had their medication as prescribed and it was stored safely.

Requires Improvement

Is the service effective?
The service was not consistently effective.

Systems regarding DoLS were adequate which would give assurance to the people who lived at the home that people would not be unlawfully deprived of their liberty.

People were offered adequate food and drink but were not always supported to eat in a way that promoted their independence.

Arrangements in place for staff training did not ensure that all staff were effective in carrying out their role.

Requires Improvement

Is the service caring?
The service was not consistently caring.

People's privacy and dignity was not always promoted.

People were not always given the support they needed to make their own choices.

Requires Improvement

Is the service responsive?
The service was not consistently responsive.

People did not always receive the support they needed to participate in recreational pastimes that they enjoyed.

Arrangements for listening and responding to complaints had not always ensured the provider had responded accordingly.

Requires Improvement

Is the service well-led?
The service was not well led.

The manager was registered with us as required by law.

Arrangements in place had not ensured that the service was run in the best interest of the people who lived there.

Inadequate

189d Walmley Road

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 Act2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection took place on 23 December 2014 and 12 January 2015. Both days of our inspection was unannounced. The inspection team included one inspector. On the first day of our inspection we focused on speaking with people who lived in the home, staff and observing how people were cared for. We returned to the home to look in more detail at some areas and to look at records related to the running of the service.

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 observed how people were supported during their lunch and during individual tasks and activities.

We also reviewed the information we held about the service and the provider. This included notification's received from the provider about deaths, accidents and safeguarding alerts. A notification is information about important events which the provider is required to send us by law.

We requested information about the service from Birmingham Local Authority who are responsible for monitoring the quality and funding people's care at the home. We used the information to inform our inspection.

During our inspection we met with all four people who lived at the home, seven care staff and the registered manager. We looked at safeguarding records, maintenance records, audits, complaints records, medication records and sampled three people's care records. Following our inspection we spoke with two relatives and a health care professional.

Requires Improvement

Is the service safe?

Our findings

All of the people living in the home needed a high level of staff support to meet their needs. Staff told us that the staffing levels had been very difficult in recent months. There had been a turnover of staff resulting in four vacant posts and this was a third of the overall staffing team for the home. Staff told us that some agency staff had been used to provide staff support. One staff member said, "It has been very difficult we have been short staffed, It can be stressful with agency staff because they don't' always know how to support people properly". A relative told us, "When I visit now I don't know half of them, there is always someone different working". Staff told us and records looked at confirmed that night time staffing levels on some occasions had been reduced from two staff to one, due to the staff shortage. This meant that if needed they would not be able to follow a person's emergency medical procedure to keep them safe, but would be reliant on the emergency service to do this. Staff told us that they worked day and waking night shifts and they found this tiring and difficult. Staff told us that there were not always enough staff to support people safely on community activities. Arrangements for staffing had not ensured that appropriate steps had been taken to ensure at all times there were sufficient numbers of staff to keep people safe. This was a breach in regulation 22 of HSCA 2008 (Regulated Activities) Regulations 2010.

All staff spoken with and records looked at confirmed that staff had received training on how to keep people safe from the risk of harm. Information about keeping people safe was on display in the home so that all staff and visitors were aware of how to report concerns. All staff knew about the different types of abuse and the signs to look out for which would indicate that a person was at risk of abuse. For example staff said they would report a change of behaviour or signs of neglect, which could indicate that people were being mistreated. Two staff members knew the different agencies that they could report concerns to should they feel the provider was not taking the appropriate action to keep people safe.

Since the last inspection we have received one notification of a safeguarding incident from the provider. We found that the provider initially failed to follow their own safeguarding procedures until a family member and the Local Authority intervened. At the time of this inspection, several months after the incident we found that learning from the incident and action to explore the delay in the reporting of the incident had not been taken. This showed that systems to keep people safe from the risk of harm were not robust.

We saw that some risks to people had been assessed and actions were put in place to reduce the risk of harm to people. Some staff we spoke with could tell us about these risks. However we found that peoples care records were not always updated following an incident or injury. During our inspection staff told us about incidents and injuries that had happened and we also saw incidents happen but these were not always recorded in the homes records. This showed that arrangements to minimise risks did not ensure that staff would have the up to date information they needed to ensure that risks to people would be well managed and ensure the safety and welfare of people.

We spoke with staff about what they did in emergency situations. Staff gave us examples of how they would manage different incidents. One staff member told us, "If it was serious and the manager wasn't here. I would call the emergency service first. Then contact the manager to let them know what was happening". Records showed that staff had completed fire safety training and first aid training. This showed that staff had some knowledge and skills to ensure people would be supported safely in an emergency situation.

All the people required staff support to take their medication safely. We saw that medicines were stored securely in a locked cabinet. We looked at three people's Medicine Administration Records (MAR), to see whether medicines were available to administer to people at the times prescribed by their doctor. We found that medicines were available to people as prescribed. MAR records had been completed and maintained. We saw that written protocols were in place for medication prescribed on a 'when required' basis so staff would know when to administer these. Staff told us that they had received training on how to administer medication safely and that competency assessments had also been completed to ensure that medication was safely administered.

Requires Improvement

Is the service effective?

Our findings

The Mental Capacity Act 2005(MCA) sets out what must be done to make sure that the human rights of people who may lack capacity to make decisions are protected. The MCA Deprivation of Liberty Safeguards (DoLS) requires providers to submit applications to the Local Authority for authority to deprive someone of their liberty. We, CQC are required by law to monitor the operation of DoLS and to report on what we find. We observed that people that lived at the home may not have mental capacity to make an informed choice about decisions in their lives. We observed that the home had locks on access and exit doors and the kitchen. People also had close constant staff supervision and the use of listening monitors was in place in a person's bedroom. The manager told us that they had made DoLS applications for people who lacked capacity, where they believed that a person's care needed a level of supervision and control. The applications had been made as needed to the local authority to authorise these restrictions placed on people's freedom, and the manager was waiting on their decision. This showed that the manager had complied with this important legislation.

We saw that people were not always supported by a staff team with the right knowledge, skills attitudes and behaviours. We observed on the first day of our inspection that staff were focused on people's behaviours rather than the person themselves or on doing household tasks and jobs and not engaging with people. We saw when a person became anxious that a staff member just called out their name and made no attempt to reassure or divert the person towards engaging in an activity or reassuring them. Only one staff member that we spoke with had some understanding of DoLS and why some restrictions were in place to keep people safe. However, on the second day of our inspection we observed some interactions that were appropriate and demonstrated that staff had some understanding of people's needs. Staff that we spoke with and the manager told us that staff training had taken place and this was confirmed by looking at records. The arrangements for staff training did not ensure that staff consistently delivered safe and effective care to people.

We saw that one person became anxious. We saw that two staff members did not follow the persons care plan which was to de-escalate the situation. However we saw that another staff member did reassure the person and took steps to alivate the person's anxiety. This showed that staff were inconsistent in their approach to identify triggers to behaviours and respond to people's needs effectively.

We saw some people made their own drinks with support from staff. We observed people eating a lunch time meal. We saw staff supported people to eat. However, the support given was not always in line with people's guidelines. For example specialist equipment including plates designed to aid independence and specific sized cutlery were not used, as stated in people's guidelines. When we asked staff about this, they did not know why the right equipment had not been used. We saw that during the meal time staff did not engage with people, did not tell people what they were eating, did not encourage people to promote their self-esteem and independence. Staff did not make meal times a pleasurable experience.

Staff told us that they did knew people's nutritional needs. They knew people's specialist dietary requirements and told us that these were followed. For example, some people needed their drinks thickened to prevent swallowing risks and we saw staff followed these guidelines and understood the reason for this. We saw that referrals had been made to health care professionals for help and advice on safe eating practice. Although the guidance regarding equipment was not always followed.

Two relatives that we spoke with told us that their family member had been supported to meet their health care needs. A health care professional that we spoke with told us that they had no concerns about people's wellbeing. Staff that we spoke with told us that people were supported to attend doctor appointments and other health care appointments when needed. We found that records looked at did not always detail health care professional advice clearly to ensure any follow up action would be taken as needed. However, by the second day of our inspection improvements had been made to those records and showed that people received support to attend medical appointments so their health care needs were met.

Requires Improvement

Is the service caring?

Our findings

We observed on the first day of our inspection that the relationship between staff and people did not always demonstrate that people's dignity was respected. Staff were focused on doing tasks for example cleaning and laundry tasks. We saw that staff did not sit and talk with people for any meaningful period of time. We saw that staff did not always explain to people what they were doing and wait for the person's approval before they gave them support.

We saw that people had limited opportunity to make day to day choices and decisions. Some staff did try to offer people choices for example they showed people different drinks so they could make a choice about what they wanted to drink. We saw that opportunities to support people to make choices were missed. We asked staff why a picture menu board was not in use. They told us, "Because of the staffing problems we haven't been using it". We saw that work had taken place between the two days of our inspection. We saw that information about people's individual communication needs and how they should be supported in a way that took account at all times of their individual needs was available for staff to refer to. The provider's representative told us that staff training on communication would be provided to ensure that people's communication needs were met.

We found that people's privacy and dignity was not always promoted. We observed that staff ensured that toilet doors were closed when they were in use. We observed the use of a listening monitor. We asked two staff members about this and they told us that it would be turned off when staff were assisting the person with their personal care. However, we observed that this was not consistently carried out by all staff. This showed that people's dignity and privacy was not understood and respected by all staff.

A relative told us that they were able to visit the home at any time and there were no restrictions in place. Another relative told us that their family member was supported to visit them. We saw that family member's birthdays and important events were recorded in people's records and staff told us that people were supported to send cards and presents to celebrate these events. This showed that staff recognised the importance of maintaining links with people's family.

Requires Improvement

Is the service responsive?

Our findings

One relative told us that they felt involved in their family members care. Another relative told us that staff did not really consult with them. However, they told us they knew that they could telephone the staff and ask if they needed to know anything about their relative care.

On the first day of our inspection we observed that people were not supported to take part in activities or supported to do things they found interesting. We observed that after lunch people sat in the lounge and a television music channel was put on and was listened to by two staff members. There was very little engagement from staff with people and no attempt was made to find out if this was people's choice or preference. On the second day of our inspection all the people went out for a drive in the homes transport and they also had lunch out. On their return staff told us that people had enjoyed it. A staff member said, "They like going for a drive and being out of the house". Records looked at and staff we spoke with told us that the planning and taking part in recreational hobbies and interest had been very difficult in recent months. They told us that a decrease in staffing levels had meant that mainly group activities had taken place. Three staff members also told us that they had noticed a negative change in people's behaviour caused by the decrease in opportunities to take part in activities in the community. Staff told us and records confirmed that people had been supported on some occasions to go for walks, visit local shops and travel on public transport but the opportunity to do these activities had reduced. This showed that people's individual recreational and interests were not always met.

We saw that one person became upset and tearful during our inspection. We asked a staff member about this and they told us, "They are always doing this, we do not know why they do it". Some staff told us that they had reported changes in a person's behaviour to the manager and a GP appointment had been made for the person. People would not be able to tell staff if they were unhappy or in pain and our observations showed that staff would not always respond consistently to changes in people's needs.

We spoke with two relatives. One relative told us that they did not know how to make a complaint, and that they had not been given information about this but would contact the home, if needed. Another relative told us that they did know how to make a complaint and that they had not been happy with how a recent concern had been dealt with by the provider. We saw that there was a complaints procedure and an easy read version was also available. Arrangements for managing concerns and complaints had not always ensured they had been managed accordingly.

Inadequate

Is the service well-led?

Our findings

The manager was registered with us, as required by law. During our inspection we observed some aspects of a negative culture within the home. We found that the home had not been people led. A manager of a well led home would identify the culture of a home and make the changes needed to ensure a positive, person centred culture. This had not happened.

We found the service did not have a clear vision and values. People were not supported in a way that promoted their dignity and respect. We saw examples of poor practice and a lack of effective communication from staff with people that lived in the home. We found that staff resources had not been used effectively. Staff were mainly task focused. The night time staffing arrangements put people at risk of harm.

The manager told us that questionnaires had been sent to people's relatives so they could comment on the quality of the service, but these had not been collated and analysed. One relative told us that they had not received a questionnaire to complete. Another relative told us that they had received one a while ago. We were told by the manager that meetings with people's relatives had not taken place. This showed that systems were not in place for seeking the views and experiences of people's family members and representatives on the running and culture of the home.

At our last inspection in April 2014 we identified that quality monitoring systems were not effective and also that systems in place did not always ensure accurate and appropriate records were maintained and breached the regulations. We received an action plan from the provider telling us what they were going to do to address the two breaches in the regulations. At this inspection the provider had not taken all the required action to ensure that home was operating in a way that complied with the law. The manager told us that because of the staffing situation she had needed to work on occasions directly supporting people with care tasks and she had not always been able to fulfil her management role. After the first day of our inspection the manager made senior managers aware of the concerns we raised and additional management support had been provided. In a well led service we would expect that the providers quality monitoring systems would of identified the failings in a timely way, so that the risk to people could be managed. On the second day of our inspection some steps had been taken to address the concerns we had identified. Staffing levels had been reviewed, and immediate steps had been taken to ensure two staff were working at night. Some improvements had been made to care records.

Systems in place for assessing the quality of the service were not robust. Audits had been completed by the manager and the providers representative to assess the quality of the service. However, these had not been effective in identifying where improvements were needed. For example where incidents, accidents, and safeguarding incidents had taken place the systems in place to monitor quality had not been used to analyse the information so that themes and trends could be identified and action taken to manage the risk to people. The systems in place had not identified that the number of staff available were insufficient to manage the risk to people using the service. The systems in place had failed to identify that not all staff adopted a person centred approach to people's care so that their welfare was promoted. The systems in place had not identified that not all staff were providing care in the way that was effective in enabling people to make choices. This is a breach in regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing **The provider had not taken appropriate steps to ensure that , at all times there are sufficient numbers of suitably qualified, skilled and experienced persons employed for the purpose of carrying on the regulated activity.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision **The provider had not taken appropriate steps to ensure that an effective system was in place to assess and monitor the quality of the service provided, and to identify, assess and manage risks relating to the health and safety of service users.**