Care Quality Commission

Sidney Avenue Lodge Residential Care Home

Sidney Avenue Lodge Residential Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate
Is the service safe?	Inadequate
Is the service effective?	Inadequate
Is the service caring?	Requires Improvement
Is the service responsive?	Requires Improvement
Is the service well-led?	Inadequate

Overall summary

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, and to provide a rating for the service under the Care Act 2014.

This was an unannounced inspection. At the last inspection carried out on 4 March 2014 we found that the provider was not meeting the regulation in relation to medicines as there were not appropriate arrangements in place for the safe storage, administration and disposal of medicines. Following the inspection the provider sent us an action plan telling us about the improvements they were going to make. During this inspection we found that the provider had not taken action to address these issues. We have taken action against the provider and issued a warning notice about the unsafe management of medicines.

Summary of findings

Sidney Avenue Lodge Residential Care Home provides care and support for eight men who have learning disabilities and also have a mental health diagnosis. There were eight people living at the service at the time of our inspection. It is a family run business and four family members were working at the home, one of whom was the registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service and has the legal responsibility for meeting the requirements of the law; as does the provider.

People were not kept safe at the home. There were poor arrangements for the management of medicines that put people at risk of harm, staff were unable to demonstrate they knew how to identify or respond to abuse and the recruitment checks for new staff were not complete.

We found that there were restrictions imposed on people that did not consider their ability to make individual decisions for themselves as required under the Mental Capacity Act (2005) Code of Practice.

Although people's needs had been assessed and care plans developed these did not always adequately guide staff so that they could meet people's needs effectively. Also, potential health concerns such as significant weight loss were not always identified which could result in people's healthcare needs not being met.

Staff were not provided with sufficient supervision and training to ensure they were able to meet people's needs effectively but they were given an induction to the service so that they knew what people's needs were.

Staff did not always respect people's privacy and standard restrictions were unnecessarily applied to everyone using the service. For example, people were at times restricted from making themselves snacks and drinks which meant their independence was not always promoted.

The provider was not adequately monitoring the quality of the service and therefore not effectively checking the care and welfare of people using the service. In addition to this the provider had failed to provide information requested by the Care Quality Commission about the service.

People told us they were cared for by staff and we saw that people were involved in the recruitment of new staff and planning social events at the home. They told us they enjoyed the food and were supported to maintain relationships with family and friends. We observed caring interactions between staff and people using the service and saw that people were encouraged to access local amenities and take part in leisure activities.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. 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?

Inadequate

The service was not safe. Systems for the management of medicines were unsafe and did not protect people using the service.

Staff recruitment checks were not fully completed and therefore did not protect people from staff unsuitable to work with vulnerable people.

Not all staff had the skills and knowledge to recognise and respond to abuse.

There were enough staff to meet people's needs.

We found that there were restrictions imposed on people that did not consider their ability to make individual decisions for themselves.

Is the service effective?

Inadequate

The service was not always effectively meeting people's needs. Staff did not receive adequate supervision and training and were therefore not always equipped to meet people's needs.

Potential health concerns such as significant weight loss were not always identified which could result in people's healthcare needs not being met.

People were supported to attend routine health checks for their eye, dental and foot care.

People told us they enjoyed the meals prepared at the service and were involved in making decisions about what meals were served.

Is the service caring?

Requires Improvement

People's personal information was not always kept confidential and therefore people's privacy was not always respected.

People told us that staff treated them well and we observed warm and caring interactions between staff and the people using the service.

Steps had been taken to meet people's cultural needs.

Is the service responsive?

Requires Improvement

People's rights to make choices and maintain their independence were not promoted as there were restrictions on when people could use the kitchen to prepare snacks and drinks for themselves.

People told us staff listened to any concerns they raised, however, the complaints process was not accessible to people who used service.

Although people's needs had been assessed and care plans developed these did not always adequately guide staff so that they could meet people's needs effectively.

Summary of findings

People were involved in some decision making about social events being planned and were asked for their views about new staff.

Is the service well-led?

Inadequate

The service did not have effective systems in place to ensure it was well led. Although people had been asked for their views about the service and included in the recruitment of new staff, there were no other quality monitoring systems being used to ensure that the service was operating safely and effectively.

In addition to this the service had failed to provide information requested by the Care Quality Commission and had not addressed a previous breach of regulation.

The provider was not considering best practice in relation to meeting the needs of people using the service.

Sidney Avenue Lodge Residential Care Home

Detailed findings

Background to this inspection

This report was written during the testing phase of our new approach to regulating adult social care services. After this testing phase, inspection of consent to care and treatment, restraint, and practice under the Mental Capacity Act 2005 (MCA) was moved from the key question 'Is the service safe?' to 'Is the service effective?

The ratings for this location were awarded in October 2014. They can be directly compared with any other service we have rated since then, including in relation to consent, restraint, and the MCA under the 'Effective' section. Our written findings in relation to these topics, however, can be read in the 'Is the service safe' sections of this report.

The last inspection of this service took place on 4 March 2014. During this inspection we found that the provider was in breach of the regulation that related to the safe storage, administration and disposal of medicines. The provider sent us an action plan stating what steps they would take to address the issues identified.

An inspector carried out this inspection on the 8 July 2014. Before the inspection we reviewed the information we held about the service and contacted the local safeguarding authority and learning disabilities team. They raised some concerns about the environment, staff training and supporting people's independence.

The provider was sent a Provider Information Return (PIR) to tell us about the operation of the service and how people's needs were met but this was not completed.

We used a number of different methods to help us understand the experiences of people living in the service. We spent time observing care in the communal areas such as the lounge and dining area and two people showed us their bedrooms. We spoke with all eight people who were using the service and interviewed the registered manager, deputy manager, a senior care worker and three other care workers.

We looked at five people's care records and carried out pathway tracking for two people. Pathway tracking is where we look at a person's care plan and check that this is being followed and their needs met. We did this by speaking with the person, the staff that cared for them and by looking at other records relating to the management of the home. We looked at three sets of recruitment records, duty rosters, accident and incident records, selected policies and procedures and medicine administration record sheets (MARS).

Following the inspection we spoke with a relative of someone who was using the service to find out about their views of the home and also spoke with local authority representatives.

Is the service safe?

Our findings

At our inspection in March 2014 we were concerned about the management of medicines in the service. Following the inspection the provider sent us an action plan detailing how they would make improvements. However during this inspection we still found significant problems with the way in which medicines were managed in the home and therefore people were not protected against the risks associated with the unsafe management of medicines.

We saw medicines such as a herbal sleeping remedy and prescribed eye drops stored in an unlocked cupboard in the lounge area. The eye drops container stated that they required refrigeration and expired 28 days after opening, however, no date of opening was recorded. Staff were unaware of the storage requirements for the eye drops and did not know why medicines were stored in the lounge cupboard. They told us that the person using the eye drops had made a choice to keep them in his room and self-administer them but we saw no evidence of a risk assessment to determine he was able to do this safely. Staff also told us that there were no arrangements in place to store medicines that required refrigeration and therefore people were not protected from risks associated with the unsafe storage of medicines.

Other medicines were stored in a locked medicines cabinet. At our last inspection there had been storage of many medicines that were no longer in use. During this inspection we found that some of these medicines had been removed from the home but the record kept for the disposal of medicines was not up to date and did not include these medicines. The deputy manager told us that he had taken these medicines home to count them before returning them to the pharmacy. We noted that the controlled drugs cupboard was labelled 'back up medication' and when we looked inside found a store of medicines that the deputy manager told us were left over and kept in case medicines ran out. This is not safe practice as there were no checks in place to ensure these medicines had not passed their expiry date and it meant that excess medicines were unnecessarily stored at the service. In addition we found out of date eye drops stored in the cabinet that had not been disposed of.

The arrangements for the administration of PRN (when needed) medicines did not protect people from the unnecessary use of medicines for the control of their behaviour. For example, people's care records did not clearly explain when these medicines should be used and did not detail what other action staff should take to try and manage people's behaviour before using these medicines. There was also no evidence of any discussions that had taken place with healthcare professionals to ensure that these medicines were used appropriately. We saw comments in the medicines administration record sheets (MARS) that stated PRN medicines had been administered because someone was "very rude, shouting and swearing" but there was no incident report relating to this or any record of how staff tried to support the person to manage their behaviour before the medicines were administered. Team meeting minutes also stated PRN medicines were to be administered when someone was "disruptive and un co-operative" which again indicated that these medicines were being used excessively to control people's behaviour rather than as a last resort.

Staff had not received adequate training to ensure the safe management of medicines. Four of the eight staff responsible for administering medicines had received safe handling of medicines training in 2012, the other four staff had not received any training since working at the service. Therefore the provider had not ensured that all staff responsible for administering medicines were equipped with the skills and knowledge to ensure people were protected from the risk of the unsafe administration of medicines. Staff told us that they were not permitted to administer medicines alone until they had attended training. However, during our inspection we observed a member of staff who had not received medicines training administering medicines to people unsupervised.

The home did not have a policy in place for the use of over the counter medicines. However, medicines such as herbal sleeping remedies were being administered to people using the service. The deputy manager said that the use of these medicines had been agreed for one person in consultation with healthcare professionals. However, he also told us that these medicines were used for anyone who wanted to take them and there was no evidence in people's care records that the appropriate use of these medicines had been discussed and agreed in consultation with their GPs to ensure it was safe for them to take them when other prescribed medicines were taken.

The deputy manager told us that no systems had been implemented for auditing the safe management of

Is the service safe?

medicines in the service. He told us that a local authority was carrying out a medicines audit on 10 July 2014 after concerns had been raised about a medicines error at the service. This meant that there were inadequate systems for monitoring the safe management of medicines. All of the above information relates to a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. As we have identified a continued breach of regulation we will make sure action is taken. We will report on this when it is complete.

Staff recruitment practices at the home did not protect people from staff unsuitable to work with vulnerable people. We looked at recruitment records and found that inadequate checks had been completed. For example, there were gaps in employment history that had not been explored with staff and there were no references or proof of identification in two of the three recruitment files we looked at. This is a breach of Regulation 21(a) and (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Two staff said they had not yet had safeguarding training and training records confirmed that the rest of the staff team had not had safeguarding training since 2011. One member of staff was unable to demonstrate that they knew what action to take or who to report safeguarding concerns to in order to protect people. In the records for a team meeting we saw reference to a person making repeated comments about people hitting them which was detailed as a behaviour that challenged the service. In the meeting minutes staff had been advised not to believe these comments. This did not promote good practice in relation to listening to concerns raised by people using the service. This is a breach of Regulation 11(1)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People told us that there were always enough staff to help them. We looked at the staff rotas covering a period of three weeks and saw that there were a minimum of three staff on duty in the morning and evening which were the busier periods of the day. We found that staffing numbers were flexible to support people to attend appointments.

Staff told us that one person worked at night and 'slept in'. However, they said that they were often disturbed during the night and also had to get up at regular intervals to support people with personal care. We noted that there were occasions especially at weekends where people worked a shift either before or after working at night. This meant that staff would not always get sufficient rest to ensure they were able to safely respond to people's needs.

We found that there were restrictions imposed on people that did not consider their ability to make individual decisions for themselves as required under the Mental Capacity Act (2005) Code of Practice. For example, a decision had been made to lock the kitchen at night without considering what was in the best interests of everyone using the service. Before our inspection a local authority representative had also raised concerns about the service as they felt a person was being restricted from managing their own money without consideration of their capacity to do so. We discussed this with the provider during our inspection who told us that a 'best interests' meeting had been arranged with staff from the home and health and social care professionals to discuss this person's capacity to manage their own money. Staff had not received training about the Mental Capacity Act (2005) or DoLS. This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Identified risks had been assessed for individuals and management plans developed to minimise these and protect people from harm. We saw risk assessments relating to issues such as medical conditions, road safety, healthy eating and smoking. People told us they felt safe.

There was a business continuity plan in place for foreseeable emergencies such as fire, flood and power failure so that staff knew what action to take to protect people in these circumstances.

Is the service effective?

Our findings

Staff did not receive adequate supervision, appraisal and training to enable them to fulfil their roles effectively. A senior staff member told us that staff did not have one to one meetings to monitor their performance and identify training needs. They told us that an appraisal system had been developed but this had not yet been implemented.

The training matrix showed that staff had attended training covering a range of topics including fire safety, safeguarding, infection control, medicines management and food hygiene. However there were no dates to show when the training was completed and we found that some training had taken place two or three years ago. In addition to this although staff had received recent training on how to support people who challenged the service staff demonstrated limited understanding about this and other areas such as medicines management and safeguarding adults. Therefore staff were not adequately supported to acquire and maintain the skills and knowledge to meet people's needs effectively. This is a breach of Regulation 23(1)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Staff told us that they had an induction to the service that helped them to find out about people's needs and the policies and procedures. A senior member of staff told us the home followed the Skills for Care Common Induction Standards to support new staff and we saw completed workbooks that confirmed this.

People told us the food was "tasty" and said they were able to choose what they had for their meals. One person told us he had chosen cauliflower cheese for the evening meal and this was prepared during our inspection. A member of staff showed us menus but said these were flexible as people often wanted something different to what was on the menu and were supported to choose an alternative.

We saw that healthy eating was considered in people's care plans especially where people had a medical condition that was affected by poor diet or where they were overweight. Staff were monitoring people's weight on a monthly basis, however we noted that in four of the five care plans viewed people had lost a significant amount of weight since January 2014 ranging from between three and nine kilograms. When we asked staff about this they had not noticed and no action had been taken to explore the reasons for this. The provider had not considered that weight loss could indicate ill health. Therefore staff were not adequately monitoring people's nutritional and health needs. This is a breach of Regulation 9(1)(b)(ii) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People were supported to arrange and attend health appointments and regular check-ups to maintain their dental, eye and foot health. Records were kept of appointments attended including the outcome so staff were aware of any further treatment required. One person told us they made their own appointments and their care records confirmed that staff supported them with this. The deputy manager showed us a new health action plan format which included detailed information about people's needs and was in a pictorial format to encourage people's involvement and understanding. However, this was not in use at the time of our inspection.

Is the service caring?

Our findings

People's privacy was not always respected in relation to their confidential information. We noted two whiteboards on the wall of one of the communal areas people used to watch television and interact with staff, their peers and visitors. Personal information about individuals was recorded on these boards such as details of health appointments and instructions for the administration of medicines. Prior to our inspection a local authority representative had told us that they had visited the service and raised concerns about the use of these white boards. However, the provider had not yet taken action to address this. This is a breach of Regulation 17(1)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. We spoke with the deputy manager about this who said that the whiteboards would be taken down.

We observed staff knocking on people's doors prior to entering their bedrooms and people told us that staff respected their personal space.

People told us that staff were kind and treated them well. We saw people reacting positively as staff arrived at the home and staff responded warmly in return. Staff were observed offering choices and discussing decision making with people to encourage them to make appropriate choices. For example, we saw one staff member sensitively pointing out to someone that their top was dirty and that they may want to change it before going out. When the person asked what they should wear the staff member told the person where their clean tops were and encouraged them to pick one out that they wanted to wear that day.

All of the interactions we observed between staff and people using the service were positive and indicated that staff had developed good relationships with people. A relative said, "He's happy, it's his home" when talking about their family member and one of the people using the service told us "The staff are good here, they listen to what I want".

The provider had taken steps to meet people's cultural needs by ensuring there were staff available who were able to speak their first language and by supporting people to access local amenities that supported particular ethnic and cultural groups such as the Greek community.

Is the service responsive?

Our findings

People's individual needs were not always being met in relation to encouraging and promoting independence. During our inspection one person told us he was going to the kitchen to get something to eat. When he returned he told us he was unable to find anything to make a sandwich. We looked in the fridge and found that there was bread, butter and some salad items but no other sandwich fillings. When we spoke with the deputy manager about this he said the person didn't normally eat lunch and that food was kept locked away as people helped themselves and ate too much. He told us that items such as cheese and ham were stored in the freezer and then brought out in small amounts and defrosted and that people could ask staff for food when they wanted it. There was no information in care plans about this decision and no evidence about the impact on other people using the service.

In addition to this people told us that the kitchen was locked at night. Staff told us this was because people had used electrical appliances when preparing snacks during the night which could pose a fire hazard. Staff said that people could wake staff during the night if they wanted a drink or a snack. There were no records detailing the assessment of this risk and the decision to manage it in a way that restricted the independence of all people using the service. This is a breach of Regulation 17(1)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

There were no recorded complaints for the service. We saw a complaints procedure, however, this was not produced in an easy read format, for example using pictures and plain English or displayed where people using the service could see it and was therefore not accessible to people using the service. However, people did tell us that they felt happy raising any concerns with staff and said they felt listened to. Surveys completed by people using the service also confirmed this.

Although people's needs had been assessed and care plans developed these did not always adequately guide staff so that they could meet people's needs effectively. For example, care plans did not always provide sufficient information around managing behaviour that challenged the service and did not always promote people's independence. Care plans had been reviewed in the last month and prior to this at regular intervals or as people's needs changed. One relative we spoke with told us, "They always let us know if they have any concerns about him."

People were very active in the community, attending day centres, visiting local shops and places of interest. One person told us he was off to work at the garden centre and said he enjoyed planting and watering the flowers.

Meetings were held with the people using the service to discuss plans for the home and to find out their views. We saw minutes of two recent meetings, one that was to discuss plans for someone's birthday party and the other to ask people's views about the new staff that had started work at the service.

People told us that their families were able to visit anytime and that staff supported them to make arrangements to visit family and friends. Care plans confirmed this and a relative we spoke with said they visited regularly and were always welcomed.

Is the service well-led?

Our findings

The deputy manager showed us forms that had been developed for quality monitoring areas of the service such as health and safety, care and medicines. However, these had not been used and we found no evidence of any quality monitoring to identify areas for development and improvement. Therefore there were no systems in place to check that people's needs were being met and that the service was operating safely. This is a breach of Regulation 10(1)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Prior to our inspection we had asked the provider to complete a Provider Information Return (PIR) containing information about the operation of the home. This had not been returned and the provider did not have a satisfactory explanation for this. This is a breach of Regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

In addition to this we found that the provider had not addressed a breach of the regulation relating to the management of medicines found during our last inspection. As we have identified a continued breach of regulation we will make sure action is taken and report on this when it is complete.

Although staff told us they felt supported by the management team, we found that there were not systems in place to ensure that staff were able to carry out their role and responsibilities safely and effectively. The provider had failed to provide staff with adequate guidance and support in relation to best practice when supporting people with mental health needs and learning disabilities.

We did observe that staff were supportive of each other and shared information between shifts so that staff were aware of people's plans and any concerns.

In the last few months people using the service had completed surveys about the care they received and placed these in a suggestion box kept in the lounge. People had written comments such as, "I'm very happy all the time" and "managers are very caring". A visiting relative had also written positive comments and a healthcare professional had written, "never had to make a complaint but happy with responses to suggestions."

One person told us that they had been involved in interviewing prospective staff to work at the home and showed us the questions they had asked. He said he had enjoyed this experience and felt included in choosing "good" people to work at the home. Staff confirmed that another person using the service had also been involved in these interviews.

Team meetings were taking place at times when senior staff had information to share with staff. For example, two meetings had taken place since September 2013, one to discuss expectations for new staff and the other to discuss an individual's needs that had changed significantly. There were no other systems in place for staff to discuss issues and influence the operation of the home

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 21 HSCA 2008 (Regulated Activities) Regulations 2010 Requirements relating to workers **The registered person was not operating effective recruitment procedures as they did not ensure all information specified in Schedule 3 was available. Regulation 21(a) and (b).**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse **The registered person had not made suitable arrangements to ensure service users were safeguarded against the risk of abuse. Regulation 11(1)(a)(b).**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment **The registered person did not have suitable arrangements in place for obtaining, and acting in accordance with, the consent of service users in relation to the care and treatment provided for them. Regulation 18.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff **The registered person did not have suitable arrangements in place to ensure that persons employed for the purposes of carrying on the regulated activity received adequate training. Regulation 23(1)(a).**

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services The registered person had not taken proper steps to ensure that each service user was protected against the risks of receiving unsafe or inappropriate care as they had not taken action to ensure the welfare and safety of service users. Regulation 9(1)(b)(ii).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services The registered person had not made suitable arrangements to ensure the privacy and independence of service users. Regulation 17(1)(a).

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 providers People who use services were not protected from unsafe or inappropriate care as the registered person did not regularly assess and monitor the quality of services provided. Regulation 10(1)(a).

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 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines The registered person was not protecting service users against the risks associated with the unsafe use and management of medicines. Regulation 13

The enforcement action we took:
A warning notice was issued