Runwood Homes Limited

Lancaster Court

Inspection report

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Ratings

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

Overall summary

This inspection took place on 8 October 2014 by three inspectors and was unannounced. The service was found to be meeting the required standards at their last inspection on 8 October 2013.

Lancaster Court is a nursing and residential care home which provides accommodation and personal care for up to 65 older people. The home has three floors with a residential dementia unit on the ground floor and nursing units on the other two floors.

At the time of our inspection a registered manager was in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the home is run. The home has had the same registered manager since 1 October 2010.

Summary of findings

CQC is required to monitor the operation of the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards (DoLS) and to report on what we find. DoLS are in place to protect people where they do not have capacity to make decisions and where it is considered necessary to restrict their freedom in some way, usually to protect themselves or others. At the time of the inspection applications had been made to the local authority in relation to some people who lived at Lancaster Court and may be considered to have their freedom restricted. The provider had acted in accordance with the Mental Capacity Act (2005) and DoLS.

There were insufficient numbers of care staff available to meet people's care needs. We observed that people had lengthy waits for personal care to be provided in circumstances that compromised their dignity. Whilst appropriate arrangements were in place in relation to storage, disposal and recording of medicines, people did not always receive their medicines on time due to a lack of staff.

The home was not meeting the required standards for infection control and people were at risk of acquiring an infection as published guidance was not always being followed.

People were happy with the care they received from staff and we observed positive interactions when staff assisted people with their care needs. People were generally treated in a courteous and respectful manner. However we saw that two people were left in an undignified state as staff did not attend to their care needs in a timely manner. People's health needs were assessed and regularly reviewed, however we found that their nutritional needs were not always supported.

There was a quality assurance system in place. The manager carried out regular audits and reviewed these with the regional manager. However, there were no action plans in place to address issues of concern, such as staffing. Where concerns had been identified there had not been a timely response to improve the quality of the service for the people that live there.

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.

There were not sufficient numbers of staff available to meet people's needs and effective recruitment procedures were not followed to keep people safe.

People had not been adequately protected against the risk of infection.

Staff were able to demonstrate a good understanding of the types of abuse that may occur and knew how to report their concerns.

People's medicines were managed.

Is the service effective?

Requires Improvement

The service was not effective.

Where people were at risk of weight loss or dehydration, they were not always supported as required by their care plan.

The home was well maintained and adaptations had been made to assist with people's mobility needs.

The provider had trained and prepared their staff in understanding the requirements of the Mental Capacity Act in general, and the specific requirements of DoLS.

People had access to healthcare services.

Is the service caring?

Requires Improvement

The service was not always caring.

People were treated with dignity and respect when care was being provided, however peoples dignity was not always respected when staff were unavailable to help them.

Staff knew people well and had positive relationships with the people they cared for. Care records clearly detailed people's preferences and choices.

Is the service responsive?

Requires Improvement

The service was not responsive.

People and their relatives were involved in developing care plans.

Activities were in place but were not reflective of people's specific interests or needs, particularly where people lived with dementia.

People and their relatives told us that concerns were dealt with promptly.

Meetings were held for staff and people's relatives to provide feedback.

Summary of findings

Is the service well-led?

The service was not well led.

The service had a registered manager in post.

People, their relatives and staff told us that the manager was approachable and supportive.

There were quality assurance processes in place to audit the quality of service people received. However these were not always responded to in a timely manner and action plans were ineffective.

Requires Improvement

Lancaster Court

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 was 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 following the requirements of the Care Act 2014.

This inspection took place on 8 October 2014 and was unannounced. The inspection team was made up of four inspectors and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. Their experience was in residential care.

Before we visited the home we checked the information that we held about the home including statutory notifications and enquiries relating to the service. Statutory notifications include information about important events which the manager is required to send us. We reviewed the home's statement of purpose. The statement of purpose is an important part of a provider's registration with CQC and a legal requirement, it sets out what services are offered, the quality of care that can be expected and how the services are to be delivered.

We spoke with a contracts monitoring officer for the local authority which commissions services from the home prior to our inspection.

During the inspection we spoke with 18 people and eight relatives. We also spoke with the manager, the cook, one domestic worker, one nurse and 12 care workers. We looked at the care records for nine people and selected management records.

We carried out observations throughout the day and used the short observation framework tool (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us due to their complex needs.

Inadequate

Is the service safe?

Our findings

People told us they felt safe at the home. One person told us, "Of course I do [feel safe]; the staff are very caring and sensitive." However we found that there issues with infection control and insufficient staff.

We were told by the manager about a suspected outbreak of sickness. People visiting their relatives were not made aware that there was a suspected outbreak and freely accessed the home. No notices had been placed on the front door to inform visitors of the risk. People who staff confirmed had been unwell the previous evening, were sitting in the dining area eating breakfast with people who displayed no symptoms. We observed staff providing care to people and noted that enhanced hand washing practises had not been implemented. Sanitising gels used to support good hand hygiene, were not provided. The manager told us that gels were provided only in the locked nurse's office and people's bathrooms. The manager had not followed guidance published by the Department of Health for prevention and control of infection in care homes in the event of a suspected outbreak.

We observed staff take meals to the rooms of people who were unwell. Once they had delivered the meal and supported the person they returned to collect further meals for people without cleansing their hands. This presented an infection risk to people with no symptoms. Staff did wear appropriate personal protective equipment, however not all staff were using gloves when providing personal care to people.

We saw that the cleaner used equipment which was colour coded to minimise the risk of cross contamination. Some of the carpets in people's rooms were stained and dirty. The cleaner we spoke with said they did not know what the programme was for deep cleaning of carpets and that there was only one specialist carpet cleaning machine for all three floors.

People were not provided with their own sling to use when they were required to be moved using specialist equipment. We saw that staff used the same slings to move different people which increased the risks of cross infection. Staff confirmed to us that people did not have their own slings.

This was a breach of Regulation 12 of the Health and Social care Act 2008 (Regulated activities) Regulations 2010.

Staff told us that it was difficult to provide assistance in a timely manner due to a lack of staff at times. For example we saw one person continually request staff to assist them with personal care and staff were not available to assist. This meant that due to pressures as a result of insufficient staffing numbers, staff were not always able to meet people's needs when required. One person told us they had been waiting since breakfast that morning at 9am to get washed and dressed; it was 11am and they were still waiting.

We saw one person was distressed as they were lying in soiled bed clothes. We brought this to the registered manager's attention, however it was not responded to in a timely manner as staff were busy assisting other people. Our observations demonstrated that staff followed an allocation sheet to assist people rather than assisting them to meet their individual needs, by supporting people room to room in order and not when they needed the assistance.

We observed that people's dignity was not always maintained where there were insufficient numbers of staff to respond to people in a timely manner. We saw that two people had been waiting for an extended period of time after requesting support with their personal care needs. Despite requests for assistance, care staff did not provide the care needed in a timely manner. One person was visible from the corridor whilst in a state of distress and in a manner that did not promote their dignity. We spoke with this person who said, "I really need to be washed. Can you help me? I can smell a dreadful smell all around me. This is just unbearable. Should I go back to sleep and try to forget this?"

We saw that staffing levels at lunchtime were supplemented by visiting relatives who assisted people to eat. Some people who had no relatives supporting them had to wait as there were insufficient numbers of staff to support people at busy times.

The registered manager told us that staffing levels were set by the provider based on budgetary requirements and were unable to demonstrate to us how they assessed this based on people's needs.

We identified that the service was in breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2010.

Medicines were stored, received and handled effectively and people were supported by staff that had been trained

to provide medicines safely. However, people did not always receive their medicines when they required them. On one unit a person told us that they were in a lot of pain and distress. We looked at their MAR and found that they had been prescribed a strong pain killer to be taken when required. The person told us that they had not received this medication in spite of informing members of staff of their pain.

We observed on two of the units that medicines were not administered as prescribed. On one unit the morning medicine round was completed at 11.15 and the lunchtime round started at 13.00. We observed that people on that unit did not receive their medication in accordance with the prescriber's instructions. On another unit medication administration records (MAR) we looked at showed us that two people required their medicine to be given with or just after food. We saw that one person was prescribed an antibiotic to be taken with food as this ensures the antibiotic is most effective. This antibiotic was not given with food at the morning medication round as it was completed late. We confirmed with the nurse that people regularly had not received their medicine as prescribed.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2010.

We reviewed recruitment files and noted that prospective employees had completed an application form, and had criminal records check carried out prior to starting work at the home. However, we saw that references and gaps in employment histories had not always been verified. This meant that the manager had not obtained satisfactory evidence of a person's conduct in their previous employment.

We saw that the provider had up to date policies designed to protect people from abuse which included safeguarding adults and whistleblowing. Staff were knowledgeable about the risks of abuse and how to report concerns. They were also able to demonstrate their awareness of the whistleblowing policy and which external agencies they could report their concerns to. One staff member told us, "I feel very confident to raise any concerns with my manager, although I have not needed to."

The staff that we spoke with showed that they knew the people who lived in the home and the support individuals needed with their care. They told us that any risks to an individual, or actions that needed to be taken were recorded within peoples care plans. Staff knew how to mitigate risks to people who were at risk of falls, behaviour that challenged or pressure sores for example. Guidance for staff on how to manage individual risks were contained within people's care plans and discussions were held during handovers to ensure any new risks were well communicated.

Requires Improvement

Is the service effective?

Our findings

People and relatives gave mixed views about the food provided. One person told us, "I'm happy with the food here, there is a choice at lunch time and you can ask for fruit if you don't fancy a sweet." However a second person told us, "The food is boring, I often have a lot of stuff [food] brought in." A relative told us, "Food is always an issue; we have told the staff about jazzing it up a bit but it just seems to be the same old grey production line of mush."

During lunch we observed times where people did not receive the support they needed to eat and drink. Three people fell asleep, and two had slipped down in their chairs. Their lunch remained untouched and was eventually taken away without questioning if they had had enough. An alternative was not offered other than their dessert. We asked the nurse what happened for the people who didn't eat their lunch. They said that biscuits and toast would be offered in the afternoon. We saw that cake was offered on one of the units in the afternoon but not across all of the units as the nurse suggested. We saw that full plates of food remained untouched in people's rooms which meant their nutritional needs may not have been met.

There were pictorial menus on the tables with the day's current menu. However people were unable to tell us what they had chosen from the menu and didn't know what they were eating. Staff told us that people chose from the menu the day before and were asked again at the mealtime. However, where people had communication, memory or sight difficulties they were not always able to select a meal of their preference.

People's nutritional needs had been assessed and this had identified that some people were at high risk of not having enough to eat or drink. We saw that drinks were provided at set times of the day but for those at greater risk no further drinks were offered. Records for one person highlighted they needed prompting with food and drink as were assessed as being at high risk of malnutrition and pressure ulcers. However, monitoring charts showed the person had not been provided with adequate fluids over a significant period of time which increased the risks. Shortly following lunch this person was then heard to ask for a drink, however this was not provided as requested.

Where people could not be weighed due to frailty, no other methods were used to assess their weight. Staff were unaware of other methods such as mid upper arm circumference (MUAC) to support the overall impression of the person's nutritional risk. Where people were identified as being at risk of weight loss, the provider's policy stated food fortification should be commenced. Food fortification is a method of adding foods to meals to increase the calories. This can be an effective method to increase calorific intake using foods such as cheese, butter and cream. However when we spoke with kitchen staff they were not aware of the risks or the requirement to fortify these people's food and had not been doing so.

This was a breach of Regulation 14 Health and Social Care Act 2008 (Regulated activities) Regulations 2010.

There were policies and procedures in place in relation to the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). Staff told us that they had received training on the MCA 2005 and DoLS. DoLS authorisations had been applied for where necessary. Staff were able to demonstrate to us through discussion, how they supported people who may lack capacity and provided examples of this to us. This showed that the requirements of the MCA 2015 had been followed.

People told us that they were able to access healthcare services when they needed them. One person told us, "If I need to see the doctor for anything [staff] arrange it for me with no hesitation." A relative told us, "[Relative] needs quite of a bit of care, and whenever the staff or I am worried they call the doctor or whoever immediately." Where appropriate we saw that people were referred to dieticians and nursing teams.

Staff told us the training provided was good. They told us the manager had linked in with a local hospice who had supported them with end of life care arrangements which staff felt was beneficial to them. Training records for staff that provided care showed that training was delivered in subjects relevant to the needs of the people they cared for. The majority of staff had recently completed this training and those that had not were scheduled to commence this shortly. Staff told us they felt supported by the manager and that they received regular supervision and annual appraisals. This meant that staff received appropriate development to support them to perform their roles.

Requires Improvement

Is the service caring?

Our findings

People who were able to speak to us were positive about the care they received from staff who knew them well . One person told us, " I get all the support and help I need." A second person told us, "It's spot on here, this place is the top of the tree." However people we observed who had not received care in a timely way to meet their needs were unable to tell us about their experiences.

The manager told us that each month staff focused on key areas of a dignity challenge. This was an initiative by the provider to highlight key areas of treating people in a dignified manner. We saw that people's bedroom doors were either open or closed depending on their preference. We asked about one person whose door was closed and staff told us, "[Resident] likes their door closed, they will come out when they feel up to it but like the privacy of it."

However, we did see a number of examples where people's dignity was not respected. We saw people having to wait to have their personal care needs met and we saw people spending time in soiled bedclothes whilst waiting for support.

We observed staff on one unit support a person positively when they were distressed. Staff clearly knew the person well and were able to support them positively by talking about their family which helped to ease the person. The staff member stayed with the person until they were settled.

Relatives told us that they felt involved in planning and reviewing people's care needs and records confirmed this. One relative told us, "Communication is excellent here and I am never kept in the dark, if [relative] needs something then the nurse or carer talk to us all and listen to what we want first and foremost." We saw that care plans and reviews had been signed by either the person or their representative to confirm this. This meant that people were able to express their views in relation to developing their own care.

We saw that visitors arrived throughout the day and staff appeared to know them well. One relative had commented that they felt welcome to visit the home at any time. People told us they had built positive relationships with staff.

We saw positive interactions between staff and residents. Staff were patient, respectful and kind in their manner and worked at a pace that suited people's needs. Even though staff were under pressure when providing care they did not rush. However, this did mean that some people had to wait to have their needs met. Staff addressed people by their preferred names and were friendly. They did not assume without asking but sought people's permission when providing care.

Staff were knowledgeable about people's care needs and preferences. One staff member told us about a person's history, family, interests and preferences in detail. However, one staff member told us that they would like to be able to spend time assisting people with the, "Nice tasks that carers used to do like giving a manicure or helping [resident] read a book." We saw that care was provided in a manner that was positive and caring.

Care records detailed people's preferences and choices well. For example they included preferred bed times, name, daily routines and how they wished to take their medicines.

Requires Improvement

Is the service responsive?

Our findings

People told us that they were involved in planning their care and support. One person told us, "The staff ask me all the time how I want things done and keep me abreast of any changes." A relative told us, "When it comes to talking about [relatives] care, we all sit down together and look at the options. [Relative] unfortunately doesn't really know what is going on, but by discussing things with the carers I know they get the care they would want."

Whilst people's needs were assessed and care was planned in line with their individual needs, we found that regularly people's personal care needs were not being met as staff were unable to find the time to provide the care required. We saw that care plans reflected people's individual needs, contained risk assessments where necessary and were updated regularly. We saw that when they were able, staff had followed available guidance, for example, people at risk of skin tissue breakdown were repositioned in bed to reduce the risks. However as there were insufficient staff to meet the needs of all of the people that used the service not everyone received the care they required when they needed it.

People told us there was usually a range of activities provided to support their hobbies and interests. One person had an interest in gardening and told us, "They have given us an area in the garden that we tend to, and weather permitting I try to go there each day." We saw that people had access to a minibus, to go for trips out. A range of outside organisations visited regularly to provide activities including acting, singing, chaplaincy, Tai Chi and hairdressing

However, people were not always able to decide how they spent their time. One person told us, "There are activities going on, but they don't really interest me, I'm too old to make things out of paper." One person's relative told us, "This year there has been hardly anything organised." We also saw the results of a recent relatives survey had highlighted a lack of activities. When we spent time on each of the floors in the home we only observed meaningful activity taking place on one unit. There was only one person responsible for providing activities within the home. In one unit we saw people seated in the dining room table with little interaction or stimulation. Two people fell asleep at the table and remained there until lunchtime. We saw that the dementia care unit lacked items of comfort or stimulation. The manager told us they had been reviewing activity provision in the home however they were only able to recruit one activity co-ordinator for the three floors and this was not sufficient. They told us they were looking to recruit a part time activity staff member, however had not identified a suitable person at the time of inspection.

People told us that when they raised concerns with staff they tried to resolve them quickly.

There was a complaints system which showed that people's complaints were listened to and action taken to rectify a situation to the person's satisfaction. However the manager had not always routinely listened and learned from people's experiences and concerns when these were raised. We saw from feedback that noted relatives had been concerned that there were insufficient numbers of staff to support people at meal times. We were unable to see any evidence of an increase in staffing to assist people, and our observations during inspection demonstrated that at peak times there had not been an improvement made in this area.

People told us that a range of groups came to visit the home. These included a chaplaincy, community groups and members of the local council. We noted there had recently been a function held at the home for local dignitaries and volunteer groups that included people who lived at the home. This showed that there were arrangements in place to ensure links with the community were maintained.

Requires Improvement

Is the service well-led?

Our findings

People and their relatives told us that they could always go to the staff if they had any concerns or worries. They told us that they informally discussed matters relating to the home and their care needs with the staff. We found that whilst staff and the manager listened, concerns were not being addressed which meant that the service was not improving the quality of care provided.

Although there were systems to assess the quality of the service provided in the home we found that these were not always effective. The systems had not ensured that people were protected against some key risks described in this report. We found problems in relation to the infection control processes, cleanliness in parts of the home, staffing levels, and the safe administration of medicines.

We looked at the quality assurance systems in place and saw that regular auditing was being completed. However, there were no action plans to show if concerns identified had been responded to effectively. For example, we were told by people and relatives that there were insufficient numbers of staff to support people in a timely manner. We saw from surveys completed throughout 2013 and 2014 that the same themes and trends appeared. This meant that systems were in place to assess the quality of service provided, however, where issues were identified; they were not always clearly reviewed and actioned.

The registered manager told us that staffing levels were set by the provider based on budgetary requirements. They were unable to demonstrate to us how they had responded to people's feedback and assessed this based on people's dependency needs. They told us that they were in the process of recruiting staff; however we were unable to see how they had determined the numbers required.

Surveys had been carried out during 2014 to capture the views of people and their relatives. The majority of feedback was very positive, with comments such as, "More of a personal home than an institution," and, "[Person] has only been here a couple of months but I am happy with the care the staff provides to [relative]." However, in several responses received this year, people's relatives had identified they were not satisfied with the laundry service. The manager told us that no action plans had been developed to address the concerns.

The regional manager conducted monthly reviews of the home and had identified areas that the manager was required to develop. However action plans had not been reviewed and the implementation of these plans had not addressed the areas that required improvement. For example the management team had identified that an additional 35 hours of casual staff had been required since February 2014. The manager was unable to demonstrate to us how they had achieved this action, or how they were progressing towards achieving this. Another identified improvement area that had not been addressed was to create further dementia champion roles within the home. We saw that prior to February there had been twelve champions, however this had slipped to 8 and since February no further champions had been identified.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2010.

The provider had had implemented a set of values, beliefs and behaviours within the home and a vision to aspire to. Staff were able to tell us about them and how they were used in practice. We looked at minutes of staff meetings and found that issues had been discussed with staff, which included good practice and complaints or concerns within the home. Staff told us that the felt they could go to the management team and discuss concerns where needed however, our observations on inspection showed that improvements were not implemented to ensure the service maintained high quality care.

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 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers **The quality monitoring systems in place failed to identify where improvements were required and address areas of concern.** **Regulation 10 (1) (a) and (b)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control **The registered person did not ensure that people were protected against acquiring a healthcare associated infection.** **Regulation 12 (1) (a) (b) (c) (2) (b) (c)**

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 did not ensure people received their medicines safely and followed recommended prescribing regimes.** **Regulation 13.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010 Meeting nutritional needs

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
	The registered person did not ensure that people were protected from the risks of inadequate nutrition and dehydration. Regulation 14 (1) (a) (b) (c) (2)
Accommodation for persons who require nursing or personal care	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing The registered person did not ensure there were sufficient numbers of suitably qualified, skilled and experienced staff to carry on the regulated activity. Regulation 22.

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.