Living Plus Healthcare Limited

Living Plus Healthcare Ltd t/a Queen Anne Lodge

Inspection report

1-5 Nightingale Road
Southsea
Hampshire
PO5 3JH
Tel: 02392 827134
Website: www.queenannelodge.co.uk

Date of inspection visit: 21 and 22 October 2014
Date of publication: 16/03/2015

Ratings

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

Overall summary

This inspection took place on 21 and 22 October 2014 and was unannounced. The home provides accommodation and nursing care for up to 40 people who tend to be older and who may be living with dementia. There were 32 people living in the home at the time of our visit. The home is built on four levels and there is a lift between the floors. There is a communal lounge and separate dining room on the ground floor where people can socialise and eat their meals if they wish.

There was a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like

Summary of findings

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 service is run.

The provider had not undertaken the necessary pre-employment checks to ensure staff were safe to work which put people at risk of harm. Staff had not received appropriate training or supervision which put people at risk of receiving inappropriate care and support.

People's care plans were not personalised and did not cover all aspects of their changing needs or whether they consented to care and support. There were some medicine discrepancies which meant people may not have been receiving their medicine as prescribed.

There were limited opportunities for people to give the provider formal feedback about the home. People were not therefore able to easily express their views or suggest ideas for improvement.

People gave us positive feedback and we saw staff cared about the people they were supporting. Staff had time to chat with people, support them with eating and talk them through tasks such as supporting to move around the home. People said staff answered the call bell and they did not have to wait too long. People could choose if they had a preference for male or female staff to support them with personal care and staff said they made sure people's choices were known and followed.

People enjoyed the food and staff ensured there was a choice of meals available. People were also supported with special diets and were given equipment, where needed, to promote their independence whilst eating. There was a programme of activities and we saw people joining in when a singer visited the home. Healthcare professionals visited people when necessary.

Although aspects of the home were not well led, staff felt the registered manager was open and they could discuss or challenge if they wished. The registered manager gave us examples of improvements they had made in the home. The registered manager had a system for auditing aspects of how the home was run but these audits had not identified all of the issues we found.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we have taken at the back of the full version of the report.

We have made a recommendation about professional support for the registered manager to develop a robust system of audit.

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

Staff had not been trained with regard to safeguarding people.

Risk assessments were not in place for all risks and where they were in place, they were unclear about what action was needed to be taken to reduce risks.

Systems were in place regarding the administration of medication. However, there were inconsistencies with the number of tablets in the home for some people.

Is the service effective?

Requires Improvement

Aspects of the home were not effective. People were not supported by staff who were trained and supported through supervision.

Deprivation of Liberty Safeguards and the key requirements of the Mental Capacity Act 2005 were not understood by staff who had not received training in the topic.

People were supported to eat and drink and enjoyed their meals. People could choose what to eat and meals were provided which met their individual needs.

Healthcare professionals visited people at home when necessary.

Is the service caring?

Good

The staff were caring. People were treated in a kind and compassionate way.

The staff were friendly, patient and discreet when providing support to people.

People were able to make decisions, such as whether they wanted personal care at that time, or whether they preferred male or female care staff.

People were treated with respect and their independence, privacy and dignity were promoted.

Is the service responsive?

Requires Improvement

Aspects of the home were not responsive. Care plans were not written in an individual way to meet assessed needs. People were not involved in their care planning.

The registered manager had sought the views of some people living in the home and there was a complaints procedure in place. Improvements had been made in the home following feedback provided, but the methods used to gain feedback were limited.

Summary of findings

Is the service well-led?

The service was not well led in all areas. Although the registered manager undertook a range of audits, there were areas of concern which had not been identified by the management of the home or the provider.

The registered manager did not receive any clinical supervision or support from within the company.

Staff thought the registered manager was good and felt able to express their views.

Requires Improvement

Living Plus Healthcare Ltd t/a Queen Anne Lodge

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014. This inspection took place on 21 and 22 October 2014 and was unannounced. We responded to concerns raised about the service so did not ask the provider to complete a Provider Information Return prior to our visit. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. The inspection team consisted of an inspector and a specialist advisor in nursing.

Before the inspection, we reviewed the information we held about the service. This included notifications about important events which the service is required to send us by law and our previous inspection report.

We looked around the premises, spent time talking with people around the home, observed people having their lunch and socialising in the dining room. We spoke with 12 people, three visitors, the registered manager, five care staff, the chef and the activities co-ordinator. We looked at a range of records including five care plans and associated daily notes, medication charts, three recruitment records of staff, duty rotas and the complaints book.

We last inspected the service on 3 December 2013. At that inspection we found the service was meeting all the essential standards that we assessed.

Inadequate

Is the service safe?

Our findings

There was a policy in place for the recruitment of new staff and the registered manager explained recruitment checks would include two references and a Disclosure and Barring Service (DBS) check. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services. One file for a new staff member showed the recruitment policy had been followed and there was a DBS check and two references in place before they started work.

Two new staff had been working in the home, 'shadowing' staff in their work. The new staff were not able to undertake any physical or personal care, but were present in people's bedrooms whilst care was undertaken. The registered manager told us the checks were in place for the new staff. However, we found there were not any checks in place. We were told by a staff member that sometimes people start work after all the checks have been completed and then leave quite soon after. They said they had therefore not done the checks to save the cost of the DBS application. One other file showed there was a DBS check in place before they started work but no references. The provider had not undertaken the necessary pre-employment checks before staff started working in the home which put people at risk of harm.

This was a breach of regulation 21of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Not all staff had been trained with regard to safeguarding people: records showed two staff out of the team of 45 had undertaken safeguarding awareness training. One staff member said they had not received training and two said they had but this was years ago and not whilst working at this home.

This was a breach of regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Staff said if they suspected or witnessed abuse they would report to the manager or other senior personnel. The registered manager knew how and when to make safeguarding referrals to the local authority safeguarding team. Records showed that two referrals had been made appropriately.

There was a range of assessments in people's care plans which identified risks to their health and action to be taken. One person's care plan showed they should always have the bed rails down as they were at risk of getting trapped in the rail. However, the registered manager had been walking around the home and found the person with their arms caught in between the bed rails. The registered manager investigated the incident and took a range of subsequent actions, such as discussing with all staff and putting a notice by the person's bed. The registered manager told us the incident had occurred because a staff member had thought the person would be safer with the rails up. There was also confusion about whether the person needed to be in bed during the day. A staff member supported them to go into the lounge because they had "been in bed for days" and they were worried about pressure areas being at risk. However, the staff member was told by other staff that the person should be in bed and was asked to support them back to their room. There was not an assessment of their needs and the care plan did not give any information about the risks to the person concerned. Staff found care plans useful, but had not read them all. Care plans did not always give sufficient information to enable staff to act consistently and meet people's needs.

This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Each person had a Medication Administration Record (MAR) chart in place which was used to record the medicines people took. A review of the medicines held in the trolley against service users' MAR charts found there were inconsistencies and errors around the number of tablets which should be stored. The registered manager had identified this as an issue and had asked the nurses to count the tablets each day but they had not done this. The provider did not have appropriate arrangements in place to ensure the safe administration of medicines.

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

Medicine was stored securely and safely in locked cupboards and was refrigerated when necessary. Staff monitored the temperature of the fridge daily although records showed two gaps in recent weeks. Staff would not have seen if the fridge was at a different temperature which therefore could have meant medicines were not stored correctly on those days.

Policies and procedures were in place, detailing the different aspects of medicine management such as

Inadequate

Is the service safe?

ordering, giving tablets covertly and error reporting. There were protocols in place for medicine prescribed as 'when needed'. People were given their medicine by the trained nurses. Observations showed that medicine was dispensed and the MAR signed appropriately.

Some prescription medicines are controlled under the Misuse of Drugs Act 1971; these medicines are called controlled drugs or medicines. Appropriate records were being maintained by staff who signed when they gave out controlled drugs which followed guidance produced by the Royal Pharmaceutical Society.

People had call bells in their bedrooms which were within reach. One person said they could call staff with their call bell and someone would "come quite quickly". A second person echoed this statement. Another person said the length of time it took staff to attend to them depended on where staff were. However, they had, "never been disappointed" and staff had never been more than ten minutes.

Care and nursing staff were part of a team which included domestic, laundry, kitchen and maintenance staff. The registered manager worked out the staffing levels based on people's needs. Currently, the registered manager attempted to have seven care staff and two nurses on duty in the morning, which was the busiest time in the home. On the first day of our inspection, two care staff had unexpectedly not gone into work, which left "six staff when there should have been eight". However, throughout the day people were not rushed and staff had time to talk to people. No one stated they thought there should be more staff. Agency staff had not been used previously to fill gaps in the rota, but now this was possible, meaning shifts could be fully staffed. The provider was able to demonstrate that there were sufficient numbers of staff to meet people's basic health and social care needs.

Requires Improvement

Is the service effective?

Our findings

Staff did not receive regular supervision. Staff thought they had supervision session six months ago. A third staff member said they had not received any supervision since starting work at the home. The records for five staff showed each had received one or two supervision sessions since January 2014. A sixth file showed the person had been working at the home for 11 months but there was not a record of any supervision.

A training spreadsheet was in place to record which training had been undertaken by staff. This showed not all staff had completed training such as moving and handling and fire safety. Moving and handling training was provided "in house" by a senior staff member who was trained to train others. Other training was available but the records showed staff had not undertaken courses. One senior staff member and the registered manager had completed a Dementia Awareness course, but other staff had not. There was not a system in place to monitor training needs or to ensure training was up to date. The registered provider did not have suitable arrangements in place to ensure staff received appropriate training.

This was a breach of regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Staff had not received training on the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS) and were not able to show an understanding of the subject. The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. The registered manager was aware of when it was appropriate to make referrals under DoLS. The process had been followed appropriately for one person recently.

One person was assessed as having the capacity to make day to day decisions but there were rules about when they could have an alcoholic drink and how much. There was not a detailed care plan around how this decision had been made and by whom and the alcohol was locked away so the person could not access it. The registered manager told us the person knew the routine and did not ask for additional drinks. However, records showed the person asked for their alcohol throughout the day, outside of the time they were 'allowed' to have it. Their freedom to access alcohol was restricted without the correct procedures being followed.

This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Staff demonstrated they gained consent from people before they supported them with personal care. If people did not want to be supported at that time, staff went back later. We observed two staff supporting a person to move and heard them talking the person through the process, getting consent as they went. People who were able to give consent were able to do so.

People enjoyed their meals. One person told us they needed a soft diet which was provided. Another person said, "I enjoyed lunch, the pork was soft." We heard one person telling staff they would like chicken kiev to be available on the menu. This item was purchased and during our second visit, the person told us they had kiev for their lunch. People could choose food from the menu or something different, we heard a staff member asking a person, "What can I tempt you with?" and offering them food which they knew they liked. People being offered dessert from the menu and one person said they would just like one scoop of ice cream, which was not on the menu. This was provided.

People were supported to eat and drink in ways which met their needs. This was by staff members physically supporting them to eat and equipment enabled them to eat independently. Staff took care to see that people knew the food and drinks were in front of them. People were offered a choice of hot and cold drinks.

Some people had specific dietary needs, such as a diabetic diet. The chef was aware of who was diabetic and how to ensure food met their needs. The chef made the same food that other people were eating, such as cakes and desserts but made them with sweetener rather than sugar. This meant people would not feel they were missing out. One person who was a vegetarian ordered their meal the previous day which gave the chef time to prepare. People who were assessed as needing soft or pureed food were served food prepared in this way. Food was pureed individually on a plate so each could be tasted. The menus were discussed with people and changed where necessary,

Requires Improvement

Is the service effective?

although people could ask for a range of different food. People were offered a choice of suitable nutritious food and drinks in sufficient qualities to meet their individual needs.

People had visits from healthcare professionals such as GPs and chiropodists. Referrals were made to specialist healthcare professionals when assessments were needed. These included the mental health team and continence nurses.

Good

Is the service caring?

Our findings

People felt staff cared about them. One person said, “The staff are lovely people, very kind and caring.” Another said “staff are very willing.” A visitor said staff were, “caring and helpful” whilst another visitor felt their relative was, “well cared for.” One person told us, “If I want anything, they get it for me...I couldn’t wish for anything better”. A visitor said their relative was “happy to ask for anything.”

All care staff behaved in a manner which was caring and friendly towards people. Staff showed patience and understanding when supporting people with behaviour which could challenge others. We also saw a person walking up and down the dining room and the staff member asked respectfully and kindly, “do you want me to take you upstairs or are you still exercising?” Staff delivered food to people with care and thought and did not rush them when they were eating.

Staff gave people choices if they had capacity to decide, such as what clothes to wear. If people expressed a preference, for example, they would now rather have a shower than a bath, care staff noted this for the nurses to update the care plan. The registered manager and staff were aware that some people had a gender preference for who supported them with personal care and staff told us they ensured people were supported by the gender they preferred.

One person told us, “I can’t say anything against anyone, they are angels, and they treat us with respect.” Staff were respectful of people’s privacy and maintained their dignity. We spoke with one person who was in a shared bedroom about how staff respected their privacy when undertaking personal care. They confirmed the curtains were closed and a screen used between the beds. We heard a staff member discreetly suggesting to a person that they may need the toilet. Staff described how they ensured they respected people’s privacy and dignity when they supported them with personal care.

There were some aspects of care plans which showed how to meet individual needs, such as how people were supported to move around the home, or move from chair to bed. Staff described how they did this, which was the same as described in the care plans we looked at.

Requires Improvement

Is the service responsive?

Our findings

People, or their families, were asked about their preferences, if possible, when they moved into the home. Care plans were not personalised to the person's individual assessed needs. The care plans were the same for each person and a 'tick box' style was in use, for example, "If he/ she takes Senna", "He/she has a good/ fair/ poor appetite" and "He/she manages a normal /soft / pureed diet, independently /supervised /assisted." The relevant detail was circled and the he or she was crossed out. One care plan for a person with complex communication needs did not show staff any particular strategies for responding to the person's needs. The plan used sentences such as, "give extra time to process conversation and verbalise", "if he/she can be verbally aggressive…" and "if he/she needs glasses/ hearing aids …"

The information in care plans was muddled and difficult to follow. Aspects of the plans were written in the style of general information, for example, how to support a person in the bath, rather than how the particular person liked to be supported in the shower, which they preferred. Staff were not provided with clear information on how individual people preferred to be supported.

This was a breach regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Staff identified and responded to people's changing needs, such as people needing more support to use the toilet or move around the home. Continence assessments showed how people's individual continence needs were to be met. There was a 'wound file' in place which gave good information to staff about the care of pressure areas.

People were actively joining in with a singer who visited the home weekly. The home had recently employed an activities co-ordinator who had established a programme which included musical sessions, art and armchair exercises. They were building up a stock of activity items and said they were happy to ask for anything they needed. They had gathered information on each person which outlined their likes and dislikes, life histories and family life. The registered manager responded to a person who was becoming anxious by ensuring staff undertook an activity with them, which had a positive impact on the person.

The registered manager kept a complaints book in the office, which was to be completed if there was a complaint. The registered manager showed us the record book which they had completed. We looked at a recent complaint and saw the registered manager had investigated the complaint, taken action, followed it up and told the complainant what action had been taken.

Ten people had completed a survey in September 2014 and there was some negative feedback as well as positive. One issue raised was a problem with maintenance being carried out in a timely way. The registered manager had addressed this concern and had been able to increase the amount of time dedicated to maintenance of the building. Four relatives had been given a survey in September 2014 and we were told one had been returned. However, the registered manager had not yet given the survey to other relatives and there were not any meetings held in the home to enable people or relatives and visitors to attend to give their feedback. Opportunities to gather formal feedback were limited.

Requires Improvement

Is the service well-led?

Our findings

The registered manager had a system for auditing the service provided and took action where they identified concerns. One example of this working was an audit of the medication administration records, where they found some people had missed a dose of medicine and took action to address the issue with the nurse involved. Recording issues were also found in other areas and were addressed. The manager arranged a staff meeting but a group of staff did not attend. The manager wrote to them about this and then organised a training session, where staff were showed scenarios and asked to find the errors. Staff did identify the errors which showed the manager that staff were aware of the correct procedures to follow. Other audits included falls, wounds and pressure area audits. The manager gave us examples of improvements they had made in the home since they started work there.

The registered manager was registered with the Care Quality Commission in 2014. One staff member told us they thought the manager was a "good manager"; they had never needed to challenge anything but felt they would not have a problem in giving their point of view. Another staff member said staff could "talk openly" and would be able to say if they had concerns. They felt the leadership was good and that the manager would say exactly what they wanted done and how.

The majority of concerns we found had not been identified by the registered manager or provider. The manager did not receive any clinical supervision or support from within the company. They had formed links with the manager of another home in the group and said they could ask for support from the district nurse.

The registered manager undertook a spot inspection in September 2014, which they intended to do twice a year. They gave us an example of how they had improved an aspect of staff uniform following the inspection. They had also identified charts were not being completed fully which showed when staff had assisted people to move in bed. The registered manager was developing systems to enable them to be aware of daily practice within the home.

We recommend that the service seek professional support for the registered manager as well as embedding a robust audit system.

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 How the regulation was not being met: The provider did not have an effective recruitment procedure in place.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records How the regulation was not being met: The provider did not ensure people were protected against the risks of receiving care that is inappropriate or unsafe.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines How the regulation was not being met: The registered provider did not have appropriate arrangements in place to ensure the safe administration of medication.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff How the regulation was not being met: The registered provider did not have suitable arrangements in place to ensure staff received appropriate training and appraisal.

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 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment How the regulation was not being met: The registered provider did not have suitable arrangements in place for obtaining and acting in accordance with, people's consent.