

Lomack-Health Company Limited

Lomack Lodge

Inspection report

10 St Georges Road
Bedford
Bedfordshire
MK40 2LS

Tel: 01234290013
Website: www.lomackhealth.co.uk

Date of inspection visit:
11 October 2016
12 October 2016

Date of publication:
16 November 2016

Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

Requires Improvement 

Is the service effective?

Good 

Is the service responsive?

Requires Improvement 

Is the service well-led?

Requires Improvement 

Summary of findings

Overall summary

Lomack Lodge provides care and support for up to seven people with learning disabilities and complex needs. The service is located in close proximity to Bedford town centre. On the day of our inspection there were four people living in the service.

Prior to this inspection we had received concerns in relation to the way in which people were cared for at the service, staffing levels and the general management of the service, including the staff culture. The concerns raised alleged that staff did not always take appropriate action to safeguard people from abuse and neglect and did not always provide them with the required care to meet their needs. Allegations also claimed that individual risk assessments were not always adhered to in order to keep people safe, and that staffing levels were not conducive to allow staff to perform their duties or to support people to undertake their preferred activities throughout the week.

Concerns had been raised in respect of people's dietary intake; stating that the service had no food or finances available to purchase food items. Alongside this it was also alleged that the general culture and morale amongst staff was poor following the registered manager's recent absence from the service. Concerns had been raised about the impact that this absence had upon the people that lived at the service.

There was a registered manager in post although they were absent from the service at the time of our inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The service was being overseen by a registered manager from one of the providers other services, with support from the quality and compliance manager, office manager and provider.

This inspection took place on 11 and 12 October 2016 and was unannounced.

We found that accidents and incidents had not always been reviewed appropriately to determine whether they should be raised as a potential safeguarding. This meant that not all incidents had been referred to the local authority for further investigation and that appropriate action was not always taken to keep people safe from abuse or neglect. Potential service user on service user safeguarding incidents had not always been reported to the relevant external agencies.

Risk assessments were not always reflective of people's current needs and the guidance contained within them was not always consistently carried out by staff. This meant that risks to people's health, safety and well-being were not effectively managed.

Care plans did not always provide staff with sufficient guidance to meet people's specific needs and wishes and were often not user-friendly. We found that care plans had not consistently been reviewed and there

was no evidence to show that people or their families had been involved in reviewing them. As a result they were not always reflective of people's current needs and requirements.

Quality monitoring systems and processes had not always been used as effectively as they could be to ensure that action was taken to make improvements when required. Audits checks and satisfaction surveys had been completed but there had been no attempt to analyse or have oversight of the outcome of these in order to drive future improvement. Although the staff we spoke with felt positive in respect of their roles, it was apparent that there had been an adverse impact caused by the absence of the registered manager.

There was sufficient staff on duty, with the correct skill mix, to support people with their needs. Staff were able to meet people's basic care needs, however; their deployment within the service could have been improved so as to provide people with increased levels of support at mealtimes.

People were not able to comment on whether they felt safe but their demeanour was generally relaxed in the presence of staff. Staff had received training to enable them to recognise signs and symptoms of abuse and felt confident in their knowledge of how to report them.

People were able to make choices about the food and drink they had, and staff gave support when required to enable people to access a balanced diet. There was access to drinks and snacks throughout the day. We found that people were supported to access a variety of health professionals when required, including opticians and doctors, to make sure they received appropriate healthcare to meet their needs.

We identified that the provider was not meeting regulatory requirements and was in breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not always safe.

Accidents and incidents had not always been reviewed appropriately to determine whether they should be raised as a potential safeguarding.

Risk assessments were not always reflective of people's current needs and the guidance contained within them was not always consistently carried out by staff.

There were sufficient numbers of staff on duty, with the correct skill mix, to support people with their needs. However the deployment of these staff could have been better so as to enhance the quality of care that people received.

People were protected from harm. Staff were knowledgeable about the principles and reporting requirements of safeguarding people from abuse.

Requires Improvement ●

Is the service effective?

The service was effective.

Food and drink was provided, to ensure people's dietary needs were met. People had a choice of what they ate and their specific wishes and needs were catered for.

People were supported to maintain appointments with healthcare professionals within the service and the local community.

Good ●

Is the service responsive?

The service was not always responsive.

People did not receive person-centred care. Care was task-based and plans did not provide staff with personalised, specific information that they required to meet people's needs and wishes

Requires Improvement ●

Is the service well-led?

Requires Improvement ●

The service was not consistently well-led.

There was not always an open and transparent culture within the service, with there being an adverse impact caused by the absence of the registered manager to the running of the service.

Records were not always well maintained or up to date in respect of people.

Systems to assess and monitor the quality of care provided to people or to manage risks of unsafe or inappropriate treatment were not always effective as they had failed to highlight some areas of the service which required attention.

Staff members were generally positive about working at the service and working with the people they provided care for. They felt they were supported by the provider and other senior staff in the absence of the registered manager.

Lomack 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 was planned to check 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 11 and 12 October 2016 and was unannounced.

The inspection was carried out by one inspector.

Prior to the inspection we had received information of concern regarding the way in which people were cared for, staffing levels and the general lack of management support. We checked the information we held about the service and the provider, such as notifications. A notification is information about important events which the provider is required to send us by law. In addition, we asked for feedback from the local authorities and clinical commissioning groups, who both have a quality monitoring and commissioning role with the service.

During the inspection we used different methods to help us understand the experiences of people using the service, because some people had complex needs which meant they were not able to talk to us about their experiences. We observed how staff interacted with people who used the service and also observed breakfast in the main dining area and people being supported with daily tasks.

We spoke with one person who used the service and observed three others who could not express themselves verbally because of their complex needs. We also spoke with three care staff, the registered manager of a sister service, the office manager and provider.

We then looked at care records for four people, as well as other records relating to the running of the service such as: staff rotas, medication records, and accident and incident records; to corroborate our findings, and to check the delivery of service in these areas.

Is the service safe?

Our findings

Prior to this inspection we had received concerns about people's safety within the service. It had been alleged that people were not always kept safe and that staff did not take appropriate action to raise incidents and accidents when these took place.

Although staff were aware of their reporting responsibilities in respect of safeguarding, when we reviewed accident and incident records we found that not all potential concerns had been reported to the local authority or the Care Quality Commission (CQC), once staff had completed an incident report. Staff told us that they would always complete an incident form if they noted a bruise or wound when delivering personal care or if they had witnessed a service user altercation.

However, we checked accident and incident records, and found that although these incidents had been reported to the provider, no identifiable action had been taken to determine if the incident should be referred for further investigation. This meant that reportable incidents had not always been reported in the appropriate manner.

We found that accident and incident records often lacked detail and did not always consider appropriate interventions for managing behaviour, when compared against guidance in people's care plans. During the inspection, a social care professional raised their concerns with us about the completion of accident and incident records for people. They told us, "Incident reports indicate a lack of appropriate behaviour management strategies. Whilst the incident is documented it is not robust and could be more detailed providing a more accurate account of the incidents." As such, from the information provided on the accident and incident records, we found that it was not always possible for the provider to investigate and take action to ensure that people were safe from avoidable harm or abuse.

In addition to this, there was no evidence to show that potential safeguarding incidents had been analysed or used to identify trends which may indicate that abuse had taken place. Staff could not provide this information for us when asked. This meant that people were not always protected from avoidable harm or abuse and that there were ineffective systems in place to protect people from abuse.

Systems and processes were not operated effectively to ensure that people were protected from potential abuse. This was a breach of regulation 13 (1) (2) (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff members had however received training in safeguarding, and were aware of abuse and the different forms that it could take. During this inspection they told us that they were aware of their responsibilities in terms of recording and reporting incidents, including incidents of potential abuse. One staff member told us, "We have had training on safeguarding. If I thought that anyone was being hurt I would report it to senior staff or the office straight away."

We discussed our concerns about one recently missed safeguarding and were told that this had been an

oversight. Our records did show that we had previously been notified of other safeguarding concerns and the provider confirmed that they would be more vigilant to this in future.

Prior to this inspection it was also alleged that individual risk assessments were not always followed appropriately by staff in order to keep people safe and free from harm.

We found although risk assessments provided staff with the basic guidance they required to support people, that this information was not followed consistently in practice. Staff members told us that they used the risk assessments to guide them in the delivery of care; however our observations found that this was not always the case. Therefore risk assessments were not always used effectively by staff to care for people in accordance with their needs.

During this inspection, we spoke with a social care professional who also had concerns about the information contained within people's risk assessments. They said, "There is a lack of focus on tailoring the support." They considered that other forms of support were not always sought from other appropriate agencies to support staff in managing risk. We found there was no defined method of formulating the assessed score of low, medium or high and no identifiable method of establishing the required action as a result of this. Therefore if staff needed to seek additional support for people, the risk assessment process did not always provide them with robust risk management strategies.

For example, we found that one person had a choking risk assessment in place, which gave a risk rating of 'high risk'. There was no evidence in the risk assessment to demonstrate how this rating had been determined, or the resulting action that should be taken. For example whether a referral to a speech and language therapist or GP or was required for additional intervention. Neither was there any information as to the frequency with which the risk assessment should be reviewed on the basis of the high risk rating.

We found that the risk assessment was clear in saying that staff should support the person when they were eating. However, we observed that on the day of our inspection, the person was given their breakfast and left to eat independently. Staff did not return for over ten minutes by which time the person had eaten their porridge. They were then given a banana and again left alone to eat this. We observed that the person ate very quickly and filled their mouth with food. This information was clearly indicated within their risk assessment and the guidance had not been carried out by staff on the day of our inspection to reduce the risks to this person.

For another person, who had a risk assessment in respect of their behavioural challenges, at the time of our inspection it clearly stated that they should have an additional member of staff with them on each shift. Staff told us that this was not taking place, and that the person only had one to one care three times per week when they undertook an activity which was known to trigger excess anxiety. We discussed this with the provider and registered manager from the sister service and were told that funding had still be to be agreed for the full one to one; therefore the guidance contained within the risk assessment was inconsistent with the provision of care. This was attended to with immediate effect on the day of our inspection and the content of the risk assessment changed so it accurately reflected the person's needs.

We spoke to the registered manager from the sister service about the issues we had found in respect of risk management. They agreed that the risk assessments in people's care plans were inconsistent with their assessed needs and said that they would review them with immediate effect, to ensure they were accurate and provided staff with the information they needed. They told us they wanted to ensure they were robust so as to keep people safe from harm.

Risk assessments did not reveal a full understanding of the risk assessment process, or of the necessity to provide robust control measures to mitigate risk. These were breaches of Regulation 12 (1) (2) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Prior to our inspection we had received concerns that staffing within the service was not always sufficient to keep people safe and to enable staff to support people to undertake activities of choice.

During the inspection, our observations confirmed that although there was sufficient staff on duty, with appropriate skills to meet the needs of people, their deployment within the service could have been better at peak times of day. For example, to ensure people were better supported during meal times. We observed that the meal time experience for people could have been improved with staff being more prominent and accessible. For example, we observed one person who was presented with a bowl of porridge on the first morning of our inspection. They were left for a period of ten minutes without support from staff, during that time they did not take a spoonful of porridge. They had also been left with a cup of tea in front of them and did not take any of this until staff returned and gave them some prompting. Although people received appropriate nutrition, the mealtime experience could have been made more pleasurable for them had the staff been better deployed.

We discussed this with the registered manager from the sister service who said that on previous visits, they had observed staff supporting people with their dietary intake. On the second day of our inspection, we did however observe staff taking a more active role in supporting people to take dietary intake, sitting by the side of people and engaging with them more meaningfully. The registered manager of the sister service took our feedback on board and agreed they would monitor this aspect to ensure that people received the best possible experience at meal times with better staff deployment.

Records confirmed that two staff members were on duty in the morning and afternoon, with there being one waking staff member at night. In addition to this the service had support from the provider, office staff and the registered manager of the sister service. This was to compensate for the absence of the service's registered manager. Throughout our inspection we observed that staffing levels matched those on the staffing rota. We spoke to the registered manager of the sister service about staffing. They told us the provider would be continuing to try to recruit new staff members, and also reviewing staffing levels to determine whether or not they were sufficient to meet people's needs.

Is the service effective?

Our findings

Prior to our inspection we received allegations that people were not provided with sufficient amounts of food. Concerns were raised that staff did not have access to the finances to purchase food items for people and that there was not enough food in the service to maintain people's dietary intake.

People told us that they enjoyed the food they received at the service. One person said, "I like the food we have here." Another person smiled when asked if they had enjoyed their breakfast. Staff said that when required, information was incorporated into people's care plans so that the food they received was to their preference and in accordance with their dietary needs, for example, soft or chopped diet. We saw that details of people's dietary needs were recorded within care records and indicated people's food likes and dislikes and if they needed any support with eating and drinking. Much of the food preparation at mealtimes was completed by staff with support from people as they were able to.

Snacks and drinks were available to people when these were required. We spoke with the staff about food at the service and reviewed the content of the food cupboards, fridges and freezers and found that they had enough food for the people who used the service. Staff explained that food was purchased twice weekly but that if items ran out, they could go to the shops to purchase additional items, based upon people's preferences. Staff showed us that fresh fruit and vegetables were available, along with supplies of dried and canned goods. Staff were aware of people's specific dietary needs and we found that records showed that these were taken in to account in planning menus, which worked on a four weekly rolling programme.

Prior to this inspection it was also alleged that people did not receive the support they needed to ensure consistent healthcare interventions. We found that people's health needs were being met by the service. People told us that, if necessary, staff would arrange appointments with healthcare professionals for them, both in the local community and within the service. One person said, "I have seen the doctor." Members of staff told us that they reported any health concerns to senior staff, who made sure that people saw health and social care professionals when they needed to. Records confirmed that people were seen by their GP, and that specialist appointments were made and attended when required. For example, psychiatrist and physiotherapist reviews. Staff had taken appropriate steps if they had any concerns and liaised appropriately with other health professionals when needed.

Is the service responsive?

Our findings

Prior to this inspection we had received concerns which alleged that people's care was not always based upon their assessed care needs or personal preferences.

We found that people's care was not always delivered in a person-centred manner or reflective of their specific needs. People had care plans in place but were unable to comment on the content of them or to say whether they felt their care met their needs, due to their complex needs. Members of staff told us that although the care plans contained a lot of information they were not always easy to use to locate the information or guidance they needed to support people. One staff member said, "The care plans have a lot of information in them." Another staff member told us, "They are ok but they do have a lot in them, sometimes it is hard to find what you need."

We reviewed people's care plans and found they did not always guide staff as to the most up to date care that people required. For example, one person had been assessed by a physiotherapist in April 2016. Although staff had access to a copy of the exercise regime that they needed to follow to enhance this person's mobility, we found that this information had not been incorporated in to their care plan. There was no evidence to suggest that this omission had impacted upon the person's level of mobility or range of movement. We observed them to be mobilising freely without support within the home environment. However, this meant that the written assessment of the person's mobility was not reflective of their current needs.

For another person who presented with behaviour which challenged, the guidelines in place had not been reviewed to take account of a recent increase in agitation and anxiety. For example, there was no reference to the specific details that the person could become fixated on or anxious about; just stating, "Can become fixated on certain items and subjects." This statement did not offer staff specific and individualised guidance on how to address the increasing level of challenge for this person.

We also found that, whilst care plans recorded people's needs, they did not always demonstrate that people's individual wishes and interests had been taken into account. For example, for one person, their communication care plan stated, "It is possible to use objects of reference and pictures." It offered no advice or guidance to staff as to what objects of reference or what type of pictures could be used. In another care plan in respect of someone's mobility, we found that it said, "[Name of Person] is very bombastic with movements." There was nothing to clarify exactly what this meant in respect of the physical impact of this upon the person's movements or ability to mobilise.

Care plans showed that there were reviews of people's care plans, however they did not show that people had been consulted, or that their family members had been invited to contribute to the review process. This meant that care plans were not always reflective of people's current needs and wishes and therefore failed to provide staff with the information they needed to ensure that people's preferences were being met by the service. There was however no evidence to suggest that any harm had been caused to people by this lack of information.

Information in care plans and daily notes was often difficult to follow and double check. Care plans and daily notes were stored separately from each other, which resulted in further repetition and increased the chances that staff may miss important information.

People's care and treatment was not always planned in such a way as to ensure that their preferences and needs were met by the service. People and their family members were not always involved in making decisions about their care.

This was a breach of regulation 9 (1) (a) (b) (c) (3) (a) (b) (d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We spoke to the registered manager of the sister service about the care plans. They informed us that they would ensure that a review of each person's care would be carried out.

Is the service well-led?

Our findings

Due to concerns that had been raised prior to this inspection and the issues that we identified as part of this inspection, we reviewed the quality assurance processes used by the provider to monitor and review the delivery of care to people. We found that there were some shortcomings in the internal systems in place which had failed to identify the areas of concern that we found.

During our review of people's care records it became apparent that there were issues in respect of the maintenance of people's care records and in how staff recorded information within people's daily records. Staff told us that they relied on the information provided within people's care plans, to care for people in conjunction with their practical knowledge. As this information was not always current, any staff that were not familiar with the service providing care and support would not always have appropriate information upon which to deliver suitable care.

People had care plans that detailed their care needs but we found that some had not been reviewed since January 2016. Not all of the care plans we reviewed had been evaluated on a regular basis, in accordance with the provider's expected processes. We found inconsistencies in staff's knowledge of the frequency of review for people. One staff member told us that people's care plans would be reviewed on a monthly basis, whereas another said that they would be reviewed on an annual basis or sooner if people's needs had changed. However where we had found that people's needs had changed, for example in respect of medication or mobility, these changes had not been taken into account in updated care plans or risk assessments. There had not been an impact to people because of this omission but it meant that the care plans were not always reflective of people's current needs.

One person had a risk assessment in place to minimise the risk of harm should a seizure occur. Although they had not suffered with a seizure for some time, their risk assessment was clear in saying that they required monitoring when they were given personal care, were in the bath or shower. There was no evidence within this person's records that they were observed or monitored during personal care and although no harm had been caused, it was not clear from the records if the guidance contained within the risk assessment was being followed consistently by staff.

In some care plans, we found that accidents and incidents had not been cross referenced within the progress and evaluation records, which meant that appropriate action may not have been taken by staff when attending their needs. For example, where bruising was found, this had not been fully detailed within the progress records. It was not always easy to determine what action had been taken to address this.

Staff told us that audits had been completed in areas by the provider compliance manager. These included medicines administration, and those which assessed the provision of care against compliance with regulatory standards. However; although we found that the service had monitoring systems in place, we identified that these had not always been used as effectively as they could have been. We found that despite the service having had a quality assurance audit completed in August 2016, this had not identified that care plans had not always been updated in a timely manner which meant that they did not contain current

information about people's needs. This demonstrated that the mechanisms in place to ensure quality delivery of care were not always applied as effectively as they could have been.

The information and concerns we had raised prior to this inspection highlighted that there was not always a positive atmosphere amongst the staff at the service. The staff we spoke with on the day told us that they felt supported and valued by the management of the service, and that they were empowered to perform their roles to the best of their abilities. However, the recent whistleblowing concerns we received, identified that not all staff felt the same. The recent absence of the registered manager had caused an impact to the normal working ethos within the service. We spoke to the registered manager of the sister service and provider about this. They informed us that they were committed to working with staff to make improvements to the service and to help them to feel more secure in their roles and involved in the running of the service. Since our inspection the provider held a meeting with staff to discuss any concerns they have about the service and how they could all move forward as a staff team for the best of the people who lived at the service.

The registered person had not consistently implemented effective systems or processes to assess, monitor and improve the quality and safety of the services being provided. This was a breach of Regulation 17 (1) (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People's care and treatment was not always planned in such a way as to ensure that their preferences and needs were met by the service. People and their family members were not always involved in making decisions about their care.
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risk assessments did not reveal a full understanding of the risk assessment process, or of the necessity to provide robust control measures to mitigate risk.
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Systems and processes were not operated effectively to ensure that people were protected from potential abuse.
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered person had not consistently implemented effective systems or processes to assess, monitor and improve the quality and

safety of the services being provided.