Mrs Susan Kay Hardman

Luke's Place

Inspection report

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Tel: 01582458201

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Luke's Place is a small residential care home providing accommodation and personal care to four people at the time of this inspection. The service can support up to four people with a range of different learning disabilities and physical needs. The environment of this service was designed and developed in line with Registering the Right Support.

People's experience of using this service and what we found

We had concerns about how people's safety was being managed at the home. Some people's risk assessments were not complete. The provider did not have a robust way of responding to incidents when they happened, to try and prevent them from happening again. Potential safeguarding concerns were not being managed in an appropriate way which promoted people's safety and rights.

The provider was also not ensuring safety issues relating to the building were being responded to in a timely way. The provider could not evidence certain safety issues had been acted upon. We observed shortfalls with how a person's medicine was administered. We were also told about an occasion when the home was left understaffed which was an increased the risk to people's safety.

New staff did not receive adequate support when they started their new roles. Staff did not always have the day to day direction from the leadership of the service and training to do their jobs well.

People were supported to have enough to eat and drink. Staff knew how to support people who had specialist diets and eating requirements. Although, more work was needed to make the meal experience a pleasant and social occasion which promoted people's choice of food.

People were not always supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

Staff were not always caring and thoughtful towards people. At times staff were not mindful of being respectful or treating people as adults. People were not being involved in the planning of their care.

Some events and outings were taking place. But these were not always in line with people's interests. Staff did not consider and promote people's goals, interests, and ambitions. Staff were not considering ways to make these happen for people. The provider was not promoting or supporting staff to do this.

There was an inadequate leadership at the home, the provider was not assessing the quality of the service provided and then taking action to make sustained improvements. The provider had not had a positive compliance history with the CQC, since 2016 it has not achieved an overall rating of good.

The service did not apply the principles and values of Registering the Right Support and other best practice guidance. These ensure that people who use the service can live as full a life as possible and achieve the best possible outcomes that include control, choice and independence.

The outcomes for people did not fully reflect the principles and values of Registering the Right Support as people's rights were not always promoted at the home. Staff and the provider did not look at ways to encourage people to have maximum choice and control of their lives.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
The last rating for this service was requires improvement (published in 16 March 2019). The service remains rated requires improvement. This service has been rated requires improvement for the last four consecutive inspections. Before this it was rated inadequate for three consecutive occasions.

Why we inspected
This was a planned inspection based on the previous rating. You can see what action we have asked the provider to take at the end of this full report.

We have identified breaches in relation to people's safety, how safeguarding concerns were responded to, how people's consent is promoted at the home, and the quality of the provider input, at this inspection.

Follow up
We are mindful of the impact of Covid-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. In this instance we will continue to monitor the service.

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. Details are in our safe findings below.	**Requires Improvement**
Is the service effective? The service was not always effective. Details are in our effective findings below.	**Requires Improvement**
Is the service caring? The service was not always caring. Details are in our caring findings below.	**Requires Improvement**
Is the service responsive? The service was not always responsive. Details are in our responsive findings below.	**Requires Improvement**
Is the service well-led? The service was not well-led. Details are in our well-Led findings below.	**Inadequate**

Luke's Place

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
This inspection was carried out by one inspector and an assistant inspector.

Service and service type
Luke's Place is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service did not have a manager registered with the Care Quality Commission. This means that they the provider was legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We spoke with the local authority about their views of the service. We also reviewed our records about the service. We used all this information to plan our inspection.

During the inspection
We looked at three people's care records, staff recruitment folders, records relating to the building and equipment and we also spoke with staff. Most people could not communicate with us in ways we could

understand, so we completed observations.

After the inspection
We sought further information. These were in relation to the risks which one person faced, staff supervisions, Deprivation of Liberty Safeguards (DoLS), staff medicine competency checks and confirmation of safety checks. We also telephoned and spoke with more staff.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management

- The leadership of the service did not have an effective way of responding to and identifying incidents which involved people living at the home.
- A person had a history of having scratch marks on their body. This was not investigated to check this person was safe. No risk assessment was completed about this, and no action was taken to try and prevent this from happening again. This placed this person at risk of potential harm.
- People had risk assessments in place, but these were not always complete, and one person's assessment was not up to date. For example, a person slept with an item around their neck. This had not been checked to see if it was safe and that the person was not at risk of choking. This increased risk to the person was not being monitored. Another person's risk assessment about their skin did not explore what had happened and what the service was doing about this to try and manage and reduce this risk.
- We were told it was cold at night at the home. The leadership were not completing any checks to test the temperature of the home was neither too cold or too warm. We identified the home was cool during the day time so we were not confident people were warm enough at this time. We were told the provider resolved this issue, but this was only after we had identified this.
- The service's emergency contingency plan had not considered what action should be taken if there was a sudden shortage of staff due to an emergency. This had not been looked at by the provider or updated even in the current outbreak of the coronavirus and the increased risk of staff having to self-isolate.
- Some building and equipment records were not complete. The leadership could not confirm if these checks had been completed and any issues resolved. For example, relating to some firefighting equipment.
- The hydro-pool at the service managed by the provider, which people from Luke's Place also used had shown signs of Legionella when it was tested. We were told this was resolved but no records to prove this could be produced. The provider could not demonstrate if a Legionella test had been completed for the home. This put people at risk of potential harm. We therefore could not be confident the provider was ensuring aspects of the service were safe.

Preventing and controlling infection

- A person's bathroom was not clean. There was food debris on the floor, which the deputy manager suspected came from this person's meal from the night before. Their equipment to assist them to transfer to a shower chair was also not clean.
- The home was dusty. The kitchen had a stale aroma to it. The extractor fan above the cooker was greasy and dusty. A portable fan in a person's room was dusty. This was an increased risk to people becoming unwell.

● We saw staff not adhere to good infection control practices. A member of staff came in from supporting a person to attend a club. They had not washed their hands on their return. They picked up a straw from its tip to put into a person's cup. A cap to a medicine was dropped onto the floor and put straight back on the bottle without cleaning it. A person was being supported to eat a biscuit. The member of staff placed the half-eaten biscuit on the arm of a lounge chair. They left the person and returned to continue feeding them the biscuit, taking it from the arm of the lounge chair. These were examples of increased risks of cross contamination, which could make people unwell.

Using medicines safely

● We observed a member of staff preparing to administer a person their medicine. Another member of staff was talking to them in an animated loud way during this time which increased the risk of distraction and errors being made. At one point the member of staff administering the medicine was trying to hold the medicine administration record (MAR), bottle of liquid medicine, and oral syringe. They dropped the lid and still both members of staff continued to talk. This is not safe practice.

We found no evidence that people had been harmed however, people's safety was not being effectively managed at times. This placed people at potential risk of harm. Systems at the service did not identify these safety issues. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People had guidance for staff on how to administer as required medicines. However, this information did not include the unique way some people who had communication difficulties would tell staff they might need this medicine.

● We completed a count of a sample of people's medicines and found this tallied with the MAR.

Systems and processes to safeguard people from the risk of abuse

● During this inspection we were informed about two events which should have been processed as safeguarding incidents, but they were not. For example, one person had potentially come to harm through neglect. Staff told the then registered manager about this, but they and the provider did not take the appropriate next steps of informing the local authority Safeguarding team and the Care Quality Commission. To promote people's safety at the home.

We found no evidence that people had been harmed however, the leadership of the service were not responding to potential safeguarding concerns in a robust and appropriate way. This was a breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

● We looked at a sample of staff recruitment checks. Staff did not always have full employment histories with any gaps explained. Staff had references in place, but these were not always verified which included identifying how the referrer knew the applicant.

● On the day of inspection there appeared to be the appropriate amount of available staff. However, we were informed by the local authority that on 11 March 2020 when they visited the home there was only one member of staff on duty to support two people who had high care needs.

Learning lessons when things go wrong

● The provider has not learnt from previous errors.They also did not have effective systems in place to identify shortfalls in the first instance or put in place actions to remedy and sustain any improvements required.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Staff support: induction, training, skills and experience

- Staff had not received a full and robust induction to their new roles. New staff only received training in moving and handling and basic fire awareness. Staff did not have training in other key areas to their work. Agency staff were not given information about people's health and communication needs. This increased the risk of people not receiving good high-quality care.
- New staff did not have a meeting to review their induction and consider their support and training needs moving forward. Team meetings for staff to discuss any concerns or updates were not regularly held. The last staff team meeting took place 27 August 2019.
- New and existing staff did not receive competency checks (apart from medicine competency checks) to assess the quality of their work. The medicine competency checks did not show how the assessor had reached their conclusions. No issues had been identified during these checks, but we had identified issues with staff knowledge about safe medicine administration.
- Staff were not being clearly directed during their shift, in relation to care tasks and supporting people's social needs and interests. Staff left in charge and senior staff often worked 60-hour weeks. The provider had not completed any checks to see if these staff were competent and safe working these hours.
- The leadership had no current over view on whether the training staff had received was in date and if training needed to be refreshed. They had not completed any checks to see if the training was effective.

We found no evidence that people had been harmed however, staff were not receiving strong direction and support to do their work well. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Ensuring consent to care and treatment in line with law and guidance

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA.

In care homes, and some hospitals, this is usually through MCA application procedures called the

Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

● A member of staff had filmed a person during their time at a club, this was on the member of staff's personal phone, they left the home finishing their shift, without downloading this to be stored in a secure way at the home. Which the deputy manager said should have happened. They confirmed there was no documentation to record when the staff member had downloaded this video in a secure way.
● No mental capacity assessment and no best interest process had been followed to see if this person would have agreed to this video, if they had capacity.
● We found staff did not always offer people choices or explain the choices to them. For example, in relation to food choices and entertainment.

We found no evidence that people had been harmed however, the provider had not ensured people's personal data was being managed in a way which people consented to. This was a breach of regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to eat and drink enough to maintain a balanced diet
● We saw records which showed what people were drinking and eating. People were being weighed monthly and food specialists had been involved in the past.
● Staff told us what people's specialist diets were and we saw staff following this guidance.
● People's food likes, and favourites were not explored in their care records. There was no evidence of involving people with the creation of the weekly menu. A member of staff said to another member of staff, "Have you given him his lunch? Can you make him a sandwich then?" This member of staff did give this person two choices of a sandwich filling, but they did not explore if they wanted something else to eat.
● No consideration had been made to make the meal experiences a pleasant one or social occasion for people. One person ate their lunch whilst a member of staff sat next to them. We saw no interaction by staff with the person they were sat next to nor did they check if they liked what they were eating.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● People had guidance of how to complete exercises by professionals in their care records.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care
● We saw evidence of health appointments and reviews. Two people were supported to attend appointments about their needs during the inspection. We were told by the deputy manager about referrals they had made to investigate some people's health needs.

Adapting service, design, decoration to meet people's needs
● The service had been designed to support people to mobilise about the home as independently as possible.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant people did were not always treated in a caring way and with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity

- We spoke with a member of staff about a person's expression of their sexuality. This member of staff referred to this as, "Gross." This is not respectful or kind.
- A person needed support to wipe their nose, despite a member of staff sitting next to them looking at them, they did not respond to this for some time. We needed to prompt this.
- One member of staff did engage with a person in a friendly and caring way. However, other staff did not routinely engage with people in this way. We did not believe staff meant to be uncaring, but this element of their role had not been developed or addressed before.

Respecting and promoting people's privacy, dignity and independence

- A person had spilt some crumbs down their top when they were eating their lunch. A member of staff placed a plastic disposable apron on them. They did not ask them or consider if this was thoughtful or kind. No other options were explored with them. When they spilt a small amount of their drink this member of staff also said to this person, "You lemon" and later "Mucky pup." This was not appropriate or respectful of them as an adult.
- Staff routinely referred to people as "He" and talked to one another about the person in the same room as them. Staff did not use people's first names. One member of staff said to another, "I'll do the three o'clocks then."
- Staff were seen knocking on a person's door and then immediately entering, without checking it was okay.

- A person's bathroom had been left in an unclean condition with food debris on the floor. This is not respectful of their environment.
- People's rooms were personalised, but their bathrooms and bedrooms had incontinence and care protective equipment on display.

We found no evidence that people had been harmed however, staff were not always respectful to people. This was a breach of regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- We spoke with one person who told staff were, "Nice."

Supporting people to express their views and be involved in making decisions about their care

- People were not being involved in the planning of their care. Reviews did not ask people for their views of

their care or try and find ways to do so. People's records were not accessible or in formats they could understand.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has now remained the same. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- People had care plans and assessments which contained detail about how their health and their physical needs. However, these were not always complete or up to date. These records captured people's interests, but they did not create goals or consider people's aspirations and make plans to fulfil these.
- We were told staff were not routinely looking at these records to make use of this information.
- The deputy manager had started to consider people's reviews of their care. But these did not evidence people's experiences, what was working well and plans for the future. Nor did they try and involve the person, their relatives, or staff.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

- We looked at people's daily notes and we could see trips out were taking place. Some of these were related to people's interests. But mostly they were not. Activities had not been tailored to people's interests. Nor had staff tried to be creative in order to promote people's interests. We needed to make suggestions to how someone's like of football could be realised.
- Staff did not spend time chatting or engaging with people. Often, we saw staff looking blankly into the room. There was no activities or events planned in the evenings.

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

- People had communication plans in place to support staff to know how to communicate with people. However, we noted that one person's plan was not complete. We saw staff communicating with this person in a way which was not reflected in the plan. The purpose of the plan is to guide staff, especially agency staff, which the service was using.

Improving care quality in response to complaints or concerns

- The leadership of the service were processing concerns about people's safety through a complaints process and not a safeguarding process. We did not have confidence complaints were being processed appropriately.

End of life care and support

● End of life planning was not being considered. This is important to ensure people's wishes and wants are realised during this time in their life.

Inadequate

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has now deteriorated to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- The provider had not ensured robust quality monitoring processes were in place to assess and promote improvements. We found key shortfalls in how some risks were being managed including safeguarding concerns. The provider had not identified these shortfalls during their audits.
- We observed issues with how staff interacted with people and with their practice, again these issues had not been identified by the provider. The provider had also not identified or addressed the shortfalls in staff training and new staff's inductions.
- People's rights and their interests were not routinely being promoted at the home by the staff or by the leadership.
- The provider had no oversight if key safety checks had been completed. When issues were identified during these checks the provider did not know if these had been resolved. Robust plans were not being made in response to recommendations from the fire service. Suitable emergency plans had not been made even in light of the coronavirus outbreak.
- The provider has had a non-compliant history with a poor rating since January 2016. The provider had also not been able to secure strong consistent daily leadership at the home.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- There was not a positive culture at the home. We found staff were disrespectful towards people at times. We have been told the provider responded negatively to criticism. Systems were not in place to enable an open discussion about improvements and suggestions, to make the experience of living at the home and care provided better for people.
- Staff were not empowered to promote people's rights and experiences.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

- Concerns which should have been raised as a safeguarding referral to the local authority and the CQC were not.
- The provider had not told us about recent concerns raised by professionals.

We found the leadership at the home at provider level was not effective in bringing about positive change and sustaining this at the service. Nor were they effective in creating a positive person-centred culture at the

home. This was a breach of regulation 17 (Well led) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others; Continuous learning and improving care

● People and staff were not being involved in the development of the service. The provider had started to use a consultant; however, their role was a supportive one to the deputy manager following the registered managers departure. They were not being tasked to assess and drive improvement. Organisations skilled in supporting and promoting people's rights who had a learning disability had not been used to assess and make improvements at the home.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We 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 RA Regulations 2014 Dignity and respect The provider had not ensured people were always treated with respect. 10 (1) (2) (a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had not ensured people's consent was always being sort and according to best practice. Regulation 11 (1) and (2) (3).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not ensured that care and treatment was provided in a safe way. Regulation 12 (1) and (2) (a) (b) (d) (e) (h).

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 The provider had not ensured safeguarding concerns were identified and processed appropriately.

Regulation 13 (1) and (2) (3).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance There was a lack of effective systems to ensure quality care was always provided. There was a lack of robust action to respond to shortfalls in care. Regulation 17 (1) and (2) (a) (b) (c) (e)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had not ensured staff were well trained and supported to do their jobs well. 18 (1) (2) (a)