Life Style Care (2011) plc

Coniston Lodge Care Centre

Inspection report

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Ratings

Overall rating for this service	Requires improvement
Is the service safe?	Inadequate
Is the service effective?	Requires improvement
Is the service caring?	Good
Is the service responsive?	Requires improvement

Overall summary

The inspection was carried out on 21, 24 and 25 September 2015 and the first two days were unannounced. We undertook a focussed inspection in response to concerns received regarding the number of safeguarding issues raised by the service and by the local authority. We inspected against four of the five questions we ask about services: is the service safe, is the service effective, is the service caring and is the service responsive?

At the last inspection on 13, 14 and 15 January 2015 we asked the provider to take action to make improvements with areas of safeguarding training and care and welfare.

We received an action plan from the provider telling us they would meet the relevant legal requirements by 30 September 2015 which had not been reached at the time of inspection.

Coniston Lodge is a nursing home providing care for a maximum of 92 people. The service has four units, three of which are for general nursing care and one for people with dementia care needs. At the time of the inspection there were 75 people using the service.

The service is required to have a registered manager in post, and the registered manager has been managing the service since June 2015 and registered with CQC on 3

Summary of findings

September 2015. 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.

Risks to individuals were being identified, however staff did not always follow the care instructions to minimise risks to people. Accidents and incidents were not being effectively monitored and managed leading to people not being adequately protected from the risk of further injuries.

Staff vacancies were being covered with agency staff, however the numbers of staff deployed did not always meet people's complex needs.

Shortfalls were identified in medicines recording and management, which could put people at risk of not receiving their medicines as needed.

We found the service was not meeting the requirements of the Deprivation of Liberty Safeguards (DoLS) and Mental Capacity Act 2005 (MCA). DoLS are in place to ensure that people's freedom is not unduly restricted. Applications had not always been made to the local authority where people were being deprived of their liberty.

Care records did not always confirm that people were receiving the care and treatment their care records identified they needed.

People and relatives were confident to make complaints, however we found these were not always being recorded and responded to.

Staff understood safeguarding and whistleblowing procedures and knew which outside agencies they could report concerns to.

Staff were caring and understood people's individual needs and how to meet these. People's choices were respected and staff treated them in a gentle and dignified way.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe. Although risks were being identified, staff were not always following the care instructions to minimise risks to people. Accidents and incidents were not being managed and people were not being adequately protected from the risk of further injuries.

Staff vacancies were being covered with agency staff, however the numbers of staff deployed did not always meet people's complex needs.

Shortfalls were identified in medicines recording and management and this could put people at risk of not receiving their medicines as needed.

Staff were clear on what constituted abuse, understood safeguarding and whistleblowing procedures and knew which outside agencies they could report concerns to.

Is the service effective?

Requires improvement

Some aspects of the service were not effective.

Applications had not always been made to the local authority where people were being deprived of their liberty.

Is the service caring?

Good

The service was caring. Staff listened to people and responded to them in a gentle and courteous way.

Staff understood the individual support and care people required and were able to meet people's needs. Staff treated people with dignity and respect.

Is the service responsive?

Requires improvement

Some aspects of the service were not responsive. Care records did not always confirm that people were receiving the care and treatment that was identified in their care plans.

People and relatives were confident to make complaints however we found these were not always being recorded and responded to.

Coniston Lodge Care Centre

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.

We undertook a focussed inspection in response to concerns received regarding the number of safeguarding issues raised by the service and by the local authority. We inspected against four of the five questions we ask about services: is the service safe, is the service effective, is the service caring and is the service responsive? The inspection was carried out on 21, 24 and 25 September 2015 and the first two days were unannounced.

The inspection team consisted of four inspectors, one of whom was a pharmacist inspector. Medicines management was inspected on 21 September 2015 and the other areas inspected were covered on 24 and 25 September 2015.

Before the inspection we reviewed the information we held about the service including information received from the local authority and notifications. Notifications are for certain changes, events and incidents affecting the service or the people who use it that providers are required to notify us about.

During the inspection we viewed a variety of records including ten people's care records, some in detail and some looking at specific areas such as risk assessments or wound care, three staff files, medicine records for 32 people, 16 incident/accident reports, auditing and monitoring reports. We observed interaction between people using the service and staff throughout the inspection.

We spoke with 11 people using the service, 13 relatives, the registered manager, the deputy manager, the relief manager, the regional director, the training manager, the quality support lead, seven registered nurses, nine care staff, the chef and two domestic staff.

Inadequate

Is the service safe?

Our findings

People confirmed they felt safe at the service. One person said, "Yes. I feel safe enough here." When we asked a relative if they felt their family member was safe they said, "100 percent."

Where unexplained injuries had occurred these had been documented, photographs taken as appropriate, body maps completed and safeguarding referrals had been made to the local authority. For one person we saw the daily log was not detailed, information recorded was brief and did not detail the circumstances prior to the injury being noted. The registered manager told us the written information and verbal information provided by staff was inconsistent and this would be covered as part of the investigation. The monthly reviews of care plans associated with falls risks did not always identify falls had taken place. For example, a review in respect of mobility recorded 'remains stable. No changes' despite the fact the person had a fall nine days earlier. Therefore inaccurate records put people at risk of unsafe and inappropriate care.

Where risks had been identified and interventions to minimise a risk recorded we saw staff were not always following the information provided. For example, where footwear had been identified to be worn to help minimise the risk of falls, we saw in the record of falls the person had not always had shoes on when they fell. We observed the person was not wearing footwear and pointed this out to staff, who then addressed the situation. No link was therefore being made about day to day practice and the person's risk of falls. For another person we saw information about behaviours that could identify a cause for unexplained injuries was included in the daily records, however there was no evidence to show this information was being used to feed into any investigation. We viewed 16 incident forms, which were used for recording incidents and accidents that occurred. These had been completed to include the detail of the incident or accident and a record of the action taken by staff at the time of the occurrence. However the analysis section of the forms had not been completed and there had not been any analysis done of each incident or accident to identify trends or what action should be taken to minimise the risk of recurrence. Although accidents had taken place in July 2015, these had not been identified on the monthly Quality Monitoring return, so this information had not been fed back to the provider. This meant that people were not being kept safe because falls risks that could be discerned and rectified were not being identified and so people were at risk of recurrence.

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Risks to people's health, safety and welfare had been assessed, recorded and were specific to the individual. Risks including those relating to falls, pressure care, moving and handling and malnutrition were assessed and management plans put in place as necessary. Assessments we viewed had been completed and risks had been accurately rated and recorded. For example, where people were at risk of developing pressure sores, we saw that pressure relieving equipment was identified and provided to reduce the risk. Where people had been identified as being at risk of malnutrition assessments had been carried out, weights were being monitored and appropriate referrals were made to the GP, dietician and speech and language therapist. Care plans for people that were at risk of swallowing difficulties and choking were in place. Individual guidance prepared by the speech and language therapists was available for staff to refer to. Staff were able to describe how they supported two people who were at risk of choking. The information they described matched the information in both care plans such as positions for eating and consistency of food and drink. Information about the support required for two people was displayed in their bedrooms and our observations of staff supporting them confirmed they were following the guidelines.

Relatives we spoke with said the service felt safe overall but there had been times when they felt it was not safe because there were not enough staff working, especially at the weekend. They also expressed concerns about the high levels of agency staff being used at the service. Comments included, "The weekends are the worst. When I visit I look at which staff are on duty, and then I know whether it will be good or bad. A few weekends ago I saw how desperate they were and fed a resident that had been waiting for ages. Other relatives also helped." "It's chaos, they are so disorganised." "There are too many agency staff – there is a new person every day." "We don't know from one night to another what staff are coming and their capabilities." "Most

Is the service safe?

staff are good intentioned but some of them simply don't know the people here." "There's a lot of good things about the home but there has been a lot of change and a lot of staff leaving."

The registered manager told us the service was using a high number of agency staff, both registered nurses and carers, to cover current vacancies. She said they used one agency only and the agency provided written confirmation that the required recruitment checks had been carried out on each member of staff they supplied to the service. The service was actively recruiting for more staff and we saw four interviews took place on the second day of inspection. The regional director told us they were also looking towards providing management cover within the service at weekends, rather than this being done remotely by telephone, so there would be a management presence in the service for people, relatives and staff to speak with. The service had previously had one unit specifically for people with dementia care needs and three for those requiring general nursing care, however it was clear at this inspection that all units were providing care to people with dementia care needs. The provider had already declared their intention to restructure the units to more effectively accommodate people and the relief manager said this would be discussed with people, families and care managers, in order to ensure people were informed and involved with any changes to be made.

Although staff were busy, we saw they were available to meet people's needs for the majority of the time. However, on one unit on the afternoon of the second day of inspection, an agency carer had not turned up on time to provide one to one support for a person. Two carers were supporting a person with personal care in their room and this left one carer on the floor. One person was distressed and kept saying they wanted to leave as they did not feel safe. No staff were available to support them. They were supported by a visiting relative to go to the lounge. We saw two carers and the registered nurse all went for their break at the same time. Staff told us that sometimes they were unable to have a break due to the lack of staff to cover the floor. Several times during the afternoon we observed a person that was at risk of falling attempting to get up from their chair. The agency carer carrying out one to one care for another person intervened to stop them from falling. On another occasion when no staff were in the lounge we asked staff in the corridor to intervene. Staff told us there were not enough staff on duty and the staffing numbers did not reflect the dependency levels and assessed needs of the people on the unit. One staff member said, "This is the hardest unit to work on and other staff do not want to work here, mainly because of the needs of people. I know that they are trying to recruit. They need to look at the quality of staff they are recruiting." On another unit we observed a person walking around and looking for staff to assist them to the toilet, however no staff were available at the time and there was a delay in the person receiving this help.

This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at the medicine practices in the service during this inspection as we had been alerted to incidents involving medicines. The registered manager told us that in response to these incidents a new system for supplying medicines to the service had been implemented and a training session with the pharmacist booked. We saw that medicines were in stock and available for people, however we noted two occasions where nurses had been unable to locate the correct supply, but had given people medicines that should have been used later in the month to ensure they had their medicines as prescribed. We saw nurses giving medicines to people and this was done in a safe and caring way. Nurses signed the record immediately after administering the medicines and after the round they checked the number of medicines in stock to see that they tallied. This showed them if any medicines had not been given correctly. During the inspection a nurse noticed that one medicine did not tally as it should and immediately notified the registered manager to investigate. On the second day of the inspection we were told of a further incident that was investigated and showed that nurses had given an incorrect dose of medicines.

Some people were prescribed medicines to be taken 'when required'. We saw that for people who were prescribed laxatives or pain killers in this way there were clear protocols for staff to follow, however there were no protocols for medicines prescribed 'when required' that were used to modify behaviour or mood. Nurses could describe to us how they were used and agency nurses told us that they would refer to permanent staff if they did not know the person well. We pointed this out to the registered manager during the first day of the inspection and the protocols were in place by the time we returned.

Some people had difficulties swallowing and we saw thickeners to thicken their drinks to the appropriate

consistency were prescribed and used. We also saw that their GP and pharmacist were involved in arranging suitable medicines administration for them. We saw that some people had their medicines given covertly (disguised in food or drink); again the GP and pharmacist were involved in making suitable arrangements for the medicines to be given. However on the first day of the inspection we noted that one person had not had a mental capacity assessment to establish if they had capacity to refuse their medicines before a best interests decision had been made to give these medicines covertly. This had been completed by the second day of the inspection.

Medicines were managed in the service by nurses who were both permanent staff and agency. We saw that a short version of the medicine policy (called a snap shot) was available to nurses which highlighted their responsibilities. This was designed to be covered with all agency nurses before they commenced their shifts. We heard from some agency nurses that this had not happened yet but was done during the period of our inspection.

This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

On the second day of inspection we noted several people on two units did not have call bell leads and some had leads but these were out of reach. We asked staff about this. They told us that some people could not use a bell but agreed that there were others that could but no bell was available in these people's rooms. Staff directed maintenance staff to address this issue without delay, which we saw was done. We spoke to one person who did have their call bell. They told us 'Staff come reasonably quickly when I ring'. We noted two items of equipment that were in need of repair, one of which had been out of order for some weeks. They had been identified to the registered manager who said she had reported them to the provider's maintenance department for action and would follow this up to get the repairs carried out.

People were supported to move by staff who were trained in the use of moving and handling equipment and knew how to assist people to transfer safely, for example, from wheelchairs to armchairs. We observed staff took care to tell each person what they were doing and ensured they were happy to be moved. We saw several people being moved using hoists and each time this was done safely and with care and the person being supported was calm and comfortable. Where people needed to be supported by two staff we saw this was being adhered to, even when staff were very busy. For example we noted one person being supported to stand with a hoist and two members of staff.

At the last inspection we found staff did not all know which outside agencies they could contact to report allegations of abuse. Also, staff did not always demonstrate an awareness of what constituted abuse. Staff had undertaken safeguarding training and were able to describe the various types of abuse that people could experience. Staff told us what they would do if they had a concern about someone, mentioning the need to report the concern, to record details about it and to ensure the matter was followed up. All the staff were aware of their responsibility in respect of whistle blowing. They could name external agencies such as the local authority and the Care Quality Commission that they would contact if they felt the provider was not addressing the concern they raised.

Requires improvement

Is the service effective?

Our findings

The Care Quality Commission (CQC) is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS). This is where the provider must ensure that people's freedom was not unduly restricted. Where restrictions have been put in place for a person's safety or if it has been deemed in their best interests, then there must be evidence that the person, their representatives and professionals involved in their lives have all agreed on the least restrictive way to support the person. The provider was not meeting the requirements of the DoLS. The registered manager told us there were nine DoLS authorisations in place for people in the service and the required notifications for these had been made to CQC. For a person that required one to one supervision we saw that a DoLS application had been authorised, however the authorisation had expired two weeks prior to the inspection. For another person who was on one to one supervision no DoLS application had been made. For a person for whom bedrails were in use with a safety mattress next to the bed, we saw they were quite restless at times and putting their legs over the bedrail. No DoLS application had been made. This meant people were under continuous supervision or having their movement restricted with no valid authorisation in place and had been deprived of their liberty. The registered manager said she had identified 45 people for whom DoLS applications needed to be made and she would be making these in the near future.

On one unit a person's room was kept locked during the day and they spent time in the day room. We asked why the person was not able to go to their bedroom for periods during the day. A member of staff told us the door was locked because another person living at the service had a habit of walking into this room and making a mess, but this did not explain why only one person's room was locked nor why action had not been taken to manage this person's behaviour rather than penalise the occupant of the room.

This is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Good

Is the service caring?

Our findings

A relative told us, “The permanent staff are good. They give good care and have a good rapport with the people here.” Comments about the staff included, “I cannot fault them.” “[relative] is pretty well cared for.” “Superb, wouldn’t have [relative] anywhere else.” “They do a good job.” “Some of them don’t understand English and you spend a lot of time explaining things to them.” “We get some that are better than others.” “The ones I speak with love [relative], they give a hug and they are doing their best under difficult circumstances.”

People’s dignity and privacy was maintained. For example, at 7.30am we saw most people were still asleep, some people’s doors were closed whilst others were ajar or open. Some people’s lights and televisions were already on and others were not, according to their preferences. As the morning progressed we saw staff knocking on doors, asking people how they were and offering support and assistance with care needs in a courteous and gentle way.

Where people displayed behaviour that challenged we observed staff responding to them positively, using various strategies so that their dignity was maintained. We saw a staff member suggesting they support a person to take a walk in the garden when the person had been constantly approaching other people on the unit. For another person, we heard the staff member reassuring them and providing information to the questions they were asking.

People were supported with personal care and other tasks and were encouraged to do as much for themselves as possible in order to maintain their independence. For example, staff supported a person to mobilise independently with the use of a walking frame. In another instance a plate guard was in place for a person who wanted to eat independently but who had limited movement in their hands. The permanent staff knew people well and had a good understanding of their likes, dislikes and individual preferences. They were able to support agency care staff who were less familiar with people’s care. For example, we saw one person being taken to the dining room by an agency carer and a permanent carer intervened and explained the person did not like eating in front of other people.

Mealtimes were busy, with people needing support with their meals. Staff provided this in a gentle way, sitting by the side of them and telling people what they were doing. For example, we heard one carer say, “[person], I will help you with your porridge, is that alright?” Drinks were offered and staff listened to what people asked for and provided it. We observed signs of wellbeing amongst people who were smiling and engaging with one another.

The quality manager was present during our inspection and was observing care staff providing care and support to people. They explained that a comprehensive exercise was being carried out to assess the performance of each member of the care staff team and provide direct feedback to improve care practice within the service. Care staff said they had received training in customer care and we saw staff were caring for people to meet their individual wishes and needs.

Requires improvement

Is the service responsive?

Our findings

We received varying comments from relatives of people using the service. These included, "The staffing levels have improved but the problem is that so many of the staff are agency. They don't know the people. My [relative] likes to sit by the window. They are content to sit and look out. But they keep putting [relative] somewhere else. They get upset." "They have been really good here with my [relative]. They have been able to sort out the problem with their balance and have been able to reduce their medication. There is generally a good atmosphere."

The care plans provided staff with sufficient information to know how to care for the person, setting out people's preferences, the support they required and the number of staff needed to provide personal care. Some care plans had not been updated to reflect changes, for example, one person who had been supplied with a low bed still had a reference to the use of bedrails in their care plan, which we saw were no longer in use.

We viewed wound care records for four people. These detailed the treatments that people required in respect of their wounds, frequency of dressings, pain assessments and the progress of the wound. Photographs had been taken to mark the progress of each wound. Where a wound had been reviewed by the tissue viability nurse we saw that changes had been incorporated into the care plans, with one being updated at the time of inspection. For three people staff were following the guidance provided and records demonstrated this. For the fourth person it was not possible to check if the frequency of dressing change instructions had been followed, as there were occasions where there were gaps of up to ten days between entries on the dressing change records. We saw there were entries in the daily log made during some of the intervals, indicating the dressings had been checked, however it was not clear from the information if the dressings had been changed and staff were not able to tell us this information. The wound photographs did not indicate that the wounds had deteriorated during the time period we checked. The training manager reviewed the wound care records at the time of inspection and the registered manager said action would be taken to ensure dressing changes were kept up to date and recorded accurately.

We viewed daily fluid intake charts for three people. We noted for one person they were consistently taking in less than the recommended daily fluid intake of 1.5 to 2 litres per day that was recorded in the care plan. For another we noted the person was not always compliant with taking fluids, however it was not being recorded if they refused to take fluids when offered. We noted a fluid intake chart was being completed for someone who had not been identified in their care plan as needing to have their fluid intake monitored, and staff were not able to explain why this was being done. We saw hourly check charts were in place in people's individual records and also in a general file in the lounge area. These had been completed at night but not always during the day. There was also a form for hourly checks of the lounge, which was being completed by the day staff. Staff were duplicating work and entries and there was some confusion, for example, a person's fluid intake being recorded on the observation chart and not on the fluid intake chart, or on both.

Our findings indicated that accurate records were not being maintained so people were at risk of not having their needs met. We fed back our findings to the registered manager who said records would be reviewed.

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

The service had a complaints procedure on display in the lobby area. One relative told us, "When I have raised things with the staff they do their best to sort it out." Relatives told us they would be confident to raise concerns, however there were times when they had not received a response. We looked at the complaints file. There had been 10 complaints recorded since the last inspection and the complaints process had been followed. We became aware of two complaints that had been made to the service and were not recorded in the complaints file. We spoke with the registered manager who was able to recollect that the two complaints had been made and confirmed these had not been responded to.

This is a breach of Regulation 16 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 legal requirements 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 Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent **The registered person had not always ensured that they were acting in accordance with the legislation and guidance when people did not have capacity to consent.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Care and treatment for people who lived at the home was not provided in a safe way because medicines were not managed safely for the protection of people living in the service.** Regulation 12(1)(2)(g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints **The registered person did not have an effective system for the management of complaints.**

Regulated activity	Regulation
	Regulation 17 HSCA (RA) Regulations 2014 Good governance The registered person did not 1. monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity.

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 Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Sufficient numbers of suitably qualified, competent, skilled and experienced persons were not deployed. Regulation 18(1)
	2. maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided. Regulation 17(1)(2)(b)(c)