Mrs Susan Kay Hardman

Luke's Place

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Luke's place is a residential care home providing personal care to 3 people who were living with different types of learning disabilities. The service can support up to 4 people.

People's experience of using this service and what we found
The registered manager had worked hard during the pandemic keeping people safe. They had started to make changes to the service following the last inspection. This included an improvement to the culture and leadership of the home. However, the development of the service was limited by a lack of effective and robust oversight by the provider. We had identified this issue at previous inspections. The registered manager was also new in this role and they did not receive the support and direction required to fulfil all aspects of their role.

There was a lack of robust and consistent leadership at the home when the registered manager was absent. There was no plan to manage the home from the provider even when they knew the registered manager was unavailable. Although the culture of the home had improved staff were still reluctant to raise issues and make suggestions to help the service improve. Some staff were concerned about reprisals from speaking with us as part of the inspection process. The service still had a closed culture.

Swift action had not been taken when issues were identified about fire safety at the home. Regular testing of fire equipment was not taking place. Changes in people's physical and mental health were not fully responded to. Support and guidance from health and social care professionals was not always considered or sought.

We were not confident incidents and accidents were being investigated with timely actions to prevent them from happening again and to consider if harm or neglect had taken place. Care plans were not always updated. Prescribed creams were not always managed in a safe way. There were shortfalls with staff not wearing the level of personal protective equipment as directed by the registered manager.

Staff were not always supported by the leadership structure. Staff members knowledge and skills were not being assessed with support being offered when there were shortfalls. Recently there was a lack of management presence in the home to support and direct staff.

In people's day to day care people were supported to have choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

Staff spoke with people in friendly and kind ways. They had formed good connections with people.

We expect health and social care providers to guarantee autistic people and people with a learning disability

the choices, dignity, independence and good access to local communities that most people take for granted. Right Support, right care, right culture is the statutory guidance which supports CQC to make assessments and judgements about services providing support to people with a learning disability and or autistic people.

The service was not able to demonstrate how they were meeting the underpinning principles of Right support, right care, right culture. Timely planned action was not taken to respond to a change in people's mental well-being and to ensure the environment was safe. There was a lack of planning to explore people's interests and ambitions in life. People were not being encouraged to shape the service. There was a risk these issues could have a negative impact on people's well-being and safety. We asked the provider to take urgent action. The provider confirmed to us they were addressing these issues.

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

Rating at last inspection and update
The last rating for this service was requires improvement (published 16 May 2020).

At this inspection enough improvement had not been made and sustained and the provider was still in breach of regulations.

Why we inspected
This was a planned inspection based on the previous rating.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

You can see what action we have asked the provider to take at the end of this full report.

We asked the provider to take action about our concerns shortly after the inspection. They produced an action plan which included how they were addressing our concerns.

Enforcement
We are mindful of the impact of the 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. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to; the lack of leadership and the lack of effective leadership of the service and provider's input to continuously assess and monitor the quality of the care provided. The lack of action and systems to promote people's safety from potential harm and abuse. Also, the lack of support for staff to perform well in their roles.

Please see the action we have told the provider to take at the end of this report.

Follow up
We will request a further action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress.

We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it. And it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

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.

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our safe findings below.

Is the service caring?

Requires Improvement

The service was not always caring.

Details are in our caring findings below

Is the service responsive?

Requires Improvement

The service was not always responsive.

Details are in our responsive findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

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.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was carried out by two inspectors

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 had a manager registered with the Care Quality Commission. This means that they and the provider are 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 spoke with the local authority to gain their views of the service. Information we hold about the service was reviewed. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the

service and made the judgements in this report. We used all of this information to plan our inspection.

During the inspection
We spoke with one person who lived at the home. We completed many observations to see how staff treated people. We looked at people's care plans and risk assessments. Mental capacity and best interest assessments. People's daily records, food related documents, and other records related to people's care. Fire related assessments and records were also reviewed. We completed a check of people's medication and we also reviewed staff recruitment records.

After the inspection
We spoke with two people's relatives about their experience of the care provided. We spoke with seven members of staff and a social care professional. We also sought clarification of some issues with the registered manager and shared our findings with the local authority.

Inadequate

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 requires improvement. At this inspection this key question has now deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management

At our last inspection the provider had failed to ensure people's safety was promoted in terms of the environment and incidents were investigated robustly. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12

- The provider had instructed a fire safety company to assess the safety of the building. They made a number of recommendations including two which they recommended were completed immediately in May 2021. No action had been taken about these matters when we inspected in August 2021.
- This included removing the storage of personal combustible material, the provider had chosen to store in the home. In doing so the provider had evidenced a poor understanding of fire safety.
- Other important checks on the fire related equipment had stopped since June 2021. We were not confident the fire alarm was also being tested since June 2021. We needed to ask the local fire service to visit and support the registered manager with these issues.
- The registered manager had left a personal oxygen cylinder lying on the floor in the office which staff and a person who lived at the home entered regularly. There was no knowledge of how this item should be stored safely. This placed people at potential risk of harm.
- There was no system for the registered manager or provider to investigate and monitor incidents and accidents. Nor had they considered they should be investigating these events. We identified some incidents which should have been investigated to ensure people were safe, but they had not been.
- When one person self-harmed or were about to these were not documented and investigated.
- People's care plans were not always updated to give staff current clear guidance on managing the risks people faced.
- Food was not always stored safely. We found an out of date food item in the fridge and food with no date showing when it was cooked and when it should be discarded.

Preventing and controlling infection

- Safe infection protection control (IPC) measures were not routinely being followed by staff.
- When the inspector entered the home on two days their entry was not managed in a safe way. On one occasion a member of staff opened the door wearing no personal protective equipment (PPE) eating a cake.

● One member of staff was observed on three occasions not wearing the level of PPE which staff had been directed to wear by the registered manager.

Using medicines safely

● There was no process to monitor prescribed creams and ensure homely remedy creams where used within their expiry dates. We found one cream had expired.
● An 'as required' controlled medicine had been prescribed for one person. The registered manager was reluctant to administer this. But they did not seek further medical guidance about this matter, and they did not administer it.

Staffing and recruitment

● When we completed a check on two members of staff recruitment checks; one had an incomplete work history, and another did not have evidence of references.
● One person was funded to receive one to one care due to the risks they faced. We were told staff were not always present to provide this care if another person needed assistance. We observed this person being left for a short time during the inspection. Therefore, we were not confident this staffing need was being well managed.

We found no evidence that people had been harmed however, there were still significant shortfalls in promoting people's safety at the home. These failures placed people at potential risk of harm. This was a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We completed a medicine check and found the administered medicines tallied with the medicine administration record.

Systems and processes to safeguard people from the risk of abuse

At our last inspection the provider had failed to ensure people's safety was promoted in relation to potential harm and abuse. 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.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 13

● There was not a system to investigate the injuries people experienced so see if harm or neglect had occurred.
● Staff had told us about some events where potential harm may have occurred. But the registered manager said these had not been reported to them so they could consider if a safeguarding referral was needed, or if this needed investigating.
● Some staff had a knowledge of what significant abuse could look like and what they must do about this. But we were not confident they understood what potential neglect looked like and what they must do about this.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to protect people from potential harm and abuse. This placed people at risk of harm. This was a continued breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Despite this, improvements had been made with the registered manager responding to safeguarding concerns put directly to them from people last year.

Preventing and controlling infection

● We were not assured that the provider was preventing visitors from catching and spreading infections.

● We were not assured that the provider was using PPE effectively and safely.

● We were assured that the provider was meeting shielding and social distancing rules.

● We were assured that the provider was admitting people safely to the service.

● We were assured that the provider was accessing testing for people using the service and staff.

● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.

● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.

● We were assured that the provider's infection prevention and control policy was up to date.

● We were assured the provider was facilitating visits for people living in the home in accordance with the current guidance.

We have also signposted the provider to resources to develop their approach. The provider told us they have now taken action about these shortfalls

Learning lessons when things go wrong
● Some actions were taken by the registered manager when incidents occurred but there were not systems or a culture to ensure lessons were learnt and these were embedded into the practice of staff and into the management oversight of the service.

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 requires improvement. At this inspection this key question has remained the same. 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

At our last inspection the provider had failed to ensure staff were fully supported in their role. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 18

- The registered manager and provider were still not assessing the competency of staff to check they knew how to meet people's needs and the training was effective.
- Staff were not always following or were knowledgeable about how to meet some people's needs.
- We were told by the registered manager staff had up to date training. But they were unable to confirm this by producing records of staff's training. They did not have a system to demonstrate this.
- Staff spoke well of the training they received. But they were unable to explain why it was good or give us details about their training. We were therefore not confident the training was effective.
- Staff spoke well of the registered manager. But they did not feel supported to do their jobs in the registered manager's absence. Staff told us there was a lack of management presence to support, deal with issues and direct staff. When we spoke with the registered manager they confirmed this.

We found no evidence that people had been harmed however, we were not confident staff were being supported to be effective in their roles. This placed people at potential risk of harm. This was a continued breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

- People's personal data was not always kept secure in the home.
- One person's mental health was not being managed in an effective way. Some action had been taken, but no further action had been taken to support this developing need for this person.
- Another person had been diagnosed by a professional as having a new condition. No additional interim support was requested to check the registered manager and staff were managing this need in an effective

way.
● Health and social care professionals were not always being contacted to seek their input and advice even when the registered manager and staff did not know what else to do.
● We spoke with the registered manager and the local authority about these issues. We were later told social services reviews had been arranged for these people, to look at what support could be given to them.

Supporting people to eat and drink enough to maintain a balanced diet; Adapting service, design, decoration to meet people's needs
● We saw people were offered a varied diet with food they liked. Staff had a good understanding of what people's favourite food and drinks were.
● However, there was no monitoring of people's weight since the start of the pandemic in March 2020. No effective action had been taken about this. One person was at risk of being a low weight due to their health needs and this was not being monitored.

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

At our last inspection the provider had failed to ensure people's consent was not always obtained. This was a breach of regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 11.

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.
● We saw mental capacity assessments had taken place and best interest processes followed in relation to people receiving the COVID-19 vaccination. The best interest report showed staff had followed this process correctly. Involving professionals, staff, relatives and the person.
● People's capacity was assessed as part of this process, however information was limited as to why a person lacked the mental capacity to make this decision in the first place. We spoke with the registered manager about this who said they would address this issue.

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 requires improvement. At this inspection this key question has remained the same. There were still shortfalls with how people were treated and supported.

Respecting and promoting people's privacy, dignity and independence

At our last inspection the provider had failed to ensure people were always treated with dignity and respect. People were spoken to by staff in an infantilised and judgemental way. This was a breach of regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 10

- The way in which staff spoke to and about people had improved. Staff were consistently respectful and thoughtful towards people at the home. However, there were still issues with staff not treating the environment as people's own home. Staff left their bags and coats in the kitchen dinner. Left their food in people's fridge. A used rapid flow test had been left in the lounge.
- There was a notice on the fridge from the management telling staff they were not to eat people's food and it they wanted to do this they would have to pay.
- The provider was storing their personal items in the home. Staff did not routinely adhere to the PPE policy of the registered manager.
- There were no plans made to promote people's independence.

Ensuring people are well treated and supported; respecting equality and diversity
- One person said, "I would give it ten stars I wouldn't want to live anywhere else…My key worker is the best in the world."
- We saw staff treating people in a kind and friendly way. When one person became distressed staff were quick to offer a hug and support.

Supporting people to express their views and be involved in making decisions about their care
- We saw people were involved in their day to day care needs.
- However, there was a lack of involving and attempts to involve people with other decisions about their care for example their physical and mental health needs.

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 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; End of life care and support

- There was a lack of planning and consideration regarding people's mental health needs. One person required support in this area, work had started but it had stopped.
- The registered manager told us people were struggling with the idea of socialising again. But there was no plan to try and tackle this issue. Staff, relatives, and professionals had not been involved to respond to this need.
- Some goals had been identified for people but there was a lack of action and planning to try and achieve these. The goals were limited in scope. No real consideration was being given to what people wanted to do next with their lives.
- There was still no end of life planning. There were no effective plans to do so, for people at the home in the future.

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

- People had been supported to see their relatives during the pandemic. The registered manager had looked at ways to enable people to visit their relatives.
- People's entertainment interests were being supported as they had been before the pandemic in the home. However, these were again limited in scope. With no plans being made about how these could be developed.

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.

- Staff appeared to communicate well with people, despite the communication challenges some people faced.
- However, daily records and care plans were not produced in a way to try and fully involve people and reflect their communication needs.

Improving care quality in response to complaints or concerns

- There was a complaints process in place, there had not been any complaints recorded for some time.
- Despite this, we were told staff and relatives were not confident in raising issues about the service and making suggestions for improvements. People were not being asked about their views of their care and the

service.

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 inadequate. At this inspection this key question has remained the same. 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

At our last inspection the provider had failed to ensure there was effective oversight and monitoring of the service. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17

● When we inspected Luke's Place it was evident there was insufficient leadership at the home. The registered manager was unwell and physically absent from the service. The provider had not ensured there was any leadership present at the home during this time.
● The provider had not made plans to manage the absence of the registered manager. They had not assured themselves the service was operating in a safe way. This put people at risk of harm.
● Prior to this time the provider had not made plans to support the new registered manager. They had not equipped them with the training and support needed to carry out their role.
● The provider was not assessing the quality of the care which was being provided. They were not directing the registered manager when improvements were needed and checking these issues were resolved.
● When issues were identified by the registered manager work started but there was no conclusion to these issues. For example, people not being weighed, and people's mental health needs not being met.
● Important areas to people's safety and well-being were not being managed or followed through to a timely conclusion. We needed to prompt action regarding all these matters.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; 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
● There was still a closed culture at the home. Some improvements had been made in this area under the tenure of the new registered manager. But this culture of staff being fearful of reprisals remained.
● The culture of the service still did not allow people and staff to make suggestions about improvements to the service and raise issues.
● People's expectations and ambitions were not being considered in a meaningful way. These aspects of the service were not being assessed by the provider.

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

- There was not a culture at the home to consider if lessons needed to be learnt or situations investigated.
- There were no systems in place to guide the registered manager and staff when events should be reflected on, investigated, and actions taken.
- Although the registered manager had started to make improvements to make the leadership more open, we found there was still a reluctance to engage with professionals and seek their input and opinions.

We found no evidence that people had been harmed however, there were still significant shortfalls in how the service was being managed. There was a lack of management presence. The provider had not responded to this issue. They were not supporting the new registered manager and they were not assessing the care provided to ensure positive changes were being made. There was still a closed culture at the service. These failures placed people at potential risk of harm. This was a continued breach of regulation 17 (Good governance) 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 12 HSCA RA Regulations 2014 Safe care and treatment Regulation 12(1) and (2) (a) (c) (d) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 - Safe care and treatment Various actions had not been taken to ensure service users were safe.

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 Regulation 13 (1) and (2) (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 - Safeguarding service users from abuse and improper treatment. There were no systems to investigate incidents and accidents to consider if harm or neglect had taken place. Safeguarding systems and staff were not knowledgeable about when certain concerns should be reported.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Regulation 17(1)(2)(a)(b)(d)(e) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014-Good Governance. There was no effective provider oversight of the service. Combined with limited day to day management. Which put service users at potential risk of harm.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Regulation 18 (1) and (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 - Staffing Staff were not being supported by the provider and through effective leadership to perform well in their roles. This put service users at potential risk of harm.