Lovett Care Limited

Goldendale House

Inspection report

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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?	Good
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

This inspection took place on 27 May 2016 and was unannounced. At the last inspection in October 2015, the service was rated as 'Requires Improvement'. We saw that improvements had been made in some areas.

The service was registered to provide accommodation and personal care for up to 31 people. People who used the service had physical health needs and/or were living with dementia. At the time of our inspection 28 people were using the service.

The service had a registered manager. 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.

We had not been informed about some important events which occurred in the home, which is a requirement of registration with us. This was a breach of Regulations 16 and 18 of The Care Quality Commission (Registration) Regulations 2009 (Part 4). You can see what action we told the provider to take at the back of the full version of the report.

People were not consistently protected from avoidable harm and abuse because we saw that potential safeguarding incidents had taken place and concerns had not been reported to the local authority in line with local safeguarding adult's procedures.

People's risks were not always suitably assessed and planned for to ensure they received consistent care to keep them and others safe.

People's oral medicines were managed so that they received them as prescribed. However, there were gaps in the administration records for topical creams so we could not be sure that people were receiving them as prescribed.

There were sufficient staff to meet people's needs and staff were trained and supported to deliver effective care.

The principles of the Mental Capacity Act (2005) were not consistently followed to ensure that people's legal and human rights were respected.

People were provided with enough food and drink to maintain a healthy diet. People's health was monitored and access to healthcare professionals was arranged when required.

People were treated with kindness and compassion and they were happy with the care they received. People were encouraged to make choices about their care and their privacy and dignity was respected.

People's plans of care were not always sufficiently detailed and up to date so there was a risk they may receive inconsistent care that was not personalised.

People had access to activities that interested them and could spend their time how they chose.

People knew how to complain if they needed to. A complaints procedure was in place and complaints had been dealt with in line with this procedure.

Systems were in place to monitor quality and actions were usually taken to make improvements when required. However, these systems had not identified all of the issues we found during the inspection.

People did not know who the registered was though they knew the providers and the assistant managers and felt they were approachable and visible around the service. There was a positive culture and people and staff felt included in the development of the service.

We identified two breaches of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

Incidents of potential abuse were not always reported to the local authority in line with safeguarding adults' procedures. People's risks were not always suitably assessed and planned for to keep them and others safe. People's oral medicines were managed so they received them as prescribed, however when people required topical creams, records had gaps so we could not be sure people received them as required. There were sufficient staff to meet people's needs.

Is the service effective?

Requires Improvement

The service was not consistently effective.

The principles of the Mental Capacity Act (2005) were not consistently followed to ensure that people's legal and human rights were upheld. People were provided with enough food and drink to maintain a healthy diet and had access to healthcare professionals when required. Staff were trained and supported to deliver effective care.

Is the service caring?

Good

The service was caring.

People were treated with kindness and compassion by staff who showed concern for their wellbeing. People were supported and encouraged to make choices and decisions about their care. People's privacy, dignity and independence was respected and promoted and they were happy with the care they received.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People's plans of care were not always detailed and did not always contain life history information, so there was a risk that people may receive inconsistent care. People had access to activities that interested them and could spend their time how they chose. People felt able to complaint when required and

complaints were handled in line the provider's complaints procedure.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

We were not notified about important events, which is a requirement of registration with us. Quality assurance systems were in place but they had not identified all of the issues we found during the inspection. People did not know who the registered manager was but they knew the providers and assistant managers and felt they were approachable and supportive. People and staff felt included in the development of the service and we observed a positive atmosphere.

Goldendale House

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 was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 27 May 2016 and was unannounced.

The inspection team consisted of one inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We looked at the information we held about the service. This included information we had received from members of the public and commissioners of the service.

We spoke with eight people who used the service and one relative. Not everyone who used the service was able to talk with us about their experiences so we spent some time observing how staff interacted with and supported people in communal areas. We spoke with six members of staff including a member of kitchen staff and an assistant manager, a visiting professional, the registered manager and the providers.

We looked at three people's care records to see if they were accurate and up to date. We also looked at records relating to the management of the service. These included quality checks, three staff recruitment files and other documents to help us to see how care was being delivered, monitored and maintained.

Requires Improvement

Is the service safe?

Our findings

We found that some incidents of alleged abuse between people who used the service had not been reported to the local authority in line with local safeguarding adult's procedures. This meant that suitable investigations could not be considered. Staff we spoke with were knowledgeable about how to recognise the signs of abuse and the types of abuse which may occur. They told us they would report their concerns to the person in charge. One staff member said, "I'd pass my concerns on to the assistant managers or the provider, whoever was the senior person in charge." We saw that incidents of potential abuse, including one person being slapped across the face by another, had been recorded in a 'safeguarding log'. However, these had not been reported to the local authority when required which meant that safeguarding adults procedures were not being consistently followed to ensure that people were protected from abuse and avoidable harm. We discussed this with the registered manager and assistant manager who recognised that these incidents should have been reported to the local safeguarding authority.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found that some risks were not suitably assessed and planned for to ensure that people received consistent care that kept them and others safe. For example, staff told us and we saw that one person could be inappropriate with their use of language. Their care plan stated, "[Person who used the service] can be inappropriate with [their] language towards staff and residents." There was no specific risk assessment or management plan in place for this and the person's care plan stated that staff should, "redirect" but it did not explain how to do this, or what techniques were successful in supporting the person. This meant there was a risk that the person may receive inconsistent care because there was a not a clear, specific risk management plan. However, staff explained how they managed the risks and told us about appropriate strategies that were successful to help support the person, though this was not recorded. Staff also said they had completed training that helped them to know how to support people with behaviours that may challenge. A staff member said, "It's about the way you speak to people, you should speak calmly and say 'please don't do that.'"

We saw that a risk assessment tool had been used to determine a person's risk level of developing pressures sores to their skin. This tool identified that the person was at medium risk; however there was no risk management plan in place to say what would be done to prevent the person developing pressure sores. There was a personal care risk management plan which stated that one carer should apply creams on dry skin as stated on the topical creams chart. However, when we asked to see the person's record of creams applied, staff told us the person's doctor had "discontinued" their creams, so it was unclear how the identified risks to their skin were being managed.

We found that people's oral medicines were administered so that they received them as prescribed. However, when people were prescribed topical creams, we saw that there were gaps in the recording of the administration of these so we could not be sure that people were receiving their creams as prescribed. For example, some people were prescribed pain relief gel three times daily. We found that there were gaps

where nothing was recorded on the administration record. Staff told us that sometimes people chose not to have the gel applied; however there was no consistent recording system to show that the gel had been offered but refused or not required and blank gaps were being left on the administration records. This meant that people could not be sure they were being offered their topical creams as prescribed.

Some people required 'as and when required' medicines such as pain relief or laxatives. There were no specific protocols in place for these people so that staff were guided on when to administer these medicines. One person was prescribed paracetamol for pain relief. The staff member administering medicines told us that the person was unable to verbally communicate when they were in pain and that staff had to observe them for visual signs of pain. However, this was not written down with the person's medicines administration records, so there was a risk they may not receive their 'as and when required' pain relief medicines when they needed them if staff administering medicines did not know this information.

People told us they felt safe at Goldendale House. One person said, "I feel very safe here, they look after you well." There were sufficient staff to meet the needs of the people who used the service. One person said, "All you've got to do is just call them and they come over to you or press the buzzer and they come to you." We saw that people's needs were met and call bells were responded to in a timely manner. The registered manager told us and we saw that they completed a monthly review of people's needs, called a dependency tool, which helped them to determine how many staffing hours were required to safely meet people's needs. We also saw that staffing was discussed at weekly assistant managers meetings to allow the registered manager and provider to make any changes to staffing levels if required.

Staff told us and we saw that safe recruitment practices were followed. This included references and Disclosure and Barring Service (DBS) checks to make sure that staff were safe and suitable to work at the home. The DBS is a national agency that keeps records of criminal convictions.

Requires Improvement

Is the service effective?

Our findings

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 make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. We saw and people told us they were asked for their consent before they were supported by staff and when they were able to, they were encouraged to make their own decisions. One person said, "Yes [staff] ask for your consent. They ask, do you want a shower wash or a strip wash." However, despite receiving training and having prompt posters displayed in the staff room, staff we spoke with were not always clear about their responsibilities under the MCA and were not clear about how it was used in practice to ensure that people's legal and human rights were respected.

We saw that the MCA was not always applied correctly. Records showed that a relative had signed consent to care and consent to administer medications on behalf of a person who used the service. We could not see any evidence that the relative had any legal powers to make decisions on the person's behalf and when we asked the registered manager, they confirmed that the relative did not have the legal powers to make the person's decisions. We saw that an assessment of a person's capacity to make decisions about their care planning was in place. This determined that the person lacked the mental capacity to make the decision and there was 'best interests' paperwork in place. However, this paperwork did not record what decision had been reached in the person's best interests and how the decision had been reached. Another person who used the service had signed to give consent to their care. However, during a monthly review of their care plan it was documented that the person's son gave consent during the review. These examples show that the MCA was not always followed correctly.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked and saw that applications for DoLS authorisations had been completed when required. However, we saw that a DoLS authorisation had been requested for one person who was recorded as having capacity to consent to their care. This suggested that the principles of the MCA had not been fully understood or followed correctly.

These issues constituted a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us and we saw that they enjoyed the food at the home. People said, "The food is marvellous, if you want more food you get it" and "The chef here is really good, he listens and does everything to make it easy for you. I've eaten better here than I have for a long time; it's good to have real food." We saw that people were offered choices of food at meal times and one person was provided with a salad they chose instead of the hot options on offer. People could choose where to sit and we saw that some people chose to sit outside in the sunshine and eat their lunch. People told us and we saw they were regularly offered and provided with a choice of hot and cold drinks. Soft and pureed diets were presented nicely to ensure they

looked appetising. When people needed support to eat, we saw that staff did not rush them and chatted whilst they supported them. We saw that one person was supported to eat in short intervals by three separate staff. When we looked at the person's care records, we saw there was a 'food and fluid management plan' however it did not clearly detail what level of support the person needed to eat, so we could not be sure they were receiving the support they required. Staff told us that the person's ability to feed themselves varied on a daily basis and they assessed the support required at each meal time. However, this was not clearly documented which meant there may be a risk they did not receive the support the required to eat and drink.

People were supported to maintain good health and had access to healthcare professionals when they needed them. One person said, "They call the GP quickly when needed." We saw that one person complained that their thumb was hurting. A staff member sat with them and spoke to them to understand the problem. They ensured they had some pain relief and said they would arrange for them to see the doctor. People's records showed that they had access to a range of healthcare professionals including GP, district nurses, opticians and occupational therapists.

Staff had completed training to help equip them with the skills and knowledge to support people effectively. One person said, "Yes they [staff] have the right skills but not when they first start, they have to learn." Staff were able to demonstrate how training had helped them to better support the people who used the service. One staff member said, "We've all done all of the training on offer. Some is online and we did manual handling training in person." We observed that staff supported people to move safely, using equipment correctly to effectively support people.

Staff were supported to carry out their roles. They told us they had a thorough induction which included shadowing more experienced staff members and that they had regular supervision and found this useful. A staff member told us, "Supervision is every few months; you can talk about anything that is on your mind. We get feedback, positive and negative and it gives us something to work towards. We are well supported."

Good

Is the service caring?

Our findings

People told us and we saw that staff treated them with kindness and compassion. People's comments included, "I have a really good relationship with the staff, and they make me feel as if I was home. They treat you with respect and when you're old that means a lot" and "We have a laugh and a bit of fun." We saw that staff were caring towards people and showed concern for their wellbeing. For example, one person who had Dementia was worried they had lost their wallet. A staff member sat down with them and said, "You have nothing to worry about, it is safe in your room, shall I show you?" This helped the person to relax and they smiled at the staff member and thanked them. We saw that one person asked a staff member if they could have a hug, the staff member responded, "Of course you can", they hugged the person which made them smile.

People were supported to be involved in choices and decisions about their care. One person said, "They ask, what do you think about that or would you like this?" Another person said, "They give us choices, such as if you don't want to get up yet, they will ask you." We observed that people were given choices about what to eat, where to sit and how to spend their time. One person expressed a wish to share a room with their friend and we saw they had been supported to do this when a double room became available. Staff told us how they encouraged people to make their own choices and decisions. One staff member explained how a person struggled to communicate their choices and they supported them to do this. They said, "I gave the person both drinks to try, I could tell by their face which one they liked. We give everyone the opportunity to make decisions, we don't wade in."

People were supported to have the privacy they needed. One person chose to have a key to their bedroom so they could choose to lock the door when they wanted to have some privacy. There was a small lounge available and we saw that people used this to have private time alone, with relatives or meetings with visiting professionals. People's dignity was respected and they were encouraged to be as independent as they could be. We saw a staff member ask one person, "It's a lovely day, would you like to come for a walk outside, keep your legs moving?" They accepted and we saw the staff member walked and chatted with them in the sunshine before helping them back to their seat. A staff member told us how they supported people to maintain their dignity. They said, "One person we support likes to wear nothing on their bottom half when they are in bed. We always make sure we help them to put their dressing gown on before walking to the shower, it helps to maintain their dignity."

People were happy with the care they received and we observed a relaxed and friendly atmosphere. One person said, "I'm very happy with the care here, I can't ask for more." Another person said, "I'm highly satisfied, it's very, very nice and you're treated nicely." Staff we spoke with were enthusiastic about their role and they told us they were committed to providing a caring service for people. Staff member's comments included, "I enjoy my work, I love the residents, they're brilliant" and "I think it's more like a family unit, the residents always appear happy."

Requires Improvement

Is the service responsive?

Our findings

We found that some people's plans of care were very brief and some did not contain life history information. This meant that staff did not have access to detailed information about the person and the specific care they required to help them provide personalised care. However, staff knew people well and told us they gained information from people or their families and shared information with each other informally to help them meet people's preferences. Plans had been regularly reviewed, however when changes were required the main plan of care was not updated so it was not clear to see the person's up to date needs. For example, at a recent review it was documented that one person sometimes needed encouragement to eat and drink a sufficient amount; however, this was not reflected in their plan of care. This meant that people did not always have detailed plans of care that reflected their needs and may not receive care that reflected their current care needs. A visiting professional said, "Staff are very good at knowing people, they know their history and what they like." Our observations confirmed that staff knew people well; however care plans did not always contain these details which meant that people were at risk of receiving inconsistent care.

People told us they had access to activities that interested them. People's comments included, "Sometimes I go to Tunstall market with staff or a trip to Llandudno", "There's Bingo or trying to bake cakes if you want to, you wouldn't get bored in here" and "My favourite is the quizzes, I'm the one who's always first there, I love them!" We observed staff supporting people to play a game of skittles. People and staff were laughing and cheering together and staff encouraged people who needed extra support to participate. We heard staff encouraging people to take part in activities. We heard a staff member say, "Would you like to play dominoes? Oh go on, let's have a game." The person laughed and joked with the staff and told us they enjoyed the game.

People told us they could spend their time how they chose. One person said, "You can have a lie-in in the mornings if you want to and go to bed when you like." We saw that people were able to access different areas of the home including the garden and their bedrooms whenever they chose to.

People told us they knew how to complain if they needed to. One person said, "I don't think I have one complaint, if I did, I'd speak to [the assistant managers], and if I had any trouble with staff I'd talk to them about it." There was a complaints procedure in place and we saw that all complaints received, including verbal complaints had been logged and dealt with in line with the providers own policy. People felt able to share their experiences, concerns and complaints. One person said, "They listen, they don't just push you off or anything." Another person said, "If you want to talk they listen to you. I've no complaints at all; they've got the patience with everybody."

Requires Improvement

Is the service well-led?

Our findings

We found the provider had not informed us of some important events that had occurred in the home, which is a requirement of registration with us. We had not received any notifications from the home since January 2015. However, the assistant manager told us there had been at least one serious injury and three DoLS authorisations which we should have been informed about. The home's safeguarding log also showed safeguarding incidents that we had not been informed about. This meant the provider was not meeting the requirements of their registration with us by keeping us informed of risks to people. We discussed this with the registered manager who said we should have received notifications but they could not evidence these had been sent to us.

This was a breach of Regulations 16 and 18 of The Care Quality Commission (Registration) Regulations 2009 (Part 4).

People did not know who the registered manager was but they knew the providers and assistant managers. They told us they were approachable and often visible around the home. One person said, "They're approachable, all you've got to do is call them." Another person said, "I think they're very nice, very kind. They always bid you the time of day." We saw that the providers spent time in communal areas chatting to people; they knew them well and talked to them about things they were interested in. Staff felt supported by the management team. A staff member said, "We are well supported, any queries and there is always someone we can go to." The registered manager was also the registered manager at another home and told us they spent one day per week at Goldendale House and that the assistant managers and providers were present more often in the home.

Quality checks were completed by the management team. These included audits of skin condition, fluid balance and nutrition and an analysis of falls and accidents. We saw that these were discussed at weekly management meetings and where concerns were identified, action was taken to improve quality. For example, when an audit identified that a person had lost weight, a referral was made to the person's GP and recording of their diet and fluid was commenced. However, quality assurance systems had not identified all issues identified during the inspection. We found that potential safeguarding incidents had not been reported to the local authority in line with procedures. We also found gaps in recording of topical creams administration and we were told that these records were not included in the regular medicines audits. These issues had not been identified through the quality assurance systems in place and therefore action had not been taken to drive improvement. The registered manager told us that safeguarding incidents would now be included for discussion at weekly management meetings and topical creams charts would be included in medicines audits to ensure these issues would not be missed.

The providers told us they intended to make improvements and updates to the care planning systems used in the home. However, they were also planning to make improvements to the medicines systems and did not want to implement the changes at the same time, as not to overwhelm the staff. This meant that the providers were aware that improvements were required and were taking action to implement improvements, at a pace that staff would be able to manage.

People and staff felt included in the development of the service and supported by the managers and providers. People told us that were asked for their feedback about the service. One person said, "We have meetings, there was one a couple of months ago." As well as these face to face opportunities to express their views, we saw that a comments box was available for people to use and regular surveys were completed. We saw that these were analysed by the registered manager and action was taken was required.

We observed a positive, open culture. People told us, "The atmosphere is good, with the staff you don't get any long faces" and "The home is marvellous, it very nice, very comfortable and everybody at your beck and call."

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 16 Registration Regulations 2009 Notification of death of a person who uses services We were not notified of deaths of service users which occurred whilst services were being provided.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents We were not notified of significant events that occurred at the service including serious injuries, allegations of abuse and authorisations to deprive people of their liberty.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The Mental Capacity Act (2005) had not been followed when people were unable to give informed consent to their care and treatment.

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 Potential safeguarding adults incidents had not been reported to the local authority in line with local safeguarding adults' procedures which meant that suitable investigations could not be

carried out.