B J Poore

Lincoln Lodge Residential Home for the Elderly

Inspection report

2 Lincoln Square, Hunstanton,
Norfolk, PE36 6DL
Tel: 01485 535328
Website: not available

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Ratings

Overall rating for this service	Requires improvement
Is the service safe?	**Requires improvement**
Is the service effective?	**Requires improvement**
Is the service caring?	**Requires improvement**
Is the service responsive?	**Requires improvement**
Is the service well-led?	**Requires improvement**

Overall summary

Lincoln Lodge is a service providing accommodation and personal care for up to 25 people. At the time of our inspection there were 19 people receiving a service. Of these, 16 people were living at the home and three people were staying there for respite care. All bedrooms have wash basins and there were internal communal areas for people and their visitors to use. The provider is also registered to provide personal care to people living in their own homes. This was not being provided at the time of this inspection and was therefore not assessed or reported on.

Our last inspection took place on 30 April 2014 and we found the provider was meeting all the regulations we looked at.

This unannounced inspection took place on 3 September 2015.

The service did not have a registered manager in place. 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

Summary of findings

the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The last registered manager cancelled their registration with the CQC in May 2015. The provider told us they had appointed a new manager who would apply for registration shortly.

The quality assurance system was not always effective and had failed to identify some shortfalls in the service provided.

The CQC monitors the operations of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) which apply to care services. People's rights to make decisions about their care were respected. However, where people did not have the mental capacity to make decisions, processes were not in place to protect them from unlawful restriction and unlawful decision making.

People were not always supported to manage their prescribed medicines safely. People could not be assured they would be kept safe from harm because the provider and staff were not aware of how to report their concerns to the local safeguarding team.

Staff did not always respect people's dignity. People and their relatives had limited opportunities to be involved in the care planning process.

There was a lack of opportunity for people to leave the home and access the local community. There were few organised activities for people to join in and there was limited encouragement for people to maintain or develop hobbies or interests

Some group activities, such as exercise were offered. However, personalised activities that focused on people's interests or hobbies were limited. Opportunities for people to leave the service and access the local community were also very limited.

People received care and support from staff who were kind, thoughtful, friendly and caring. And people's views were listened to and acted on. Staff were well supported by their managers. There were sufficient staff to meet people's assessed needs.

There were systems in place to ensure people's safety was managed effectively. People's health, care and nutritional needs were effectively met and people were provided with a balanced diet.

Care records were detailed and provided staff with sufficient guidance to provide consistent care to each person that met their needs. Changes to people's care was kept under review to ensure the change was effective.

We found a number of breaches of the Health and Social Care Act (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.

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?

Requires improvement

The service was not always safe.

People could not be assured that their medicines were managed safely and as prescribed.

People could not be assured they would be kept safe from harm because the provider and staff were not aware of how to report their concerns to the local safeguarding team.

There were systems in place to ensure people's safety was managed effectively.

There were sufficient staff to ensure people's needs were met safely.

Is the service effective?

Requires improvement

The service was not always effective.

People's rights to make decisions about their care were respected. However, where people did not have the mental capacity to make decisions, processes were not in place to protect people from unlawful restriction and unlawful decision making.

People received care from staff who were well supported. Staff knew the people they cared for well and understood, and met their needs.

People's health and nutritional needs were effectively met. People were provided with a balanced diet and staff monitored people's nutritional needs.

Is the service caring?

Requires improvement

The service was not always caring.

Staff did not always respect people's dignity.

People and their relatives had limited opportunities to be involved in the care planning process.

People received care and support from staff who were kind, thoughtful, friendly and caring.

Is the service responsive?

Requires improvement

The service was not always responsive.

There were limited opportunities for people to access the community and limited encouragement for people to maintain or develop hobbies or interests.

People's views were listened to and acted on.

People's care records were detailed and provided staff with sufficient guidance to provide consistent care to each person.

Summary of findings

Is the service well-led?

The service was not always well led.

The quality assurance system was not always effective.

There were opportunities for people to voice their opinions about the service and these were listened to.

The provider intended improve the premises and had plans in place for development over the next 12 months.

Requires improvement

Lincoln Lodge Residential Home for the Elderly

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This unannounced inspection took place on 3 September 2015 and was undertaken by two inspectors 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.

Before our inspection we looked at all the information we held about the service. This included the provider information return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and any improvements they plan to make.

We looked at other information that we held about the service including notifications. A notification is information about events that the registered persons are required, by law, to tell us about.

We asked for feedback from commissioners of people's care.

During our inspection we spoke with 13 people and six relatives. We also spoke with the provider, the manager, a care co-ordinator, a key worker and a chef who worked at the service. Throughout the inspection we observed how the staff interacted with people who received a service. We received feedback about the service from two visiting health care professionals.

We looked at four people's care records. We also looked at records relating to the management of the service including audits, rotas, meeting minutes and records relating to compliments and complaints.

Requires improvement

Is the service safe?

Our findings

People were not safely supported with their medicines. We looked at three people's medicines administration records (MARs). Records showed that two people's medicines had not been administered in accordance with the prescriber's instructions.

One of these people was prescribed a medicine to be taken "two at night". Records showed these had not been administered for two weeks. Staff told us they thought they were prescribed to be administered "when required". We checked the pharmacy label and hospital discharge letter and found this not to be the case. This meant this person had not received their medicine in line with the prescriber's instruction.

A second person was prescribed a cream to be applied to their body twice each day. For the month of July 2015 this should have been applied on 62 occasions. However, the record for July 2015 showed that the cream had been applied on 14 occasions. Staff were unable to find any records that the cream had been applied from 1 August 2015 until the inspection on 3 September 2015. This meant that we could not be confident this person's medicine had been applied in line with the prescriber's instruction.

This was a breach of Regulation 12(1) and (2)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found the provider had failed to follow local safeguarding procedures in that they investigated a safeguarding concern without reporting it to the local safeguarding team. No information was available for people or visitors to about how to raise a concern if they suspected someone was at risk of harm. Although staff were aware of their responsibilities to external agencies, they were unable to find the correct contact details to make this referral during our inspection.

This is a breach of Regulation 13(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The people we spoke with said that they felt safe at the service. One person told us, "I do feel safe here." Another person told us, "I feel relatively safe with the carers." A relative told us, "My [family member] seems to like it here and we think [my family member] is safe here."

All the staff we spoke with told us they had received safeguarding training. Staff showed a good understanding and knowledge of how to recognise and how to report any concerns to their managers to protect people from harm.

Care and other records showed that assessments of any potential risks to people were carried out. These were to reduce the risk of harm occurring to people, whilst still promoting people's independence. These included risks such as skin care, falls and nutrition. We saw that the actions in these risk assessments were being followed in order to promote people's safety. However, we noted during our inspection one person being transported around the service without footplates on their wheelchair on which to rest their feet. The provider confirmed this was unsafe practice and assured us they would address this with staff.

Staff were aware of and followed the provider's reporting procedures in relation to accidents and incidents. The manager audited incident and accident reports and identified where action was required to reduce the risk of recurrences. For example, reviewing people's risk assessment and care plan after a fall.

The provider and staff considered ways of planning for emergencies. For example, each person had an individual evacuation plan within their care plans. This helped to ensure that appropriate support would be given in the event of an emergency, such as a fire at the service.

People told us that staff always responded when they pressed their call bell. One person said, "Early morning, late at night they're [the staff are] there. They never complain." We saw that a staff member responded quickly when a person we were with inadvertently pressed their call bell. Some people told us they felt the care staff were very busy. One person said, "The [staff] here are really lovely. The staff are always very busy." Another person said, "There were changes in the staff but it is more stable now. They are generally quite nice."

Staff told us, and we found that, they were busy, but that there were sufficient staff to safely meet the needs of the people receiving a service.

The manager told us they did not use any formal tool to measure the level of staff needed at the service. However, they said they used observation and feedback from the people who used the service and staff to assess how many staff were needed throughout the day and night. Rotas

Requires improvement

Is the service safe?

showed that staff on duty matched the numbers the manager described to us. They also showed that shift start and end times overlapped in the morning to provide additional support during breakfast. We noted there was one waking night staff and another member of staff on call, sleeping at the service. Staff told us there were people who used the service who would need two members of staff to move safely. However, they told us these people rarely required assistance during the night. On those occasions when they did, the person on call was woken and assisted the waking member of staff.

We saw the provider had used the disciplinary process effectively when concerns about staff members practice had been raised. The manager told us that new staff were only employed after satisfactory checks about them had been received. These included employer references and a criminal records check. This meant the provider only employed staff who were suitable for the roles for which they were employed.

Staff told us that they had been trained to administer medicines. We saw medicines being administered during our inspection. We observed that staff were respectful of people's dignity and practiced good hygiene. We found that medicines were stored securely and at the correct temperatures. Appropriate arrangements were in place for the recording of medicines received.

Requires improvement

Is the service effective?

Our findings

We saw limited information on how people's capacity was assessed and how people were supported with specific decision making. We found that people may not have been protected from unlawful restriction and unlawful decision making processes. The provider had procedures in place in relation to the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). However, some staff told us they had not received training in this, and we found that staff lacked knowledge in this area. In addition, the manager had not been aware of a ruling by the Supreme Court in March 2014, which may have affected people using the service. Staff told us that they felt it was not safe for one person to leave the service without staff supervision and that they had intervened when the person had attempted to do so. This was recorded in the person's care record. This person had had an authorisation to deprive them of their liberty prior to moving to the service. However, the staff had not considered applying to the local authority to lawfully deprive this person of their liberty when they moved into Lincoln Lodge.

This is a breach of Regulation 13(5) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw that staff were aware of whether people had a "Do not attempt cardio pulmonary resuscitation (DNACPR)" order in place and were clear about the action to take if a person collapsed. These DNACPRs had been completed appropriately and staff were able to find them quickly. Staff were clear that if a person collapsed they would attempt to resuscitate the person unless a DNACPR was in place.

People told us their care needs were met by the staff and that the staff were competent. People's relatives agreed that their family member's care needs were met. One person told us, "The staff generally understand my needs and what I want to keep me happy." Another person told us, "The staff do understand my needs and how to help me."

Staff confirmed that they had undertaken training in a range of topics related to their work they performed. This included moving and handling, fire safety and food hygiene. The manager told us they had organised further training in topics such as end of life care and equality and diversity. The manager told us that most staff had achieved National Vocational Qualifications (NVQ) in care and that one staff member was working towards the Care Certificate.

Staff said they had received regular supervision, which included observation of care practice, and an annual appraisal from a senior member of staff. One member of staff said the managers were "very good. We can talk to them."

People and their relatives spoke very favourably about the quality, quantity and choice of food that was provided. People said they could choose where they sat to eat their meal. One person said, "The food is really good here and it's nice to sit and have lunch together." Another person told us, "[The service provides] very good food. I like my meals in my room because I don't want to mix."

Staff encouraged people to be as independent as possible with their meal, for example cutting up food if the person was not able to do it themselves. Those who needed assistance were given it.

A choice of drinks and snacks was available throughout the day. No special diets were required when we visited, but staff told us these had been provided for people when they required them in the past. Records showed that people's weight was monitored regularly and action taken where concerns were identified. This included increased monitoring and referral to appropriate healthcare professionals such as a dietician or a speech and language therapist. This showed us that people at an increased risk of malnutrition or dehydration were provided with food and drink options which supported their health and well-being.

People told us that their health care needs were met. Visiting healthcare professionals told us, and records confirmed, that people were supported to access the services of a range of healthcare professionals, such as the community nurses and their GP. People's care plans included a 'healthcare passport.' This provided key information about each person's needs to healthcare professionals and helped them to be able to provide appropriate healthcare for each person. This meant that people were supported to maintain good health and well-being.

Requires improvement

Is the service caring?

Our findings

We saw examples of people's dignity not being respected. We saw a chiropodist and a community health care worker treat people in the lounge with other people present. Staff made no effort to offer to assist these people to somewhere more private. Staff did not show respect in the language they used in records. For example, one person's care record referred to them having "a bad attitude" rather than describing the behaviour being exhibited. Whilst in conversation with an inspector a member of staff used unprofessional language to describe a person's lack of continence. In addition we found that the locks on two of the three toilets on the first floor did not work. The manager told us these were repaired the day after our inspection.

People told us that they had not seen their care plan "recently" or could not remember seeing it at all. One relative told us they had been involved in their family member's care plan "at the start" but had not seen it recently. This meant that people were not fully involved in the planning or review of the service they received.

People described the staff as being "kind", "thoughtful" and "friendly". One person said, "The staff are helpful and friendly and nothing is too much trouble." Another person said, "The [staff] here do a lot to make me feel comfortable here." A relative said, "My first impression is that it's very good. The staff are caring and it has a nice atmosphere." A visiting health care professional said staff were courteous and polite.

We observed staff speaking to people in a courteous, polite and friendly manner. However, for most of the inspection staff interactions with people were limited to passing comments unless care was being provided. When care was provided staff were calm and patient in their dealings with people and did not make people feel rushed. For example, when medicines were being given, the member of staff talked with each person and put them at their ease. Staff helped people to feel comfortable. For example, we saw a staff member ask a person if they could help them move closer to the table at lunch time, so they could reach their food more easily. The staff member checked once the person had moved to make sure they were in the correct position and comfortable.

All the staff, and one of the visiting healthcare professionals, told us they would be happy for their family members to be cared for at the service. Care plans contained information about people's preferences and staff were aware of these. A relative told us, "The staff here always smile and use my [family member's] first name."

People and their relatives told us that visitors were encouraged to visit people who used the service. One person told us, "I get lots of visitors and they can come any time they like." Relatives told us the staff kept them informed of any changes in their family member's condition. One relative told us, "The staff are pretty good. They always give me a ring if there is anything [I need to know]."

Staff gave people opportunities to make choices about the way they led their lives. People commented that they got up and went to bed when they wanted to and chose where to spend their time within the service, including at mealtimes.

People told us they felt able to talk to staff about their care needs and said that staff knew their needs well. One person said, "The staff are polite and friendly and know what I like and dislike." Another person said, "The [staff] know me well which helps.]"

Staff were aware of people's religious beliefs and a Christian service was held in the service twice each month. In addition one person received communion monthly from a visiting minister. This information had been incorporated into people's care plans and was taken into consideration when care was delivered.

Requires improvement

Is the service responsive?

Our findings

There was a lack of opportunity for people to access the local community and minimise the risk of them becoming socially isolated. There was limited encouragement for people to maintain or develop hobbies or interests. There were few organised activities for people to join in. People had mixed views about whether there were sufficient activities or things to do to keep them occupied at the service.

Several people told us they would like to go out more. One person said, "We don't get out much even if the weather is good. It would be nice to get out for some fresh air." Another person told us, "I would like to go out but I have to go out with somebody else, [but] the staff are too busy to take us." Staff agreed that this was the case and there was rarely the opportunity to escort people out of the service.

During our visit those people who were sitting in the main lounge watched television during the morning or received visitors. Seven people joined in a group exercise session and activity during the afternoon. Staff told us these were arranged two or three afternoons each week. People told us they enjoyed these organised activities. One person said, "I have had a go at the activities which are fun." Another person told us, "There are not many activities and I spend a lot of time watching television which I don't like." A third person said, "The activities are alright but I would like more because I don't like watching television all day."

Some people told us they preferred to stay in their rooms watching TV, reading or sleeping. One person said, "I prefer to stay in my room. I don't like group activities or mixing with people. I'm not interested in going out, it's too much trouble." Another person told us, "I prefer to stay in my room and I'm not keen to mix. I'm happy just reading or watching the television." Staff respected these people's choices.

Prior to people moving to the service staff received an assessment of people's care needs. These helped to ensure staff could meet people's needs. The assessments were then used to develop care plans and guidance for staff to follow. This included information about people's health needs and how the person preferred their care needs to be met. Care plans were very detailed and included guidance for staff to follow so they could provide care safely and in the way each person preferred. Examples included guidance on assisting people to move, to eat and with skin care. People's care plans were reviewed by a senior member of staff regularly and staff told us people's care plans were accurate and updated promptly.

People and their relatives said that staff understood and met people's care needs. One person told us, "It's lovely here. [The staff] really understand me." Another person told us, "[The staff] understand what I like and what I need."

People and their relatives said that staff listened to them and that they knew who to speak to if they had any concerns. Everyone we spoke with was confident the manager would listen to them and address any issues they raised. One relative said, "We've not made any complaints but they are receptive to change." Staff had a good working understanding of how to refer complaints to senior managers for them to address. We found that complaints were investigated and dealt with appropriately.

Requires improvement

Is the service well-led?

Our findings

We saw that various monthly audits were carried out by members of the senior team and an external consultant. These included audits of care plans, accidents and falls, pressure sores, people's weight and medicines. This had identified errors in the recording and administering of medicines. We saw the manager had taken appropriate steps when errors had been identified. This included notifying the local safeguarding team and CQC. They had also suspended a staff member from administering medicines until they were re-trained. The provider had clear plans to update the premises over the next 12 months. These included modernising the 'tea bar' in the dining room and installing a wet room and sluice room.

However, despite these audits we found shortfalls in the service which had not been identified or action taken to bring about improvement. These shortfalls included, failure to report a safeguarding concern to the local authority and failure to apply to lawfully deprive a person of their liberty. We also identified further concerns about the management of medicines, and a lack of opportunity for people to access the local community and join in organised activities or help them maintain or develop hobbies or interests. This meant the audits were not always effective.

There were opportunities for people to voice their opinions about the service and these were listened to. People and their relatives said they had felt able to voice their opinions to the provider, manager or staff. One person's relative described the service as "being receptive to change." The provider had instigated bi-monthly meetings between a senior member of staff and each person who received a service. The provider told us that this was an opportunity for each person to say what they thought of the service, what they liked about it and what could be improved. The provider went on to tell us how they had listened to what people were telling them and had taken action. For example, several people had said they were not happy about the way a member of staff had treated them. We saw the provider had taken action and used their procedures to bring about improvement. The provider told us they were in the process of sending surveys to staff and the people who used the service to gain additional feedback on the service provided.

The last registered manager cancelled their registration with the CQC in May 2015. The provider told us they had appointed a new manager, who was present for part of this visit. They told us they would apply for registration shortly.

The manager was supported by senior staff, key workers and ancillary staff. We found that the manager and staff had a good understanding of people's care needs. Staff told us they could talk with the managers and that they found them approachable. The provider told us that the senior team met weekly to discuss any issues that had arisen at the service. They told us they were in the process of recruiting more staff. Once fully staffed they planned to re-introduce general staff meetings.

All the staff we spoke with were familiar with the procedures available to report any concerns within the service. They told us that they felt confident about reporting any concerns or poor practice to their manager. They said they felt able to question practice, both formally during supervisions, or more informally. The staff said they enjoyed their jobs and felt supported by senior staff and the manager to meet people's needs.

Records we held about the service, and looked at during our inspection confirmed that notifications had been sent to the Care Quality Commission (CQC) as required. A notification is information about important events that the provider is required by law to notify us about.

The provider and manager confirmed that the regulated activity 'personal care' (providing care to people living in their own homes in the community) was not organised from this service at this time. We therefore did not assess this during our inspection on 3 September 2015. We have asked the provider to consider removing this regulated activity from their registration.

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	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment People could not be assured that their medicines were managed safely and as prescribed. Regulation 12 (1) and (2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 People could not be assured they would be kept safe from harm because the provider and staff were not aware of how to report their concerns to the local safeguarding team. Regulation 13 (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 Where people did not have the mental capacity to make decisions, processes were not in place to protect people from unlawful restriction and unlawful decision making. This was a breach of Regulation 13 (5) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.