Care Quality Commission

Sidney Avenue Lodge Residential Care Home

Sidney Avenue Lodge Residential Care Home

Inspection report

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Ratings

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

Overall summary

We carried out an unannounced comprehensive inspection of this service on 8 July 2014. Several breaches of legal requirements were found. As a result we undertook a focused inspection on 4 November 2014 to follow up on whether action had been taken to deal with the most significant breaches.

You can read a summary of our findings from both inspections below.

Comprehensive Inspection of 8 July 2014

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, and to provide a rating for the service under the Care Act 2014.

This was an unannounced inspection. At the last inspection carried out on 4 March 2014 we found that the

Summary of findings

provider was not meeting the regulation in relation to medicines as there were not appropriate arrangements in place for the safe storage, administration and disposal of medicines. Following the inspection the provider sent us an action plan telling us about the improvements they were going to make. During this inspection we found that the provider had not taken action to address these issues. We have taken action against the provider and issued a warning notice about the unsafe management of medicines.

Sidney Avenue Lodge Residential Care Home provides care and support for eight men who have learning disabilities and also have a mental health diagnosis. There were eight people living at the service at the time of our inspection. It is a family run business and four family members were working at the home, one of whom was the registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service and has the legal responsibility for meeting the requirements of the law; as does the provider.

People were not kept safe at the home. There were poor arrangements for the management of medicines that put people at risk of harm, staff were unable to demonstrate they knew how to identify or respond to abuse and the recruitment checks for new staff were not complete.

We found that there were restrictions imposed on people that did not consider their ability to make individual decisions for themselves as required under the Mental Capacity Act (2005) Code of Practice.

Although people's needs had been assessed and care plans developed these did not always adequately guide staff so that they could meet people's needs effectively. Also, potential health concerns such as significant weight loss were not always identified which could result in people's healthcare needs not being met.

Staff were not provided with sufficient supervision and training to ensure they were able to meet people's needs effectively but they were given an induction to the service so that they knew what people's needs were.

Staff did not always respect people's privacy and standard restrictions were unnecessarily applied to everyone using the service. For example, people were at times restricted from making themselves snacks and drinks which meant their independence was not always promoted.

The provider was not adequately monitoring the quality of the service and therefore not effectively checking the care and welfare of people using the service. In addition to this the provider had failed to provide information requested by the Care Quality Commission about the service.

People told us they were cared for by staff and we saw that people were involved in the recruitment of new staff and planning social events at the home. They told us they enjoyed the food and were supported to maintain relationships with family and friends. We observed caring interactions between staff and people using the service and saw that people were encouraged to access local amenities and take part in leisure activities.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of this report.

Focused inspection of 4 November 2014

After our inspection of 8 July 2014 the provider wrote to us to say what they would do to meet legal requirements for the breaches we found. We undertook this unannounced focused inspection to check that the most significant breaches of legal requirements, concerning the management of medicines, which had resulted in enforcement action, had been addressed. We checked to see that the provider had followed their plan and to confirm that they now met legal requirements. We found that the provider had followed their plan in relation to this regulation. This means legal requirements for the management of medicines had been met.

A system for auditing the management of medicines had been implemented to check whether medicines were being administered safely and as prescribed. Medicines were stored safely. Medicines policies had been updated. A risk assessment was now in place for a person who wanted to self-administer their medicines. Care plans were in place for people prescribed medicines for

Summary of findings

challenging behaviour. Staff managing medicines for people had received medicines training, and staff without recent medicines training did not administer medicines unsupervised.

We found that there were some issues with the recording of medicines. We were provided with evidence following the visit that medicines records were now completed fully and that systems were now in place to manage medicines safely, to protect people using the service against the risks associated with the unsafe use and management of medicines.

We will undertake another unannounced inspection to check on all other outstanding legal breaches identified for this service.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

8 July 2014

The service was not safe. Systems for the management of medicines were unsafe and did not protect people using the service.

Staff recruitment checks were not fully completed and therefore did not protect people from staff unsuitable to work with vulnerable people.

Not all staff had the skills and knowledge to recognise and respond to abuse.

There were enough staff to meet people's needs.

We found that there were restrictions imposed on people that did not consider their ability to make individual decisions for themselves.

4 November 2014

We found that action had been taken to address the most significant concerns about the management of medicines arising from our previous inspection. Appropriate arrangements for the safe management of medicines were now in place.

We will carry out another unannounced inspection to check on all outstanding legal breaches identified under this question.

Is the service effective?

Inadequate

8 July 2014

The service was not always effectively meeting people's needs. Staff did not receive adequate supervision and training and were therefore not always equipped to meet people's needs.

Potential health concerns such as significant weight loss were not always identified which could result in people's healthcare needs not being met.

People were supported to attend routine health checks for their eye, dental and foot care.

People told us they enjoyed the meals prepared at the service and were involved in making decisions about what meals were served.

4 November 2014

This focused inspection was to follow up on whether action had been taken to deal with the most significant breaches found at our previous inspection. Evidence for those breaches did not fall directly under the question of 'Is the service Effective?' and so we did not consider this question.

We will carry out another unannounced inspection to check on all outstanding legal breaches identified under this question.

Summary of findings

Is the service caring?

Requires Improvement 

8 July 2014

People's personal information was not always kept confidential and therefore people's privacy was not always respected.

People told us that staff treated them well and we observed warm and caring interactions between staff and the people using the service.

Steps had been taken to meet people's cultural needs.

4 November 2014

This focused inspection was to follow up on whether action had been taken to deal with the most significant breaches found at our previous inspection. Evidence for those breaches did not fall directly under the question of 'Is the service Caring?' and so we did not consider this question.

We will carry out another unannounced inspection to check on all outstanding legal breaches identified under this question.

Is the service responsive?

Requires Improvement 

8 July 2014

People's rights to make choices and maintain their independence were not promoted as there were restrictions on when people could use the kitchen to prepare snacks and drinks for themselves.

People told us staff listened to any concerns they raised, however, the complaints process was not accessible to people who used service.

Although people's needs had been assessed and care plans developed these did not always adequately guide staff so that they could meet people's needs effectively.

People were involved in some decision making about social events being planned and were asked for their views about new staff.

4 November 2014

This focused inspection was to follow up on whether action had been taken to deal with the most significant breaches found at our previous inspection. Evidence for those breaches did not fall directly under the question of 'Is the service Responsive?' and so we did not consider this question.

We will carry out another unannounced inspection to check on all outstanding legal breaches identified under this question.

Is the service well-led?

Inadequate 

8 July 2014

Summary of findings

The service did not have effective systems in place to ensure it was well led. Although people had been asked for their views about the service and included in the recruitment of new staff, there were no other quality monitoring systems being used to ensure that the service was operating safely and effectively.

In addition to this the service had failed to provide information requested by the Care Quality Commission and had not addressed a previous breach of regulation.

The provider was not considering best practice in relation to meeting the needs of people using the service.

4 November 2014

This focused inspection was to follow up on whether action had been taken to deal with the most significant breaches found at our previous inspection. Evidence for those breaches did not fall directly under the question of 'Is the service Well-Led?' and so we did not consider this question.

We will carry out another unannounced inspection to check on all outstanding legal breaches identified under this question.

Sidney Avenue Lodge Residential Care Home

Detailed findings

Background to this inspection

Background to the inspection:

This inspection report includes the findings of two inspections of Sidney Avenue Lodge Residential Care Home. We carried out both inspections under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The inspections checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, looked at the overall quality of the service, and provided a rating for the service under the Care Act 2014.

The first, a comprehensive inspection of all aspects of the service, was undertaken on 8 July 2014. This inspection identified breaches of regulations.

The second inspection was carried out on 4 November 2014, and focused on following up on action taken in relation to the most significant breaches of legal requirements we found on 8 July 2014. You can find full information about our findings in the detailed findings sections of this report.

Comprehensive inspection

We undertook an unannounced inspection of Sidney Avenue Lodge Residential Care Home on 8 July 2014. The inspection team included an Inspector.

This report was written during the testing phase of our new approach to regulating adult social care services. After this testing phase, inspection of consent to care and treatment, restraint, and practice under the Mental Capacity Act 2005 (MCA) was moved from the key question 'Is the service safe?' to 'Is the service effective?

The ratings for this location were awarded in October 2014. They can be directly compared with any other service we have rated since then, including in relation to consent, restraint, and the MCA under the 'Effective' section. Our written findings in relation to these topics, however, can be read in the 'Is the service safe' sections of this report.

The last inspection of this service took place on 4 March 2014. During this inspection we found that the provider was in breach of the regulation that related to the safe storage, administration and disposal of medicines. The provider sent us an action plan stating what steps they would take to address the issues identified.

An inspector carried out this inspection on the 8 July 2014. Before the inspection we reviewed the information we held about the service and contacted the local safeguarding authority and learning disabilities team. They raised some concerns about the environment, staff training and supporting people's independence.

The provider was sent a Provider Information Return (PIR) to tell us about the operation of the service and how people's needs were met but this was not completed.

We used a number of different methods to help us understand the experiences of people living in the service. We spent time observing care in the communal areas such as the lounge and dining area and two people showed us their bedrooms. We spoke with all eight people who were using the service and interviewed the registered manager, deputy manager, a senior care worker and three other care workers.

We looked at five people's care records and carried out pathway tracking for two people. Pathway tracking is where we look at a person's care plan and check that this is being

Detailed findings

followed and their needs met. We did this by speaking with the person, the staff that cared for them and by looking at other records relating to the management of the home. We looked at three sets of recruitment records, duty rosters, accident and incident records, selected policies and procedures and medicine administration record sheets (MARS).

Following the inspection we spoke with a relative of someone who was using the service to find out about their views of the home and also spoke with local authority representatives.

Focused inspection

We took enforcement action for one of the breaches identified at our inspection on 8 July 2014. This concerned the management of medicines. We carried out an unannounced focused inspection of Sidney Avenue Lodge Residential Care Home on 4 November 2014 to check that improvements required following our enforcement action had been implemented. We inspected the service against part of one of the five questions we ask about services: is the service safe? The inspection was carried out by one pharmacist inspector.

The deputy manager told us that there were eight people using the service at the time of our visit. We did not speak with the people using the service as we focused on the breaches of medicine storage, records and medication staff training. We spoke with the deputy manager and one member of staff. We looked at medicines supplies, medicines storage and medicines records for the eight people currently using the service, along with medicines policies, medicines audits and evidence of medication training for staff.

Is the service safe?

Our findings

Findings from the comprehensive inspection of 8 July 2014

At our inspection in March 2014 we were concerned about the management of medicines in the service. Following the inspection the provider sent us an action plan detailing how they would make improvements. However during this inspection we still found significant problems with the way in which medicines were managed in the home and therefore people were not protected against the risks associated with the unsafe management of medicines.

We saw medicines such as a herbal sleeping remedy and prescribed eye drops stored in an unlocked cupboard in the lounge area. The eye drops container stated that they required refrigeration and expired 28 days after opening, however, no date of opening was recorded. Staff were unaware of the storage requirements for the eye drops and did not know why medicines were stored in the lounge cupboard. They told us that the person using the eye drops had made a choice to keep them in his room and self-administer them but we saw no evidence of a risk assessment to determine he was able to do this safely. Staff also told us that there were no arrangements in place to store medicines that required refrigeration and therefore people were not protected from risks associated with the unsafe storage of medicines.

Other medicines were stored in a locked medicines cabinet. At our last inspection there had been storage of many medicines that were no longer in use. During this inspection we found that some of these medicines had been removed from the home but the record kept for the disposal of medicines was not up to date and did not include these medicines. The deputy manager told us that he had taken these medicines home to count them before returning them to the pharmacy. We noted that the controlled drugs cupboard was labelled 'back up medication' and when we looked inside found a store of medicines that the deputy manager told us were left over and kept in case medicines ran out. This is not safe practice as there were no checks in place to ensure these medicines had not passed their expiry date and it meant that excess medicines were unnecessarily stored at the service. In addition we found out of date eye drops stored in the cabinet that had not been disposed of.

The arrangements for the administration of PRN (when needed) medicines did not protect people from the unnecessary use of medicines for the control of their behaviour. For example, people's care records did not clearly explain when these medicines should be used and did not detail what other action staff should take to try and manage people's behaviour before using these medicines. There was also no evidence of any discussions that had taken place with healthcare professionals to ensure that these medicines were used appropriately. We saw comments in the medicines administration record sheets (MARs) that stated PRN medicines had been administered because someone was "very rude, shouting and swearing" but there was no incident report relating to this or any record of how staff tried to support the person to manage their behaviour before the medicines were administered. Team meeting minutes also stated PRN medicines were to be administered when someone was "disruptive and un co-operative" which again indicated that these medicines were being used excessively to control people's behaviour rather than as a last resort.

Staff had not received adequate training to ensure the safe management of medicines. Four of the eight staff responsible for administering medicines had received safe handling of medicines training in 2012, the other four staff had not received any training since working at the service. Therefore the provider had not ensured that all staff responsible for administering medicines were equipped with the skills and knowledge to ensure people were protected from the risk of the unsafe administration of medicines. Staff told us that they were not permitted to administer medicines alone until they had attended training. However, during our inspection we observed a member of staff who had not received medicines training administering medicines to people unsupervised.

The home did not have a policy in place for the use of over the counter medicines. However, medicines such as herbal sleeping remedies were being administered to people using the service. The deputy manager said that the use of these medicines had been agreed for one person in consultation with healthcare professionals. However, he also told us that these medicines were used for anyone who wanted to take them and there was no evidence in people's care records that the appropriate use of these medicines had been discussed and agreed in consultation with their GPs to ensure it was safe for them to take them when other prescribed medicines were taken.

Is the service safe?

The deputy manager told us that no systems had been implemented for auditing the safe management of medicines in the service. He told us that a local authority was carrying out a medicines audit on 10 July 2014 after concerns had been raised about a medicines error at the service. This meant that there were inadequate systems for monitoring the safe management of medicines. All of the above information relates to a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. As we have identified a continued breach of regulation we will make sure action is taken. We will report on this when it is complete.

Staff recruitment practices at the home did not protect people from staff unsuitable to work with vulnerable people. We looked at recruitment records and found that inadequate checks had been completed. For example, there were gaps in employment history that had not been explored with staff and there were no references or proof of identification in two of the three recruitment files we looked at. This is a breach of Regulation 21(a) and (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Two staff said they had not yet had safeguarding training and training records confirmed that the rest of the staff team had not had safeguarding training since 2011. One member of staff was unable to demonstrate that they knew what action to take or who to report safeguarding concerns to in order to protect people. In the records for a team meeting we saw reference to a person making repeated comments about people hitting them which was detailed as a behaviour that challenged the service. In the meeting minutes staff had been advised not to believe these comments. This did not promote good practice in relation to listening to concerns raised by people using the service. This is a breach of Regulation 11(1)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People told us that there were always enough staff to help them. We looked at the staff rotas covering a period of three weeks and saw that there were a minimum of three staff on duty in the morning and evening which were the busier periods of the day. We found that staffing numbers were flexible to support people to attend appointments.

Staff told us that one person worked at night and 'slept in'. However, they said that they were often disturbed during the night and also had to get up at regular intervals to support people with personal care. We noted that there were occasions especially at weekends where people worked a shift either before or after working at night. This meant that staff would not always get sufficient rest to ensure they were able to safely respond to people's needs.

We found that there were restrictions imposed on people that did not consider their ability to make individual decisions for themselves as required under the Mental Capacity Act (2005) Code of Practice. For example, a decision had been made to lock the kitchen at night without considering what was in the best interests of everyone using the service. Before our inspection a local authority representative had also raised concerns about the service as they felt a person was being restricted from managing their own money without consideration of their capacity to do so. We discussed this with the provider during our inspection who told us that a 'best interests' meeting had been arranged with staff from the home and health and social care professionals to discuss this person's capacity to manage their own money. Staff had not received training about the Mental Capacity Act (2005) or DoLS. This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Identified risks had been assessed for individuals and management plans developed to minimise these and protect people from harm. We saw risk assessments relating to issues such as medical conditions, road safety, healthy eating and smoking. People told us they felt safe.

There was a business continuity plan in place for foreseeable emergencies such as fire, flood and power failure so that staff knew what action to take to protect people in these circumstances.

Findings from the focused inspection of 4 November 2014

At this inspection we looked at the actions taken by the provider in respect of the breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. We will follow up the breaches found under other regulations at the previous inspection at a later date.

We found that the provider had followed the action plan they had sent us to meet the shortfalls in relation to the requirements of regulation 13 we found previously, as described above.

Is the service safe?

All of the medicines prescribed for people were available at the service, and were now stored securely. The temperature of the medicines storage area was monitored daily and records were kept of this, showing that medicines were stored at the correct temperatures to remain fit for use. A medicines refrigerator had been obtained for the storage of medicines requiring refrigeration. There were no expired or excess medicines stored at the service. A risk assessment had been completed for a person who had requested to store and administer some of their medicines, to identify the risks and the support needed to help this person to do this safely. This meant that arrangements were now in place to protect people against the unsafe storage of medicines and to support people to manage their own medicines safely.

The medicines policy had been updated, and there were now policies in place for over-the-counter remedies and how to deal with medicines errors. There was a form in place for each person, signed by their GP, confirming which over-the-counter remedies were safe to use. We saw that there had been a medicines error at the service in November 2014. The deputy manager, who was also the responsible individual for the service, provided evidence that they had completed an incident form. They had taken corrective action by seeking medical advice to ensure that the person was safe and their health had not been compromised. This incident highlighted further training needs related to the supply of leave medicines. This is the supply of medicines when people are away from the service. We were given evidence that the new process for leave medicines had been put in place.

At our last inspection, we noted an issue with the timing of one person's antipsychotic medicine. We saw evidence that the provider had contacted this person's relevant health professional to confirm the timing, and we saw from records that this medicine was now being administered at the correct time. An appointment had been made with the GP to clarify the use of when needed (PRN) medicines for challenging behaviour. Care plans were now in place for people prescribed these medicines. We saw that these medicines were not being used excessively to control people's behaviour.

The service was now carrying out regular medicines audits. We looked at the audit reports from 30 August 2014, 15 September 2014 and 16 October 2014 and saw that these were thorough and had identified issues with medicines management. Following on from these audits, the provider had recognised that they needed support with the management of medicines, and had commissioned an external company to help make the necessary improvements. This company had completed two medicines audits and provided advice and medicines training for staff. This meant that there were now adequate systems in place to monitor the management of medicines.

There were seven members of staff on the list to administer medicines. We saw that four of these had received recent training in 2014. We saw evidence that the remaining staff were enrolled on medicines training. The deputy manager supplied written confirmation that these members of staff had only administered medicines under the supervision of trained staff. They were in the process of completing medicines competency assessments for staff and understood that medicines could only be administered by staff who were adequately training and competent. This means that arrangements were now in place to equip staff with the skills to manage medicines safely. Therefore we saw that the issues we found at the last inspection had been addressed.

People received their medicines as prescribed. However, we found there were some issues with the recording of medicines. The medicines administration records (MAR) did not list people's allergies or their PRN medicines. The deputy manager told us that nobody at the service had any allergies to medicines and they showed us evidence they had sought and been advised incorrectly not to make hand written entries on the MARs. The deputy manager provided evidence following the inspection that they had amended the MARs to include people's allergy status and the PRN medicines that people were prescribed so that the service held accurate medicines records to reduce the likelihood of any errors. Systems for the safe management of medicines were now in place to protect people using the service against the risks associated with the unsafe use and management of medicines.

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 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 21 HSCA 2008 (Regulated Activities) Regulations 2010 Requirements relating to workers **8 July 2014** The registered person was not operating effective recruitment procedures as they did not ensure all information specified in Schedule 3 was available. Regulation 21(a) and (b). **4 November 2014** We will undertake another unannounced inspection to check on this legal breach.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse **8 July 2014** The registered person had not made suitable arrangements to ensure service users were safeguarded against the risk of abuse. Regulation 11(1)(a)(b). **4 November 2014** We will undertake another unannounced inspection to check on this legal breach.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment **8 July 2014**

This section is primarily information for the provider

Action we have told the provider to take

The registered person did not have suitable arrangements in place for obtaining, and acting in accordance with, the consent of service users in relation to the care and treatment provided for them. Regulation 18.

4 November 2014

We will undertake another unannounced inspection to check on this legal breach.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff **8 July 2014** The registered person did not have suitable arrangements in place to ensure that persons employed for the purposes of carrying on the regulated activity received adequate training. Regulation 23(1)(a). **4 November 2014** We will undertake another unannounced inspection to check on this legal breach.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services **8 July 2014** The registered person had not taken proper steps to ensure that each service user was protected against the risks of receiving unsafe or inappropriate care as they had not taken action to ensure the welfare and safety of service users. Regulation 9(1)(b)(ii). **4 November 2014** We will undertake another unannounced inspection to check on this legal breach.

Regulated activity	Regulation

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services **8 July 2014** The registered person had not made suitable arrangements to ensure the privacy and independence of service users. Regulation 17(1)(a). **4 November 2014** We will undertake another unannounced inspection to check on this legal breach.
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers **16 April 2014** People who use services were not protected from unsafe or inappropriate care as the registered person did not regularly assess and monitor the quality of services provided. Regulation 10(1)(a). **4 November 2014** We will undertake another unannounced inspection to check on this legal breach.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines **8 July 2014** The registered person was not protecting service users against the risks associated with the unsafe use and management of medicines. Regulation 13 **4 November 2014** The provider is now meeting this regulation.