Mrs A Kelly & Mr A Kelly

Lancaster House

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

We carried out an unannounced inspection of Lancaster House on 25 and 27 January 2017.

Lancaster House is a care home providing personal care and accommodation for up to 13 adults with a mental health need. The home is a large semi-detached house and is situated on the main bus routes close to a busy slip road leading off Eccles Old Road onto the A6. The driveway and back garden are shared with the house next door, Cairn House, which is also a care home owned by the same provider.

The home was last inspected on 03 May 2016, when we rated the service as 'requires improvement' overall. We also identified three breaches of the regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These were in relation to ensuring premises and equipment was properly maintained, ensuring staff received appropriate support and professional development and good governance. We asked the provider to take action to improve the overall standard of the premises, ensure quality assurance and auditing systems were in place and being utilised and staff received the necessary support and professional development to enable them to carry out their roles effectively.

At this inspection we identified 10 breaches in seven of the regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, including continuing breaches relating to premises and equipment, staffing and good governance along with additional breaches relating to safe care and treatment, management of medicines, safeguarding people from abuse or improper practice, person-centred care and receiving and acting on complaints. We are currently considering our enforcement options.

At the time of the inspection the home 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.

The service was not being cleaned effectively, with areas of dust, cobwebs and other stains noted during a walk round of the premises. Infection control processes were also absent, especially in relation to hand hygiene practices, with no guidance available and cotton hand towels, rather than paper towels being provided in all bathrooms and toilets. The service employed a cleaner, however they were currently suspended resulting in care staff being responsible for these tasks. Cleaning equipment was stored safely and securely and Control of Substances Hazardous to Health (COSHH) forms were in place for the cleaning products in use.

We identified on-going issues with the overall décor and maintenance of the property. We saw broken or damaged fixtures and fittings, including bath panels and shower curtains, with no record that these had been noted by the service. Paintwork in a number of areas was worn, cracked or flaking away, the majority of the carpets throughout the service were old and stained and in some places had completely worn through. Most of the communal areas were also cluttered, with a variety of items such as boxes and step

ladders left lying around. The registered manager stated this was due to a lack of storage and all bedrooms being occupied.

Our review of medicines management highlighted a controlled drug was not being stored correctly. We also noted the service did not use 'as required' medicine protocols or topical medicine charts and the system in place for documenting medicines received and in use, made it difficult to ensure stock levels were correct. We did see that the Medicine Administration Record (MAR) chart was being filled in correctly and robust systems were in place to ensure staff knew what medicines people took and at what time.

People we spoke with told us they felt safe. The home had safeguarding policies and procedures in place, with all referrals being stored electronically. Staff had been trained in safeguarding vulnerable adults and had knowledge of how to identify and report any safeguarding or whistleblowing concerns.

People who used the service and staff we spoke with said there was enough staff employed to meet people's needs. The service encouraged people to retain their independence and they were free to come and go as they wished, with staff there to provide support and assistance when required or requested.

We looked at four care files in detail, each contained detailed personalised information about the people who used the service, their background and life history. Care files were stored electronically and covered a range of areas including care plans and risk assessments. However we saw there were a number of gaps in people's records, with care plans being started but left unfinished, no risk management plans in place for behaviours or situations which were documented as being a potential hazard. Records of medical appointments attended or the involvement of professionals were also inconsistent.

We found the service was not working within the principles of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). Training in both areas had yet to be facilitated, despite being identified as an issue at the previous inspection in May 2016. As a result staff knowledge around capacity, restrictive practice and best interest decision making was variable.

Staff told us training at the service required improvement. The training matrix identified that since the last inspection in May 2016, only one training session had been completed in first aid. We saw that aside from this session and training in safeguarding completed in April 2016, most people had not completed any additional training since their induction, in some cases this was over five years ago. Despite the service providing support to people with a mental health diagnosis, only two people had completed any training in this area.

The supervision policy stated staff would receive supervision on a bi-monthly basis, however our review of staff records demonstrated this was not being done. Most people had only completed one meeting in the last year and one staff member had not had a meeting since 2013.

People told us they enjoyed the food provided by the service and received enough to eat and drink. People could choose when and where to eat, with provision being made in the way of a packed lunch or monies being given to people who would be out during meal time.

Throughout the inspection we observed positive and appropriate interactions between the staff and people who used the service. Staff were seen to be patient, caring and treated people with dignity and respect. People who used the service were complimentary about the staff and the standard of care received.

Complaints were documented in people's electronic care files, however a centralised log of complaints

received was not in place, nor did the service have specific complaints forms which were accessible to people using the service. We also noted the complaints procedure was not displayed anywhere in the service.

The service advertised in its literature that people would be consulted about the service through regular resident meetings; however we saw that none had taken place for some time. We also saw that staff meetings were not being held. Staff told us the need for these meetings had been discussed, but had not been arranged.

The service did complete annual quality assurance questionnaires with people using the service, relatives and professionals. People we spoke with told us they liked having their say and found the forms easy to complete.

The service did not currently use any systems or procedures to monitor the safety, quality and effectiveness of the service. The registered manager told us the only audit currently being carried out was in regards to medication, and we saw this just involved a stock count, rather than an audit of the entire process. Documentation was in place, including a comprehensive audit document, however this was reported as being too complicated to use and a revised version had yet to be drawn up. Neither fire nor environmental risk assessments were in place, although regular checks of fire equipment and fire drills had been completed.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

The building in many places was not well maintained. Much of the décor, carpets, fixtures and fittings throughout required replacement, repair or re-decoration.

Appropriate infection control procedures were not in place, especially in regards to hand hygiene practices and equipment.

A controlled drug was not being stored as per legal requirements.

Risk assessments were not being completed fully and in some cases not at all, in order to minimise the risks to people who used the service

Is the service effective?

Requires Improvement

Not all aspects of the service were effective.

The service was not adhering to the principles of the Mental Capacity Act 2005, with restrictive practices in place for one person using the service, without the necessary procedures and documentation being completed.

Training and supervision were not completed regularly to ensure staff received the appropriate amount of support and personal development.

People enjoyed the meals provided and reported getting enough to eat and drink.

People were supported to stay well through involvement of a multidisciplinary team and annual health checks with their GP.

Is the service caring?

Good

The service was caring.

People using the service were positive about the care and support provided, telling us that staff were kind, respectful and treated them with dignity.

Throughout the inspection we observed positive interactions between staff and people using the service.

Staff had a good understanding of the people they cared for and were actively involved in promoting people's independence.

Is the service responsive?

Requires Improvement

Not all aspects of the service were responsive.

Care files contained personalised information about people including their background and life history, which ensured care provided was person-centred.

Care plans and other documentation was not completed fully or consistently, meaning that contemporaneous records were not being kept.

The service did not have an effective system for managing complaints, with no policy or guidance displayed or option for people to complete complaint forms anonymously.

Is the service well-led?

Inadequate

The service was not well-led.

No audits and monitoring tools were in place to assess the safety, quality and effectiveness of the service.

Meetings with both the staff and people using the service were not completed, which impacted on the dissemination of information.

Policies and procedures were out of date, with no robust system in place for reviewing these. This meant that staff would be unaware of changes to legislation, procedure and best practice.

Annual questionnaires were given to people, relatives and professionals to request feedback on the service.

Lancaster 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 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.

The inspection took place on 25 and 27 January 2017 and was unannounced.

The inspection team consisted of two adult social care inspectors from the Care Quality Commission (CQC).

Before commencing the inspection we looked at any information we held about the service. This included any notifications that had been received. A notification must be sent to the Care Quality Commission every time a significant incident has taken place, for example where a person who uses the service experiences a serious injury. We checked any complaints, whistleblowing or safeguarding information sent to CQC. We also contacted the local authority to request any information they had about the service.

The provider had completed a Provider Information Return (PIR) prior to the last inspection in May 2016. A PIR is a form which asks the provider to give some key information about the service, what the service does well and improvements they plan to make. A further PIR was not requested prior to this inspection.

During the course of the inspection we spoke to the registered manager and two staff members. We also spoke to four people who lived at the home.

We looked around the home, including communal areas and people's bedrooms. We viewed a variety of documentation and records. This included three staff files, four care plans, Medication Administration Record (MAR) charts, policies and procedures and audit documentation.

Inadequate

Is the service safe?

Our findings

We checked the progress the provider had made following our inspection on 03 May 2016 when we identified a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, in relation to premises and equipment. This was because the service had failed to ensure the premises and equipment were properly maintained.

At this comprehensive inspection a review of the premises was completed including all communal areas, all bathrooms and toilets and three people's bedrooms. Although we saw some remedial work had been carried out, including repairing the roof and the re-plastering and decorating of some damp affected walls, we identified ongoing issues with the overall cleanliness, décor and maintenance of the property.

In both lounges we found thick areas of dust on fixtures and fittings, with stains on some of the furniture. Carpets throughout the home were worn and stained and in some areas had actually worn through completely. Each of the bathrooms and toilets we viewed contained a number of issues including a cracked cistern, cracked bath panel, damp patches on the wall, cracked and peeling wallpaper, broken shower curtains and flaking paintwork on window frames. Areas harder to reach such as skirting boards, light fittings and ceilings were covered in dust and cobwebs.

Throughout the home we identified areas were either wallpaper or plaster was cracked and coming away from the wall, paintwork which was grimy and worn and thick layers of dust on furniture, lampshades and other fixtures and fittings. We also observed that communal areas appeared cluttered due to a number of items being left lying around such as boxes, step-ladders and old furniture.

We asked the registered manager if the home had a schedule of works or a maintenance plan in place to ensure the property was kept up to required standards. We were told that neither of these were in place. We completed a walk round of the home with the registered manager, highlighting the issues that we had identified. The registered manager told us they were "embarrassed" by the state of the property and that all areas needed decorating and all carpets replacing.

We looked at the procedures in place to ensure the premises were kept clean. The registered manager told us they employed a cleaner, who worked 16 hours per week. However the cleaner was not currently working at the service and as a result staff were carrying out all cleaning duties. Despite cleaning checklists being in place, this had impacted on the thoroughness with which this was being completed.

This is a continued breach of Regulation 15 (1) (a)(c)(e)of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, in relation to premises and equipment, because the service had failed to ensure the premises and equipment were properly maintained.

As part of the inspection we looked at the systems in place to ensure safe infection control practices were maintained. We saw bathrooms and toilets contained cotton hand towels, usually hung on the back of the door and bottles of hand wash located on the sink. We saw there was no hand hygiene guidance in place.

Both Department of Health and The National Institute for Health and Care Excellence (NICE) guidelines for the prevention and control of infection in care homes, state that providers should 'educate residents and carers about the benefits of effective hand hygiene; the correct techniques and timing of hand hygiene; when it is appropriate to use liquid soap and water or hand rub and the availability of hand hygiene facilities'. Hand hygiene facilities should include as a minimum, disposable paper towels and wall mounted liquid soap dispensers. Top up/refillable dispensers and hand towels should not be used as these pose a risk of contamination and cause the spread of infection.

We spoke to the registered manager about hand hygiene requirements in care homes, however they were unaware that the current systems in place were contrary to these, or that pictorial hand hygiene guides should be in place in all bathrooms and toilets.

This is a breach of Regulation 12(2)(h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, in relation to safe care and treatment, because the service did not assess the risk of, or control the spread of infections.

We asked both people using the service and staff working there for their views on staffing levels. One person told us, "Plenty of staff around, no worries with this." A staff member said, "Staffing levels seem fine, well until someone phones in sick." Another told us, "We have had a few staff leave recently but existing staff fill in the gaps until more people are recruited."

We asked the registered manager what contingencies were in place to cover staff absence or sickness. They told us, "I come out of here (office) and go on the floor, [owner] is also on hand should we need them."

We found there was not a clear approach to determining staffing requirements based on people's needs. People's dependency had been assessed in their care file, but there was no overview of dependency levels to determine staffing levels. We asked the registered manager about this who told us, "There is no tool in place, we decide staffing levels by what we observe and the support people need during the day."

We looked at the number of staff on shift during the day and night. Between 8.00am and 5.30pm three staff were on duty, one staff member worked 3.00pm until 10.00pm and another worked from 10.00pm until 8.00am. Unless required to cover for sickness or absence, the registered manager was supernumery to these figures. All people using the service were able to access the community independently and those we spoke with reported requiring very little support from staff during the day.

We asked people who used the service if they felt safe living at Lancaster House. One person said, "I feel safe here, the house is secured in the evening and staff check the windows." Another told us, "Yes, I do. Been here for years, they're not a bad bunch." However a third said, "I am not happy here, the other housemates are not nice to me." We observed this person over both days of the inspection and did not see any evidence of this.

We looked at the home's safeguarding systems and procedures. The home had a dedicated safeguarding file, however this just contained general information about safeguarding along with the reporting procedure. The registered manager told us that all referrals were stored electronically. We looked on the computer and saw that a colour coded system was used to 'flag' any safeguarding referrals that had been emailed to the local authority. However the service did not have a matrix or other system in place to document progress or outcomes of the referrals. We found there had been no referrals since the last inspection in May 2016.

The staff we spoke to confirmed they had received training in this area, which had been refreshed in April 2016. The staff demonstrated a reasonable understanding of what to look out for and how to report concerns. One staff member told us, "Safeguarding is about ensuring a safe environment. If I saw something I didn't like I would escalate to either management or the commission."

We reviewed three staff files to check if safe recruitment procedures were in place and saw evidence that Disclosure and Baring Service (DBS) check information had been sought for all staff and was logged on each file. Staff also had a completed application form, at least two references as well as a full work or educational history documented. A DBS check helps a service to ensure the applicant's suitability to work with vulnerable people.

We looked at how accidents were managed at the home. An accident file was in place, which contained an accident book and some basic guidance. Accidents were recorded in the accident book with the completed sheet stored in either the staff members personnel file or the 'non-working' file of the person using the service, this file was used to store miscellaneous information about the person, due to the service having electronic care files in place. There was no incident log in place within the accident file, which meant it was not possible to determine when or to whom accidents had occurred.

People's care files contained a risk management section, which was used to detail any risks, the level of risk using a scale of low, medium and high along with a management plan to minimise or mitigate the risk. Of the four care files looked at we noted that three people's risk sections had not been completed properly. One person's risks section was completely blank despite taking a medicine which can be toxic and also having other medical diagnoses which could present risks to themselves or others. Another person was reported to us as being at risk due to excessive smoking and consumption of fluids, however this was not mentioned in their risk management section. A third person was at risk of falls, due to a medical condition and especially after alcohol. According to their records the risk assessment was last reviewed in March 2016.

We looked at the home's safety documentation, to ensure the property was appropriately maintained and safe for residents. Gas and electricity safety certificates were in place and up to date. Call points, emergency lighting and fire doors were all checked regularly to ensure they were in working order. However when reviewing the fire file we saw neither fire risk assessments nor personal emergency evacuation plans (PEEPs) were in place, which would provide guidance on support people may require to respond to an emergency. A fire hazard list was present, which covered potential risks and how to reduce these, however this had not been updated since 2010.

During our inspection of the premises we also noted a bath lift was in place in one of the bathrooms. The Lifting Operations and Lifting Equipment Regulations 1998 (LOLER), place duties on people and companies who own, operate or have control over lifting equipment. Any equipment used for lifting should be fit for purpose, suitably marked and be subject to statutory checks, with records kept of all examinations and any defects found. As the bath lift can also be classed as work equipment, it also falls under the Provision and Use of Work Equipment Regulations 1998 (PUWER), which has its own guidance on the safety and operational procedures that need to be in place. We spoke to the registered manager who was unaware of either LOLER or PUWER regulations and confirmed that the bath lift had never been checked, however the owner had showed staff how to use it. They added that only one person used this currently who was able to operate it themselves.

This is a breach of Regulation 12(2)(a)(b)(e) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, in relation to safe care and treatment, because the service did not assess the risks to the health and safety of service users, review these regularly and ensure they complied with statutory

requirements or national guidance.

As part of the inspection we checked to see whether the service managed and administered medicines safely. We viewed three MAR charts and saw that all prescribed medication had been administered and signed off correctly. We saw a specimen signature chart was in place and this tallied with the staff signatures on the MAR charts. The service had what they called a 'ready reckoner' sheet in place, which was a visual aid to help staff identify whether medicines were stored in a blister pack or box and the time of administration. All MAR charts contained a photograph of the person along with details of what medicines they took, when and how these were stored.

The home did not have 'when required' medicines (PRN) protocols in place. These are used to inform staff what a medicine is for, the required dose, how often it can be administered, the time needed between doses, if the person is able to tell staff they need it and if not what signs staff need to look for. This ensures 'as required' medicines are being administered safely and appropriately. The registered manager told us that as all people using the service had capacity and were able to communicate their wishes, these were not required.

The service had a system in place for recording when medicines were received on site and when they were issued to the medicine cabinet. However the system did not include documenting the amount of each medicine remaining when new medicines were added. We attempted stock checks of three people's medicines, but due to not having an accurate record of how much of each medicine should be in the cupboard, we were unable to confirm the correct amount were remaining.

Some prescription medicines contain drugs that are controlled under the Misuse of Drugs legislation. These medicines are called controlled drugs (CD). When reviewing the MAR charts we saw that one person was prescribed a Schedule 3 controlled drug, which should be stored in a CD cupboard, separate to the main medicine cabinet. Despite having guidance on file relating to the management of CD's, the service did not have a CD cupboard in place and was storing this drug with the rest of that person's medicines.

A medicine fridge was in place although at the time of inspection was unplugged. The fridge was only used once a month to store eye drops, which needed to be kept between 2°C and 8°C until opened. Fridge temperature monitoring was in place however this showed that whilst in use it had regularly exceeded the required temperature level.

None of the creams or topical medicines in use had a date of opening recorded on them and we saw that cream charts were not in place to record where these had been applied. We were told this was because people applied them themselves.

We saw the medicines policies and procedures in place were out of date, the policy was dated 2010 and the guidance on file was from 2003. Records showed that whilst all staff authorised to give medicines had completed training in this area and had their competency assessed, this had only been done when they commenced employment and had not been refreshed.

This is a breach of Regulation 12(2)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, in relation to safe care and treatment, as the service did not ensure the proper and safe management of medicines.

Requires Improvement

Is the service effective?

Our findings

As part of this inspection we checked the progress the service had made following our inspection in May 2016, when we found a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, in relation to staffing, because the provider could not demonstrate staff had received the appropriate support and professional development.

We asked the registered manager about the procedure for completing staff supervision. They told us, "These are every three to four months and are done by the senior. I used to do them but don't anymore. The completed sheets are kept in the staff files." The home's supervision policy stated supervision should be completed every other month, which was contrary to the information given by the registered manager. We looked at supervision documentation in three staff files and saw that one staff member had attended two meetings in the last 12 months, another had only attended one meeting during the same period, whilst the third had not had a supervision meeting since September 2013. The senior responsible for completing supervision meetings confirmed they had not been done as required stating, "My supervisions are not up to date." This meant staff had not received a regular opportunity to formally discuss their roles, receive feedback on their performance and request additional support or guidance.

The registered manager told us that since the last inspection all staff had completed first aid training. We looked at the training matrix and noted that aside from the first aid training which had been completed in August 2016 and safeguarding training held in April 2016, most staff working at the service had not completed any training since their initial induction. This meant some staff had not had their knowledge and learning refreshed for over five years. As the service caters for people with mental health needs, we looked to see how many people had received training in mental health awareness. Of the twelve staff on the matrix, only two had done so, one of whom was in 2002. This meant staff had not received training necessary and appropriate to their roles..

We asked staff for their views on the training provided at the service. One told us, "I don't feel we get a lot of training. In my previous job, I had lots of training. I have done medicines, safeguarding, first aid, fire safety and catering whilst I have been here, can't really think of any others." Another said, "I have had medicines training and first aid. To be honest we don't get enough training. I think we need more specialists training like mental health awareness and person centred practice."

This is a continued breach of Regulation 18 (2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, in relation to staffing, because the provider could not demonstrate staff had received the appropriate support, training and professional development to enable them to carry out their duties.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as

possible.

People can only be deprived of their liberty 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 are called the Deprivation of Liberty Safeguards (DoLS).We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met.

The registered manager told us there were no restrictive practices in place and everyone was free to come and go, as a result no DoLS were required. However during a conversation with one person using the service, they told us, "I can only have a cigarette every hour and a cup of tea every two hours." We spoke to staff about what had been said who confirmed this was correct. We were told this programme had been in place at the person's previous placement, before they came to Lancaster House and so they had just carried it on. We were also told that upon admission the person had requested the programme continue to help them manage their cigarettes and drink intake. We looked at this person's care file and could not find any information about such discussions, any assessments or documentation regarding the restrictive practice or completed capacity assessments to indicate the person did not have the capacity to manage their cigarette or fluid intake.

Staff we spoke with told us they had not received any training in the MCA or DoLS, and the matrix showed that only six staff had ever done so, four of whom had completed it in 2010 and so were out of date with current practice. We spoke to the senior and registered manager about this person's programme and the fact that as people are deemed to have capacity until proven otherwise, regardless of what the person may have said upon admission, they have a legal right to have a cigarette and drink whenever they request one. The registered manager said they would ensure all staff were informed the current programme was no longer in place from that point onwards, they would still hold the person's cigarettes, as this is something they had aksed for, but would provide one whenever asked. The registered manager also showed us an email which evidenced MCA/DoLS training had been sourced externally, which the service was looking at facilitating.

This is a breach on Regulation 13(4)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, in relation to safeguarding service users from abuse and improper treatment, as the service did not monitor or review the approach to, or use of, restrictive practice or act in accordance to the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.

People using the service told us they enjoyed the food and got enough to eat and drink. One person said, "Meals are good, had chicken curry and chips yesterday, it was really tasty." Another told us, "There is always nice food. I have a kettle in my room and my own tea and coffee, so can make a drink whenever I want one." A third stated, "The food is good. I can make my own snacks and have a drink whenever I like."

At the time of the inspection no one using the service required a special diet. One person had requested a 'healthy' diet, details of which were located in the kitchen. We saw meals were prepared by members of staff, all of whom had completed food hygiene and 'food for better business' training. A six weekly menu was in place, with an alternative choice available each day in case people did not like the option provided.

Individual food and fluid monitoring was not in place, however a record of the choices people had made was recorded within a notebook, set aside for this purpose. Meal information was also documented in the diary, which was used to record a range of daily information.

Prior to meals being served, dining tables were set out with a table cloth, placements and cutlery along with a jug of cordial. We noted that people were able to eat where and when they wanted to. Prior to lunch being served on the second day of inspection, one person said they were not hungry and would eat later. Staff agreed to keep food to one side, for when the person wanted it.

Our review of people's care records showed the service worked with other professionals and agencies to meet people's health needs, these included general practitioners (GPs), district nurses and podiatrists. Any involvement or appointments were recorded in the multidisciplinary section of the care plan. People we spoke with told us they received help and support to stay well, with one stating, "If I did not feel well I go and see my doctor. I know staff would help me with that if I asked."

We looked at how the home sought consent from people who lived there. Despite everyone being deemed to have capacity and therefore able to consent to their own care and treatment, we saw no signed consent forms within the care files we viewed. However people we spoke with told us they were happy to be at Lancaster House and welcomed the support received. During the inspection we saw staff seeking verbal consent from people before providing care and support.

Good

Is the service caring?

Our findings

All the people we spoke with told us they found the staff to be kind and caring. One person said, "Staff are kind to me and always listen." Another told us, "The staff are not a bad bunch." A third said, "This is my home, I love living here."

We asked people using the service if staff treated them with dignity and respect. All but one confirmed they did. One person told us, "I feel I am spoiled, I get looked after very well." Another said, "I feel staff listen to me, they will sit down with me and have a chat." A third stated, "Staff are very respectful." Whereas a fourth person told us, "Staff sometimes moan at me. Other people living here are not nice to me but staff just turn a blind eye." Over both days of the inspection we saw this person happily chatting to other people and did not witness any inappropriate interactions.

Over the course of the inspection we spent time observing the care and support provided. We saw staff interaction with people was warm and friendly, and it was apparent staff knew each person well. Staff demonstrated patience and understanding, especially when dealing with people who were anxious or repetitive in their questions, providing reassurance and encouragement.

We noted that conversations were not purely task focussed, but person centred and involved asking people how they were, about their day and what plans they had. It was apparent that people had developed routines, which the staff were aware of and asked about, such as enquiring if a person was going to the same supermarket again this week, or if another person was planning to visit their relatives again.

It was evident that people were able to choose how to spend their time and what they wanted to do during the day. One person told us, "I make my own choices, staff don't stop me doing things." Another said, "I have lots of friends and I meet them every day it's great." A third stated, "I am a creature of habit and like my routines, staff just let me get on with it."

The staff we spoke with displayed an awareness and understanding of how to promote people's independence, as well as knowledge of person-centred practice. One said, "People here are encouraged to be independent, they come and go as they please." Throughout the inspection we observed people informing staff they were going out as well as letting them know where they were going. Staff documented each person had gone out in the diary and updated this upon their return. One person told us, "I have lots of independence." Another said, "I go out every day, it keeps me out of trouble."

The service also utilised a staff communication book, which was used to log any changes to a person's programme and other information staff needed to be aware of. Each staff member was required to read and sign this when they were next back on shift.

At the time of inspection no one using the service had an advocate in place, however the service had links with 'Care Aware Advocacy Service', which is a community based mental health advocacy service. Contact details and information relating to this service was contained in the service user guide, given to all people

who use the service.

Requires Improvement

Is the service responsive?

Our findings

During the inspection we looked at four care files in detail. These were produced and stored electronically on the service's laptop using a system that had been devised by the provider. The registered manager told us this system had been in place since April 2016, prior to which they had used paper records. However over the weekend, staff did not have access to the laptop as this was locked away, therefore each person also had a small file into which daily notes were recorded during this period.

The care files consisted of 13 sections, which included sections for personal details, assessments, care plans, daily reports and social activity. The initial sections of the files showed that people's care was personalised and responsive to their individual needs and preferences. The details section covered basic information about the person such as name, date of birth, next of kin and mental health diagnosis as well as capturing their previous occupation/s and any special wishes they had. The 'other info' section of the care file contained people's life stories, which succinctly captured their background and life history up to their admission to Lancaster House. This provided a quick reference point for staff to assist in their interactions with people.

The assessment section contained a range of assessments covering areas such as physical capabilities, which included self-care, hygiene and physical health; psychological needs which looked at each person's likes, dislikes, cultural and spiritual needs and wishes; emotional well-being which looked at what helps keep the person well.

Each person had a range of care plans all of which followed the same format, consisting of the area of need, assessment of the problem or need, goal or objective, care instructions, evaluation and outcome. This was to ensure that staff were aware of each person's needs, how best to support them and when this had been achieved. Examples worked on included personal care, dietary management, domestic tasks such as keeping their room clean and health related matters such as cutting down or giving up smoking.

However we saw that three people's care plans were incomplete. In one instance a person's area of need was documented, this being a diagnosis of dementia, however the rest of the care plan was blank, resulting in staff not having information about how this may impact on the person's ability to function and how best to support them. Another person had a care plan for shaving, which again had the area of need filled in but the rest incomplete. There was no indication anywhere within this person's care file regarding if support was required or what the staff's role was with this task. The daily notes section referred to the person shaving and the service's handover sheet was pre-printed with an instruction to support with shaving daily, but there was no guidance on how to do so.

Any attendance of medical appointments such as GP visits or blood tests along with the involvement of professionals such as podiatrists and district nurses were to be logged in the multidisciplinary section of the care files. We saw that these had not been updated consistently. For example one person's care plan said they attended podiatry every three months however there was only one appointment recorded on the log. Another person required three monthly blood tests due to a medication they took, however these were not

documented.

This is a breach of Regulation 17(2)(c) of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, in relation to good governance, as the service failed to maintain accurate, complete and contemporaneous records.

Each person using the service was allocated a keyworker. The purpose of this was to 'provide one to one support for certain areas of need or development, with the primary focus being on social needs.' The keyworker sessions were used to generate goals and then track progress, ensuring each person was fully involved in their programme. We reviewed the key worker files for five people using the service and saw that completion of these sessions was inconsistent and infrequent. Three people had not completed any sessions since April 2016, another person had completed two sessions between August and November 2016, based around their need to improve the tidiness of their room and open their window when smoking, with nothing recorded relating to social needs or wishes. The fifth person had only one session recorded from August 2016, when they had asked for support to complete some forms.

We asked the registered manager how often care files were reviewed. We were told this was done each month. However we could not confirm this had been completed, as review dates on the care plans we looked at had either not been updated for several months or recorded at all. People we spoke with could not recall being involved in reviewing their care plans and we noted there was no record kept of who had been involved, to confirm if this had been the case.

This is a breach of Regulation 9(3)(d)(e) of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, in relation to person-centred care, as the service did not ensure people were actively involved in their care or sought their views regarding if their needs were being met.

We looked at how complaints were handled. There was no complaints procedure displayed anywhere within the home, to let people using the service know how to complain or who else to speak to if they were not satisfied with how a complaint had been handled. The registered manager told us there had been one on the notice board but must have been removed. They also told us they "rarely get any complaints". The service did not have a complaints file in place with any complaints or issues received recorded in the 'comments' section of that person's electronic care file. The service did not keep a centralised complaints log, so had to rely on staff's memory to remember who had made a complaint and when. We saw two examples of complaints received which showed that as well as detailing the issue, the action taken had also been documented. We asked if the service had a complaints form, and was this easily available, so that people who may wish to raise an issue anonymously could do so. We were told that no such forms were in place.

This is a breach of Regulation 16(2) of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, in relation to receiving and acting on complaints, as the service did not have information and guidance available about how to complain or have an accessible system for the identifying, receiving, recording and handling of complaints.

The service did not provide an activity schedule, with people choosing how they wanted to spend their time. There were three lounges / communal areas along with a dining area, which people used to either watch television or chat with each other. The service also had a selection of board games which people could access should they wish to. People told us they were happy with this arrangement and enjoyed the freedom to come and go as they pleased. People spent their time visiting friends and relatives, going shopping, attending day centres and activity groups. Once a year the service arranged and paid for a holiday, which

people had the option to attend.

Inadequate

Is the service well-led?

Our findings

At the time of our inspection there was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like the registered provider, 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.

There were no audits completed or in place at the service. We saw that an audit tool had been designed by the provider but was not being used as the registered manager said it was too complicated and had requested a different format. We were shown an audit file, which contained an 'interior and exterior check' document. The description on this form stated it was to be used for 'an annual audit of the interior and exterior of the home. Areas should be inspected for their quality, state of repair and suitability for purpose, with any deficits or uplift requirements recorded.' The file contained blank forms dated January 2017, and some partially completed ones dated January 2013.

Due to the issues we identified with cleanliness, overall décor and documentation within the service, we asked the registered manager if they had a system or systems in place for monitoring the cleanliness of the environment, assessing the safety and suitability of the premises and to monitor and assess the quality of the service. They told us, "We have cleaning checklists for each room, staff do this and report back to me, but we don't have any monitoring in place to check it's been done and to the required standard. We used to do a health and safety check once a month, but not done this since 2013 and we do medication audits but have no others in place at the moment."

We did see that checks of people's bedrooms had been carried out, with the staff member responsible having to determine if the room was satisfactory, what action was required and date of completion. These checks looked at amongst other things the overall cleanliness of the room, fixtures & fittings and décor. We noted that prior to July 2016, these had been completed on a monthly basis, however since then had only been done once in November 2016. None of the completed sheets contained much detail nor highlighted any of the issues we had noted during the inspection.

During the last inspection in May 2016, we identified that the service's policies and procedures were in need of review and updating to ensure they covered the most recent best practice guidelines. At this inspection we saw no review or updates had taken place. We also noted that the service had no MCA and DoLS policy, which was an area of practice in which issues had been identified. We asked the registered manager how often policies were reviewed and updated and how this was done. They told us the service "receives updates by email from the federation of small businesses, but have not been updated for some time, not sure when they were last reviewed to be honest."

We asked staff whether staff meetings were completed and were told these had never been held. One told us, "A handover is done before each shift, but we never have staff meetings." Another said, "We don't have staff meetings. Management keep saying we will, but never seem to get round to it." We spoke to the registered manager who told us, "No, we have not had these for some time." From speaking to the registered

manager it was also apparent that meetings with both people who used the service and their relatives had also not occurred. The service's statement of purpose and the service user guide both stated regular resident' meetings would be held in order for people to be consulted and involved.

This was a breach of Regulation 17 (1)(2)(a)(b)(f) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, relating to good governance, as the provider had failed to operate effective systems to asses and monitor the quality, safety and effectiveness of the service and have effective communication systems in place for people using the service and the staff.

The staff we spoke with told us they liked working for the service and felt supported by the manager. One said, "I find working here alright, I think I have settled in well. The manager is approachable. I feel if we have any concerns they would be dealt with." Another told us, "It's not too bad working here. I feel supported in my role."

We asked how people were able to provide feedback on the service and were told that annual questionnaires were sent to people, relatives and professionals every April. We looked at four of the most recent questionnaires from people using the service and saw that feedback was positive. People had been asked to rate a number of statements about the service using the following scale; strongly agree, agree, don't know, disagree or strongly disagree. All four people had chosen agree or strongly agree to answer all questions, which included; do you feel safe, are staff courteous and friendly, do staff respect your dignity and is the food of good quality. One person told us, "We get questionnaires. They ask us all sorts of things and they are easy to follow as they are tick boxes with spaces to put extra things."

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 9 HSCA RA Regulations 2014 Person-centred care The provider did not ensure people were actively involved in their care or sought their views regarding whether their needs were being met.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider did not assess the risk of, or control the spread of infections, assess the risks to the health and safety of service users, review these regularly and ensure they complied with statutory requirements or national guidance and ensure the proper and safe management of medicines.

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 The provider failed to monitor or review the approach to, or use of, restrictive practice or act in accordance to the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The provider failed to have information and

guidance available about how to complain or have an accessible system for the identifying, receiving, recording and handling of complaints.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider could not demonstrate staff had received the appropriate support, training and professional development to enable them to carry out their duties.