Careline Lifestyles (UK) Ltd

Lanchester Court

Inspection report

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Date of inspection visit:
07 April 2016

Date of publication:
07 June 2016

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We carried out an unannounced comprehensive inspection of this service on 29 and 30 October 2015 as a result of concerns we had received about the service. Eight breaches of legal requirements were found. As a result of the inspection findings enforcement action was taken by CQC against the provider. After the comprehensive inspection, the provider wrote to us to say what they would do to meet legal requirements. These related to the breaches of regulation regarding staff competency and staffing levels, safe care and treatment, cleanliness and suitability of the premises, nutrition and hydration, dignity and respect, requirements of the Mental Capacity Act, record keeping and good governance.

We inspected the service on 7 April 2016 to follow up on the breaches and to carry out a comprehensive inspection as the breaches related to several areas of the peoples' care and treatment. This inspection found that improvements had been made to ensure people receive safe care and treatment.

Lanchester Court provides accommodation for personal and nursing care for up to 22 people. Care and support is provided for people with learning, neurological and physical disabilities.

A new manager was in place but they were not yet registered with the Care Quality Commission. 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.

Due to their health conditions and complex needs not all people were able to share their views about the service they received.

We found significant improvements had been made to ensure the safe care and treatment of people. People and staff told us they felt safe and there were enough staff on duty at all times to provide safe and individual care to people. There was an improved emphasis on providing person centred care to ensure people received care and support in the way they wanted and at times they chose rather than task centred care being provided. Staff had time to interact and spend time with people and not just when they carried out tasks.

Risk assessments were in place and they accurately identified current risks to the person. People were protected as staff had received training about safeguarding and knew how to respond to any allegation of abuse. People received their medicines in a safe and timely way.

People had access to health care professionals to make sure they received appropriate care and treatment. Staff followed advice given by professionals to make sure people received the care they needed.

Records had been updated and they were regularly reviewed to reflect peoples' care and support

requirements. Staff knew the people they were supporting well. Care was provided with kindness and people's privacy and dignity were mostly respected. We considered some improvement was still required in one area to protect a person's dignity.

Staff had received training and had a good understanding of the Mental Capacity Act 2005 and best interest decision making, when people were unable to make decisions themselves. Not all the relevant people had been involved in the decision making process when people without mental capacity received medicine without their knowledge.

Staff received other opportunities for training to meet peoples' care needs and in a safe way. A system was in place for staff to receive supervision and appraisal but improvement was necessary to ensure all the staff team received an updated supervision in a timely way.

Menus were varied and a choice was offered at each mealtime. Staff supported people who required help to eat and drink and special diets were catered for. Activities and entertainment were available for people and people were being consulted to increase the variety of activities and outings.

A complaints procedure was available. People told us they would feel confident to speak to staff about any concerns if they needed to. People had the opportunity to give their views about the service. There was regular consultation with people and family members. Their views were used to improve the service. The provider undertook a range of audits to check on the quality of care provided.

Staff and people who used the service said the manager was supportive and approachable. Communication was effective, ensuring people, their relatives and other relevant agencies were kept up to date about any changes in people's care and support needs and the running of the service.

Changes had been made to the environment so more comfortable communal areas were available for people to relax. It was cleaner and brighter and areas had been refurbished.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

Improvements had been made to ensure the service was safe.

People were kept safe as systems were in place to ensure their safety and well-being at all times. Regular checks were carried out to ensure the building was safe and fit for purpose. The cleaning schedule had been revised and the domestic hours increased to ensure a clean environment. Appropriate checks were carried out before staff began work with people.

Staffing levels were sufficient to meet people's needs safely. People received their medicines in a safe and timely way.

People were protected from abuse and avoidable harm as staff had received training with regard to safeguarding. Staff said they would be able to identify any instances of possible abuse and would report it if it occurred.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff received the training they needed but not all staff had received a recent supervision.

People's rights were protected. Best interest decisions were made appropriately on behalf of people, when they were unable to give consent to their care and treatment. Where people without mental capacity received medicine without their knowledge not all the necessary people were involved in the decision making process.

Effective communication ensured the necessary information was passed between staff to make sure people received appropriate care. Staff liaised with General Practitioners and other professionals to make sure people's care and treatment needs were met.

People received food and drink to meet their needs and support was provided for people with specialist nutritional needs.

A programme of refurbishment had taken place in areas of the

home.

Is the service caring?

Requires Improvement

Not all aspects of the service were caring.

Good relationships existed and staff were aware of people's needs and met these in a sensitive way that mostly respected people's privacy and dignity. We considered improvement was required in the way care was delivered to one person to protect their dignity.

The dining experience for people who were more independent required areas of improvement to make it more organised and leisurely.

The staff team were caring and patient as they provided care and support. Staff spent time interacting with people and they were all were encouraged and supported to be involved in daily decision making.

There was a system for people to access and use, if they wanted the support of an advocate. Advocates can represent the views of people who are not able to express their wishes.

Is the service responsive?

Good

The service was responsive.

Records had improved so people received support in the way they wanted and needed because staff had detailed guidance about how to deliver their care.

People were provided with a range of opportunities to access the local community.

A copy of the complaints procedure was available for people and it was written in a way to help them understand if they did not read.

Is the service well-led?

Good

Improvements had been made to the service to ensure it was well-led.

A management team was in place who promoted the rights of people to live a fulfilled life within the community.

Staff felt more supported, listened to and involved in the running of the home.

An ethos of individual care and involvement was encouraged for the benefit of people who used the service.

The manager monitored the quality of the service provided and had introduced improvements to ensure that people received safe care that met their needs.

Lanchester Court

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 inspection took place on 7 April 2016 and was unannounced. The inspection team consisted of two adult social care inspectors.

Before the inspection we reviewed the information we held about the service. This included the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally obliged to send the Care Quality Commission (CQC) within required timescales. We carried out the inspection to follow up on action taken by the provider to become compliant and to review improvements to the service.

During this inspection we carried out observations using the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not communicate with us.

We undertook general observations in communal areas and during mealtimes.

During the inspection we spoke with seven people who lived at Lanchester Court, the manager, the head of home operations, the head of compliance, the training manager, a registered nurse, nine support workers including one senior support worker, one member of catering staff and two members of domestic staff. We observed care and support in communal areas and looked in the kitchen, dining rooms, bathrooms, lavatories and some bedrooms after obtaining people's permission. We reviewed a range of records about people's care and how the home was managed. We looked at care plans for seven people, the recruitment, training and induction records for four staff, two people's medicines records, staffing rosters, staff meeting minutes, meeting minutes for people who used the service and their relatives, the maintenance book, maintenance contracts and the quality assurance audits that the manager had completed.

Good

Is the service safe?

Our findings

At our last inspection in October 2015 breaches of legal requirements were found. These included a failure to ensure suitable arrangements for the safe care and treatment of people using the service, inadequate staffing arrangements and unsatisfactory standards of hygiene and infection control. We reviewed the action plans the provider sent to us following the inspection. These included details of how they planned to ensure compliance with legal requirements.

At the last inspection we had concerns that due to the range of people's diverse needs that there were not enough staff on duty at all times.

At this inspection we found improvements had been made to ensure sufficient staff were on duty to provide safe and timely care to people who used the service. Comments from staff included, "I feel safe working here, the regular staff back me up," "It's picked up a lot, we use the odd agency worker, it's much better now," "Some days it's non-stop, but we now get time to sit down with people and get to know them," "It's a lot better now. The main thing was staffing. We now get breaks. You can get your job done," "It's all been working well, it's running smoothly," "We're now allowed to sit and have a chat with people, it's much more relaxed," "There are enough staff to support activities and appointments."

Due to some people's complex needs we were not able to gather their views. Other people said they felt safe and they could speak to staff. The head of home operations told us staffing levels were now determined by the manager of the service and the head of home operations rather than head office as they were more aware of peoples' needs and the amount of one to one support that some people required.

At the time of our inspection there were 18 people living at the home, 16 people were present as two people were away. The building contained 12 flats and 10 en-suite bedrooms to accommodate 22 people. We were told staffing levels had increased as an additional two support staff worked at peak times so there were 12 support workers between 9am and 2pm. At other times of the day there was one nurse and ten support workers. Night staffing levels consisted of one nurse and four support workers from 8pm to 8am and two additional support workers were on duty from 6pm to 11pm, therefore six support workers were now available in the evenings. An occupational therapist and therapy assistant were also on duty from 8.30am until 5pm daily. This meant staffing levels had increased and arrangements were in place, managed by the home, to keep staffing levels under review as peoples' needs changed.

We previously had concerns that care and treatment including respite care was not planned and delivered in a way that ensured people were safe. We found improvements had been made to ensure peoples' safe care and treatment. The head of home operations informed us arrangements were in place for the registered manager, supported by the head of home operations, or a nurse assessor to carry out future pre-admission assessments of people to the service. This was to ensure the compatibility of people and to check that staff had the required skills to meet people's needs before they were admitted. This had previously been carried out centrally by the admission's team based at head office who would not necessarily know the skill mix and if people who were to be placed at the service may be compatible with existing people.

Care plans were now in place to show peoples' care and support requirements when they became distressed and they were regularly updated to ensure they provided accurate information. A new care planning system for distressed behaviour had been introduced called positive behaviour care planning which gave staff more insight and understanding as to why people may become distressed and challenging. This was to supplement the behaviour management guidelines that were in place for people to help staff support them. A three page profile had been completed for each person so staff would have succinct information to help them recognise triggers and help de-escalate situations if people became distressed and challenging. A staff member commented, "The three page summary is really helpful." One person's profile stated, "When I am happy I will smile and laugh a lot with my support staff. If something is upsetting me I may be restless and not interact. If I reach crisis point I may repetitively hit myself …in front of staff. Two MAPA, (management of potential and actual aggression) trained members of staff must support me during this time."

The majority of the staff had received MAPA and positive behaviour training. We were told training was planned for May 2016 for the three staff members where the training was outstanding. Staff members comments included, "It was good training," "We rarely have to use permitted physical restraint, the priority is to talk people down," "We look out for warning signs and actions to keep people safe," "I did the training as part of my induction, I did three days of essential mandatory training, two days of positive behaviour training followed up with two days of MAPA training." This training helped to prepare staff and ensure they had the knowledge to support people with distressed behaviour and recognise signs to de-escalate any potentially unsafe situations. Staff told us they felt safe supporting people. Their comments included, "Staff come straight away to help if you press the buzzer," and, "If there's an emergency we'd press the buzzer. They're all over every room and when I used it, it was fine."

We checked the management of medicines and found previous concerns had been addressed with regard to the use of 'when required' medicines which may be required when people were in pain or agitated or distressed. Detailed information and guidance was available for each person to help staff support them if they were agitated or distressed. We were told this guidance was followed to try to calm people before any sedative medicine was administered, which was used as a last resort. Guidance was in place to advise staff 'when required' medicines should be used for agitation and distress to ensure a consistent approach. For example, a care plan stated, "I am prescribed medicine to help me to relax when I am displaying extreme behaviours and am putting myself at risk."

Other concerns with regard to the storage of medicines and recording of fridge temperatures in the treatment room had also been rectified. Inspection of the treatment room showed a stock check of stored medicines had taken place. Systems were in place to regularly check that all medicines for use were in date. There were daily recordings of the maximum and minimum temperature for the fridge to ensure medicines that needed refrigeration were appropriately stored at the requisite temperature.

People received their medicines in a safe way. We observed medicines as they were administered to people. Medicines were administered by the nurse for people with nursing needs and the senior support worker, who was responsible for administering medicines to people with non-nursing needs. We saw they checked people's medicines on the medicine administration records (MAR) and medicine labels to ensure people were receiving the correct medicine. The staff administering medicines explained to people what medicine they were taking and why. Medicines records were accurate and supported the safe administration of medicines. There were no gaps in signatures and all medicines were signed for after administration. People who were able were supported to manage their own medicines safely and systems were in place to monitor this. For example, we observed a person who was diabetic was monitored by staff as they managed their diabetes, they were learning to inject themselves and take their own blood readings.

The manager understood their role and responsibilities with regard to safeguarding and notifying CQC of notifiable incidents. They had ensured that notifiable incidents were reported to the appropriate authorities where necessary. A safeguarding log was in place and six safeguarding concerns had needed to be raised since the last inspection and these had been appropriately managed.

Staff had an understanding of safeguarding and knew how to report any concerns. They were able to describe various types of abuse and tell us how they would respond to any allegations or incidents of abuse and knew the lines of reporting within the organisation. They told us they would report any concerns to the manager or senior person. One person commented, "Information about safeguarding is also in the staff handbook we are given." Records showed and staff confirmed they had completed safeguarding adults training.

Staff were aware of the reporting process for any accidents or incidents that occurred. The number of incidents that had been reported had reduced significantly since the last inspection. Records showed seven incidents had been reported to the police and no staff accidents had needed to be reported, this had reduced from 30 that had taken place between March 2015 and October 2015. 'Health and safety trends analyses' were completed three monthly by the manager. The forms covered the numbers of accidents, safeguarding referrals, accidents to employees and notifiable incidents. We were told incidents were analysed by the manager at the home to make sure any learning from incidents took place to look with staff. A staff member told us, "Everyone concerned would have a chat and offer advice about how to handle the incident next time. If needed we would alter the care plan." We were told all serious incidents were audited by the responsible person at head office who investigated serious incidents separately.

Risk assessments and their evaluations, which had previously not been in place or up to date to reflect current risks to people, were now in place to ensure they remained relevant, reduced risk and to keep people safe. They included risks specific to the person such as for choking, losing weight, falls and pressure area care. A detailed risk assessment was also in place for a person with a medical condition which highlighted areas of risk and guidance for staff to recognise symptoms if the person became unwell.

A personal emergency evacuation plan (PEEP) was available for each person taking into account their mobility and moving and assisting needs. The plan was reviewed monthly to ensure it was up to date. This was for if the building needed to be evacuated in an emergency.

At the last inspection we had concerns about the standards of hygiene and cleanliness around the building. We looked around the building and saw improvements had been made. There was effective odour control. All areas of the building looked clean and arrangements were in place to ensure all lavatories were cleaned daily. We were told the number of ancillary hours had increased by 21 hours and these additional hours were being carried out by two workers from a cleaning organisation until extra domestic workers were recruited.

We spoke with members of staff and looked at personnel files to make sure staff had been appropriately recruited. We saw relevant references and a result from the Disclosure and Barring Service (DBS) which checks if people have any criminal convictions, had been obtained before applicants were offered their job. Records of checks with the Nursing and Midwifery Council to check nurses' registration status were also available and up to date. Application forms included full employment histories. Applicants had signed their application forms to confirm they did not have any previous convictions which would make them unsuitable to work with vulnerable people.

We saw from records that the provider had arrangements in place for the on-going maintenance of the

building and a maintenance person was employed. Routine safety checks and repairs were carried out, such as checking the fire alarm and water temperatures. External contractors carried out regular inspections and servicing of, for example, fire safety equipment, electrical installations and gas appliances. There were records in place to report any repairs that were required and this showed that these were dealt with. We also saw records to show that equipment used at the home was regularly checked and serviced, for example, the passenger lift, hoists and specialist baths.

Requires Improvement

Is the service effective?

Our findings

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

At the last inspection records did not contain detailed information about people's mental health and the correct 'best interest' decision making process, as required by the Mental Capacity Act 2005. Best interest decision making is required to make sure people's human rights are protected when they do not have mental capacity to make their own decisions or indicate their wishes. Peoples' care records showed improvements had been made. They showed when 'best interest' decisions may need to be made when a person's mental health had relapsed. For example, a care plan for a person with a mental health condition stated, "Bi-polar is a condition that affects my mood and will move me from one extreme to another…I may go from being unsettled and depressed to being very excitable." It also stated, "…decisions should be determined at a multi-disciplinary meeting (MDT) with my best interests considered." People were involved in developing their care and support plan, identifying what support they required from the service and how this was to be carried out. For people who did not have the capacity to make these decisions, their family members and health and social care professionals involved in their care made decisions for them in their 'best interests'.

CQC monitors the operation of the Mental Capacity Act 2005 (MCA). This is to make sure that people are looked after in a way that does not inappropriately restrict their freedom and they are involved in making their own decisions, wherever possible. Staff were aware of and had received training in the MCA and the related Deprivation of Liberty Safeguards (DoLS). They had a good understanding of the MCA and best interest decision making, when people were unable to make decisions themselves. The manager and staff were aware of the deprivation of liberty safeguards and they knew the processes to follow if they considered a person's normal freedoms and rights were being significantly restricted. The manager told us applications were authorised and in place and one person who was subject to a DoL had successfully appealed against the authorisation. Another person's care plan stated, "I'm deemed as lacking capacity to make informed decisions regarding my care planning. DoLS put in place as I am under constant supervision or deemed not safe when out in the community alone. I am unable to consent to treatment. This is why staff are to act in my best interests."

Some improvements had been made with regard to the decision making process where medicines were administered covertly (covert medicine refers to medicine which is hidden in food or drink). Records showed that where people lacked mental capacity to be involved in their own decision making a meeting had taken place but the correct process had not been used. We saw 'best interest' decision making did not adhere to the National Institute for Health and Care Excellence (NICE) as NICE guidelines state, "A best interest meeting involving care home staff, the health professional prescribing the medicine(s), pharmacist and family member or advocate to agree whether administering medicines without the resident knowing

(covertly) is in the resident's best interests." A meeting had taken place with relevant people but the pharmacist had not been involved. We were informed after the inspection arrangements were now in place and the pharmacist had become involved to sign off the decision making process for each person where covert medicines were used.

Care records now showed where relatives had become Court of Protection approved deputies, or if they had enacted power of attorney for care and welfare if people lacked mental capacity to be responsible for their own finances and make decisions with regard to their care and welfare.

Improvements had been made to ensure people's nutritional needs were met by staff and regularly reviewed. People who were at risk of poor nutrition were supported to maintain their nutritional needs. This included monitoring people's weight and recording any incidence of weight loss. Referrals were also made to relevant health care professionals, such as dieticians and speech and language therapists for advice and guidance to help identify the cause. Records were up to date and showed people with nursing needs were routinely assessed monthly against the risk of poor nutrition using a recognised Malnutrition Universal Screening Tool (MUST) and a nutritional screening tool. Care plans were in place that recorded people's food likes and dislikes and any support required to help them eat. For example, "I am a vegetarian and I follow this diet strictly and have done so for a number of years," and, "No special dietary needs but preference is for soft diet. Will spit out crusts. Staff should support me to have high calorie snacks as I am at risk of losing weight."

Systems were in place to ensure people received drinks and varied meals at regular times when the regular cook was not working. We spoke with the chef who was aware of people's different nutritional needs and special diets were catered for. They explained about how people who needed to increase weight and to be strengthened would be offered a fortified diet and how they would be offered milkshakes, butter, cream and full fat milk as part of their diet. The chef told us they received information from nursing staff when people required a specialised diet. Written information was available in the kitchen to inform any cook of the dietary preferences and specialised diets for people when the regular cook was not available. For example, diabetic, vegetarian and soft or pureed diets. A staff member told us, "The kitchen have a list of each person's dietary needs."

A four week menu was in place and an alternative to the main meals was available. The chef told us, "Things are moving in the right direction here. I look at the residents as my customers. I've always had an open door. If people don't like what's on the menu I'll do them something else, such as a bacon sandwich." They also told us menus were devised that included people's suggestions. They commented, "I sit in on resident's meetings. We'll be having another one next week to list ideas about what they want to eat." Comments from people who used the service included, "That was a lovely meal," "The food has improved," and, "I love the cook, I'd make them permanent, the food's good."

At the previous inspection we had concerns staff had not received the necessary specialist training to meet people's needs safely. For example, Percutaneous Endoscopic Gastrostomy (PEG) training. (PEG is a tube which is placed directly into the stomach and by which people receive nutrition, fluids and medicines.) This was needed to make sure staff knew how to deliver a person's care and treatment when they were fed by PEG. This had been actioned and staff had received this training although it was not required at the current time as no one had such a need but staff were trained for if it did become necessary to feed someone this way.

Staff told us when they began working at the service they had completed an induction programme and had an opportunity to shadow a more experienced member of staff. This ensured they had the basic knowledge

needed to begin work. They said initial training consisted of a mixture of face to face and practical training.

The staff training records showed and staff told us they had received other training to meet peoples' needs and training in safe working practices. The manager told us there was an on-going training programme in place to make sure all staff had the skills and knowledge to support people. Training gave staff some knowledge and insight into people's needs and this included a range of courses such as, distressed behaviour, management of potential and actual aggression (MAPA),positive behaviour support ,(PBS) care planning and recording, equality, diversity and dignity, dementia care, Parkinson's disease, acquired brain injury awareness, continence care, catheter care, epilepsy, nutrition and hydration and professional boundaries. Staff had also received Mental Capacity Act (MCA) 2005 and Deprivation of Liberty (DoLS) training. Staff comments included, "We've had some good training... we have done a lot lately. Its taught training," "I've had lots of training," "I've done training about PEG and catheter awareness, although only the nurses are qualified to insert a catheter, we don't."

People were supported to maintain their healthcare needs. People's care records showed they had regular input from a range of health professionals such as, General Practitioners (GPs), psychiatrists, a speech and language team (SALT) and psychiatrists. Records were kept of visits. Care plans reflected the advice and guidance provided by external professionals.

The concerns from the previous inspection to ensure sufficient information was available and was an accurate reflection of a person's current support requirements when they were re-admitted to the home had been actioned. Rather than just a verbal handover, a record had to be completed for each stay to check if there had been any changes in the person's medical and other care requirements.

Staff told us communication was more effective. People's needs were discussed and communicated at staff handover when staff changed duty, at the beginning and end of each shift. This was so staff were aware of the current state of health and well-being of people. The head of home operations told us staff were paid to attend the fifteen minute handover which took place before their shift began. This was to ensure all staff attended. Staff had to sign an attendance sheet to record their attendance. Staff told us a handover of verbal and written information took place between staff for each shift. There was a detailed handover record that provided information for staff about people's health and well-being and other relevant information so they were aware of risks. Information included people's health, mood, behaviour, appetite and activities they had been involved with. A staff member told us, "At handovers we're asked for suggestions and improvements for people." Staff told us the communication book also provided them with information to help make sure people's needs were met. Staff comments included, "The communication book works well, everyone looks in that," "Communication is much better than it used to be," "Handovers are quite detailed," "We're more involved," "We're kept informed," and, "A lot has improved and they (management) are taking notice of what staff are saying."

Staff told us they received supervision. Staff members' comments included, "Supervision is useful," "I have supervision with [Name]," and, "Now we are told how we are getting on. They're (supervision) monthly or more often if you need to speak about things." Records showed areas covered at supervision included, a review of the last supervision's agreed actions, workload/work performance, personal development and skills, areas of disagreement and a quality check. A staff supervision matrix was in place to show the supervisions that had been taken place with 17 staff since October 2015 and the supervisions that were planned.

We considered improvements were required to ensure all the staff team received regular supervision as records showed some staff had not received supervision between June 2015 and January 2016. A system for

the annual appraisal of staff to review their work performance was in place. However, we were aware of all the other improvements that had been prioritised and put in place by the provider and management team to ensure that people who used the service were kept safe and received effective care that met their needs. The manager told us this would be addressed and supervisions were currently being carried out by the management team.

We looked around the premises and saw the improvements that had taken place. More storage and working surfaces had been created in the kitchen. Communal areas of the building had been refurbished, new flooring and lighting was in place to brighten the home and several areas had been re-decorated. A second lounge had been created on the first floor which was comfortable and well equipped with furniture. We observed the atmosphere around the home was calmer and more tranquil with some people spending time in the newly created lounge rather than all people being congregated in the one area downstairs. We observed a person who spent all their time in their flat had been re-located to a flat which was sunny, bright and vividly decorated to provide stimulation and some relaxation for the person.

Around the home the environment was becoming more homely and personalised and there was an acknowledgement it was the person's home and should look less clinical. However, we considered more work was required to make the newly created dining room less stark and a more pleasant room and more pleasurable dining experience for more independent people. After the inspection we were told by the head of home operations that this had been addressed and more dining furniture had been obtained, the en-suite lavatory had been taken out of the dining room and the dining room would be personalised.

Requires Improvement

Is the service caring?

Our findings

People who used the service were positive about the care and support provided. People's comments included, "The staff are kind and caring," "The staff are good," "Things have improved," and, "The staff are okay but I don't want to be here, I want my own place."

We previously had concerns that people did not receive personalised care. We saw improvements had been made so people did not receive task centred care. Care was provided in a flexible way to meet people's individual preferences. This meant staff provided support to people in the way they wanted and at times of their asking for support and not only at set times offered by staff.

During the inspection there was a relaxed and pleasant atmosphere in the service. Staff interacted well with people. Staff were warm, kind, caring and respectful with people and people appeared comfortable with them. Staff had time to spend talking with people. They were all patient in their interactions and took time to observe people's verbal and non-verbal communication. Staff asked people's permission before carrying out any tasks and explained what they were doing as they supported them. A staff member told us, "We'll ask first before helping." We observed a person was unwell during the day and staff monitored their well-being and called the General Practitioner and ambulance for further medical advice and assistance.

We had previously had concerns peoples' privacy and dignity was not respected. We considered improvements had been made at this inspection but more work was required for one person to ensure their dignity was respected. We discussed this with the manager during the inspection and they committed to taking action in relation to this person.

A protocol was in place that advised when male staff should not carry out personal care with females. It included examples of situations when a male should not be involved in aspects of intimate personal care to protect the person's dignity. Information was now available in people's care plans with regard to their wishes about the choice of a male or female carer. However, we considered improvements were still needed where a person was unable to indicate their preference. Records showed an advocate (advocates can represent the views of people who are not able to express their wishes) was involved in the 'best interest' decision making process to provide an independent view for a person who lacked mental capacity. For example, a care plan stated, "Name has an advocate who acts on their behalf and in their best interests." We advised the manager the person's advocate should become involved in the 'best interest' decision making process about the gender of support workers who provided personal care to the person as the person was unable to show their preference. At the current time males were involved in providing this care as the person historically had not objected. The person's care plan stated, "Unable to express views about support from male and female. Shows no distress signs with either gender. All staff to treat me with care and respect.. and they should respect my dignity at all times." Staff told us before the person came to the home they had been informed the person responded to being cared for by a male and this included for their personal care. We considered in the interests of the person's privacy and dignity this should be reviewed as it was historical and the person's preferences may have changed and a decision involving an independent person should be made in their 'best interests'. The manager told us this would be addressed and the person's advocate

would become involved.

Staff we spoke with understood their role in providing people with effective, caring and compassionate care and support. They were able to give us information about people's needs and preferences which showed they knew people well. For example, a staff member told us, "[Name] will push your hands and food out of the way to indicate if they don't like things." People's privacy was respected. Staff treated people with dignity and respect. We saw staff observed and offered any prompts and words of encouragement to people at meal times to provide assistance. Staff knocked on people's doors before entering their rooms. People looked clean and well presented. Most people sat in communal areas but some preferred to stay in their own room. Staff members' comments included, "You always have to promote privacy and dignity. Shut doors and blinds, knock on doors. It's a lot to do with respect," and, "You don't talk about people in front of others or divulge information to visitors."

People's care plans provided detailed information for staff of how people communicated. For example, if they were in pain and did not communicate verbally. One care plan stated, "If I'm in pain I tend to display self-injurious behaviours." Another listed some behaviours a person may exhibit and stated, "These behaviours may be a sign that I'm unwell or in pain." Staff told us they also observed facial expressions and looked for signs of discomfort when people were unable to say if they were in pain. Not all of the people were able to fully express their views verbally. Support plans provided detailed information to inform staff how a person communicated. For example, "I use a communication board of A4 laminated sheets to show me meals and activities," and, "[Name] has no problems in understanding information given to them. [Name] uses a letter board to communicate, staff must place a pencil in between [Name]'s fingers on their left hand and allow them to point to each letter." Staff supported people to be independent and to maintain some control in their day to day living. For example, one person had a possum, which is an electronic aid strapped to their leg which enabled them to alert staff if they required assistance and to alter the speed on their electric wheelchair.

We observed the lunch time meal. People were informed of the daily menu choices on a board situated in the downstairs lounge that advertised the meal selection. Meals were served in two 'sittings' with more dependent people receiving their meal first. The meal time was relaxed and unhurried for people who required support from staff. Staff were seen to be seated with the person and interacted with them individually. There was pleasant and appropriate conversation between people and staff. Specialist equipment such as cutlery, plates and plate guards were available to help people. Some people remained in their bedroom or a quieter area to eat. Staff provided prompts to people where needed to encourage them to eat, and they did this in a quiet, gentle way. As the dining room was next to the kitchen the chef served people a choice of meal from the hot trolley and we observed they had the advantage of collecting peoples' views directly about the food served. The chef remained in the dining area to serve second helpings as people requested. Support staff were available during meals to attend to people as required and to provide supervision in case any incidents should occur. In the newly created dining room it was more of a canteen environment although people had the opportunity to sit at tables set for two or three people. People helped themselves to cutlery as tables were not set. There were no table cloths or table mats or condiments available. We observed people did not linger over their meal. Most people ate hurriedly and without speaking. The manager told us this would be addressed to provide a more pleasant dining experience for people.

Good

Is the service responsive?

Our findings

At the last inspection we had concerns that records did not accurately reflect people's care and support needs for staff to provide the correct care and support to people in the way the person wanted and needed.

We saw that improvements had been made to ensure that records accurately reflected peoples' care and support needs and arrangements had been put in place to ensure staff had access to peoples' care and support plans. Peoples' care records had been moved to a more accessible, but secure area of the home so staff could read them and familiarise themselves with peoples' care and support requirements before they began to work with them.

Previously peoples' needs were assessed by a pre-admission co-ordinator at head office before people moved into the home. This was to ensure that staff could meet their needs and that the home had the necessary equipment to ensure their safety and comfort. We were informed this was now localised as arrangements were in place for the manager, supported by the head of home operations, or a nurse assessor to carry out future pre-admission assessments to ensure the compatibility of people who were to use the service and to check that staff had the required skills to meet peoples' needs before they were admitted.

Assessments were carried out to identify people's support needs and they included information about their medical conditions, dietary requirements and their daily lives. Care plans were developed from these assessments that outlined how these needs were to be met. For example, with regard to nutrition, personal care, activities of daily living, communication and moving and assisting needs. Records showed that monthly assessments of people's needs took place with evidence of regular evaluation that reflected any changes that had taken place. For example, with regard to nutrition, communication, pressure area care, mobility and falls and personal hygiene. Evaluations were more detailed and included information about peoples' progress and well-being.

Staff at the service responded to people's changing needs and arranged care in line with their current needs and choices. The service consulted with healthcare professionals about any changes in people's needs. For example, the speech and language therapist was asked for advice with regard to swallowing difficulties and communication. Staff completed a daily diary for each person and recorded their daily routine and progress in order to monitor their health and well-being. This information was then transferred to people's support plans which were up-dated monthly. Charts were also completed to record any staff intervention with a person. For example, for recording when staff turned a person in bed, where it was identified a person was at risk of developing pressure areas. These records were necessary to make sure staff had information that was accurate so people could be supported in line with their up-to-date needs and preferences.

Care plans were detailed and provided information for staff about how people liked to be supported For example a care plan for personal hygiene stated, "About 9am to 9.30am I like my personal care to be carried out. I like a wet shave and after my hair is washed I have a full body wash…" Another care plan stated, "I like staff to come into my flat at 8.30am." Staff were knowledgeable about the people they supported. They were

aware of their preferences and interests, as well as their health and support needs, which enabled them to provide a more personalised service.

The service helped some people to prepare for more independent living and they were encouraged to take part and learn daily living skills such as cooking, laundry, food shopping, meal preparation and cleaning their rooms or flats. One person told us, "I've been cleaning today." Another person who was preparing to move out said, "I'm dead excited about it. I've been involved and working on my care plans." We were told a new care planning system, 'Life Stars' was in the process of being introduced. A new care plan that had been completed for a person who was learning to administer their own medicines showed it was detailed and provided guidance for staff to ensure care and support was delivered consistently. This was to ensure more person centred care was provided and to enable people to develop certain skills and to assist them to become more independent in aspects of daily living. This was achieved by attaining the individual goals set with people as part of 'Life Star' planning.

People's care records were up to date and personal to the individual. They contained information about people's likes, dislikes and preferred routines. For example, "I like to listen to Songs of Praise on television," "I love cheese it is one of my favourite foods," "When I am in a bad mood then I will not get dressed," and, "I sleep by curling up on my bed without any sheets or covers."

Written information was available that showed people of importance in a person's life. Staff told us people were supported to keep in touch and spend time with family members and friends. Most people had visitors every week. Some people went to spend time at home on 'home leave' for a day or overnight stays.

The head of therapeutic services told us part of the therapy assistant role was to assist the occupational therapist and behaviour care lead in their work. A therapy assistant had started work at the home and part of their remit was to help provide activities with people. A programme of activities advertised activities that were available and this included arts and crafts, cookery classes, bingo, board games, baking sessions, indoor sports and movie nights. People told us a breakfast and luncheon club also took place on some days of the week. The remit of the clubs was to teach people skills to help them become more independent and make their own breakfast and snack lunch on club days. One person told us, "I made a fry up for my breakfast."

Records showed that reviews or meetings took place for people and their relatives to discuss their care and to ensure their care and support needs were still being met. People told us 'My Say' meetings took place every month to discuss some issues regarding the running of the home. Meeting minutes were available in an easy read format which showed items discussed included, meals and menus, seasonal entertainment, outings and group activities. The chef was involved in the meetings and asked people for suggestions to improve the menus and for ideas so more home baked food was available. The minutes showed people were consulted about changes such as to the environment and they were kept informed about other changes that were taking place as a result of the last inspection to provide more person centred care to people.

Records showed people were supported to become part of the local community. Some people attended college supported by staff. People, told us they went out for meals with staff and shopping. We observed people who had 'one to one' time had opportunities to go out to places and to pursue their previous interests and hobbies such as shopping, for meals out and to concerts. We were told the home shared a minibus with another home and it was available for trips out. Staff members' comments included, "There are enough staff to support activities and appointments," and, "We offer to take people out, but it's difficult to motivate people."

People said they knew how to complain. The complaints procedure was on display in the entrance to the home. People also had a copy of the complaints procedure that was available in the information pack they received when they moved into the home. A record of complaints was maintained and we saw one had been received and had been investigated and resolved.

Good

Is the service well-led?

Our findings

A new manager had been appointed in March 2016 and was in the process of becoming registered with the Care Quality Commission.

We found that the several areas of non-compliance identified at the last inspection had been rectified and the provider and management team had made several improvements to the service to benefit people who used the service and staff. Systems were in place for managing and mitigating risk. Care records accurately reflected peoples' support needs and contained the information staff needed to safely care for people. A protocol was in place to ensure the required information and documentation was completed for any respite or emergency admission to the service to ensure staff had information about how to support them. Training had been carried out to provide staff with the knowledge and skills to support people safely. The environment had improved so it was more tranquil as people had more areas to relax.

Records showed audits were carried out regularly. They showed action that had been taken as a result of previous audits where deficits were identified and the follow up action that had been taken. Weekly checks included for the nurse call system, fire checks, medicines stock and financial checks. Monthly audits included checks on, care documentation, staff training, medicines management, accidents and incidents, infection control, nutrition, skin integrity, falls and mobility. Two monthly checks were carried out on personnel files. Records of spot checks were available that were carried out by the compliance manager at regular intervals at nights and at weekends to check aspects of care provision. A provider inspection also took place and we saw the 75 page action plan that had been developed to ensure improved care for people and the progress that had been made to achieve the required outcomes.

It was noticeable there was more of an ethos of involving people and empowering staff in order to provide person centred care. The culture now promoted person centred care, for each individual to receive care in the way they wanted. Information was available to help staff provide care the way the person may want, if they could not verbally tell staff themselves. There was evidence from observation and talking to staff that people were encouraged to retain control in their life and be involved in daily decision making.

The atmosphere in the service was friendly. Staff said they felt well-supported. They said they could approach the management team at any time to discuss any issues. Staff members' comments included, "The support is good," "No matter how little the problem is you can ask the manager or deputy anything you want," "The new manager is approachable," "Management are really good," "The new manager's more involved, more open to suggestions. They're helpful," and, "You can raise problems, they (management) will respond and try and change things."

The provider had introduced an extra tier of management at head office and the new head of home operations was in post to support and provide direct line management to the managers of services. The manager at Lanchester Court told us they were well supported and their line manager, the head of home operations visited the home and was also available by telephone for advice and guidance. The head of home operations told us they were available 'out of hours' to provide advice and guidance to staff if needed.

Staff told us monthly staff meetings took place. A standardised agenda was advertised seven days before the meeting and made available so staff could add any suitable topics for discussion. Meetings were held to keep staff updated with any changes within the home and to discuss any issues. Meeting minutes showed recent meetings had discussed health and safety, the safeguarding process, staff performance, the environment and people's care.

The manager told us the registered provider monitored the quality of service provision through information collected from comments, compliments, complaints and survey questionnaires that were sent out annually to people who used the service. Surveys had been completed by people who used the service in 2015. A survey had not taken place for 2016 although people had questionnaires they could complete to comment about aspects of service provision.