Parkcare Homes (No.2) Limited

Lammas Lodge

Inspection report

Lugwardine
Hereford
Herefordshire
HR1 4DS

Tel: 01432853185
Website: www.craegmoor.co.uk/www.priorygroup.com

Date of inspection visit:
28 April 2016
22 June 2016
23 June 2016

Date of publication:
15 August 2016

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 28 April 2016 and 22 and 23 June 2016 and was unannounced.

Lammas Lodge provides accommodation and personal care for up to seven people who have been diagnosed with autism. There were six people living at the home when we visited.

A registered manager was in post, but at the time of our inspection they were on leave. 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.

People had not been fully supported and empowered to give their views about the care they received and to be involved in decisions which affected them.

There was no consistent management and leadership and this had had an adverse impact upon the care and support provided. The provider's quality assurance systems had not been used consistently and shortfalls in the quality of the care provided had not been identified or addressed.

Staff had not been well-supported or directed by the management team. They did not have the right skills and knowledge to communicate as effectively as possible with all of the people living at the home. Staff lacked knowledge about the requirements of the Mental Capacity Act 2005 and what this meant for their day to day work with people.

People were safe because staff recognised the signs of potential abuse and knew the action to take if they were concerned about people's safety or wellbeing. The provider had clear procedures for dealing with any concerns of abuse.

The risks associated with people's individual care and support needs and the overall running of the home had been assessed and managed to keep people safe. Accidents or incidents were monitored on an ongoing basis to minimise the risk of reoccurrence.

There were enough suitable staff to meet people's needs because the provider adhered to safe recruitment practices. Staff treated people with dignity and respect.

The provider had developed systems and procedures to ensure that people received their medicines in a safe manner. People also received appropriate support with eating and drinking. The risks associated with people's eating and drinking had been assessed and managed.

People were supported to maintain good health with the involvement of a range of external healthcare

professionals.

Staff helped people to keep in contact with those important to them. People's friends and relatives were able to visit them without unnecessary restrictions. People's relatives knew how to raise concerns or complaints about the service and felt confident that they would be listened to.

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

The service was safe.

People were safe because staff understood how to identify and report abuse. The risks associated with people's care and support needs had been assessed and managed. The provider adhered to safe recruitment practices. People received their medicines safely.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People were not always supported in a way they needed because staff couldn't effectively communicate with them. Staff were not well-supported by the management team. The risks associated with people's eating and drinking had been identified and managed. People's health needs had been assessed and they were supported to access health services.

Is the service caring?

Good

The service was caring.

Staff knew people well, listened to them and talked to them in a polite and respectful manner. Staff treated people with dignity and respect and took appropriate action in the event that people became distressed. People's relatives were made to feel welcome and could visit whenever their family members wanted.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People did not receive consistent, personalised care. Their involvement in decisions that affected them was not fully supported. People's views about the quality of the care and support provided were not actively sought out and acted upon.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

The management and leadership of the home had not been consistent. Staff did not have a clear sense of direction. The provider's quality assurance systems had not been consistently employed to identify shortfalls in the quality of care.

Lammas Lodge

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 28 April 2016 and 22 and 23 June 2016 and was unannounced. The inspection team consisted of two inspectors.

We looked at the information we held about the service. We reviewed the information received from the local authority commissioners and the statutory notifications the registered manager had sent us. A statutory notification is information about important events which the provider is required to send to us by law. Commissioners are people who work to find appropriate care and support services which are paid for by the local authority. This inspection was brought forward because we had received information about a serious incident involving this service.

We met with two of the people who lived at the home and saw the care and support offered to people at different times of the day. Many people who lived at the home were not able to tell us in detail about how they were cared for and supported because of their complex needs.

During our inspection we spoke with the regional manager, nine members of staff and the provider's behaviour specialist. We also spoke with four relatives by telephone. One relative requested they emailed their response to us. We looked at the care records of four people, the medicine management arrangements and records, people's activity records, staff training records, records associated with the provider's quality assurance systems and the home's complaints log.

Good

Is the service safe?

Our findings

We were not able to speak with most of the people living at the home about whether they felt safe there. In response to this question, one person told us, "Yes, staff look after me and feed me." People's relatives were satisfied that their family members were safe at the home. One relative told us, "They're with [person's name] all the time. They have a monitor by him at night if he wakes up."

People were supported by staff that recognised the signs of potential abuse and knew the action to take if they were concerned about people's safety or wellbeing. Staff described how their knowledge of the people they supported would enable them to pick up on any changes in people's moods or behaviour that may point towards possible abuse or mistreatment. The provider had clear procedures for dealing with any such concerns and notifying the relevant authorities. We saw that the provider had reported previous concerns of this nature to the local authority.

The provider had assessed, documented and developed plans to address the risks associated with people's individual care and support needs in order to keep them safe. These plans dealt with, amongst other things, people's mobility needs, their mental and physical health and any behavioural issues. Staff were aware of this information and understood their role in protecting people from harm. For example, one member of staff described how they supported one person to shower safely, taking into account their long-term health conditions and mobility issues.

Staff told us that, where possible, people were involved in decisions about the risks affecting them. We saw an example of how one person had been involved in decision-making about the installation of a listening device in their bedroom to help keep them safe at night. People's relatives did not feel that their family member's freedom to do things was unduly restricted as a result of the home's risk assessment. One relative told us, "They (staff) try to stretch them and encourage them to do things."

We saw that the provider had also put measures in place to manage the risks associated with the overall running of the service, including the maintenance of the building and fire safety arrangements within the home. Emergency evacuation plans had also been developed and staff were aware of these.

The provider monitored any accidents or incidents at the home on an ongoing basis in order to identify patterns of risk and to ensure lessons were learned to minimise the risk of reoccurrence. Monthly multi-disciplinary meetings were organised at the home, attended by the management team, behaviour specialist, consultant psychiatrist and speech and language therapist. As part of these meetings, any recent incidents at the home were discussed in order to examine their implications for people and the support needs of the staff team.

We saw that there were enough staff available to people to meet their needs and ensure safe care and support. The regional manager explained that staffing levels reflected people's assessed needs and their funding arrangements. People's relatives were satisfied that staffing levels were safe and appropriate. One relative told us, "There always seem to be plenty of staff there." Staff told us that a lack of permanent staff

due to staff turnover had, at times, impacted on staffing levels at the home, but that these had not dipped below safe levels. The regional manager acknowledged this had previously been a problem, but assured us that staffing levels were now being consistently maintained. The provider was actively recruiting to fill the remaining staff vacancies. Regular use was being made of agency staffing to maintain the home's staffing levels until these recruitment activities had been completed. Consistent agency workers were used to promote continuity of care and to reduce risks to the people living at the home.

The provider adhered to safe recruitment practices. The information held on staff members' files confirmed that they had undergone a Disclosure and Barring Service (DBS) check and had had to supply employment references before starting work at the home. DBS checks help employers to make safer recruitment decisions and to ensure only suitable people are employed.

We saw that people's medicines were managed and administered safely. We observed the administration of one person's medicines. The staff member told this person what they were taking before offering their medicine to them, and treated them in a friendly and professional manner at all times. Staff told us that they received training before they were allowed to support people with their medicines, and periodic assessments were completed to confirm their continued competence. We saw that people's medicines were stored in a safe and appropriate manner. The management team carried out regular audits in relation to the safe handling of people's medicines to quickly identify and resolve any discrepancies or issues. People's ability to self-administer their medicines had been assessed. No one was self-administering at the time of our inspection. Staff had been provided with written guidance around the use of "as needed" medicines in order that they were clear about the circumstances in which these were to be offered to the relevant individuals.

Requires Improvement

Is the service effective?

Our findings

Staff told us that they did not have the right skills and knowledge to communicate as effectively as possible with one of the people living at the home due to a lack of Makaton training. Makaton is a language programme based upon signs and symbols used with speech to help people to communicate.

Staff described the significant impact which the lack of Makaton training had had on their ability to communicate with this person. One staff member told us, "It would help us have more interaction with the likes of [person's name], even about pain. Otherwise, it's a guessing game limited to "yes" and "no". If they sign things, we won't understand and we could miss anything." Another staff member said, "One agency staff comes in and they're brilliant with [person's name]. They can ask them anything and get a response straight away." Another staff member told us, "[Person's name] would flourish if we used Makaton. They respond really well to it." This staff member told us that they had raised the lack of Makaton training in their one to one meeting with management in December 2015, but that the relevant training had not been organised.

We saw that the use of Makaton was referred to in the person's care records. These stated, "I use symbols and basic Makaton to communicate my wants and needs." We also noted that the speech and language therapist had previously recommended the use of Makaton with another person living at the home. The regional manager acknowledged the need to organise additional Makaton training for the staff team. They told us that they were in the process of sourcing an appropriate training course.

Staff spoke positively about the induction training they had received upon starting work at the home, as part of which they had worked alongside more experienced staff and been given time to read people's care plans. One staff member said, "I had two weeks of shadowing. They were really supportive and I was told to let them know if I had any concerns." We saw that agency staff were provided with a condensed induction to the home. On the subject of their induction, an agency worker told us, "I've not been left to my own devices."

Staff benefitted from an ongoing programme of training. One staff member described the benefits of a seminar they had attended on autism, which had given them valuable insights into the condition and how to support people's behaviours. Another staff member described how the physical intervention training they had completed had given them a clear understanding of how to respond to people who are posing a risk to themselves or others in a safe and lawful manner.

Staff told us that they had not received effective support from the management team in the form of regular one to one sessions, over a number of months. One staff member told us, "I can't remember the last time I had a supervision. They were coming up, but the manager wasn't here." This person went on to describe the impact this had had upon them , explaining that, "You need to get things off your chest and talk about what's going wrong." Another staff member said, "You are more aware of things and get more feedback." They went on to say that staff had not received enough feedback or praise from management. We discussed the inconsistency of staff supervision and appraisals with the regional manager who acknowledged this

issue and assured us these meetings would be arranged on a more consistent basis moving forward.

We looked at whether the service was working in line with the requirements of the Mental Capacity Act 2005. 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

We saw that some information about people's capacity and the support they needed with decision-making had been recorded in their care files, however improvements were needed. Staff lacked knowledge about the requirements of the MCA, and what this meant for their day to day work with people. Not all staff had received training to ensure they understood their associated responsibilities. The regional manager also told us they were not confident that staff were consistently working in line with the MCA, as they had seen little evidence of mental capacity assessments and best interest decision-making. They assured us that staff would receive additional training and support in relation to the requirements of the MCA.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We found that the provider had carried out an assessment of people's mental capacity and their individual care and support arrangements and had made DoLS applications on this basis

We looked at the support people received with eating and drinking. We observed how staff supported and assisted people during lunchtime. We saw that the lunchtime meal was an unrushed and relaxed affair, involving freshly-prepared sandwiches and lots of conversation and humour. One person eating lunch received lots of encouragement from staff to finish their meal.

The risks associated with people's eating and drinking had been assessed, recorded and plans introduced to manage these, with the involvement of the speech and language therapist where necessary. One person was provided with a specialist diet for health reasons. Staff were aware of this information, and we saw that they supported people in accordance with their care plans during lunch.

We looked at how people were supported to maintain good health. We saw that people's health needs, including details of any long-term health conditions, were recorded in their individual care files. These files also contained the details of the various external health professionals involved in monitoring people's health needs, including GPs, the consultant psychiatrist, physiotherapist, community nurses, the behaviour specialist and neurologist. People had health action plans, which are personal plans setting out the help and support they needed to stay healthy. People's relatives spoke positively about the support given to their family members to maintain their health. One relative told us, "They take [person's name] to the doctor or physio if anything at all is wrong. Their interaction with other professionals is very good." The staff we spoke with had a general understanding of people's day-to-day health needs, but were unclear about people's specific diagnoses and health conditions. This had not had a significant impact upon the health and wellbeing of the people living at the home. We discussed this lack of staff awareness with the regional manager who assured us they would provide staff with additional support in this area.

Good

Is the service caring?

Our findings

Both of the people we spoke with told us they liked the staff. One person told us that if they were upset, staff would sort it out for them, adding, "They (staff) make me happy a lot."

People's relatives also spoke positively about the staff team. One person's relative described staff as, "Very caring." They went us to tell us how their family member was always keen to go back to the home following home visits. Another relative said, "It's the best place they've ever been in how they look after them. Staff enjoy their company and want their life to be better."

We spent time in the home's communal lounge to see how staff engaged with people and responded to their individual needs. Over this period, staff did not engage in meaningful conversation or activities with the two people present in the lounge. The TV was switched on at the time, but people did not appear to be actively watching it.

However, we saw a number of positive interactions between staff and the people living at the home on other occasions. People were comfortable and relaxed in their home and at ease when talking with staff. Staff spoke to people in a polite and friendly manner and helped us communicate with them. We saw staff respond calmly and patiently to a person who had become anxious and frustrated in the staff office. We later saw this person in a more relaxed mood. We heard other staff chatting to people about their plans for the day and taking interest in what was said to them.

The staff we spoke with valued the people they supported as individuals, and talked about them with affection and respect. They told us how they got to know people by reading their care plans, learning from more experienced staff and interacting with them on a day-to-day basis. People's relatives felt staff knew their family members well. One relative told us how the staff team's knowledge of their family member meant they could recognise the triggers for behaviours and prevent their anxieties from creeping in.

People's relatives said they were made to feel welcome at the home and could visit whenever their family members wanted. One relative told us, "I know I can ring up and say that I'm coming at any time." People's relatives also felt involved in care decisions. One relative told us about the benefits of their monthly meetings with their family member's key worker. These meetings were used to review the care and support provided over the last month and to make plans for the month ahead. Another parent told us they had attended two recent review meetings at the service to discuss their family member's care.

Both of the people we spoke with told us staff helped them to keep in contact with those important to them. People's relatives were also happy with the support they received to keep in touch with their family members. One relative told us, "Staff are very cooperative. They will always bring [person's name] to me if I'm unable to get him." In assisting people to stay in touch with others, staff also helped people to make phone calls, take photographs and send letters and emails.

People's relatives were happy with the support provided to enable their family members to be as

independent as possible. One relative told us, "[Person's name] will dress themselves, feed themselves and gets their own breakfast. They (staff) have made cakes with them. They (people) do as much as they can for themselves." Another relative told us how staff were supporting their family member to make use of the kitchen in their flat to develop their cooking skills. We saw that people's care plans promoted the development of their daily living skills, such as bathing, eating and drinking and handling their personal money. Staff were able to tell us about some of the ways they promoted people's independence on a day-to-day basis. For example, one staff member explained how people were encouraged to assist with their personal laundry and household chores.

Staff understood what it meant to treat people with dignity and respect and had received training on this subject. One staff member told us, "It's giving people the opportunities and time to understand what they think and feel, and offering opportunities for them to be independent." Staff talked us through the practical steps they took to protect people's privacy and dignity when, for example, supporting them with personal care tasks. This included protecting people's modesty and ensuring that doors and curtains were closed as necessary. People's relatives confirmed that staff demonstrated respect for their family member's privacy and dignity. One relative told us, "They (staff) treat people with respect and as individuals."

Staff told us that the people who used the service had previously made use of advocacy services and continued to do so. One person's relative confirmed that their family member currently had the support of an advocate supplied by the local authority.

Requires Improvement

Is the service responsive?

Our findings

People were not receiving consistent personalised care and support. Their involvement in decision-making which affected them was not being fully encouraged. This lack of involvement and choice was evident in the food and drink offered to people each day. People had not been appropriately involved in menu-planning and had not been given a genuine choice in what they ate on a day-to-day basis. One staff member told us, "I think it could be vastly improved. I haven't seen any discussion with [people] about menu planning or helping out in the kitchen." Another staff member said, "There were no choices before and the menus were not reviewed." Another staff member told us, "Before, it was a case of this is the menu, stick to that." The home's menus displayed no choice of food for people's main meals each day. Staff told us that the meal identified on the menu was normally prepared for people and consideration only given to alternatives if people refused to eat what they were presented with.

We discussed people's lack of choice and involvement in what they ate and drank with the regional manager, who acknowledged these issues. They told about their plans, and the action being taken, to promote greater involvement in menu-planning and a clear choice of food options at mealtimes.

During our inspection, we saw people taking part in activities outside of the home. For example, one person attended a local farm project whilst another went to play snooker. Both of the people we spoke to told us about the activities they enjoyed, which included playing snooker, golf and going for walks.

However, we saw that there was little forward planning taking place around people's activities and limited efforts being made to meaningfully engage with people about how they wanted to spend their time each day. As a result of staffing pressures and a lack of clear leadership, decisions about people's activities were primarily made by the senior on duty based upon their staffing resources that day. One staff member told us, "Before we used to sit down and talk with people about activities. Now it's more prescribed. It's written down on the board before we come on shift." Another staff member said, "We go off a board. They (people) should be asked on the day." Another staff member told us, "There's been no planning or incorporation of choice."

Staff also told us that there was a significant imbalance in the support people received to participate in community-based activities, with some people's activities taking precedence over those of others. One staff member told us, "Two or three days can pass by without individuals going out. Some guys are literally sitting around twiddling their thumbs." We looked at people's activities records which supported the concerns raised by staff and highlighted significant differences in the frequency with which people were able to access the community.

We spoke with the regional manager about the limited consultation and planning taking place around people's activities, and the potential imbalance in the support provided. They acknowledged that improvements needed to be made in this area and told us about their plans to introduce a new visual activities board to increase people's involvement in activities planning.

People had not been fully supported to share their views about the quality of the care provided and to raise any related complaints or concerns. Previously, people had been empowered to have their say about their care and support at regular service users' meetings and through monthly one-to-one meetings with their key worker. A key worker is a staff member who acts as a focal point for a person and their relatives and who ensures the individual's personal requirements are not overlooked. Due to a lack of management planning, and without consultation the people living at the home, neither type of meeting had been arranged for several months. Over this period, no alternative means of engaging with the people who lived at the home had been introduced to replace the loss of these meetings. The regional manner acknowledged the value of these meetings, and told us that they would now be recommencing. The regional manager also explained their plans for further developing the effectiveness of the key worker role at the service to ensure this was of maximum benefit to the people living there.

People's relatives told us they knew how to raise concerns or complaints about the service and felt confident that they would be listened to. One relative told us, "I know how to go to the main person in charge". Another relative said, "If I ever want to speak to them they are always there. Usually one of the seniors appears when I visit the home." We saw that the provider had a formal procedure in place for dealing with complaints. The last recorded complaint received in August 2014 had been investigated and responded to by the provider. The lessons to be learned from this complaint had also been discussed at the next staff meeting.

People's care files contained details of their personal histories, needs, preferences and interests. These files provided guidance for staff on how to support each individual, and staff told us they made use of these. People's individual assessments and care plans had not been regularly reviewed and updated to reflect changing needs. For example, one person's risk management plan that had been due for review on a monthly basis had last been updated in July 2015. However, the staff we met with spoke with a good understanding of people's individual needs.

Requires Improvement

Is the service well-led?

Our findings

We found that both the people who lived in the home and the staff had not benefitted from consistent management and leadership for a number of months. During this period, there had been inconsistencies in the level of management support and presence at the home due to staff sickness and a change to the registered manager's job role, amongst other contributing factors. The regional manager acknowledged that the home had had reduced management support from the point at which the registered manager had taken on their additional responsibilities outside of the service.

The lack of consistent management oversight and support had had an adverse impact upon the care and support provided to the people living at the home, in a number of ways. For example, people had not received consistent person-centred care. This was demonstrated, for example, by the failure to empower people to have their say about the quality of care provided and by the lack of involvement and choice we saw in decisions about what people ate or how they spent their time.

Where people had given their views about the service, this had not been acted upon by the management team. We saw the results of the provider's most recent annual satisfaction survey completed by or with the people living at the home in June 2015. The responses provided highlighted people's concerns in relation, for example, to their lack of involvement in decision-making and their feelings of safety at the service. We discussed the outcomes of this survey with the regional manager who was not aware of any follow-up actions having been taken by the provider or registered manager to further investigate or address these concerns.

The provider's established quality assurance systems had not been consistently used by the management team, with the result that the shortfalls we saw in the quality of the care provided had not been identified and addressed. We saw that the regional manager had taken some immediate action to address a number of these issues, and that plans were in place resolve others. We were not able to test out these improvements, but will do so at our next inspection.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff had not been well-supported or directed by the management team, which had affected staff morale and relations. One staff member told us, "There has been a lack of direction from management. I've seen [registered manager] for about 10 minutes since I've been here. [Deputy manager] is not here much and when they're here they're in the office a lot." Another staff member said, "There's been a lack of leadership. It's had a massive effect on staff. They've got no respect for the manager and morale is worse than I've ever seen it. It's at rock bottom." Another staff member told us, "No one is steering the ship." The regional manager acknowledged that staff had not experienced a clear sense of leadership and direction. They assured us that staff would receive appropriate and consistent management support moving forward. Staff spoke positively about the more consistent management presence and support provided by the regional manager since April 2016.

Three of the staff we spoke with told us that communication within the staff team was hampered by ineffective handover procedures. Staff handover is the means by which the staff leaving shift pass on important information to those arriving on duty. One member staff said, "Some things go awry because staff aren't involved in handovers. The seniors relay important things, but some day-to-day things get missed." Another told us, "Usually the senior will tell us things, but there's no handover. There is a handover book, but we don't get much from that as Support Workers." The management team had not identified or addressed these issues. The regional manager accepted staff's comments about the need for improved handover procedures. Before we concluded our inspection, we saw that steps had been taken to ensure that staff received a more effective handover from the senior on duty.

People's relatives felt that the management team were approachable, but were aware of the management issues which the home had experienced. One relative told us, "No one seems to be in control. Things are dispersed. You don't get answers because there's no one at the definite manager level." Another relative described the need for a clearer line management structure within the home and more accountability at all levels.

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 17 HSCA RA Regulations 2014 Good governance The provider had not acted on the feedback gathered from the people using the service regarding the quality of the care provided.