Care Quality Commission

Leicestershire County Care Limited

Lenthall House

Inspection report

Lenthall Square
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Ratings

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

Overall summary

This inspection took place on the 13 February 2015 and was unannounced, we returned announced on 16 February 2015.

At the last inspection on 17 April 2014 we asked the provider to take action to make improvements. The provider was not meeting one of the Health and Social Care Act 2008 Regulations. This was assessing and monitoring the quality of the service. The provider sent us an action plan to tell us the improvements they were going to make. Whilst we found that improvements had been made in some areas, we identified further concerns with a different part of the regulation that showed improvements were still required.

Lenthall house is a care home for up to 40 people and provides care and support to people with needs associated with age and physical disability and people living with dementia.

Lenthall House is required to have a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered

Summary of findings

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. At the time of the inspection a registered manager was in post. They had recently taken over managing the service and were also the registered manager for another service the provider had. An additional manager was also in post and they had day to day management responsibility.

People and their relatives told us that they had no concerns about safety and that where risks had been identified, they had been involved in discussions and decisions about how these would be managed. People told us that they received their medicines safely and at the right time. Some relatives thought the staffing levels could have been better to enable staff to have had more time to spend with people.

Staff were aware of the safeguarding procedures in place and of their responsibility to protect people and how to report concerns. We found people received their medicines safely. Medicines were stored and managed correctly and administered as prescribed by their GP. Staffing levels were determined by people's dependency needs. We found no concerns with the staffing levels provided and found them to be safe. However, improvements with the deployment of staff required addressing particularly at mealtimes.

People and their relatives told us that they were supported to maintain their health by having access to healthcare professionals when they needed to. We found some concerns with regard to the lack of information and understanding of staff about some people's health care needs.

Some people told us that the meal choices could be improved upon and that they were concerned about how the meals were served. People and their relatives said that they received sufficient to eat and drink and that their nutritional needs were met. People had their dietary and nutritional needs assessed and planned for and referrals were made to healthcare professionals on the whole in a timely manner.

Staff received an appropriate induction and ongoing training and development. The manager had identified staff training based upon the needs of people that lived at the service. Staff received opportunities to discuss and review their practice with the manager. We saw examples that consent was sought before care and treatment was provided. We saw the practice with regard to the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards required some improvements.

People and their relatives were positive about the approach of staff and said they were kind and caring. Whilst we observed at times staff to be caring and compassionate, we also saw examples where staff showed a lack of dignity and respect. Care practice required improvements to ensure consistent good quality. People did not always receive appropriate support at meal times.

People and their relatives told us that they had been asked about their routines and preferences and what was important to them in the way they were cared for. People said that they were supported to maintain contact with their relatives and friends and that their religious or spiritual beliefs were respected and supported.

People and their relatives had opportunities to share their views and experience about the service. Social activities were provided and the manager was looking at ways of improving people's leisure and social opportunities. People had information available about independent advocacy services and the provider's compliant procedure.

We found some concerns with the assessment of people's needs, plans of care and associated risk assessments. We saw examples where people had specific health conditions that did not have a plan of care advising staff of their needs and how to meet those needs. We also saw examples of plans of care that lacked detailed information and guidance for staff. Care records had not always been fully recorded and information was sometimes incorrect or inconsistent.

The quality and assurance systems in place had recently been reviewed and work was still in progress in developing these further. The audits in place had failed to identify some of the concerns we found. Staff had opportunities to be involved in decisions and discussions about how the service was provided. Staff meetings were provided and there were communication systems in place including handover meetings to discuss people's needs on a daily basis.

Summary of findings

We found the service was in breach of two of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. These correspond to regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

People told us that they felt safe. Staff were aware of how to protect people from avoidable harm and the actions to take if they had any concerns. People received their medicines safely.

The risk management plans for people with needs associated with their behaviour lacked detailed information of how to support people to reduce the likelihood of incidents occurring. Some concerns were found with the safety of the environment.

People and their relatives raised some concerns about staffing levels. The manager assessed people's dependency needs which were used to determine the staffing levels required and these were regularly reviewed for changes.

Is the service effective?

Requires Improvement

The service was not consistently effective

People told us that on the whole they found staff to be appropriately skilled and experienced. Staff received an appropriate induction, on-going training, development and support.

We found that some people were at risk of having their liberty and freedom restricted without appropriate authorisation in place. The Mental Capacity Act and Deprivation of Liberty Safeguards policy and procedure lacked guidance for staff of the action required in the absence of the manager.

People told us that they were supported to access healthcare professionals when required. People had their dietary and nutritional needs assessed and planed for. We found there was a lack of information and understanding by staff of people's healthcare needs.

Is the service caring?

Requires Improvement

The service was not consistently caring

On the whole people spoke positively about the approach of staff. We observed some good examples of care and compassion provided by staff. However, we also saw poor examples of care that showed a lack of dignity and respect.

The mealtime experience for people was not positive. A lack of leadership and organisation affected people's dining experience.

People told us they were supported with their religious and spiritual needs and that they had been consulted about their needs, preferences and routines.

Summary of findings

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

We identified that people's needs had not always been responded to in a timely and appropriately manner. Staff lacked detailed information about how to respond to people's individual and assessed needs.

People told us that they were given choices about their routines and this was respected and acted upon.

People told us that they were aware of the complaints procedure and that they felt confident to raise any concerns or make a complaint if required.

Is the service well-led?

Requires Improvement

The service was not consistently well-led

People told us that they had found the changes with the management unsettling but were positive that changes were being made to improve the service.

People and their relatives received opportunities to feedback to the provider their views and experience about the service and that they were listened to.

Staff were positive about the changes and felt valued and supported.

The provider had quality assurance checks in place but these required further improvements to check on safety and quality.

Lenthall House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider was 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 the 13 February 2015 and was unannounced. We returned on 16 February 2015 announced. The inspection was completed by two inspectors and an Expert-by-Experience. The Expert-by-Experience had personal experience of caring for someone using health and care services.

We looked at and reviewed the Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed additional information the provider had sent us, such as safeguarding notifications, these are made for serious incidents which the provider must inform us about. We also contacted the local authority who had a contract with the provider and health and social care professionals for their feedback about the service.

We spoke with seven people who used the service and five visiting relatives. We also used observation to understand people's experience of the care and treatment they received. We spoke with the registered manager, one of the provider's area managers and a manager that had day to day responsibility for running the service. We spoke with the cook, a senior care worker and four care staff. We also spoke with a visiting community nurse and received feedback from the GP about their experience of the service. We looked at the care records of four people who used the service and other documentation about how the home was managed. This included policies and procedures, records of staff training and records associated with quality assurance processes.

Requires Improvement

Is the service safe?

Our findings

People and their relatives we spoke with told us they felt safe living at Lenthall House, and no one raised any concerns about their safety. One person told us, “We are well looked after, I have no concerns.” Another person said, “I feel safer living here than I did at home.”

Staff were aware of their responsibilities and action required to protect people from abuse and avoidable harm and knew about the whistleblowing policy. The provider followed local and national safeguarding policies and procedures and reported concerns appropriately. Staff told us they had received training in safeguarding and records confirmed this.

We looked at how risks for individuals were identified and managed. A relative told us that as a result of their family member having a fall, the manager had arranged a meeting to discuss what measures could be put in place to reduce further risks. They said, “A sensor mat has been put by the bed to alert care staff if my mother gets out of bed. This was agreed with my relative and family members.”

Staff told us they had received training in health and safety and records confirmed this. We saw records that confirmed regular fire drills were carried out to ensure staff knew the procedure to safely evacuate the building if required. Staff gave example of how risks were managed. One staff said, “We keep the building secure, make sure they are well looked after, make sure any problems are solved and reported, remove trip hazards and obstacles.” We identified that the water temperatures in some of the bathrooms appeared very hot and taps had not been descaled appropriately. We were concerned that this was a risk to people and staff and discussed this with the manager. They took immediate action and arranged for the provider’s maintenance manager to visit the service and carry out the necessary work. This was completed on the second day of our inspection

From the care files we looked at we found that some people had behaviours that put them or others at risk. Staff gave examples of how they supported people with these needs but said they felt they needed further guidance. We found risk management plans provided limited information for staff of how to manage these risks. For example, detailed information about known and possible triggers was missing. Guidance was more about how staff should react to a situation rather than how to be proactive to reduce the likelihood of behaviours occurring.

We found the provider had identified and planned for risks that may have affected the service. For example, there were arrangements in place to deal with foreseeable emergencies. The provider had a ‘business continuity plan' available for staff that advised of the procedure to follow in the event of an emergency affecting the service.

The provider had specialist equipment available, such as hoists and wheelchairs to keep people using the service safe. We found that equipment had been appropriately maintained and staff had received training in how to use it. We saw several people had walking frames that were in easy reach for them to use safely to get about independently. We observed staff supported people appropriately and safely following best practice guidance in moving and handling.

People and their relatives told us that they were concerned about the high turnover of staff and that this was unsettling for people and affected consistency. Additionally, relatives said that they were concerned that not enough staff were always available to meet people’s needs.

Whilst some staff told us there were sufficient staffing levels others said they thought it could be better. For example, one staff told us, “It’s quite difficult to get staff. We need more than they [management] say we should have.” Another staff said, “It’s [staffing] a little low, but we are working as a team. There aren’t any issues really. If someone is sick the senior will ring round and try to get our staff in, if not we get agency.”

We saw how experienced staff supported recently appointed care staff in the delivery of day to day care. We observed that staff responded to people’s call bells in a timely manner and other requests for assistance. However, we noted that staff did not take time to sit and chat to people when we were there.

The manager had carried out a needs analysis and risk assessment as the basis for deciding sufficient staffing levels. We saw people’s dependency needs were reviewed regularly for any changes that may have required the staffing levels to increase.

Requires Improvement

Is the service safe?

Care workers employed at the service had relevant pre-employment checks before they commenced work. This included a check with the 'Disclosure and Baring Service' (DBS) which checks criminal records and staff suitability to work with people who use care services.

People and their relatives were all confident they were supported with their medicines safely and appropriately. One person told us they had tablets four times a day, they could not recall what they were for but did say, "They [medicines] are given at the right time." Another person told us what medicines they took and said, "They [staff] give them to me in the morning." A relative said that they had previously had concerns about their relative's medicines which they had raised with the manager and had not had any further cause for concern.

Staff responsible for the administration of medicines told us they had received appropriate training and records confirmed this. The provider had a medicine policy and procedure to support staff in the safe storage and management of medicines and we saw these were correct. We saw medicine records detailed each person's medicines and the reason they were prescribed, side effects and important details about how the person liked to receive their medicines from staff. In addition there were plans for how PRN medicines should be given. These are medicines that are given when needed, for example for pain, illness or anxiety. This meant that staff had clear guidance to follow to ensure these medicines were being given safely.

Requires Improvement

Is the service effective?

Our findings

On the whole people and their relatives told us that they found staff to be sufficiently skilled and experienced. However, a relative shared a concern about the needs of people living with dementia. They said, "Most of the staff are very good but a few sometimes show little understanding of dementia and don't respond when people ask for help." We shared this with the manager.

Staff were positive on the whole about their training, support and development needs. One staff told us, "We have training regular at the moment, I don't feel like I've got any gaps." Another care worker said, "Dementia. It was really good, it helps us to work with people with different levels of dementia." However, another care worker told us they had concerns about meeting people's behavioural needs and felt there was a lack of training and guidance in this area.

We saw the manager had a training matrix that showed staff had received training in the areas that had been identified as required. The manager told us that they were in the process of arranging for the community nurse to provide additional training for example in catheter and stoma care. They had also identified that additional training in dietary and nutritionally needs were required and this had been arranged for March 2015. We asked about the training in dementia care and the manager told us that staff accessed a distance learning course from a local college. We also saw that the manager had a plan whereby staff received opportunities to meet with them to discuss and review their training and support needs. In addition the manager carried out observational assessments on staff whilst they delivered care to ensure staff used safe and best practice methods.

We spoke with an agency worker who told us that they had received a basic induction on arrival and that they felt supported and had the required information they needed to care for people. We also spoke with care staff recently appointed. They told us what their induction consisted of and this included shadowing other experienced workers before providing care independently, and being aware of the provider's policies and procedures. However, these care staff had been in post three weeks and had not looked at people's plans of care. Some people living at Lenthall House were very reliant on staff for all their needs and relied on staff to know how to care for them effectively.

The Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS), is legislation that protects people who are not able to consent to their care and treatment. It also ensures people are not unlawfully restricted of their freedom or liberty. Some people lacked capacity to consent to their care and treatment, we saw examples where people's capacity to consent to a specific decision had been completed and a best interest decision made and recorded. This was in line with the MCA. However, it was not always clear if people had a Lasting Power of Attorney (LPA) that gave another person legal authorisation to be involved in best interest meetings and decisions. This is important to ensure people's human rights are fully protected. We discussed this with the manager who agreed to review this with people and their relatives.

Staff told us they had received MCA and DoLS training and gave examples of how they gained consent before providing care and explained what their understanding of MCA and DoLS were. One care staff said, "If a resident is able to make a decision, we don't impose decisions on them. We have to assess them first." Another care staff told us, "It's about what to look for with people with dementia, so we know how to help people and they get the right care. I think the seniors and management do things like capacity assessments and best interest decisions." Whilst the manager was aware of the action to take to adhere to the MCA and DoLS legislation, the provider's policy and procedure lacked guidance for staff to follow in the absence of the manager.

Whilst there was no person present that had an authorisation in place that restricted them of their liberty, the manager gave an example of where they had submitted an application to the supervisory body. However, we found some situations that we considered may have constituted a deprivation of a person's freedom and liberty. For example, a person living with dementia was observed to be asking to return home and was dissuaded from this. Records showed that some people living with dementia were resistant to personal care. The GP had prescribed medicines to be used at this time but we were concerned that an MCA assessment had not been completed to show that this was the least restrictive practice and in the person's best interest. We discussed this with the manager who took immediate action and contacted the supervisory body and submitted urgent DoLS applications.

Requires Improvement

Is the service effective?

We found that bathrooms and some toilets had a bolt at the top of the door which made it difficult for people to use. We were concerned that this was confusing for people, was a restriction and we did not see any associated risk assessments. We discussed this with the manager who agreed to review this.

People told us they had a choice of meals and that they received sufficient to eat and drink. One person told us, "At breakfast they [staff] come round and ask what you'd like for lunch." Another person complained about the meal being served they told us, 'I just want you to know that dinner today was disgusting and it's about time something was done about it. The food is left up there for 10-15 minutes before it is served, so it's bound to be cold. They should serve each table at a time so that we get the food together."

We saw staff offered people a choice of what to eat, including alternative meals to the ones on the menu for the day. We also observed staff offered a choice of drinks including fruit and biscuits during the day and cold drinks were available for people to help themselves. The cook was aware of people's nutritional needs and preferences and the menu appeared to be nutritionally balanced and offered people a choice of what to eat.

During lunchtime we saw that people in wheelchairs were not all correctly positioned, resulting in them being too far away from the table. This caused people difficulty with their eating. Some people needed more assistance than was offered. For example, people struggled with cutting their food, some ate with their fingers, many people struggled to eat and ate very little. Some people tried to eat their pudding with just a knife as no more suitable utensil was available.

Some people had specific dietary and nutritional needs. Staff had worked with health professionals such as dieticians and speech and language therapists to meet people's needs. Where recommendations from health professionals had been made, we saw examples these had been included in people's plans of care. For example, where the dietician had recommended food supplements for weight gain or for food to be fortified to increase calorie intake this was recorded to inform staff. Where concerns had been identified with people's weight, appropriate action had been sought from the GP and people's weight was monitored.

People told us that they felt confident their healthcare needs were monitored and they had access to healthcare professionals when required. One person told us that the optician visited when asked, the chiropodist about every six weeks, the GP every week and the nurse most days.

We spoke with a visiting nurse who told us that they received appropriate and timely referrals from Lenthall House and that staff followed recommendations made and asked if they were unsure of anything. We spoke with the GP after our inspection who confirmed that they visited Lenthall House weekly and that they had no concerns about people's healthcare needs not being met.

People received support to maintain their health and had access to healthcare services and received ongoing healthcare support. For example, we saw that one person had three specific and serious medical conditions and that they required pain relief medicines related to these conditions. The GP was regularly involved with this person's care and we noted that pain relief medicines were administered appropriately.

Requires Improvement

Is the service caring?

Our findings

People and their relatives we spoke with were on the whole positive about the level of care provided by staff. One person told us, "The staff are all very kind, they do everything for you. They sometimes ask me if I need anything from the shops and they will get me some toiletries." Another person added, "Yes they've [staff] been very kind to me." Two relatives also made positive comments, one told us, "I do like the staff here, they [staff] do look after my relative." whilst another relative said, "I've not seen anything that's given me cause for concern." One relative made a negative comment and said, "Staff don't always respond when people ask for help."

On the whole we observed staff to be attentive to people's needs. We saw staff used good communication skills when talking with people. For example, staff got down to eye level with people, used people's preferred names and people seemed relaxed and at ease chatting to staff. We also observed how staff responded appropriately when people were unwell or in distress or discomfort. For example, one person did not appear well, the GP was contacted and the person was supported to return to bed to be more comfortable. Another person became agitated when staff were supporting them with a hoist to transfer from a chair to a wheelchair. Staff offered reassurance and gave the person time and space and returned when the person was calmer. Two people were cared for in bed and we saw staff checked on them regularly and offered drinks and made sure they were comfortable.

Staff told us how they treated people with dignity and respected and promoted independence. One care staff said, 'There is a bit of time, but not much. When I'm assisting people to get up we often have time to chat to each other." Another care staff told us, 'We always ask about food, activities, what they want to do and where they want to go. We encourage mobility for as long as we can."

However, we found some concerns with the approach of care staff that showed a lack of care, dignity and respect. For example, at 9.45am we observed how a person was having difficulty leaving their bedroom due to the door closer being too strong. The manager arranged for the maintenance person to return on the second day of the inspection where they fixed the door closure. This person's room had a strong smell of urine. We found the continence sheet on the bed was wet. When we returned to the room with the manager at approximately 11am the bed had been made but the continence sheet had not been changed.

On our first inspection day we observed lunch being served, the room was decorated for valentine's day and old time music was playing. Whilst tables were set with matching glasses, napkins a flower and condiments including salt and pepper and a jug of squash, people's experience was poor. For example, one person entered the dining room who had been incontinent. Staff had not noticed this and did not respond until an inspector pointed out that they required assistance. Another person spilt juice on the floor and table. This distressed them and they tried to clean up the spillage with napkins. The spillage was not picked up and cleaned by staff for some time. Some people were supported to sit in chairs that others usually sat. This caused some people to become agitated. Staff later moved people to their regular seats which again caused people distress. The atmosphere in the dining room was chaotic with no staff monitoring or supervising the dining room.

A person said the fish was cold and the chips were tough. Two other people agreed. When people complained the food was cold staff offered to reheat the food but not everyone wanted this. The tables were not served together so some people had quite a wait and this did not add to the dining experience. One person was fed up with waiting and took chips from someone else's plate. We discussed our observations with the manager. On the second day of our inspection the manager told us they had met with the cook and the menu was being reviewed and that meals would be served differently. We observed that food was served table by table and this improved the dining experience for people.

People and their relatives told us that they were involved in making decisions about how care and support was provided. For example, one relative told us that they had been involved with their relative's plan of care. That it had been reviewed recently and amended to show that more assistance was now required.

The manager told us that they had an open door policy and encouraged people and their relatives to be involved as much as possible in discussions and decisions. We saw that information about independent advocacy services were available should people of required this kind of support.

Requires Improvement

Is the service caring?

The manager had also ensured people had access to other important information such as the service user guide that advised people what they could expect Lenthall House to provide.

Some people had particular religious preferences which they were supported to continue with. For example, a person told us that people came from local churches to give a short service every month, whilst a relative said that a member of their chosen worship community visited their family member quite regularly. Staff we spoke with however were not aware of people's religious or cultural needs.

Some people were living with dementia, we saw attempts had been made to create a dementia friendly environment with sensory items being placed along some corridor walls, and the downstairs bathroom and shower room being decorated with a seaside theme. Also some toilets and bathrooms had pictures to indicate the use of the room. However, this was not consistent throughout the home.

Requires Improvement

Is the service responsive?

Our findings

On the first morning of our inspection we noticed that a person's catheter bag was full. This person was in bed and the catheter bag was on the bed under their knees, not on the stand beside the bed where it should have been. The urine was dark coloured. We pressed the call bell and staff attended within a few minutes. A short while after at 11am we found another person in bed and their catheter bag was lodged between their mattress and the bed rail. The stand for the bag was under the sink. The bag was full and the urine dark coloured. Again we requested assistance from staff. Both these people were either too ill for us to talk with or had communication needs.

We checked the daily records for both these people that showed when and what staff had attended to their catheter care. We found that a member of staff had signed the daily records for both people stating that they had provided assistance with catheter care, this included empting the urine bags at 8am. We brought this to the attention of the manager and area manager who said that this could not have been the case due to amount and colour of the urine and the position of the urine bags.

Having a catheter increases the risk of getting a urinary tract infection as it is easier for bacteria to enter the bladder. A catheter care bag stand is required to keep the bag off the floor and to reduce pressure on the bag in order to prevent back-flow of urine. Being under pressure for example by being under someone's knees or wedged between a mattress and a bed-rail significantly increases the risk of back-flow. Back-flow of urine significantly increases the risk of infection developing and of consequential physical and psychological distress.

We also looked at these people's catheter plans of care and risk assessments and found they were not sufficiently detailed. For example, staff were not informed of what the indicators of infection were and the required action should an infection be suspected. We noted in a staff meeting record dated January 2015, catheter care was a topic of discussion and staff were given instructions about catheter care management. This therefore meant that staff had been informed of what was required of them. However, we noted that not all staff had been present at the meeting, and it was unclear if staff were required to read the records of meetings they had missed.

On the second day of our inspection the manager showed us they had amended people's plans of care for catheter care to provide staff with clear instruction. We found people who were still in bed had their catheter care bags appropriately positioned.

Some people had specific health conditions but plans of care advising staff of how these affected people were missing. For example, one person had three specific and serious medical conditions.

This person was unfortunately too ill to talk to us but we noted from records that they had been complaining of pain on several occasions for two days before the GP was called. When we asked staff and the manager about the delay in contacting the GP, we were told that the person also had behavioural needs and that they had refused pain relief on occasions when it had been offered.

We were concerned that staff did not appear to understand the possible effects that pain may have had on this person's behaviour and personality. There was a risk therefore that staff may have misinterpreted their declining pain relief medicine, as merely part of the person's 'personality' and choice. This person may have experience unnecessary pain and discomfort.

We found that the registered person had not protected people against the risk of receiving care and treatment that met their assessed needs. This was in breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We noted that the majority of the bedrooms had commodes. A person confirmed that they had a commode in their room. They said that they were happy with this arrangement and rang the buzzer when they needed assistance. They said, "Someone always comes quickly to help me." The area manager said commodes were used as a way of reducing the risk of falls and that people had been involved in discussions and decisions about this. From the care files we looked at we did not see plans of care, risk assessments or discussions with people had been completed to show this. This meant it was unclear if people had been involved in discussions and decisions.

Several people told us they had a choice of when they had a bath or shower, whilst other people said they relied on their keyworker to remind them or said, "When it suits them

Requires Improvement

Is the service responsive?

[staff].” A keyworker is a member of care staff that has additional responsibility for a named person living at the service. The home had bathing and showering facilities on both floors but the manager told us people were bathed or showered downstairs. It was not clear of why this was so and may have limited the times that people were offered a bath or a shower.

We noted that people’s plans of care included information that was important to people, for example how many pillows they preferred, what their morning and night time routines were. We also saw that reference was made about how people liked to present themselves, for example one person’s plan of care said how they preferred to wear ‘red lipstick’ and another that the person liked to wear their perfume. We also saw that plans of care were regularly reviewed and discussions with relatives were recorded.

People and their relatives we spoke with told us on the whole they found staff were responsive to people’s needs. For example, one relative said that they had looked at several places before choosing Lenthall House for their relative. “I like the building, it’s big and bright which I think is better for my relative.” A person told us, “My room is nice you can bring some of your own things if you want” and “I’m lovely and warm in bed.” People told us they had a choice of what time they got up and went to bed.

Relatives told us that whilst there were no restrictions placed upon them when visiting their relatives, they were expected to avoid early mornings when people were getting up and late evenings. A person gave us an example how they were supported to maintain contact with their family. They told us they used the office phone once a week to contact a relative.

People and their relatives told us about the activities that were available for people to participate in. This included dominoes, bingo and included day trips such as visiting the local farm shop and going on a canal boat.

Staff told us that activities had improved. One staff said, “The activities are good. In winter outings are limited. We have painting and drawing, catch and movie afternoons.” Another staff told us, “We’re getting better. It’s difficult as people don’t want to do it. We have entertainers and outings in the summer.” The manager told us they were working on improving the opportunities available for people to pursue their interest and hobbies.

During the morning we saw the activities worker went round to individuals encouraging them to throw hoops onto a ring. They then wrote done the scores for each person and the three people with the highest score received a prize.

We saw people had access to the providers complaint procedure and people and their relatives told us they would not hesitate to make a complaint if necessary. One relative said, “If I wasn’t happy I’d soon say something.” We saw the provider recorded complaints received and the action they took to respond to the complaint made. Since our last inspection we saw there were three recorded complaints, we noted that these had been responded to in a timely manner and concluded.

Requires Improvement

Is the service well-led?

Our findings

At our last inspection we identified some concerns with the quality assurance systems in place. The registered manager had failed to act upon the information and recommendations identified from a quality survey undertaken in 2013. They had not always taken into consideration or acted upon the concerns raised by people who used the service, relatives or staff. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. We asked the provider to send us an action plan outlining how they would make improvements. At this inspection whilst we found these improvements had largely been made, we identified different parts of the regulation had not been met with regard to the quality assurance systems in place that monitored the quality and safety of the service.

The manager had introduced new quality assurance systems and audits in January 2015. However, the quality assurance and audit processes had not identified the problems we identified during to our inspection. For example, appropriate plans of care and associated risk assessments were not in place for people that had significant and life limiting health conditions. In addition, we found examples where people's care files contained limited or conflicting information about people's needs and preferences. For example, it was recorded that a person had no needs associated with their hearing or vision. However, it was also recorded that the person had worn a hearing aid and refused to wear glasses. This indicated that the person did have some associated needs with their hearing and vision. Additionally, there was conflicting information about the person's night time routine. One record stated the person's preferred night time routine was to prepare for bed at 10pm and another record stated this was 7pm.

We also identified problems with the recording of people's food and fluid intake. Staff had not always clearly or accurately recorded what people's fluid intake was and the system to audit these records was not robust. It was therefore difficult for the provider to assure themselves that people received sufficient food and fluid for their needs. The manager agreed that the systems in place for auditing records to ensure people's needs were met required improvements.

The provider's systems had also failed to identify other issues for example the potentially dangerous water temperatures, a person's door closer being so strong that they had difficulty opening their door, and at times staff were not deployed appropriately. For example, there was a lack of leadership and organisation at mealtimes.

We found that the registered person had not protected people against the risk of receiving care and treatment that was effectively assessed and monitored. This was in breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Relatives told us that there had been several changes at the home over recent months and it had proved "quite unsettling." They were aware that a new manager was in place and felt they were trying hard to make the changes necessary. One person said, "I think things are getting better."

Staff we spoke with were positive about the changes being made. One staff told us, "So far so good. The manager is very nice and friendly, they don't have a closed mind to ideas. They can be strict when they want to be too." Another staff said, "Brilliant management we've got now. Helpful, they listen and take note. They help the residents, push training. I feel supported absolutely."

The leadership of Lenthall House had recently experienced several changes. The registered manager left and another registered manager within the organisation had taken on the position whilst also managing an additional service. A new manager had been appointed who had day to day responsibility of the service and was being supervised and trained by the registered manager. This was to enable them to take over the registered manager position in the future. In addition the service had an area manager that supported them. The management team were consistent in what they thought were the key challenges faced by the organisation. For example, they said that they were working on developing a strong staff team by improving communication and openness. Ensuring the home had improved quality assurance systems in place to monitor where improvements were required.

In response to some concerns that we found and raised with the manager about the unsafe and poor practice of staff in relation to catheter care and a person's bed being

Requires Improvement

Is the service well-led?

made whilst still wet, the manager immediately implemented the provider's staff disciplinary procedure. This showed what the provider's response was to poor or unsafe practice.

The manager monitored and analysed accidents, incidents and safeguarding to identify patterns or trends, for example any falls people had or where falls had occurred. We saw examples of what action had been taken by the manager following an accident to minimise further risk and to learn from incidents to avoid re-occurrence. This included amending peoples' plans of care and risk assessments, we checked these records to confirm these had been amended accordingly and found they had. In addition, referrals to the doctor and the community nurse were made and the use of assisted technology such as sensor mats, to alert staff of when a person has got out of bed were used.

People and their relatives told us that resident meetings were arranged to enable people and their relatives to give feedback about the service. One relative said, "I have been to a residents meeting, they [staff] put up a poster saying when the next meeting will be held." We saw the last two meeting records were on the notice board for people to see. We saw these meetings were used to share information such as new staff starting, the menu and activities. We saw in one meeting that the manager had introduced a communication book that was kept in people's rooms as an additional method for relatives to communicate with staff and staff to exchange information. There was also a discussion about developing more activities and resources to improve social activities. The manager told us that the provider was arranging for questionnaires to be sent to people and their relatives as an opportunity to gain further feedback about the service.

Staff told us that there were meetings where staff were encouraged to discuss any issues, concerns or make suggestions. They also demonstrated an understanding of their responsibilities and what was expected of them. One staff said, "Meetings are every three months. We feel valued and listen to and contribute to the development of the service." Another staff said, "I have raised concerns over the years and been satisfied with the outcome. After the management I would go to CQC or the big boss."

We looked at staff meeting records and saw that there were discussions about the standards of care the provider expected and the action required of how these were to be met. However, we were concerned that the staff meeting record for January 2015 demonstrated that some of the concerns we had identified about soiled bed linen not being changed had already been discussed with staff as an area that required improvement.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services **Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and Welfare of people who use services.** **The registered manager had not taken proper steps to ensure that each person using the service was protected against the risk of receiving care or treatment that was inappropriate or unsafe. Regulation 9 (1) (a) (b) (i) (ii)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision **Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision.** **The registered manager did not have an effective operation of systems to enable the safety and quality of the service to be regularly assessed and monitored. Regulation 10 (1) (a) (b)**