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Lakenham Residential Care Home

Inspection report

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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?	**Good**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Overall summary

This inspection took place on 01December 2014 and was unannounced.

When we last inspected this service in May 2014 we found breaches of legal requirements relating to respecting and involving people who use the service, management of medicines and assessing and monitoring the quality of the service. This was because we observed people were not involved in their care planning and review, the storage of medicines requiring refrigeration were not being adequately maintained. Records for the application of topical creams were not always being completed. People's views were not being sought about the quality of the service they were receiving. Auditing of systems were not always taking place.

Summary of findings

The provider responded by sending the Care Quality Commission (CQC) an action plan of how they had addressed the breaches identified. We found the improvements the provider told us they had made was continuing to be developed during this inspection.

Lakenham Residential Care Home is a care home which provides care and support to older people some of whom had a diagnosis of dementia. The home does not provide nursing care. The home can accommodate up to 24 people. On the day of the inspection there were 15 people living at the home.

There was a manager registered with the Care Quality Commission. However they had not worked in the home since May 2014. 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 and associated Regulations about how the service is run. The location Lakenham has a condition of registration requiring the service to have a registered manager in post which it currently does not have.

People with a diagnosis of dementia did not receive activities which would benefit them based on current good practice guidance for dementia care. Staff we spoke with were not familiar with activities specifically designed for people with dementia.

Staff said they had completed an induction programme and were being supported in their roles, but that it was not always a formal process. Supervision records were not always being completed to show the development and training needs of staff.

There were times of the day when there had not been enough staff available to meet the needs of people living at Lakenham. During the lunchtime period people were waiting for long periods before they received assistance with their meal.

There were some recruitment procedures which showed the provider had not gained further information to ensure staff were safe to work with vulnerable people.

During the inspection in May 2014 we identified people were not always involved in their care planning and review. During this inspection there was still no evidence to show people were involved in the writing or review of their care plans. However when we spoke with a relative they told us the 'manager' of the home and the social worker was involving them in identifying and planning (their relatives) needs. We have made a recommendation about reporting where people were involved in decisions about their care.

During the inspection in May 2014 we found the provider did not have formal systems to report on the views of people living at Lakenham. During this inspection the provider was relying on regular communication with people using the service, professionals and relatives to gain feedback. No additional surveys had taken place since 2008 to gain peoples' views. The provider told us through the PIR information that they intended to implement suitable quality assurance questionnaires rather than one to one feedback currently used to measure the effectiveness of the service.

Although most of the people who lived at the home could not provide feedback in a constructive way because of the impact of dementia. We observed staff in general displaying a warm and caring attitude when providing care. However, in one instance we observed a lack of respect when a staff member communicated with a person which compromised their dignity. We have made a recommendation about seeking best practice when supporting people.

There were procedures in place to monitor the quality of the service. Policies and procedures were in place including medication, safeguarding people and health and safety. However policies and procedures had not been reviewed for some time in order to update current good practice guidance.

Systems were in place to protect people from the risk of abuse. People told us they felt their relatives were safe and secure. However, the provider had not demonstrated how they had responded to information of concern reported by staff in daily notes.

We saw that staff knew the people who lived at Lakenham well. Staff knew where people liked to sit and what they liked to do. Where we observed people becoming confused and distressed, staff were able to reassure them.

Summary of findings

We found the provider had taken steps to address breaches in medication management. Medicines were being dispensed safely and in accordance with prescriptive instruction.

Steps had been taken to carry out mental capacity assessments and best interest decisions were being recorded where necessary The registered manager demonstrated an understanding of the legislation as laid down by the Mental Capacity Act (MCA) and the associated Deprivation of Liberty Safeguards (DOLS). Staff understood what was meant by restrictive practice in respect of depriving somebody of their liberty.

The provider told us the staff team worked very closely with people and their families and any comments were acted upon straight away before they became a concern or complaint. There were no complaints currently being investigated by the service.

We found a number of Breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which correspond to regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have told the provider to take at the end 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 always safe because appropriate checks were not always completed prior to staff commencing work in the care home.

The provider had not demonstrated how they had responded to issues reported in communication records which had the potential to be a safeguarding risk.

Staffing levels were not meeting the needs of people during the lunchtime period.

We observed medication was administered safely. People received their medication on time and associated records were properly maintained.

Is the service effective?

Requires Improvement

The service was not always effective. Staff were rushed at lunchtime. Some people were having to wait for some time before staff could provide assistance resulting in their meals becoming cooler.

Staff were being supported in their practice development by having access to suitable training but supervision sessions were not always recorded formally.

Where people did not have the capacity to make decisions, their friends and family and professionals were involved in the decision making process in peoples best interest.

Is the service caring?

Good

The service was not always caring. In one instance lacked respect when communicating with a person which compromised their dignity.

Staff showed a good understanding of the individual choices, wishes and support needs for people within their care.

Observations showed that staff were patient when responding to people who repeatedly asked them the same question in a short space of time.

Is the service responsive?

Requires Improvement

The service is not always responsive. The service did not provide meaningful activities to people, most of whom required activities designed for people living with dementia.

Staff were familiar with people's likes and dislikes and responded to peoples' needs.

People felt listened to and their concerns acted upon because the service responded positively. Information about making comments on the service was held in a prominent position within the home.

Summary of findings

Is the service well-led?

The service was not well led

The provider was not able to demonstrate how the views of people using the service were listened to and acted upon.

The service audited its systems, policies and procedures. However some policies and procedures had not been reviewed for some time in order to update current good practice guidance.

Staff spoke of a strong commitment to providing a good quality service for people who lived at the home.

Requires Improvement

Lakenham Residential Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection tool place on the 09 December 2014 and was unannounced.

The inspection team consisted of two inspectors. Before our inspection we reviewed the information we held about the home. This included previous inspection reports and information supplied to us by the provider. Before the inspection, the provider completed a 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.

During this inspection we looked at care plans for three people, two staff files and documents in respect of the homes quality assurance systems and medication processes.

We spoke with the registered provider of Lakenham . We also spoke with five staff on duty and three relatives. We spoke with four people who had capacity to communicate with us. Prior to and following the inspection we spoke with a number of professionals including social workers and health professionals who worked in partnership with the Home.

In order to find out some of the experiences of people that could not tell us about the service we used our Short Observational Framework for Inspection (SOFI) tool for two thirty minute periods in the morning and afternoon in the lounge and dining room. SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

Requires Improvement

Is the service safe?

Our findings

There had been a number of staff changes at this home and adequate recruitment checks had not been carried out. We looked at how staff had been recruited to ensure they were safe to work with vulnerable people. Not all information had been completed for the provider to consider whether the applicant was suitable for the post. There were gaps in a staff member's employment history. Where a Disclosure and Barring Service (DBS) check had highlighted issues, there were no records to show the provider had gained further information to ensure staff were safe to work with vulnerable people.

The registered person had not ensured employment checks were in place before staff were employed. This was a breach of Regulation 21 (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to 18 (1) of the Health and Social Care Act (Regulated Activities) 2014.

Staff we spoke with said they would have no hesitation in reporting abuse. They were able to describe the action they would take if they became aware of abuse. Following previous safeguarding concerns the manager and senior staff had worked collaboratively with the safeguarding team. They said other professionals had come into the home to provide additional training in care practices where there had been previous concerns. This showed us they had the necessary knowledge and information to understand about safeguarding people. However, we saw some staff concerns reported in daily notes had not been investigated by the provider to determine whether they required a safeguarding referral. This showed the provider had not considered what if any, safeguarding processes might need to be considered .

We looked at staffing levels and the skills mix of staff who supported people living at the service. Staff told us it was a busy job but they worked well as a staff group. One person told us, "Love it here, great satisfaction being able to help people who can't help themselves". Some staff felt there were not enough of them to provide person centred care and it was task driven. During the morning period we observed people did not have to wait for long periods for call bells to be answered. Staff were responding to peoples personal care needs. However during the lunchtime period staff were rushed. For example the majority of people took lunch in the dining room, but three people ate their meals outside the dining room. A number of people required support eating their lunch. Three staff were on duty during this busy period and we saw people had to wait before they received assistance. After lunch almost all the people required assistance to go to the bathroom. Some people had to wait. Call bells were ringing during this period but there were delays in answering due to staff being busy. This showed there were times of the day when not enough staff were available to meet the needs of people living at Lakenham.

The registered person was not ensuring there were always sufficient numbers of qualified, skilled or experienced staff deployed at lunchtime to meet the needs of people living at the service. This was a breach of Regulation 22 of the Health and Social Care Act 2009 (Regulated Activities) Regulations 2010, which corresponds to regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During the previous inspection it was noted a fire door which opened onto a fire escape was not clearly signed to ensure people were safe. Appropriate signage had been put in place to alert people to the risk.

People who lived at Lakenham, and were able to communicate with us and a visitor said they felt comfortable and safe. A relative told us, "Yes the staff are very attentive. (My relative) is in a safe place". A person living at Lakenham said, "We are well cared for, warm and comfortable".

We observed people were able to move about the home without restriction where they were physically able to. Care records showed people were restricted in the least possible way. Records recorded peoples assessed needs and risks. The information identified hazards relating to, nutrition, use of bedrails, behaviour management and falls. This showed the service had taken account of individual risk and records showed they had taken measures to minimise potential risks to people it supported.

At our inspection in May 2014 we were concerned about some of the areas of medicines management in the service. Following the inspection the provider sent us an action plan detailing how they would make improvements. During this inspection we found the provider had taken steps to address those issues. Medicines were being dispensed at the time prescribed. In one instance a care plan recorded a person required 'covert' administration of their medicine.

Requires Improvement

Is the service safe?

This is a method of administering medicines in a way which meant the person would not necessarily know they were taking it. The information showed this had been assessed during a mental capacity assessment involving the GP, community psychiatric nurse and the person's relative. Topical creams were being applied in accordance with instruction and recorded on a body map in the person's room. The homes storage for refrigerated medication was being maintained regularly as were the maintenance records for this appliance. This showed improvement's had been made to the overall management of medicine systems.

Requires Improvement

Is the service effective?

Our findings

Observations we made during the lunchtime period showed some peoples dining experience was not a positive one. In one instance a person was trying to eat their meal with their fingers. They were not succeeding and they were not being provided with support. The distribution of meals appeared disorganised, some people had to wait for some time before receiving their lunch, although other people at the same table had been given theirs earlier. Some people were having to wait for some time before staff could provide assistance resulting in their meals becoming cooler. Staff were working between the dining room and overseeing people who were taking their lunch in other areas. Following lunch tables were not cleared of crockery, with people remaining sat at their table for some time until staff could assist them away from the dining area. The overall observation showed the dining experience to be disruptive and disorganised.

At lunchtime people were offered a choice of meal. It was the main meal of the day. We spoke with the chef and looked at the menu options including diabetic and low fat choices. The chef understood the nutritional needs of people using the service. For example one person had required a soft diet, another person had a particular dislike to some foods. This had been noted by the chef who kept records to identify individual nutritional needs where necessary. There was a varied and cyclical menu used by the chef showing a balanced diet was available to people.

Staff induction and support was overseen by the provider and senior staff. Comments included, “Happening sometimes”, and “I’ve had better supervision”. Staff said there was always somebody in a senior role to support them whenever they needed it, but it was not always a formal process. This showed staff were not always being supported effectively in their roles.

Staff told us they had access to training relevant to their roles and responsibilities. A training record showed what was planned for the following three month period. It included dementia care, medicines and first aid. Mandatory training including moving and handling and health and safety was being carried out and updated as required. This demonstrated staff were being supported in their practice development.

During the previous inspection there was a breach of regulation as continence aids were not being managed effectively. The service had reviewed the system for ordering and there were continence aids suitable for individuals to manage their continence needs.

We discussed the requirements of the Mental Capacity Act (MCA) 2005 and the associated Deprivation of Liberty Safeguards (DoLS), with the manager. The registered provider and staff members demonstrated an understanding and knowledge of the requirements of the legislation. The Mental Capacity Act 2005 (MCA) is legislation designed to protect people who are unable to make decisions for themselves and to ensure that any decisions are made in people’s best interests. Some staff had already received training in previous employment and understood what DoLS meant and the rights of people should restrictions of their liberty be necessary. Where people did not have the capacity to make decisions, their friends and family and professionals were involved to support the decision making process’s in the persons ‘best interest’.

People’s healthcare needs were being monitored and as part of the care planning process. People’s care plans provided evidence of effective joint working with community professionals. Healthcare professionals we spoke with during the planning of this inspection told us they had provided additional training for staff in the area of pressure care to ensure they practiced effectively.

Good

Is the service caring?

Our findings

Most of the people who lived at the service could not provide feedback verbally because of their level of dementia. However, we observed staff displaying a warm and caring attitude when providing care. Staff were at ease engaging with people, for example, they sat with them when they wanted to talk. Staff made sure the person was looking at them before they spoke with them. People responded positively to this. One staff member said, "Residents are so vulnerable and we all go to any lengths to make sure they are getting the care they need. That's one thing we really do well here". Another person explained to us they had been very depressed when they first came to live in residential care. They said, "(the staff member) is a marvel and staff are mainly caring". A visitor said, "Residents are well cared for, they (staff) are warm and caring". However staff were not always consistent when responding to peoples' needs. For example, we witnessed a member of staff approaching a person waving a clean continence aid. In a loud voice they encouraged the person to "get up and come to the toilet so I can change you". This showed a clear disrespect for a person's dignity. The same staff member was also witnessed discreetly and respectfully asking a person, "What's wrong? Do you need to go somewhere?" This showed the staff member was inconsistent in how they managed peoples' privacy and dignity to ensure personal care needs were carried out in a discreet and respectful way.

Staff spoke knowledgeably about the people they cared for. They showed a good understanding of the individual choices, wishes and support needs for people within their care. One staff member told us, "Everyone is an individual; we get to know the people we care for and provide good care to meet their individual needs."

Where staff were assisting people to move from wheelchairs to lounge chairs we saw they took time to explain to the person what was happening. They were patient and spoke in a personal manner throughout so it put people at ease. Staff completed tasks like this in a caring and compassionate way. To make sure people's privacy and dignity were being upheld staff closed doors for personal care tasks.

Care planning reported on all aspects of the persons care and support needs. When we spoke with staff they knew the needs of people living at Lakenham. For example, two members of staff referred to the care plans when talking about the people they cared for. This demonstrated staff had the information they required to provide care for people they were supporting.

Our observations showed that staff were patient when responding to people who repeatedly asked them the same question in a short space of time. We observed that one person appeared agitated. A member of staff demonstrated patience and understanding of the person's condition to diffuse the situation safely in a caring and compassionate way. This showed concern for people's well-being whilst responding to their needs and an awareness of supporting people to remain independent whilst ensuring their safety.

We found staff asked people their choice around daily living. For example one person liked to sit in a specific area during the day. Staff on duty were very familiar with this person's likes and dislikes. They were seen to stop and chat with the persons whenever they passed. We observed staff talking with the person in a light hearted and jovial way which they responded to positively by laughing and smiling. Our observations indicated that staff knew what people liked.

Requires Improvement

Is the service responsive?

Our findings

The service had a limited range of activities available to people. For most of the day the majority of people spent time in a lounge with a television that repeatedly lost its signal. When we asked one person they said, "It's usually like this". Background music was playing but the CD was scratched therefore the music kept 'jumping'. This went unnoticed by staff. There was a person employed to visit twice weekly for music to movement exercises but no other activity planning was in place. The majority of people living at Lakenham had some form of dementia diagnosis. However there was no evidence of activities designed for people with dementia. Staff understanding of activities for people with dementia was limited. This demonstrated people did not have the opportunity to take part in activities which might benefit them.

The registered person was no ensuring there were suitable activities available to meet the needs of people living at the service. This was in breach of Regulation 9(1) (b) (i) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 9 (3) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During the inspection in May 2014 we identified people were not always involved in their care planning and review. During this inspection we spoke with a relative who told us the 'manager' of the home and the social worker was involving them of (their relatives) identified needs and how those needs were being met. They said, "It's been very traumatic but I feel they are working in (my relatives) best interest. The staff have been wonderful and keep me informed and involved all the time". This showed people were being involved but it was not being recorded to demonstrate involement.

Staff were familiar with people's likes and dislikes. For example staff knew where people preferred to sit and in what area of the service. We observed one person was becoming confused and distressed. Staff were able to reassure them. They knew that the person liked to read a newspaper, and so they brought one for them. One person said, "I told them I wanted a drink and they brought me my favourite juice". Another person said, "I am quite happy really, I know I can't do what I used to do but the staff keep me encouraged".

During the previous inspection we found staff were not always responding to peoples care needs by not accurately completing food and nutrition records. At the time of this inspection there were no nutrition or hydration records required by any of the people using the service. Positioning charts for people requiring regular movement to prevent pressure sores were not currently required. Staff we spoke with gave examples of when charts had been used and they recognised the importance of such records in monitoring people's needs.

A visitor explained how staff ensured that their relative was regularly moved so as not to develop any pressure sores. They told us that when their relative had first moved into the home they were still able to walk. As their physical abilities had deteriorated the home had adapted the care they provided to ensure that their relative's needs continued to be met.

The provider told us the staff team worked very closely with people and their families and any comments were acted upon straight away before they became a concern or complaint. There were no complaints currently being investigated by the service. A relative and a person using the service told us they felt confident the provider would listen to their concerns and take action if necessary.

Requires Improvement

Is the service well-led?

Our findings

A requirement of the homes condition of registration states, "The registered Provider must ensure that the regulated activity accommodation for persons who require nursing or personal care is managed by an individual who is registered as a manager in respect of that activity at or from all locations". The location Lakenham had a condition of registration requiring the service to have a registered manager in post. There was a current deputy manager who was in the process of applying to register with the commission in order to comply with the conditions of registration. The commission had returned an application to cancel registration from the current manager in May 2014. There had been no further application by the registered manager to pursue this cancellation application.

The previous inspection found the service was not seeking the views of people using the service by way of surveys. During this inspection the provider stated they continuously spoke with people using the service and their relatives and representatives. However there was no other evidence to show what action the provider had taken to improve the way views of people were taken into account in order to monitor the quality of the service.

The registered person was not taking steps to ensure the views of people using the service were being sought. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds with regulation 17(2)(e) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us the provider was not always available to approach and discuss issues. Staff commented, "We get really frustrated by not having out thoughts listened to, I am here for the residents but the owner is not always here". When we spoke with the provider they told us they worked in the home most days but had a support team including the deputy manager and other senior staff to take responsibility of day to day management of the service. We spoke with the deputy manager and a senior staff member. They confirmed they were responsible for the day to day running of the service and ensuring care and support was in place to meet people's needs.

Staff said meetings were held to discuss operational issues and staff could raise points at the meetings. However, some staff said they found it difficult to raise issues with the provider. One commented, "We just have to get on with or jobs, there is little time for anything else". Staff we spoke with felt supported by the deputy manager and senior staff but felt frustrated by no clear leadership.

The provider recognised the challenges of developing the service, including managing systems more effectively and keeping information up to date. Following guidance and support from health and social care professionals, revised systems and approaches to care had been introduced as a way of improving the service.

There were procedures in place to monitor the quality of the service. Policies and procedures were in place for aspects of service delivery. The provider was responsible for the reviews of these policies to ensure they were updated and continued to reflect current legislation and best practice.

However, most had not been reviewed since 2012, including safeguarding and environmental policies. This showed the service was not ensuring policies and procedures were up to date.

Staff spoke of a strong commitment to providing a good quality service for people who lived at the home. Staff confirmed they found their role hard but rewarding. One staff member said, "We work closely and support each other".

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 18 HSCA (RA) Regulations 2014 Staffing The registered person had not ensured employment checks were in place before staff were employed. This was a breach of Regulation 21(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which correspond to Regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care The registered person was not ensuring there were suitable activities available to meet the needs of people living at the home. This was in breach of Regulation 9(1)b(I) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 9(3)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance The registered provider was not taking steps to ensure the views of people using the service were being sought. This was a breach of Regulation 10(2) (e) of the Health and Social Care Act 2010, which corresponds to regulation 17(2)(e) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation

This section is primarily information for the provider

Action we have told the provider to take

Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing The registered person had not ensured there were always sufficient numbers of suitable qualified, skilled or experienced staff employed. This was a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.