DRS Care Homes Limited

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

Summary of findings

Overall summary

We inspected this service on 9 February 2016. The inspection was unannounced. Lansdowne Care Home is a care home registered for a maximum of six adults. Some of the people living there had long term mental health needs, and additional disabilities.

At the time of our inspection there were six people living at the service. The service is located in two adjoining terraced houses, on two floors with access to a front and back garden. We previously inspected the service on 6 November 2013 and the service was found to be meeting the regulations inspected.

Lansdowne Residential Care Home had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Care records were individualised and up to date with information regarding people's likes and dislikes. Care plans provided detailed information on people's mental health needs which were closely monitored. Risk assessments had been carried out and updated regularly and contained guidance for staff on protecting people and responding to any issues that might occur.

Staff were able to tell us about the needs of people they cared for and were aware of how to support them with their mental health needs. We saw people had regular access to healthcare professionals, such as the local mental health team and GPs, and where they were in agreement, had access to opticians and dentists on a regular basis.

People were given their medicines on time as prescribed. Medicines were locked away, but the system to check that the stocks of boxed medicines tallied with records was not easy to use. The registered manager undertook to improve the system for the auditing of boxed medicines.

On the day of the inspection there was insufficient food in the fridge and cupboards for the people at the service. The registered manager advised that he has since introduced a system to ensure the fridge and cupboards were stocked with essential items and the range of these would be discussed with people living at the service. People at the service told us they did not have enough choice for the evening meal that was prepared. The registered manager told us he would address this as a priority.

People living at the home told us that they had found it difficult having a significant number of new staff working with them recently. Staff had been recruited safely and told us they felt supported by the registered manager. There was evidence of regular supervision taking place. Staff knew how to recognise and report any concerns or allegations of abuse and were able to tell us what action they would take to protect people against harm. Staff knew what whistleblowing was and were able to tell us what they would do if they were concerned about the quality of the service.

We found the premises were clean and tidy, and measures were in place for infection control, however perishable foods were not always labelled with the date of opening and sealed as appropriate. There was a record of essential services such as gas and electrical installations being checked, with fire drills taking place regularly. There were policies in place in relation to complaints and incidents, and we saw that learning took place to minimise incidents re-occurring.

Staff, people living at the service and relatives told us the management was a visible presence within the home, and the staff we met were kind. People at the service told us there had been numerous changes of staff at the service. They also told us the kitchen was locked at night. The registered manager has since confirmed this was no longer happening.

We have made a recommendation in relation to staff training.

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. Not all food that was opened was labelled with the use by date or sealed effectively to minimise contamination.

Recruitment checks were in place to ensure that staff were fit to work at the home, however people found it unsettling having a significant number of different new staff working at the home in recent months.

Comprehensive risk assessments gave staff guidance as to what action to take to prevent or minimise harm to people using the service.

People received their medicines safely and on time.

Is the service effective?

Requires Improvement

The service was not always effective. Staff had not all undertaken mandatory training in line with the provider's requirements.

There was not always sufficient range of food available for people to prepare within the home.

People were supported in line with the Mental Capacity Act 2005. Regular supervision took place with staff to ensure that they were supported.

People living at the service could access healthcare appointments including optician and dentistry services as required.

Is the service caring?

Requires Improvement

The service was not always caring. People's specific cultural diets were not always catered for and people told us the staff often decided what food was cooked.

We saw staff were caring in their interactions with people.

People were involved in the planning and giving of care at the service.

Is the service responsive?

Good

The service was responsive. Care plans were individualised and updated regularly and identified goals people wanted to achieve.

People were invited to visit the scheme prior to moving there to ensure it could meet their needs and they were compatible with the existing residents People were encouraged to undertake activities of their choice.

There was a complaints procedure in place for the home.

Is the service well-led?

Good

The service was well led. The registered manager was open and accessible to staff and people living at the service. Routine audits were undertaken to check on the quality of the service.

Essential facilities such as gas and electrical installations had been regularly serviced to ensure the building was well maintained.

Lansdowne 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.

This inspection took place on 9 February 2016 and was unannounced. It was undertaken by one inspector for adult social care and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we reviewed information we held about the service. This included previous inspection reports and notifications we had received. A notification is information about important events which the service is required to send us by law.

During the inspection we met and spoke with all six people who lived at the service, although not everyone wanted or could answer all our questions. We spoke with three members of staff including the operational manager for the provider. After the inspection we spoke with the registered manager, two relatives and two health and social care professionals who visited the service on a regular basis.

We also looked at three care records relating to people's individual care needs, and three staff recruitment files including supervision and staff training records. We look at the records associated with the management of medicines. We reviewed documentation relating to essential services and documents relating to the management of people's money.

As part of the inspection we observed the interactions between people using the service and staff and discussed people's care needs with staff. We also conducted a visual inspection of the premises.

Requires Improvement

Is the service safe?

Our findings

We were told by people that they felt safe living at the service. One person told us, "There is no hassle, I go and come as I like." Another person told us there is, "Nothing to make me feel unsafe [here]" and a third person told us "Staff [are] quite friendly so I don't get treated badly".

There had not been any safeguarding concerns in the past year. Staff were able to tell us the different types of abuse that can occur and what they would do if they had any concerns. They were also aware of the whistleblowing procedure. The registered manager could evidence all staff had attended training on safeguarding adults from abuse.

Medicines were stored in a locked cupboard and people told us they received their medicines on time. People living at the service could tell us what their medicines were for. Not all staff were able to tell us the side effects of one of the medicines they administered. This was important. For example, some medicines can impact on a person's mobility and may contribute to them falling, or could limit their communication or cognition. Files contained a list of an individual's medicines, details of their GP, information about their health conditions and any allergies. They also contained information on the injected medicines administered by the local mental health team.

Whilst it was easy to check the medicines stocks administered via blister packs with medicines administration records, the registered manager told us it may be convoluted if wanting to easily check boxed medicines against records. He undertook to develop a system which is easy to check so he can assure himself all the medicines are accounted for. The registered manager also undertook to review the management of a controlled drug that they stored on behalf of a person living at the service. Controlled medicines are prescription medicines that are subject to legal controls in relation to how they are stored, supplied and prescribed to prevent misuse.

Individual assessments were thorough and identified the risks to people using the service and others. Risk assessments were compiled from information obtained from people living at the service, health and social care professionals and family or friends when appropriate. Each risk identified had a risk management plan in place which explained how to manage and minimise any identified risk, with information on triggers and de-escalation techniques. The action plans were easy to follow. Staff we spoke with were aware of each person who used the service and understood any risk there may be and how to minimise the risk.

We saw on the rota that there were two staff from 8am to 8pm from Monday to Friday. One member of staff was scheduled to work from 8pm to 8am. This was a sleeping night shift. There was also an additional female staff member on duty Monday to Friday from 8am to 12 noon. We noted from the rota that whilst it appeared this staff member was on duty from 8am, she was never at the service before 9-9.30am as she had to support a woman living at a local scheme with personal care prior to coming on shift at this service. The rota was therefore not an accurate reflection of staffing within the home. One person living at the home told us there was "Not much maybe one or two [staff] and they have to do the cooking". Another person told us there's "one in the day and one at night".

When asked if there were regular staff, one person told us, "Every few days there is different staff". A number of new staff had recently started working at the service from other local DRS schemes. Another person told us, "The rota is weird, new staff come in and you have to get used to them, they come from other houses, they are not agency" and "they all seem to know each other." One person told us that this occurred mostly during the weekend with staff covering the night shift. This meant that people using the service had not recently been receiving consistent staff support, due to the number of different new staff working with them.

On the day of the inspection we could see that staff had to liaise with each other closely to be able to support people with various activities, as two of the people living at the service were always supported when out of the service, and others needed support with various visits.

We looked at the records kept for one person for whom the service managed their money. Records showed the money held tallied with the records, and receipts were available and stored to evidence expenditure.

We could see the premises were clean and there were systems in place to minimise the spread of infection through the use of different chopping boards for food and mops for specific areas of the home. We saw that some food that was opened did not have a use by date and some of it was not sealed sufficiently to avoid contamination. We also saw there were the remains of a takeaway meal in the fridge that was not dated. We spoke with staff on duty at the time of the inspection who removed it. They were of the view it belonged to the staff member who had worked the previous night shift. Following the inspection we spoke with the registered manager regarding these issues who told us he had addressed this with staff, and put notices on the fridge to remind them and people living at the service to seal and date their food.

We looked at staff files and could see that written references, evidence of the person's right to work and Disclosure and Barring Service checks had been completed prior to any staff starting work. This meant staff were considered safe to work with people who used the service.

We looked at incident reports for the service for the last 12 months. They were completed appropriately and identified improvements in practice where relevant, or learning for the team to minimise the likelihood of the incident occurring again. For example a staff member had been reluctant to call the police following an assault on staff, but this gave the registered manager an opportunity to support the person and remind them of the provider's policy to always call police if an assault takes place.

Requires Improvement

Is the service effective?

Our findings

When we asked people if they thought the staff had the right training and skills for the job, one person told us "'Yes they care for us all the time. Like going to buy clothes they come with me and help me". Another person told us "Yes I suppose so". One relative told us "Staff have done a lot to help my [relative]". Another relative told us "Staff at Lansdowne site [are] competent, professional and friendly, and always aiming to give the best support when needed."

We could see from records that the registered manager carried out regular supervision with staff who worked at the scheme. The provider had initiated the new care certificate for induction as set by Skills for Care. Staff were inducted into a specific service but were expected to provide cover at other services as required.

We looked at the training records for staff, some of whom had recently joined this service. Whilst staff had received training in medicines management and safeguarding, not all the staff had received the mandatory training in key areas defined by the provider. For example, none had received training in restraint or managing challenging behaviour in the last year, none had received training in managing people's money in the last three years and two out of three people hadn't received training in moving and handling in the last year. We saw from an incident report that the service accommodated people who displayed behaviours that challenge on occasion.

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

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. The manager was able to clearly explain and evidence the process. There was one person for whom a DoLS had been applied who was waiting for an assessment. The registered manager could show us that he had applied for weekly emergency orders to ensure the restriction of one person was lawful.

One person told us they would like a key to the house but they didn't have one. This person was deemed to have mental capacity and we were told by the registered manager, could leave the home when they wanted to, but was encouraged to have staff support due to reasons of safety. The person's relative told us they had significant concerns regarding their relative's safety going outside alone. We raised this with the registered manager and the care co-ordinator. The registered manager told us that where people have complex needs there is a balance between their exposure to harm in the community and their personal freedom with the provider also having to exercise a duty of care. The registered manager and care co-ordinator undertook to

review the arrangements for this person at the earliest opportunity, to consider whether a DoLS application was necessary to ensure the service was compliant with the MCA.

One of the staff members we spoke with was not familiar with the MCA, although they understood the need for consent when providing care to people. This was not considered a mandatory course by the provider although there was evidence that two out of three staff had received training in the MCA.

The majority of the people living at the service were expected to make their own breakfast and lunch and staff were available to cook the evening meal. One person routinely cooked for himself with food purchased from his own money.

On the day of the inspection we noted that two people did not have any breakfast at all, and one person attempted to make porridge without cooking it properly. Another person made tea without waiting for the water to boil so the tea bag was floating in cold water. There was insufficient supervision or support for some of the people living at the service in the preparation of food. We spoke with the registered manager regarding this. He explained that some people's abilities fluctuated so they were sometimes able to prepare food more effectively. Also some new staff had worked at schemes where people were more independent, and were still familiarising themselves fully with the people living at the service. The registered manager undertook to discuss this with staff and provide a list of tasks to remind them of their responsibilities.

On the day of the inspection there was insufficient food in the fridge and the cupboards for the people living at the service to make breakfast or lunch for themselves. People we spoke with did not complain at the lack of food, but commented on the limited range of food available. One person told us "We don't have bacon here, we have eggs, there is not a great option, they don't buy mushrooms". We were also told, "We don't normally get dessert" and when asked what dessert they would like, we were told "sticky toffee pudding" and "There's no ice cream here". We spoke with staff about the fridge and cupboards not having enough food in them on the day of the inspection, and there being insufficient choice of food available for breakfast. Staff explained that they shopped on a daily basis for food as well as having a weekly larger shop take place. The registered manager told us he has since drawn up a list of essential items that need to be in the fridge and cupboards every day. He told us this is now displayed in the kitchen as a prompt for staff. In relation to the lack of specific desserts, the registered manager told us that there is fruit and yoghurt available.

We could see from people's records they had regular access to specialists and professionals such as psychiatrists, opticians, physiotherapists, occupational therapists, dentists and chiropodists as required. Some people were simply prompted to attend appointments, whilst other people needed support. This was documented in their care plan, and records were kept of the outcome of visits so staff had up to date information about the health care needs of each person.

We recommend that staff training is reviewed and updated in line with the provider's own policies to ensure that they meet people's needs in line with best practice.

Requires Improvement

Is the service caring?

Our findings

We asked people living at the service if the staff were kind and caring. They told us, "Yes, you have any problems you tell them and they try and help", and "If you need to go out and need help they come with you". Another person told us, "Yes. When I kicked off they were really patient, I started swearing and they didn't call the police on me". A relative told us "They maintain a good caring environment for him, and often encourage him [with showering]." We saw that staff spoke with respect to people living at the scheme and were caring in their manner to them.

However, there were some elements of the service that did not promote dignity and respect for the people living at the service.

On the day of the inspection there was a double mattress in the garden that was covered in green mould. This meant it had been outside for some time. One person living at the service told us "they need to clean the back yard up and the table." We were told that the mattress was removed the day after the inspection.

We were told by people living at the service that the kitchen was locked at night between 11 and midnight. One person told us "I don't smoke as the door is locked." Another person told us "At night they lock the kitchen door and living room door." People could knock on the door of the room the sleeping in staff member was in, to ask for something from the kitchen or gain access to the garden to smoke, but this limited people's free access to smoke or eat food/drink after 11pm. There were no issues of risk identified to justify this practice. We spoke with the registered manager about this. He was unaware this was happening and told us that new night staff had introduced this practice without his knowledge. He reported to his knowledge, this had occurred on two occasions, and the practice had now stopped and the kitchen was open at all times.

Staff were able to tell us how they would support people with religious needs. We were also shown Halal meat in the freezer for one person living at the service. When we asked people living at the service if they felt their requirements were met in relation to food one person told us, "No we don't get curry goat or rice and peas."

Another person told us, "They cook a lot of chips here. I don't like chips." The staff told us they discussed with people living at the service what they wanted to eat. When asked who decided what you eat, two people told us "the staff". Another person told us "Sometimes they ask and sometimes it's just prepared, just what they make." Care staff we spoke with either did not usually cook there due to their shift patterns or did not see themselves as particularly skilled at cooking. The registered manager told us that following the recent re-organisation of staff he was evaluating people's skills, and also undertook to address the issue of choice of food in meetings with people who lived at the service.

One person told us they were sometimes allowed to use the phone, and were encouraged to keep contact with their family. People told us they were able to have family visit them at any time, but not everyone was sure if their friends were allowed to visit. The registered manager told us that in general people were allowed

to have friends visit, but on occasion, if there were concerns about the safety of other people living at the scheme they had to refuse entry to some people entering the building.

People told us they were involved in their care and they valued this involvement. "They do the care plan with you. They ask what needs do you have what are your goals". One person told us, "If I want to buy anything to put in the flat I have to ask them first as it's a care home." Another person told us "I wanted my medication reduced and it got reduced." We were also told, "I can choose to stay on or change my medication, that's the most important part of my care". We saw people had signed their care plans and risk assessment documentation. Agreement to share information forms were completed on files so the service had permission to talk with health professionals and family members regarding a person's health and well-being. This meant people had some control over the sharing of private and personal information. We also noted each care record had a section on end of life preferences which meant that the staff had some awareness of what people would like to happen in the event of their death.

Staff were able to tell us how they supported people to have privacy and dignity. They knocked on people's doors, offered support with personal care where necessary in the least intrusive way and respected people's life choices. One person told us "They don't open my letters", and another said staff are "kind to me all the time".

We noted the shift patterns for staffing meant there were no female staff available at the weekend. One person told us this affected the way personal care was offered to them. We discussed this with the registered manager who has undertaken to involve an independent advocate to ensure there is clarity regarding the person's requirements. He told us staffing will then be adjusted if necessary.

Good

Is the service responsive?

Our findings

People's assessments provided detailed information about managing risks and meeting their holistic needs. They included information relating to people's history, followed by information about people's domestic living skills including personal care, capacity to manage money and going out alone, mental and physical health, personal care, intellectual and skill development. Where appropriate, relatives confirmed that they were consulted about their family member's care plan and their views were recorded. We found that care plans were up to date and all sections had been completed appropriately. Risk assessments were being reviewed approximately six-monthly or more frequently where significant changes to people's needs had occurred.

We saw Health Action Plans and Person Centred Plans were also in place so there was a lot of detailed information on people's health and the ambitions or goals they wanted to achieve. Key worker sessions which took place monthly provided an opportunity to discuss holistic objectives with people, and paperwork was updated as a result.

There were some board games at the service, but mainly people chose to go outside of the service for activities. Some people attended the gym, and one person attended college. People went to see family and friends as part of their leisure activities or went to local cafes or shopping. There was evidence from the residents' meeting minutes that staff tried to initiate activities at the service, but there was limited enthusiasm as many people had lives outside of the service. A relative told us that he would prefer his relative to do more activities, but acknowledged that this was related to their lack of motivation themselves. The registered manager explained that the staff actively encouraged more participation in leisure activities but it was important to listen to people's choices as not doing so impacted on their mental well-being and could increase behaviours that challenged.

There was a smoking area in the garden which was valued by the people living at the service. We could see that where possible people had visited the scheme prior to being placed at the service so they could see whether they thought it could meet their needs and whether they would fit in with the people already living at the service.

We looked at the complaints file which did not contain any complaints in the last 12 months. People living at the service told us they would feel able to make a complaint if they wanted to. One person had made a complaint which was dealt with at the time of the incident. The registered manager explained he did not record 'niggles and suggestions' he resolved immediately. A relative told us "I can talk to the [registered] manager about anything. If I have a problem, he's on it." Another relative told us, "When issues were raised, they always took it on board and gave an adequate response. For issues with a prolonged nature, a follow up contact is often established."

Good

Is the service well-led?

Our findings

DRS worked to the philosophy, "from possibility to actuality." DRS had a brochure with information on local resources and facilities to help new people to the service settle into the local area.

Staff, people living at the service and relatives told us that the registered manager was approachable and open. We found that issues raised at or following the inspection were addressed quickly. Staff told us the registered manager was willing to listen to them and involved them in the running of the service. We saw that regular staff meetings took place with staff and a range of issues were discussed.

When we asked people living at the service if they thought the home was well run, they told us "They clean the place everyday. Everything is tidy". Another person told us, "Yes I think so, days that I have dinner it's ready on time. Problems can take a while to get sorted out."

We saw from records that meetings for people who lived at the service took place monthly. The registered manager planned to have a standing agenda item of food/menus for the meeting for people living at the service to ensure there continued to be an ongoing discussion regarding the menu and the shopping bought for the service.

All of the essential equipment, for example, gas and electrical installations and fire equipment, were serviced in the last twelve months, or within timescales recommended to ensure the building was well maintained. Weekly fire systems checks took place and the buildingwas well decorated and furnished.

The registered manager carried out quality assurance audits in relation to cleanliness, medicines and care records. He also met with one person living at the service every month to ask their views on the service. The registered manager had also introduced a box for comments by the front entrance

Some of the staff had recently transferred to the service so were still getting used to the needs of the people living at the service and the way the service operated. The registered manager told us that the changes in personnel were due to restructuring within the organisation and were out of his control. The registered manager worked three long days in the middle of the week which meant that he was not available at the service for four days a week. The registered manager undertook to consider how to carry out quality assurance on the days he did not work to ensure he can evaluate the quality of the service and can ensure it is effectively managed when he is not there.