Doobay Care (Lychgate) Limited

Lychgate House

Inspection report

145 Shrub End Road
Colchester
Essex
CO3 4RE

Tel: 01206500074
Website: www.doobaycare.co.uk

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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**

Summary of findings

Overall summary

This inspection was completed on 26 January 2018 and was unannounced.

At our last inspection of the service on 5 July 2016 the service was rated as 'Requires Improvement'. Breaches of regulatory requirements were evident for Regulation 9 [Person-centred care], Regulation 12 [Safe care and treatment] and Regulation 17 [Good governance].
Following the last inspection in July 2016, we asked the provider to complete an action plan to show what they would do and by when to improve the key questions of 'Safe', 'Effective', 'Responsive' and 'Well-Led' to at least good. An action plan was received on 23 September 2016.

At this inspection we found that not all improvements had been made to meet the relevant requirements. This is the second time the service has been rated 'Requires Improvement'.

Lychgate House is a care home. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Lychgate House accommodates up to 15 adults who have mental health needs. Lychgate House is a large detached house situated within a short distance of Colchester town centre and within walking distance of local amenities and facilities. The premises is set out on two floors with each person using the service having their own individual bedroom and adequate communal facilities are available for people to make use of within the service.

An effective robust system was not in place to assess and monitor the quality of the service. Quality assurance systems had failed to identify the issues we found during our inspection to help drive and make all of the necessary improvements.

Some aspects of medicines management required further development. Not all risks to people were identified and improvements were required to record how these were to be mitigated so as to ensure people's safety and wellbeing. Improvements were required to ensure that people's care plan documentation was accessible at all times, reflected all of their care and support needs and how the care was to be delivered by staff.

Staff had received regular training opportunities; however improvements were needed to ensure staff received appropriate training relating to the specific needs of people using the service. Minor amendments were required to ensure staff recruitment practices were in line with regulatory requirements. Newly employed members of staff received an 'orientation' induction but had not received an induction that was specific to their role.

People's capacity to make day-to-day decisions had been considered and assessed. Where restrictive

practices were in place, these were not clearly recorded to show these had been discussed and agreed with people using the service. Staff member's understanding and knowledge of the Deprivation of Liberty Safeguards [DoLS] and the key requirements of the Mental Capacity Act (MCA) 2005 were much improved. The Care Quality Commission had not been notified where [DoLs] had been authorised by the Local Authority.

People were protected from abuse and avoidable harm and people living at the service had no concerns about their safety and wellbeing. Staff described the management team as supportive and approachable. Arrangements were in place for staff to receive formal supervision at regular intervals and an annual appraisal.

People's healthcare needs were supported and people had access to a range of healthcare services and professionals as required. Staff had a good relationship with the people they supported. People were treated with dignity and supported to maintain their independence where appropriate.

You can see what action we told the provider to take at the back of the full version of the report.

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 remained not consistently safe.

Medication practices required improvement. Not all staff had had their competency assessed at regular intervals.

Not all risks to people were identified and improvements were required to record how these were to be mitigated to ensure people's safety and wellbeing.

Improvements were required to ensure staff were recruited safely and in line with regulatory requirements.

The deployment of staff was suitable to meet people's care and support needs and the provider's systems to safeguard people from abuse was safe.

Is the service effective?

Requires Improvement

The service remained not consistently effective.

Though staff had received regular training opportunities in a range of subjects, consideration had not been given to provide staff with training relating to the specific needs of people living with a mental health condition.

Not all staff had received a robust induction specific for their role.

Restrictive practices were not clearly identified to evidence these had been consulted and consented on. Improvements were required to ensure the Care Quality Commission were notified once a Deprivation of Liberty Safeguards application had been authorised.

Staff felt valued and supported and had received regular supervision and an annual appraisal.

Is the service caring?

Good

The service remained caring.

People were positive about the care and support provided by

staff. People told us staff were caring and kind.

Staff demonstrated an understanding and awareness of how to support people to maintain their dignity, respect and independence.

Is the service responsive?

Requires Improvement

The service remained not consistently responsive.

Although some people's care plans provided sufficient detail, others were not as fully reflective or accurate of people's care and support needs as they should be and improvements were required.

People were supported to participate in a range of social activities.

People using the service and those acting on their behalf were confident and able to raise concerns.

Is the service well-led?

Requires Improvement

The service remained not consistently well-led.

Improvements were required to the quality assurance arrangements as these measures were not as robust as they could be or working as effectively as they should be to demonstrate compliance and to drive improvement.

The service involves people in a meaningful way and works in partnership with other agencies.

Lychgate 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 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 26 January 2018 and was unannounced. The inspection team consisted of one inspector.

We used information the provider sent us in the 'Provider Information Return'. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We reviewed information that we hold about the service such as safeguarding information and notifications. Notifications are the events happening in the service that the provider is required to tell us about. We used this information to plan what areas we were going to focus on during our inspection.

We used the Short Observational Framework for inspection [SOFI]. SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We spoke with five people who used the service, two members of staff, the deputy manager and the registered manager. We reviewed three people's care files and two staff recruitment files and three support records for other staff employed at the service. We also looked at a sample of the service's quality assurance systems, the registered provider's arrangements for managing medication, staff training records, staff duty rotas and complaints records.

Requires Improvement

Is the service safe?

Our findings

Safe was rated as 'Requires Improvement' at our last inspection on the 5 July 2016. At this inspection, we found that safe remained rated as 'Requires Improvement.' At our previous comprehensive inspection of the service in July 2016, the registered provider's arrangements for the safe management of medicines required improvement. The registered provider shared with us their action plan and this provided detail on their progress to make the required improvements. At this inspection we found that although some progress had been made in relation to medicines management, namely the introduction of PRN 'as and when required' medication protocols and stock counts for medication were routinely completed each week, further improvements were still required.

People told us, they received their medication as they should and at the times they needed them. One person told us, "I get my medication every day and staff give this to me." Where people were prescribed lithium, appropriate arrangements were in place to ensure people's lithium levels were monitored at least every three months to ensure the medication remained effective and not harmful.

However, where people required a once weekly medication that should not be given at the same time as other prescribed medications, the Medication Administration Record [MAR] showed it was being given at the same time as other medicines administered at 09.00 a.m. Staff spoken with, including the management team confirmed the above was happening and they were unaware of the specialist instructions relating to this medication and the potential risks posed if not followed.

The handwritten MAR record for one person showed they had been prescribed two short courses of medication. Neither MAR form recorded the amount of medication received. This made it difficult to determine if the person had received their medicines as prescribed as it was not possible to check the stock of medicines was correct. Although the door to the office was locked, the key to the medication cupboard was labelled and kept in an unlocked drawer. This meant if the door was not locked and the office un-occupied by a member of staff, anyone unauthorised could use the key to access the medication cupboard. This left people at risk of taking medicines that were not prescribed for them.

Suitable arrangements were in place to ensure staff who administered medication were trained. However, none of the staff had had their competency assessed to ensure they remained skilled and capable to carry out this task safely. The registered manager and deputy manager showed us a blank competency form but confirmed this had yet to be implemented.

We recommend as part of good practice procedures the keys should be kept on the person assigned to administer peoples' medicines and all staff who administers these have their competency assessed at regular intervals.

The way that the service assessed risks to people and the actions taken to reduce the risks required improvement to provide people with safe care at all times. Whilst arrangements were in place to assess individual risks to people using the service, not all areas of risk were identified and recorded. One person

was observed to have bedrails fitted to their bed. The management team confirmed the bedrails were used for this person and had been in place since they had experienced a period of illness. No risk assessment was completed as to the reason and suitability of the bedrails, including the potential risks of their use such as entrapment and rolling over the top of the bedrails. We also saw that where concerns had been highlighted about a person's swallowing ability; a risk assessment had not been completed with guidelines for staff to follow. We discussed our concerns with the registered manager and deputy manager who assured us that the above would be reviewed.

We recommend that the service seek support and training, for the management team, about how risks to people are identified, assessed and recorded.

The registered manager demonstrated an awareness of their legal duties with respect to fire safety. A fire risk assessment had been completed and the registered manager confirmed that appropriate fire detection, warning systems and fire fighting equipment were in place and checked to ensure they remained effective. Individual Personal Emergency Evacuation Plans (PEEP) were not in place for people living at the service. This is a bespoke plan intended to identify those who are not able to evacuate or reach a place of safety unaided in the event of an emergency. An assurance was provided by the management team that these would be compiled as soon as possible.

Staff recruitment records for two members of staff appointed since our last inspection in July 2016 were viewed. The service's recruitment practices were not as robust as they should be. Where relevant checks had been carried out, these included the obtaining of references, ensuring that the applicant provided proof of their identity and undertaking a criminal record check with the Disclosure and Barring Service [DBS]. Though the above was in place for both employees, a recent photograph had not been sought and evidence of a completed application form was not readily available. This was discussed with the registered manager. An assurance was provided that these had been completed but could not be located. This meant we were unable to check if a full employment history had been explored and if the above records matched up with the employee's application. Following the inspection the application form for one member of staff was provided. No information was recorded as part of good practice procedures relating to the interview so as to demonstrate the outcome of the discussion and the rationale for the appointment.

Although staff understood their responsibilities to raise concerns and to record safety incidents and concerns, appropriate arrangements were not in place to review and investigate events and incidents and to learn from these. For example, records available showed there had been an incident in November 2017 involving two people who used the service. Another incident had also occurred in November 2017 whereby one person had left the service without staff's knowledge. No information was available to show either incident had been investigated to monitor potential risks relating to people's safety or wellbeing and to ensure lessons were learned for the future.

We discussed safety with people using the service. They told us they had no concerns and that the service was a safe place to live. Two people said when asked if they felt safe living at Lychgate House, "Yes, I feel safe" and, "Safe, yes." Effective safeguarding arrangements were in place to keep people safe. People using the service were supported to express concerns about their safety and welfare to staff and the management team. No safeguarding concerns had been raised by the service since our last inspection in July 2016.

Staff were able to demonstrate a satisfactory understanding and awareness of the different types of abuse, how to respond appropriately where abuse was suspected and how to escalate any concerns about a person's safety to the management team and external agencies. Staff told us they would not hesitate to raise a safeguarding alert if they suspected abuse. Staff told us they had not needed to raise a safeguarding

concern since working at the service but would not hesitate to do so if required.

People told us there were sufficient numbers of staff available to provide the support required to meet their care and support needs. Our observations showed that people received support from enough staff throughout the day and this was suitable to meet people's care and support needs in line with information documented within their care plan. There were enough staff for people to participate in their chosen activities.

People were protected by the prevention and control of infection. The cleanliness of the service was maintained to a good standard. Staff told us and records confirmed that the majority of staff had received infection control training and understood their responsibilities for maintaining appropriate standards of cleanliness and hygiene; and following food safety guidance.

Requires Improvement

Is the service effective?

Our findings

Effective was rated as 'Requires Improvement' at our last inspection on the 5 July 2016. At this inspection, we found that 'effective' remained rated as 'Requires Improvement.' At our previous comprehensive inspection of the service in July 2016, we found the registered provider's arrangements relating to the Mental Capacity Act 2005 required improvement. The registered provider shared with us their action plan and this provided detail on their progress to make the required improvements. At this inspection we found that these improvements had been made.

Arrangements were in place to ensure that staff received suitable training at regular intervals so they could meet the needs and preferences of the people they cared for and supported. Staff training records viewed showed the majority of staff had received mandatory training in line with the provider's expectations in key areas and the training viewed was up-to-date. This was confirmed by staff as accurate. However, although staff could tell us about people's individual needs and the care and support to be provided, no staff employed at the service had undertaken specific training relating to mental health.

We recommend that the service seek appropriate training for staff in mental health conditions.

The registered manager and deputy manager told us that staff received an induction comprising of training in key areas appropriate to the needs of the people they supported and an 'in house' induction. Although both members of staff, one of which was the deputy manager had completed an 'in house' orientation induction, the deputy manager had not received an induction relating to their specific role. Staff were also given the opportunity to shadow a more experienced member of staff depending on their level of experience and competence. Staff who had no previous experience in a care setting were required to undertake and complete the Skills for Care 'Care Certificate' or an equivalent robust induction programme. The Care Certificate is a set of standards that social care and health workers should adhere to in their daily working life.

Staff told us they felt supported. One member of staff told us, "I receive good support from the manager and deputy manager." Another staff member told us, "The management team is very good and I feel very supported. I also get good support from others working here." Supervisions had been completed at regular intervals allowing staff the time to express their views, to reflect on their practice and to discuss their professional development. Although an agenda was readily available, supervisions did not routinely discuss the staff member's role as a key-worker or issues relating to people using the service. A key-worker is an identified member of staff assigned to work with the person using the service, to coordinate and organise the service to meet their needs. Staff employed longer than 12 months had received an annual appraisal of their overall performance for the period 2016 to 2017, however objectives for the next 12 months had not been identified and set. We discussed the above with the registered manager and deputy manager and an assurance was provided that these would be set in the future.

People told us they were happy with the meals provided. One person told us, "The food is very nice, I like the food." Another person told us, "I don't like too much food on my plate; they [staff] only give me half of what

everybody else has." People received sufficient food and drink throughout the day and mealtimes were flexible to suit their individual needs. One person was noted to have their main meal saved so that they could eat this later in the day rather than at lunchtime. The service also took into account people's cultural and ethnicity needs. The registered manager confirmed that one person using the service had food in line with their cultural needs and preferences. Staff spoken with were aware of this and confirmed that this person's preferences were supported wherever possible. Where people who used the service were considered to be at nutritional risk, referrals to a healthcare professional, such as a Speech and Language Therapist, had been made and guidance was being followed by staff.

Staff worked well with other organisations to ensure they delivered good joined-up care and support. The registered manager, deputy manager and staff team knew the people they cared for well and liaised with other organisations to ensure the person received person-centred care and support. This was particularly apparent where people's healthcare needs had changed and they required the support of external organisation's and agencies to ensure their welfare and wellbeing. Where this had happened, people had been referred to the Speech and Language Therapy team and local Mental Healthcare teams.

People told us their healthcare needs were met and that they received appropriate support from staff. One person told us, "The staff accompany me to the doctors if I need to go." Care records showed that people's healthcare needs were clearly recorded, including evidence of staff interventions and the outcomes of healthcare appointments.

People using the service lived in a safe, well maintained environment. People's diverse needs were respected as their bedrooms were personalised to reflect their own interests and preferences. People had access to comfortable communal facilities, comprising of a large lounge and separate dining area. Adaptations and equipment were in place in order to meet people's assessed needs.

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 the 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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals 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.

Staff now had a good knowledge and understanding of MCA and Deprivation of Liberty Safeguards (DoLS). Staff were observed during the inspection to uphold people's rights to make decisions and choices. Information available showed that each person who used the service had had their capacity to make decisions assessed. However, where restrictive practices were in place to keep people safe, for example, where people had restricted access to their personal lighters and cigarettes because it was deemed a fire hazard, this was not clearly recorded to demonstrate that the person had been consulted and consented to this arrangement. Where people were deprived of their liberty, the management team had made an appropriate application to the Local Authority for DoLS assessments to be considered for approval. Where these had been authorised the Care Quality Commission had not been notified. The registered manager told us that suitable arrangements would be made to address this.

Good

Is the service caring?

Our findings

People told us they received good care and support and were treated with care and kindness by staff. One person told us, "The staff are alright". Another person told us, "The staff are here to help me and support me. The care is alright and I get the help I need."

Our observations showed that people received appropriate support and had a good rapport and relationship with the staff who supported them, including newer members of staff employed at the service. During our inspection we saw that people and staff were relaxed in each other's company and it was clear that staff knew the people they looked after. Staff understood people's different communication needs and how to communicate with them in an effective way. This referred specifically to staff listening to what people had to say and simplifying the topics of conversation so that the individual could understand what was being said. People were addressed by their preferred names and staff interacted with people in a kind and compassionate way, taking the time to listen to what people were saying to them. Staff confirmed that no-one at the time of the inspection required specialist assistive technology aids to help them communicate.

People were supported to express their views and to be involved, as far as possible, in making decisions about the care and support to be provided. There was evidence to show that, where appropriate, people had signed their care plan to acknowledge and agree its content. People were also given the opportunity to provide feedback about the service through the completion of annual questionnaires. These were last completed in January 2017 and were complimentary about the service provided and staff employed at the service. The registered manager confirmed that currently no-one had an independent advocate assigned. An advocate supports a person to have an independent voice and enables them to express their views when they are unable to do so for themselves.

People told us their personal care and support was provided in a way which maintained their privacy and dignity. People were supported to be as independent as possible. Several people at lunchtime were supported to maintain their independence to eat their meal and some people confirmed they were able to manage some aspects of their personal care with minimal or no staff support. Three people living at Lychgate House were able to go out independently and to access the local community as and when they wanted to. This was confirmed as accurate following our discussions with people using the service.

Requires Improvement

Is the service responsive?

Our findings

People's support packages were funded by the Local Authority and NHS Continuing Healthcare. An initial assessment was completed by the Local Authority or NHS Continuing Healthcare and together with the registered provider's assessment; some of this information was used to inform the person's care plan.

At our last inspection to the service in July 2016 improvements were required in relation to the registered provider's care planning arrangements. We found the care planning documentation confusing and where information was recorded this lacked detail. At this inspection we found that not all of these improvements had been made.

The care plans viewed did not fully reflect people's holistic care and support needs or provide sufficient guidance for staff as to how these were to be met. Improvements were needed to ensure care plans included information relating to their specific care needs and the support to be provided by staff. For example, the care plan for three people did not make reference to their mental healthcare needs and how these were to be managed and monitored by staff. None of the care files viewed made reference to how people were to be supported with their personal care needs, despite some people requiring staff assistance, prompting and encouragement. We discussed this with the management team and an assurance was provided that the necessary improvements to the service's care planning records would be made. Although the above was highlighted, we did not find or observe any impact on people's care during our inspection as a result of not having care planning documentation in place.

The management team confirmed that no one was subject to a Community Treatment Order. The latter is a set of conditions made by a responsible external clinician which have to be followed and adhered to in line with the principles of the Mental Health Act 1983 [amended 2007]. People using the service were being reviewed as part of the Care Programme Approach [CPA]. People confirmed this as accurate. This is where people's care needs are reviewed and discussed by a representative of the Local Authority to ascertain what is working well and what needs to be improved or changed.

Although none of the care files viewed recorded people's social care needs and how these were to be met by staff, people told us they could spend their time as they wished and wanted. Arrangements were in place to ensure that people using the service had the opportunity to take part in leisure and social activities of their choice and interest, both 'in-house' and within the local community. This included meeting people's religious and cultural needs and interests. On the day of inspection two people accessed the local community independently and had lunch out. During the morning some people were observed to listen to a relaxation CD. Afterwards one person was observed to have several games of dominoes with a member of staff. People confirmed they were able to maintain relationships that matter to them, such as with family members and this was very important to them.

The service had a complaints procedure in place for people to use if they had a concern or were not happy with the service. No complaints had been raised since our last inspection of the service in July 2016. Staff knew how to respond to people's concerns and complaints should the need arise. People told us they

would either speak to a family member or member of staff if they had any worries or concerns.

Though no one living at the service was receiving end of life or palliative care at the time of our inspection, the management team provided an assurance that people would be supported to receive good end of life care so as to ensure a comfortable, dignified and pain-free death. Furthermore, they told us that they would work closely with relevant healthcare professionals and provide support to people's families.

Requires Improvement

Is the service well-led?

Our findings

A registered manager was 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 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. A change to the management team had occurred since our last inspection to the service in July 2016 and this referred to the appointment of a deputy manager.

We asked the registered manager and deputy manager about the arrangements in place to gather, document and evaluate information about the quality and safety of the care and support the service provided and outcomes. The registered manager confirmed that apart from a weekly medication stock count introduced following our last inspection in July 2016, no other arrangements were in place for analysing and using information to identify current and potential concerns and areas for improvement.

This inspection identified a lack of robust systems in place to monitor the quality of the service, identify potential trends and to recognise where improvements were needed. This oversight had led to the shortfalls identified as part of this inspection. Not all progress had been made in relation to medicines management following our inspection to the service in July 2016 and further improvements were still required. Quality assurance arrangements did not collate and review information relating to the incidence of accidents and incidents that had occurred or other data relating to people using the service. An accurate record of each person, including a record of the care and support provided had not been maintained. People's care plans required review as these did not reflect all of a person's current needs and the care and support to be provided by staff. Risks to people and the actions taken to reduce these risks required further development. Concerns were not consistently identified to monitor potential risks relating to people's safety or wellbeing and to ensure lessons were learned for the future. A more robust process was required for the recruitment of staff employed at the service.

While the registered provider's vision and values were recorded within the service's Statement of Purpose, staff were not able to demonstrate a good understanding of these or where these were recorded. Staff confirmed that the service's vision and values were not routinely discussed to ensure staff understanding and practice were monitored against these.

This is a continued breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Though there was no formal quality monitoring systems in place, checks of equipment and utilities were being undertaken at regular intervals. There were policies and procedures in place to provide guidance to staff and staff knew where these were located.

People living at Lychgate House knew who the registered manager and deputy manager was and felt the service was well managed. People told us they could speak openly with the management team, they could tell us staff's names and spoke about some of them with genuine warmth and friendliness. Staff told us the

management team were accessible and visible. Staff confirmed they felt supported by the management team, the service was well managed, morale was good and they enjoyed working at the service. One member of staff told us, "The manager and deputy manager are very good. I can always approach them about anything."

Arrangements were in place for seeking the views of people using the service, their families and healthcare professionals. The results of these told us that people using the service were happy and satisfied with the overall quality of the service provided. One person's comments included, 'It's alright here and at least I am not living on the streets homeless.' Another person's recorded comments stated, 'There is good solid welfare here.' Five healthcare professionals were very complimentary about the service provided at Lychgate House and the majority recorded they would recommend the service to others.

Staff meetings had been held at regular intervals to give staff the opportunity to express their views and opinions on the day-to-day running of the service.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance People who use services were not supported by the providers systems and processes to assess and monitor the quality of service provided. The arrangements in place were not effective in identifying where quality or safety were compromised and required improvement.