Warrington Community Living

Lucklaw Residential Care Home

Inspection Report

Burtonwood Road
Burtonwood
Warrington
WA5 3AN
Tel: 01925 230474
Website: www.warringtoncommunityliving.com

Date of inspection visit: 6 October 2014
Date of publication: 31/10/2014

Contents

Summary of findings

Overall summary

We carried out an unannounced comprehensive inspection of this service on 14 May 2014. A breach of legal requirements was found. As a result we undertook a focused inspection on 6 October 2014 to follow up on whether action had been taken to deal with the breach.

You can read a summary of our findings from both inspections below.

Comprehensive Inspection of 14 May 2014

Lucklaw Residential Care Home is registered to accommodate up to four adults with physical and learning disabilities. It is owned and run by Warrington Community Living, a registered charity. The home was established following the closure of a large hospital in the Warrington area in order to provide alternative accommodation.

The service is provided from a domestic four-bedroom bungalow in a residential area of Warrington. The premises have been adapted to accommodate the needs of people with a physical disability. There is level access throughout the bungalow with low gradient ramps to the front door and gardens.

There is a registered manager in place at Lucklaw Residential Care Home who has been there for three years. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service and shares the legal responsibility for meeting the requirements of the law with the provider.

We found that the staff and manager at Lucklaw Residential Care Home provided a caring service for the people who lived there and treated them with dignity and respect. People were safe and medicines were properly administered. The home provided a high standard of accommodation with appropriate adaptations for people with a disability. The staff team was relaxed and confident and led by a manager who displayed honest and caring leadership.

We found that staffing levels were not sufficient to provide the responsive service that the people who lived at Lucklaw Residential Care Home required. This was a breach of the relevant regulations which apply to this type of care. You can see what action we told the provider to take at the back of the full version of the report.

Focused desk based review of 6 October 2014

After our inspection of 14 May 2014, the provider wrote to us to say what they would do to meet the legal requirements in relation to staffing.

We have not revisited Lucklaw Residential care Home as part of this review because the provider was able to demonstrate that it had taken action to meet the standards without the need for a visit**.** We therefore undertook a desk based review to check that they had followed their plan and to confirm that they now met legal requirements.

We found that the provider (Warrington Community Living) had taken appropriate action to improve staffing levels. Sufficient numbers of staff were now deployed throughout the day to ensure the people using the service received care and support that was responsive to their individual needs.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

We found that the service was safe because staff respected the rights and dignity of the people who lived at Lucklaw Residential Care Home. The staff had a good understanding of safeguarding procedures. These procedures are designed to protect people from harm. The relatives of people living in the home told us that they felt their relatives were safe.

Medicines were stored and administered correctly and by staff with appropriate training in this. Good care records were kept so that any behavioural difficulties could be analysed and staff could be informed about the best way to predict and respond to any challenges.

We found the location to be meeting the requirements of the Deprivation of Liberty Safeguards (DoLS). While no applications have been submitted, proper policies and procedures were in place but none had been necessary. We felt that the home should consider alternative arrangements for the management of the finances of people who were not able to do this for themselves.

Are services effective?

The service was effective because people were involved in their own assessment and there were good care plans which resulted from this. People who lived in the home were involved in their own care. Care plans were reviewed frequently so that they reflected people's current needs and requirements.

The staff who worked at Lucklaw Residential Care Home had access to training so that they could develop the skills required to provide care and support for the people who lived in the home.

People also received services from a range of community health and social care professionals including nurses, social workers, and speech and language therapists. Good records of health care were available which could be easily transferred to another setting such as hospital if a person required treatment.

Are services caring?

We saw that the service was caring because staff treated the people who lived at Lucklaw Residential Care Home with kindness and compassion. People had choices between communal activities or using their own rooms which were large enough to allow this.

Summary of findings

The home is adapted to provide people with the specialist equipment such as hoists which they require. Level access is available throughout so that people who use wheelchairs can move around easily.

We saw that the people who lived in the home had positive relationships with the staff who worked there because each group was familiar with the other. People expressed choices and staff respected these and the rights of people to refuse certain activities or care if they did not wish to do them. There were good policies and procedures related to dignity and privacy and staff demonstrated awareness of these when we spoke with them.

Are services responsive to people's needs?

The care and support provided at Lucklaw Residential Care Home was planned from the point of view of the people who lived there rather than from the needs of the service. Staff were implementing up-to-date methods in helping people to express their preferences. Care plans were regularly reviewed so that staff could respond to people's current needs and requirements. People were given opportunities to take part in these arrangements.

People who lived in the home were able to participate in activities with staff support. These included activities within the home as well as outside in the community. We found though that the opportunities for the service to be responsive were restricted by the level of staffing at the home. This meant that at times people might not get the personal attention they required or be able to pursue individual activities.

Are services well-led?

14 May 2014

Lucklaw Residential Care Home is led by an experienced registered manager with a confident staff team. The staff team had access to training which meant that they had the skills to provide the right care to the people who live in the home. We saw that there were arrangements for supervision and staff confirmed that this was the case.

The manager had access to systems which allowed them to monitor the care provided and make some adjustments to care plans as required. The service required improvement however because the manager did not have access to sufficient staff to respond to people's needs effectively or flexibly. The manager was not able to vary the level of staffing by increasing it to meet the current needs of the people who lived in the home. We found that staffing levels were not sufficient to always provide the care that the people who lived at

Summary of findings

Lucklaw Residential Care Home required. This was a breach of the relevant regulations which apply to this type of care. You can see what action we told the provider to take at the back of the full version of the report.

06 October 2014

We found that action had been taken to improve staffing levels. Staffing levels had been increased throughout the day to ensure the people using the service received care and support that was responsive to their individual needs. This meant that the provider was now meeting legal requirements.

Summary of findings

What people who use the service and those that matter to them say

The three people who lived at Lucklaw Residential Care Home were not able to communicate with us verbally because of their complex needs.

Relatives of people who lived at Lucklaw Residential Care Home told us "It is very very safe – I sleep well knowing that my (relative) is safe" and "My (relative) has been there for at least 20 years – I never have any concerns about safety".

They told us that the staff involved them in the care of their family members. One relative said "I am always invited to be involved – I speak about once a week with the staff – and I turn up without appointment about once a week".

We asked the relatives if they thought that the staff at the home were caring and they told us "I think the staff need praising – I know my brother is safe and loved". One commented "They are all good staff – whoever picks the staff has always done a good job – all the new staff were always good". Another relative told us the staff were "Very concerned and caring in my opinion".

Relatives knew how to complain if there was anything wrong and that there were regular meetings with the people who lived at Lucklaw Residential Care Home. One relative told us "If I had a problem I would speak to the manager – I also know about meetings going on".

All the relatives we spoke to expressed concern about staffing levels at the home. They said "The staffing seems a bit thin at night" and "We do worry about only one member of staff at night".

These concerns about the level of staffing were repeated when we talked with some of the other agencies who worked with the home.

Lucklaw Residential Care Home

Detailed findings

Background to this inspection

This inspection report includes the findings of one inspection and a 'desk based' review of Lucklaw Residential Care Home. We carried out the inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The inspection and 'desk based' review checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008 and looked at the overall quality of the service.

The first was a comprehensive inspection of all aspects of the service and took place on 14 May 2014.

This inspection identified a breach of regulations. The second 'desk based' review was undertaken on 06 October 2014 and focused on following up on action taken in relation to the breach of legal requirements we found on 14 May 2014. You can find full information about our findings in the detailed key question sections of this report.

Comprehensive Inspection of 14 May 2014

Lucklaw Residential Care Home is registered to accommodate up to four adults with physical and learning disabilities. It is owned and run by Warrington Community Living, a registered charity. The home was established following the closure of a large hospital in the Warrington area in order to provide alternative accommodation.

The service is provided from a domestic four-bedroom bungalow in a residential area of Warrington. The premises have been adapted to accommodate the needs of people with a physical disability. There is level access throughout the bungalow with low gradient ramps to the front door and gardens.

There is a registered manager in place at Lucklaw Residential Care Home who has been there for three years. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service and shares the legal responsibility for meeting the requirements of the law with the provider.

We found that the staff and manager at Lucklaw Residential Care Home provided a caring service for the people who lived there and treated them with dignity and respect. People were safe and medicines were properly administered. The home provided a high standard of accommodation with appropriate adaptations for people with a disability. The staff team was relaxed and confident and led by a manager who displayed honest and caring leadership.

We found that staffing levels were not sufficient to provide the responsive service that the people who lived at Lucklaw Residential Care Home required. This was a breach of the relevant regulations which apply to this type of care. You can see what action we told the provider to take at the back of the full version of the report.

Focused desk based review of 06 October 2014

We undertook a focused desk based review of Lucklaw Residential Care Home on 06 October 2014. This inspection was done to check that improvements to meet legal requirements planned by the provider after our 14 May 2014 inspection had been made. We only reviewed the service against one of the five questions we ask about service; is the service safe? This is because the service was not meeting a relevant legal requirement.

The desk based review was undertaken by the lead inspector for this service. During our review we spoke with

Detailed findings

the Chief Executive Officer for Warrington Community Living (the provider), the Registered Manager for the Lucklaw Residential Care Home and the local authority which commissions the service from Warrington Community Living. We also reviewed copies of rotas, dependency assessments, emails and other supporting documentation.

Are services safe?

Our findings

The relatives of people living at Lucklaw Residential Care Home told us their family members had been living there for more than twenty years. They said that over that period they were not aware of any bullying, harassment, avoidable harm or abuse taking place in the home. We spoke to two members of staff who worked at the home and asked them if they had any concerns about the safety of the people who lived there. They told us they did not have any such concerns and that people were kept safe by the use of health and safety checks, risk assessments, and making sure they were observant about what was going on.

We asked them about how they safeguarded the people who lived there. They were able to describe accurately the kinds of abuse such as unsafe handling practices and physical or financial abuse to which people might be vulnerable. They told us they would report any such concerns to the manager immediately.

Staff told us they had received training on safeguarding within the last year and it was made available to them online through e-learning. We checked the training matrix and saw this was the case. Staff also knew about whistleblowing and that this meant that they could report any concerns if they felt these were not being dealt with within the company of which Lucklaw Residential Care Home was a part. We saw there was a safeguarding and whistleblowing policy although the whistleblowing policy did not contain the names and contact details of those organisations authorised to receive whistleblowing disclosures. The Care Quality Commission is one of these organisations.

We saw there was a series of records kept which detailed any events, accidents or incidents so they could be monitored, trends identified, and any appropriate action taken. People's care files contained a detailed analysis of any known behavioural challenges together with the action to be taken to minimise any harm to the person, other people living in the home, and staff.

We asked both the staff and manager if they were aware of the provisions of the Mental Capacity Act 2005. They were able to explain this to us and the provision of the associated Deprivation of Liberty Safeguards (DoLS) correctly. They were also aware that people who lived at Lucklaw Residential Care Home might require the protection afforded by these arrangements.

When we looked at the care files for the people living in the home we saw that assessments and best interest meetings had been documented where appropriate but these were not always signed by the professionals who had completed them. Although the professionals were not employed by Lucklaw Residential Care Home we suggested to the manager that in view of the gravity and importance of these latter documents they might ensure that they were signed at the appropriate time. The manager has since told us that the document was electronically signed and forwarded to the home by email.

During our inspection it was clear the staff and manager protected the people who lived at Lucklaw Residential Care Home and championed their human rights. We saw instances in which the manager and staff were seeking to advance these rights through multiagency discussions. When we reviewed the policies and procedures used by the home we saw they focussed on people's human rights when guiding staff actions.

We were told that because the service is a residential care home, the people who used the service were not entitled to the same community services such as aids and adaptations or day services from other agencies that they might receive if they were living in their own accommodation. This included a person whose personal finances were being considered for use in the purchase of a ceiling hoist for installation in their bedroom. This person's finances were managed by Warrington Community Living which operated Lucklaw Residential Care Home under an arrangement whereby the company acted as a corporate appointee. An appointee looks after and manages someone else's finances on their behalf.

We were concerned that no capacity assessment had been undertaken and that no arrangements for the independent management of this person's finances were in place. These arrangements would protect all parties where decisions were being made which relate to the finances of people who are unable to manage these for themselves.

We looked at the arrangements for the management of medicines in the home. None of the people who used the service administered their own medicines. The medicines

Are services safe?

were kept in a locked cupboard and staff were only permitted to administer them once they had completed suitable training. We checked the provider's records to make sure that this was the case. A monitored dosage system was in place meaning that medicines were delivered pre packed by a pharmacist into the correct doses for people at each time of day. This reduced the risk of mistakes. We reconciled the remaining supplies with the medicine administration records of two people and found they tallied. The provider reported that there had been no medicines errors in the last year.

We saw that the provider had a supply of a specific drug used to treat epilepsy. Staff told us they had to undertake additional training before they could administer this. We saw that its use was monitored using a controlled drugs book. The manager told us that even though it was not a controlled drug they felt its use merited a higher level of monitoring because of its importance to the people who used the service.

We saw that some people had been prescribed medicines to be taken PRN or "as required". We saw there were clear instructions in people's care plans about when these should be used, how staff might recognise the need to offer them, and how the person might prefer them to be given to them.

Are services effective?

(for example, treatment is effective)

Our findings

We looked at each of the care plans for all the people living at Lucklaw Residential Care Home. Each care plan was prefaced with a copy of the Warrington Community Living "promise" which outlined the way the provider would observe such things as people's rights and promote their wellbeing. We were told that people who used the service had contributed to this. Each care plan contained a photograph of the person to whom the file related.

The care plans were well-ordered and easy to follow. They included a statement of each individual's needs including detailed information about their preferences and routines such as when getting up in the morning or going to bed at night. Key information was presented clearly often using bullet points which made it easier for busy care staff to read.

Although the people who lived at Lucklaw Residential Care Home did not communicate easily verbally, it was clear from looking at the care files that they had been involved in their construction. Staff told us they sat with each person as they reviewed the plan and we could see they would know them well-enough to be able to interpret their responses to suggestions or amendments being proposed. One relative told us "My (relative) cannot speak – but they let you know when they are happy". We saw that the way in which people had been involved in discussions of their plan had been recorded within the documentation.

Some of the documents in the care plans featured "easy read" type graphics to make them easier for the people who used the service to use. The files contained essential lifestyle plans which detailed information about the care and support required for areas such as pace of life, mealtimes, eyesight, and keeping safe. We saw that the care plans were reviewed monthly and amended in response to changes in the needs of the people who used the service. We saw notes in the files that showed the manager also reviewed the whole care plan monthly. This meant information provided for staff accurately reflected people's current needs.

Each person who lived at Lucklaw Residential Care Home had a "Let's Check!" purple folder supplied by the local NHS provider trust. This allowed for key medical and other health information to be collected in one place making it easily transportable if a person living in the home needed to go into hospital or a visiting professional required access to this information. Each file contained a health passport containing key information about the person which would assist someone who did not know the person if they were offering them treatment. The manager told us about how they had used these during the recent hospital admission of a person who used the service.

The provider supplied us with a matrix which showed the current training arrangements for the staff at the home. We saw that all staff had completed induction and mandatory training and that the matrix provided the manager with an effective overview of where training needed to be refreshed. When we talked with staff they frequently referred to training as one of the key ways they were able to develop their knowledge of areas such as safeguarding and mental capacity.

We saw that the file contained other information including the names and contact details of the health and other practitioners who were involved with each person together with information about any treatment they were engaged in. Advice to care staff about treatments were made available within these files as were the results of any Mental Capacity Act assessments and relevant best interests meetings.

We saw that people who lived in the home had access to medical, health and social work services from the local multidisciplinary team. Members of the team had become concerned about the health of one of the people living in the home and had taken steps to make sure that this was thoroughly investigated so that the cause of their difficulties could be diagnosed and effectively treated.

Other community services provided included an intensive communication programme for the staff to assist them with supporting the people who lived there. We were told that this had been provided by the local Speech and Language Therapy Service.

Are services caring?

Our findings

Lucklaw Residential Care Home was large detached bungalow. Each of the people who lived there had their own bedroom. We saw that these bedrooms were large and so gave ample room for equipment which was required to provide proper care such as hoists. We were told that two of the bedrooms had ensuite bathing and toilet facilities and two had ceiling tracks for hoists. We saw that the bedrooms were personalised with private possessions and photographs and the house was clean and tidy.

Relatives spoke highly of the care provided at Lucklaw Residential Care Home. One said "My relative is always spotlessly clean whenever we pop in" and another commented "I think it is great – I know that (my relative) is happy". Another relative told us "It is so much better there than (previous placement) – I think it's great – I know that he is happy".

The people who lived in the home could not communicate easily with us verbally. We saw from the way they responded to staff that they experienced these relationships as caring. People responded warmly to the approaches made by staff and the offers of support. We saw staff helping a person to stand up using a routine which was clearly familiar to both them and the person who used the service. We saw that staff encouraged a sense of community between the three people living in the home for example by making sure that each person's photograph was displayed like a family group together in the lounge. During our inspection one person returned from a hospital stay and was welcomed home by the staff.

Apart from a cloakroom there were no areas of the house which people who lived there did not have access to. This meant that staff spent almost all of their time in direct contact with people. We saw that this meant that people who used the service were also involved in the staff meeting because they remained in the company of the staff whilst this took place. During our inspection we saw people using mainly the large kitchen dining room or the hall in which there was comfortable lounge furniture. Bedrooms were used when people wanted some quiet time or if personal care tasks were to be undertaken. Staff said it was their practice to knock on bedroom doors and introduce themselves and the purpose of their visit before entering.

Most of the people who used the service required assistance to move around but those that were more mobile were able to move around the home freely. We saw one person needed to be moved using their wheelchair and we saw that two staff used a hoist appropriately and sensitively to transfer them from the armchair in which they were sitting.

We saw from the case files that the provider developed support plans based on assessments of the needs of each individual living at Lucklaw Residential Care Home. We asked staff how they found out about each person's needs and preferences on day to day basis. They told us they did this by talking to people and noting from their responses what they liked and disliked. This was one of the ways that they compiled menus and activity timetables, for example. One member of staff demonstrated to us the particular facial expression and movement that a person would make if they did not like something or if they disagreed with a proposal. The manager emphasised that this was how people were able to express choice and control over what happened to them.

Throughout our inspection we saw the staff treating the people who used the service with care and dignity including speaking to them politely using the person's first name. We saw that staff explained to people what they proposed to do in advance of acting so as to be sure that the person was aware and that they agreed to it. Staff told us they knew that they could not force a person to take a particular course of action and any difficulty would be discussed with the manager. This meant that people were able to make choices about their care and that staff respected these choices.

We saw that information relating to dignity was available in the kitchen dining room and staff told us that they had received training in this. We saw there was a policy relating to privacy and dignity as well as autonomy and choice. The manager told us they chaired a dignity working group across the whole of the Warrington Community Living organisation and that two of the staff in the home were dignity champions. This meant that there were constant reminders to staff about the need to care with dignity.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

We saw that the care planning documents used by Lucklaw Residential Care Home already contained information that was written in such a way as to be focussed on the person rather than on the needs of the service. Staff told us they had recently received training in person-centred practice. We saw this training had been obtained from one of the leading international experts in this work. This meant that staff were implementing up-to-date knowledge and methods in their practice. We could hear from conversations amongst staff that they were excited, energised and enthusiastic about this approach.

Staff told us that a key worker system was in place at Lucklaw Residential Care Home. Whilst people who used the service might not have been able to identify it as such, a member of staff told us that this system meant that an identified individual worker was responsible for making sure that care plans were up to date, that inventories of property were properly maintained, and that appointments such as for health care were kept.

When we looked at the care plans of people who used the service we saw there were notes about the activities they enjoyed. On person's record said they liked listening to music, going shopping and to the park, and having a foot spa. Another person's care plan said that they enjoyed reflexology as well as going out and shopping.

We tracked these notes against the activities which we knew were arranged for the people who used the service. Both of the residents who were at home at the time of our inspection were taken out by staff to the park using the minibus which belonged to the home. We saw that a foot spa was offered and given to a person during our inspection. When one person decided to sit in the large hall a portable CD player was brought so that they could listen to music. We asked how people could access reflexology as this was shown as something one person enjoyed and were told that this was provided fortnightly.

We saw that staff tried to respond to individual preferences such as by organising a trip to the park. However we saw that they could sometimes only do so if they involved all the people who used the service in this activity in undertaking it at the same time regardless of individual preference. If they did not do this there would be insufficient staff to care for the remaining person safely.

We saw that at tea time it was not possible for people to eat together at the same time because they each required individual support. This meant that one person had to wait until one of the other people had been supported with eating and the staff member became available to assist them. We undertook the Short Observational Framework for Inspection (SOFI) at this time. This confirmed that staff sought to respond to individual's need but could not do so where each person required a one to one intervention such as feeding.

Staff told us that the needs of the people who lived at the home had changed over time. More of the people now needed the support of two care staff with tasks such as moving which they had not always required. This meant that when a task required two members of staff there were sometimes not enough staff available for the other people in the home.

Staff told us that they felt that staffing levels inhibited and restricted their ability to positively interact with the people who used the service. The manager was aware of this view and supported their staff in this opinion. The local authority which commissions the service from Warrington Community Living (the company which manages the service) confirmed to us that they were in discussion with them about staffing levels and were putting in place reviews of each person's needs.

We saw there had been the involvement of a local advocacy service at Lucklaw Residential Care Home. The advocate told us that the staff at Lucklaw Residential Care Home had been responsive to the suggestions made by them.

Only one complaint had been received at the home in the last twelve months. We saw that the provider had a procedure in place for the management of complaints. This meant any complaints were properly recorded and investigated.

Are services well-led?

Our findings

Findings from the comprehensive inspection of 14 May 2014

Lucklaw Residential Care Home has had the same registered manager for the last three years. There was a Statement of Purpose and this had been provided to the Care Quality Commission. The Statement of Purpose stated the aims, objectives and values of the service provider and identified the kinds of services provided and the range of people's needs which those services intended to meet.

During our inspection we saw that the manager maintained an "open door" allowing staff and people who used the service to see them at any time. We saw that when they were present the manager and senior support worker sometimes undertook direct care tasks when the staff group were under pressure.

We saw that the staff and manager were confident and relaxed during our inspection. One visitor told us "I was very impressed by meeting the manager – I would trust this person to do a good job for my son or daughter and my family". We call this "The Mum's test" because people should not have to live in accommodation which other people would not place their own relative in.

We saw that there were records of regular checks on important items such as health and safety, the condition of slings and hoists, wheelchairs, and the fire prevention and alarm system. The manager told us that Warrington Community Living was dissatisfied with the current system of internal fire risk assessment and had therefore commissioned an external firm to undertake this.

We looked at records and saw that the manager monitored care plans on a monthly basis. This meant that they were able to keep an oversight of the care being provided and make adjustments if required.

The manager provided a monthly report on key events including incidents and accidents at Lucklaw Residential Care Home which was scrutinised by the Chief Executive of Warrington Community Living. We were supplied with the most recent of these and saw that it reported on key areas relating to the care and management of the home. One relative told us they had noticed a change in the management ethos recently when they told us "I can see that the new big bosses have turned a corner – I am very happy".

Staff told us they received regular supervision with an annual appraisal of their work performance. Supervision of staff was shared between the manager and the senior support worker, with the manager receiving supervision directly from the Chief Executive of Warrington Community Living. We saw records of supervision that showed that it took place at regular intervals. Staff told us that formal supervision took place monthly but that informally it happened all the time. We saw from records that the frequency of supervision was adjusted to take account of individual needs.

We saw that there were three members of care staff on duty in the morning at Lucklaw Residential Care Home with two later in the day. We were told that staffing levels at weekends were reduced to two care staff throughout the day and that there was one member of waking staff on duty at night. The manager and senior support worker were additional to this in the daytime but were shared between Lucklaw Residential Care Home and another similar location which was some miles away. The manager and senior support worker provided support remotely at night.

Three people lived in the home when we visited meaning that in the mornings there were three care staff for the three people who used the service at that time. Since all the people who used the service might require the support of two people it followed that on occasions only one person could be attended to at a time. At other times this might leave two people unattended. At the time of our inspection the home had one vacancy meaning that if fully occupied the same staff group would have to provide care to more people.

All the people who lived at Lucklaw Residential Care Home had lived there for some years. Staff told us that people's needs had increased recently. For example, previously people had been more mobile but now required the assistance of hoists which required two people to operate them safely. We saw that the manager had reported this on their monthly monitoring return. There had been no increase in staffing to reflect this.

Concerns were expressed both by relatives and by some community services that the home was only able to meet

Are services well-led?

the basic needs of the people who lived there because of the staffing levels. They expressed concern that there was only one member of staff on duty at night. There had been a recent safeguarding referral to the local authority regarding staffing levels. The local authority confirmed that they were currently investigated this.

The manager told us that both they and the company that owned Lucklaw Residential Care Home were aware of the staffing situation but that they were not currently in a position financially to increase it. The local authority told us that it had convened a meeting to discuss this and it had arranged to reassess the needs of the people living at Lucklaw Residential Care Home.

We were concerned about the current level of staffing at the home because it did not adequately safeguard the health, safety and welfare of the people who used the service as required by the regulations which apply to this type of care. We have identified the action we have asked the provider to take at the end of this report.

We saw that the manager at Lucklaw Residential Care Home had access to a dependency tool which related the needs of people to the level of staffing. The manager told us that they were about to use this tool to re-evaluate the staffing requirements of the people who used the service. The result of this re-evaluation and the local authority review were not available to us during this inspection.

The Provider Information Return showed that the manager had identified a programme of continuous improvement including around the physical environment of the home, providing greater personalisation of the service and strengthening of staff supervision and training. We saw that Warrington Community Living had provided the home with a full set of policies and procedures which included an emergency plan. We saw from the Provider Information Return that these had been identified as requiring review.

Findings from the focused desk based review of 6 October 2014

We found that the provider had followed the action plan they had written to meet shortfalls in relation to the requirements of Regulation 22 (staffing).

During our desk based review we looked at staff rosters, dependency assessments and other supporting documentation. We also spoke with a representative from the local authority, the chief executive officer for Warrington Community Living (the provider) and the registered manager to discuss action taken since our last inspection.

The information we received confirmed staffing levels had been increased since August 2014 for the three people living at Lucklaw Residential Care Home. Three staff were now rostered to work between 08:00 am to 10:00 pm each day.

The service had also established an official 'on-call' system which was operated by the Senior Management Team (SMT). Each member of the SMT covered the on-call rota on a weekly rotating basis. The on-call manager was available to be contacted from 6:00 pm until 9:00 am the following day. Managers had access to a list of bank staff and the contact details for an out of hours agency in case emergency cover was required. We were informed that in the majority of cases the on-call manager would respond should a person(s) using the service require assistance.

The increase in staffing had enabled staff to respond to the changing needs of the people using the service. For example, people now had the support of two care staff with tasks such as moving and handling, which they had not always required. There was also capacity for another support worker to provide ongoing support and supervision to the other people living in the property when two staff were required for specific tasks.

The registered manager informed us that the extra support available had enabled the people supported by Warrington Community Living to lead a more person centred lifestyle and engage in more social activity and stimulation both within their home and the local community. People using the service were also able to access the community more frequently as they now benefitted from individual support.