

Lothlorien Community Limited

Eden Cottage

Inspection report

6 The Oval, Dymchurch, Romney Marsh
Kent, TN29 0LR
Tel: 01303 872686
Website: www.craegmoor.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?

Requires Improvement



Is the service responsive?

Requires Improvement



Is the service well-led?

Requires Improvement



Overall summary

We undertook an unannounced inspection of this home on 28 October 2014. We last inspected the service on 21 October 2013 where no concerns were identified. This service provides accommodation and care to three people with learning disabilities and is located in a residential area of Dymchurch, within reach of local amenities, shops and public transport.

There was no registered manager in place at the time of the inspection. The new manager was in the process of applying for their manager registration with the Care Quality Commission (CQC). 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.

We spoke to two out of three people who had lived in the home for many years. They told us they liked living there and had everything they needed. Some people had been supported to develop their independence skills and could travel outside the home independently, but further promotion of independence was sometimes slow to be put into practice.

Recruitment files showed that the provider ensured appropriate checks were made before staff commenced

Summary of findings

work, but the content of staff records were inconsistent and information difficult to find. Staff demonstrated a respectful, caring and friendly attitude towards the people they supported, and consulted them about all aspects of their day to day care and support. Staff understood about any special needs people had but care records did not always reflect the practice of staff.

Staffing levels were enough to support the day to day basic care needs of people when in the home, and when at home people told us they did the things they wanted to do. People were supported to access the community but more staffing hours were needed to ensure this happened more frequently.

A staff member said they felt well supported and had opportunities through individual meetings with their manager and through staff meetings to express their views. They had received an induction into their role but this was poorly recorded. Staff had received essential training to ensure they had the knowledge and skills to keep people safe. Accidents and incidents were reported and acted upon appropriately. People were supported to maintain links with their families, and external relationships were supported but not well recorded.

Minor improvements were needed to ensure that the systems in place for the management of medicines were safe. Records showed that policies and procedures were kept updated to inform staff of current best practice. A range of audits were in place to check that service quality was maintained and the home's compliance was monitored regularly by the provider.

The home was well maintained, and provided a homely, comfortable and visibly clean environment for people to live in. Each person had been enabled to personalise their own space to reflect their interests and tastes.

Staff told us and records showed that all relevant safety checks were in place. Staff undertook assessment of risks to ensure measures were implemented that kept people safe from harm and these were kept under review.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which correspond to the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not always safe.

There were enough staff to support people at home but not if they wanted to go out more often. The provider made sure that all relevant employment checks were made of new staff but content of staff files was inconsistent.

Minor improvements were needed to the management of medicines to ensure this was managed safely. Individual and environmental risks were assessed to keep people safe.

People liked where they lived. The premises were well maintained and all safety checks undertaken. Staff understood how to safeguard people from harm and report their concerns. Accidents were reported appropriately and analysis of trends undertaken.

Requires Improvement



Is the service effective?

The service was not always effective. Appropriate arrangements were in place for the induction and training and supervision of staff, however records of this were not always well maintained.

People's capacity to make decisions for themselves was assessed. The manager and staff had an understanding of Deprivation of Liberty Safeguards (DoLS) but referrals to check people's DoLS had not been made in view of recent changes.

People were consulted about what they ate and staff ensured people maintained a healthy nutritious diet. Staff ensured that people were supported to access both routine and specialist health appointments.

Requires Improvement



Is the service caring?

The service was not always caring

People told us they had everything they needed but it was not always clear how their comments had been actioned. Care and support was delivered in accordance with people's care plans but people's habitual routines were not always challenged, important external relationships were not always well documented to show how support was given.

Interaction between staff and people were respectful and friendly. People were enabled and supported to develop their skills and independence but agreed actions were sometimes slow to put into practice.

People were given opportunities to express their views though 'your voice' meetings. Relatives were made welcome and relationships with families were supported.

Requires Improvement



Summary of findings

Is the service responsive?

The service was not always responsive

People's needs were assessed and detailed care plans informed staff how to support people's needs. However records did not always reflect the level of staff practice.

People agreed objectives but these were not always actioned. People who were able to lead active lifestyles. However, opportunities for accessing the community and for individualised activities needed improvement for those people who were dependent on staff.

There was an accessible complaints procedure in place. Records showed the home responded appropriately and in a timely manner to formal complaints.

Requires Improvement



Is the service well-led?

The service was not consistently well-led.

Staff found the manager approachable and the open culture enabled staff to feel comfortable about raising issues. Staff were lone working but felt communication amongst the staff team was good.

The provider had ensured that a new manager was in post and they were in the process of registering with the Care Quality Commission (CQC). The provider ensured that policies and procedures that informed staff practice were kept updated. The provider and staff understood their responsibilities for reporting important events to the CQC and to other agencies.

People were asked for their views and these were used to inform service development and a development plan was in place and showed actions taken. Appropriate arrangements were in place for the auditing and quality monitoring of the home to drive improvement.

Requires Improvement



Eden Cottage

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 checked 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.

We undertook an unannounced inspection of this service on 28 October 2014. Because this was a small home of three people the inspection was conducted by one inspector to minimise the impact on people in the home.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also viewed other information we hold about the service in the form of notifications and complaints and previous reports.

During the inspection we spoke with the new manager and one member of staff. We met all three of the people that lived there. We used the Short Observational Framework for Inspection (SOFI) tool. SOFI is a specific way of observing care to help us understand the experience of people who could not talk to us. We also spoke with two relatives.

We reviewed a range of records. This included three care records and associated risk information; recruitment and induction information for two staff; records of training and supervision provided to the staff team; and accidents/incidents information. We also viewed a sample of four policies and procedures, three medicine records and medicine returns information, and quality monitoring audits undertaken by the manager and the provider.

We received feedback from one care manager from the local authority who raised no concerns about the service offered to the person they were funding.

Is the service safe?

Our findings

People said they liked living in the home and felt safe there.

People lived in a well maintained and visibly clean home, they had been able to personalise their own space to reflect their personal interests and tastes. The registered manager and staff were aware of peoples changing dependencies and adjustments were to be made to accommodate this through adaptations to the bathroom To meet their future needs. Records showed that all required servicing to gas, electrical and fire alarm installations were serviced and in date. People's portable electrical appliances and those provided by the home were also checked for safety.

Appropriate fire arrangements were in place to ensure testing of fire equipment and fire drills were undertaken by staff, and people were familiar with fire evacuation arrangements. Individual evacuation plans were in place for each person that took account of their specific needs and how this would affect their evacuation. Water temperatures were checked each day to ensure people were not placed at risk from water that was too hot. In discussion staff demonstrated an awareness of emergency arrangements for any event that stopped the service and knew the plan for taking people to a place of safety. A staff member knew the out of hours on call arrangements and emergency numbers to call.

Staff were mostly lone working but felt that team work and communication was amongst staff was good. A staff member we met demonstrated an understanding of safeguarding and whistleblowing. They felt confident of doing so again should the need arise but felt the manager was approachable and communication between staff was good. Records showed that staff had received safeguarding training.

The registered manager and staff were conscious of risks people could be subject to or may pose to others. Records showed that each person had risks assessed for specific areas of their support. These highlighted the measures implemented to reduce risk of harm occurring to them, and were kept under regular review. A range of environmental risk assessments were developed that highlighted potential risks to everyone in the home, and the risk reduction measures implemented. These were not kept under regular review with most having last been checked in 2012;

However, there was no apparent impact on people at the time of inspection. The new manager had identified that it would be good practice to review these more often to ensure the level of risk remained the same.

Records showed that staff reported accidents and incidents appropriately although their recording of events was sometimes unclear as to the actions they had taken or the cause of the incident /accident. All accidents and incidents were analysed by the provider and manager for trends and patterns that might help inform how people were supported.

Staffing levels were appropriate for the support of people in the house, but more staff were needed when people went out because some people used wheelchairs and needed one staff member each. The manager told us that there was flexibility within the staffing hours to provide for additional staff support for outings each week. When needed the manager supplemented shifts with bank staff hours to ensure people received support from people they knew, but records showed people were not going out very frequently.

Staff recruitment files were not consistent in their contents, although all showed that the provider ensured that all appropriate checks including conduct in employment references, and a disclosure and barring check (this is a check on whether the applicant had any previous criminal offences) and relevant sources of personal identification were provided before staff commenced their employment. The manager told us that a new staff files audit was being implemented which would ensure that content was standardised and a format introduced that ensured information was easier to locate within the files.

Appropriate arrangements were in place for the ordering, receipt, storage, administration, recording and disposal of medicines. A staff member talked through the process with us and demonstrated an understanding of all areas of managing medicines. They had received on- line training and their competency had been assessed. They told us they were also expected to complete a more advanced medicines course but had not been given a date for this.

We identified that the few shortfalls we had found in regard to the routine dating of boxed medicines upon opening, and the signing of handwritten changes on medicine

Is the service safe?

administration records, had already been identified through a medicine audit conducted by the registered manager, and that she was already taking action to discuss these issues with the appropriate staff.

One person was assessed to have capacity to help with their medicine administration and this was undertaken with staff supervision. Plans were underway for the person to take more control of their medicines but this would happen at a pace to suit them.

Is the service effective?

Our findings

People we spoke with said that staff had the appropriate skills and knowledge to support them, a number of staff had joined the home in the past twelve months but people did not feel this had affected them and that the delivery of support remained unchanged. One person said they got on well with all the staff working at the home.

A new staff member told us about the induction process when they started work. They said that they were additional to the rota and this allowed them to spend time shadowing other staff, and familiarising themselves with people's needs and associated policies and procedures. Induction records failed to reflect the range and depth of the induction completed by staff members or that their progress and competency had been appropriately monitored. In discussion the manager agreed that records needed to better reflect the actual induction staff experienced. This is a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

The manager and a staff member told us that staff were required to complete a rolling programme of essential training and to achieve a specific pass rate for this. Records showed that the core staff team had completed all essential training. Records showed that specialist training courses were also made available to staff to inform their work with people with specific needs for example, epilepsy. Staff were provided with opportunities to acquire further externally marked qualifications specific to learning disability and a staff member showed us their certificates. Staff told us that it was their responsibility to check that their essential training was kept updated and told us that their training was up to date. The manager received a print out of staff training, and if an area of a staff members training was overdue this was discussed with them at their next supervision meeting.

The manager told us that the home used their own bank staff who knew the people well. Bank staff were required to complete the same level of training as the main staff team members. Restrictions on lone working were in place for

any bank staff who had any areas of training overdue, and this remained in place until all training was updated. This ensured that people were only supported by staff that had the appropriate and up to date knowledge and skills.

Staff records showed that each staff member had a supervision contract in place. This meant that they agreed to meeting with the manager on a regular basis to discuss their work performance, learning, and development and to raise issues in private. A staff member told us that they felt able to approach the manager or team leader at any time and thought they received regular personal supervision. Records viewed showed that formal supervision frequencies for all staff had lapsed in the last 12 months or had not been recorded. The new manager was aware of this and told us that she was looking to re-instate a frequency of supervision every 6-8 weeks, to ensure staff received the support around their work and performance that they needed.

Communication dictionaries or passports were already in place and helped inform staff about the range of people's verbal skills and their methods of communication and what they were telling staff through their vocalisations and body language.

The manager and staff had received Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) awareness training. The manager demonstrated an awareness of a recent court ruling that had broadened how DoLS was interpreted. No-one living in the home was subject to a DoLS authorisation. In the provider information return (PIR) the need to recheck people's status with the local DoLS team to check if this had been affected by the recent changes to the interpretation of DoLS but at the time of inspection this had not happened.

Records showed that capacity assessments were completed for people in areas where they needed help to make decisions about their care and support, including the taking of photographs, and provision of personal care. For some people who lacked capacity to give this consent their representatives had been consulted and decisions had been taken in their best interest.

Meals were provided on a day to day basis rather than a set weekly menu. Staff were familiar with people's likes and dislikes and this informed them of the meals to prepare. People we spoke with said they were asked each day about what they wanted to eat and were very happy with the

Is the service effective?

meals provided. People had choices about what they wanted for breakfast and we observed people being asked about what they wanted to eat for lunch and the main meal. A staff member was seen showing one person a choice of three things they liked to eat, so that they could choose their lunch time meal.

People were maintaining healthy weights and these were monitored monthly by staff. Staff told us that whilst no one was on a special diet, one person was assessed as being at a nutritional risk. Steps were taken to monitor the person's food and fluid intake daily, and we viewed records of this. Staff demonstrated an understanding of why they were recording this information and what levels of fluid intake they would like to see each day to minimise the risk of dehydration. Staff also spoke about fortifying the person's food to increase nutritional value but. The person's care records did not make clear the level of support staff were offering to ensure they ate a nutritious diet.

Records showed that people were assisted to access routine and specialist healthcare appointments, and that home staff made referrals appropriately when people were unwell or needed reassessment of their health needs. There were plans for an adapted bathroom to better meet the needs of people in the home, and occupational therapy input had been requested in regard to environmental improvements to aid people's mobility. The manager highlighted that they were currently exploring the use of hydrotherapy and reflexology services for some people.

Records showed that health action plans were in place for each person and these detailed their health needs, how they were supported and the health professionals who supported them. Transfer information in the event of admissions to hospital had been developed for each person to provide hospital staff with information at a glance about the person to help provide the support they needed.

Is the service caring?

Our findings

We spoke with two of the three people living in the home who were able to tell us about their experiences of living in the home. They told us that they liked where they lived and felt they had everything they needed. They told us about recent redecoration of their bedrooms and that they had been consulted about this.

People said they liked the staff that supported them. We observed that the contacts the manager and staff member had with people were respectful and friendly, and information was given clearly. Staff demonstrated patience when they were occupied elsewhere and people wanted their attention. The wellbeing of the least able person was routinely monitored and support delivered, however we spent some time observing the contacts staff had with this person and noted these to be on a task related basis rather than allocated quality time spent with the person, and we discussed this with the manager who agreed to look into how this could be a more positive experience for the person.

People had lived together in the home for a long time and routines had become established with little change. Discussions with staff and our observations indicated that some complacency with routines had developed over time. For example, one person had always eaten in their bedroom by choice, but the dining room was now always set up to support two people not three. There was no evidence that this state of affairs was ever challenged or that plans were in place to increase the person's presence in the home by encouraging and enabling them to sit in different areas of the home, participate in the preparation of meals or take part in the usual routines of the house. Although the person themselves never made any attempt to visit the lounge/diner and felt happy in their own surroundings, in discussion, the new manager agreed that more could be done to encourage them out of their room. It was clear that the person was a central figure in the home and staff and other people in the home always ensured they acknowledged the person or conversed with them throughout the day and that they were able to see the comings and goings from the office.

People in the house had opportunities to express their views at 'your voice' meetings which were held regularly throughout the year. It was unclear how the views of a

person who was nonverbal were gathered as their views were not represented at these meetings, but staff demonstrated a good understanding of the person's body language and vocalisations.

We looked at the records of the last three meetings and noted that people made comments about things that were important to them, and in discussion people had confirmed they had everything they needed. However, no action plans were attached to show what had been done with their comments and we drew this to the attention of the manager who agreed to address this for future meetings. People's views were also gathered through survey information and an analysis of this feedback was undertaken by the provider to inform improvements to the home.

Staff gave support around personal care discreetly and without fuss, explaining what they were going to assist people with. We also observed staff supporting someone with their food when they were able to eat some foods on their own, this did not promote the persons independence and we pointed this out to them. Later we observed a staff member assisting the person concerned with their meal and helping them lift their own spoon to their mouth to aid their independence and provide dignity to their meal taking. A staff member demonstrated patience and kindness, but this could have been improved by some verbal encouragement and prompting by a staff member.

We observed and people confirmed that they helped around the house and with their own personal care routines. People were encouraged to develop their independence skills within their capabilities, for example making snacks and drinks, independent travelling, helping with their laundry and helping with the washing up.

Relatives visited and staff helped people to maintain these contacts and records confirmed this. Some people had developed friendships outside of the home that were important to them.

Staff were aware of advocacy but had not had cause to use it; this was because so far decisions had been taken by family members with appropriate legal authorisation or funding authorities in people's best interests. However the manager made clear that where a conflict became evident advocates would be sought.

Is the service responsive?

Our findings

People were heard discussing with staff what they would be doing when they went out, and one person compiled a shopping list of things she wanted to purchase and discussed this with staff. Another person told us that they were going out to a day centre.

People had an assessment of their needs in place and this was kept under review. Staff demonstrated an understanding of people's needs and the support they required but they lacked some of the background history that clarified how and for what reason some people's support had developed. For example, staff were unaware why one person's mobility had deteriorated since they first came to live at the home and this was increasingly restricting what they could do. The person's records did not highlight any health conditions that could be responsible for this and the manager was keen to look into this further with relatives. In discussion the new manager demonstrated a willingness to explore and challenge the 'norms' of some people's routines to ensure these remained in their best interest.

We found that people's care plans were comprehensive and gave staff a good understanding of people's individual needs and how they should be supported. The care plans were kept updated and people and their relatives were consulted about the information they contained. We looked at specific guidance for some people about how epilepsy, behaviour and nutrition were recorded and monitored. On one file we saw that information about how the person's epilepsy was managed was difficult to find, and meant that staff could not access this information for reference quickly. Staff told us they had received appropriate training to manage any seizures for this person if they occurred but information needed to be more readily available for staff to refer to, in the event that they had to support the person with emergency medicine if a seizure lasted longer than expected.

Staff told us how they supported someone whose behaviour sometimes challenged others. Records showed that staff completed incident and accident reports linked to

these outbursts, and managed behaviour appropriately. Staff were familiar with how to offer the support and records showed that guidance they worked to was comprehensive.

Records showed that every year people were set objectives to achieve, these were within their capabilities, and were things they had raised for themselves, showed interest in or been consulted about. On one file we saw that one of the person's objectives was to prepare and cook an evening main meal. Daily records showed this was still to be actioned by staff although they did show that the person continued to make their own breakfast and lunchtime meals. The person had told us they wanted to do more cooking and we drew this to the attention of the manager.

The provider information return (PIR) informed us that the new manager had identified the need to develop new activities and outcomes for people. One of the people at the home led an active lifestyle and was an independent traveller so they went out most days to activities of their choice; they also attended some evening clubs. The other people in the house were dependent on staff taking them out, their care records clearly stated that they needed to get out into the community but daily reports indicated this was happening on average for both people only once per week, and the manager agreed this was not often enough. This is a breach of regulation 9 (1) (b) (i) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 9 (1)(b)(3)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A complaints procedure was in place and a more accessible version with a mixture of text and pictorial prompts had also been produced for people. The complaints record showed that only one complaint had been received since January 2014, and the manager confirmed this had been resolved. We asked a staff member how they would deal with complaints from people. They told us that they always dealt with the issues immediately to the person's satisfaction where possible. But patterns to concerns raised could not be monitored as no record of these was kept. However all serious complaints would be recorded

Is the service well-led?

Our findings

People found staff approachable and spoke openly about things they wanted to talk to them about.

We spoke with a newer staff member who felt that they had settled in well to the routines of the house. They said they felt supported and able to raise issues with the new manager individually and within a staff team meeting which was held at six to eight weekly intervals.

People with the support of staff made use of the local community and visited shops and activities in the local area.

A staff member said that although the majority of shifts were lone working they felt communication between staff was good and that staff took time at handovers to ensure the person coming on duty understood what had happened in preceding shifts and to discuss any issues that had occurred. A staff member told us they also met with their team leader every week. They said that if poor practice issues were highlighted a meeting of staff would be called to discuss these. They demonstrated an understanding of the lines of accountability and knew who to contact in the event that they needed advice and guidance. From discussion with the manager we learned that there were opportunities for career progression for staff within the company.

Staff said they felt well supported by the new manager, who was helpful in supporting personal and work related issues. Staff meetings were held regularly but records showed these had not always been recorded.

The registered manager left in August 2014, and a new manager was interviewed and appointed quickly and had been in post for the past six weeks. The new manager informed us that their application to register with the Care Quality Commission was underway.

We saw that policy and procedure information to inform staff practice was kept under review. The manager told us that this was updated centrally and sent out to individual services who would adapt this if necessary to meet the specific needs of their service. All managers were required to evidence receipt of policies and procedures and were

required to cascade this information to staff. A staff member confirmed they were made aware of when policies and procedures had been updated and were required to evidence they had read them.

Records showed that a range of audits were undertaken by staff and the manager to monitor that quality standards were maintained. Records showed where audits had highlighted issues and actions had been taken as a result. The provider operated an internal quality monitoring team that undertook six monthly visits to the home. Records of monitoring visits showed these to be comprehensive and produced action plans to address issues highlighted. There were set timescales to address issues which were monitored both by the regional manager during their routine bi-monthly visits and by the company's internal quality monitoring team.

Records did not always reflect the activity that staff undertook to support people. For example, records viewed for one person showed no specific support recorded from staff with maintaining a relationship with someone external to the home. We discussed this with the manager who agreed that the importance of the relationship was understated in the person's plan of support and this would be changed. Some support information was difficult for staff to find and a system for cross referencing to signpost staff to other documents was shown not to work on one person's record viewed. Some guidance used by staff was undated so it was unclear if this was the most current guidance to ensure it kept pace with and supported staff practice. This is a breach of regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The manager understood the requirements for notifying the Care Quality Commission about events that happened that affected the running of the home or people and staff.

Previously the home had achieved Investors in People award; this has to be reapplied for in order to maintain the award. The new manager was unclear if this remained current and was planning to explore this further to ensure they could still display the award.

A service development plan for 2014 was in place and this showed that identified works had all been completed by

Is the service well-led?

the end of 2013. We heard from people and staff about further improvements to the service but these were still to be written onto the plan with clear timescales for completion.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity

Accommodation for persons who require nursing or personal care

Regulation

Regulation 9 HSCA (RA) Regulations 2014 Person-centred care

People who used the service were not being provided with enough opportunities for activity, stimulation and access to the community to alleviate isolation.

Regulated activity

Accommodation for persons who require nursing or personal care

Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

People were not protected against the risk of unsafe care and treatment through the maintenance of accurate records.