Richmond Psychosocial Foundation International

Lancaster Lodge

Inspection report

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Ratings

Overall rating for this service	Inadequate
Is the service safe?	**Inadequate**

Summary of findings

Overall summary

Our last inspection of the service took place on 1, 2, 3 and 8 March 2016 and was unannounced. During that inspection we found seven breaches of regulations as a result of which we rated the service as inadequate. These were in relation to person centred care, safe care and treatment of people, safeguarding adults from the risk of abuse, dealing with complaints, good governance, staffing and sending notifications about significant events to CQC as all providers are required to do. We are taking actions against the provider for the above breaches of regulations and will report on these when our actions are complete.

This unannounced inspection took place on 10 and 11 May 2016 in response to a serious incident that happened at the home and to check if people using the service were safe. The report should be read in conjunction with the report we produced after our unannounced inspection of March 2016.

Lancaster Lodge is a care home for up to 11 adults with mental health needs.

The home did not have a registered manager. The previous manager left on 18 January 2016. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run.

The provider did not have effective systems to manage risks and where risks were identified, comprehensive plans were not in place to ensure risks were managed appropriately and in a consistent manner.

The provider did not have proper arrangements to ensure people received their medicines as prescribed so they received the treatment prescribed by their doctor.

Some risks in relation to the safety of the premises, more specifically about the storage of cleaning products and other chemicals, were not managed appropriately to fully ensure the safety of people who use the service.

There were conflicting records meaning people were not protected from known risks. These included records associated with nutrition and hydration as staff were given conflicting directions to follow in relation to keeping people using the service safe.

The provider did not ensure appropriate skilled and experienced staff were deployed at the home to meet the various needs of people who used the service.

We found two continued breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We are taking action against the provider in combination with the findings of our inspection in March 2016 in accordance with our enforcement policy. We shall report on this when our action is completed.

Two people said that currently they felt safe living at the home and had now got used to the new staff and felt better supported by them.

Staff said they had received appropriate support with their work including support to come to terms with a serious incident which occurred at the service.

The overall rating for this service continues to be 'Inadequate' and the service is still in 'Special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

Whilst people said that they felt safe, we found that the provider did not have effective arrangements to ensure risks were assessed, monitored and mitigated. This meant there were risks to people's safety, health and welfare.
The house was not kept clean, cleaning materials were not suitably stored and there was out of date food and unlabelled food in the fridge, which could pose a risk to people using the service

Medicines were not managed safely.

Lancaster Lodge

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.

This was an unannounced focused inspection and took place on 10 and 11 May 2016. It was in response to a serious incident, on going concerns that we have about the quality of care people received at the service and to assess whether the provider was doing all that was practicable to keep people safe.

This inspection was carried out by one inspector and an inspection manager.

Before the inspection, we considered notifications made to us by the provider, whistle-blowing concerns raised and information we held on our database about the service and provider.

During our visit we observed care and support provided, was shown around the home and checked records, policies and procedures. These included the staff recruitment, training and supervision systems and the home's maintenance and quality assurance systems. We also spoke with two people using the service, four staff and the nominated individual.

We looked at the personal care and support plans, risk assessments, daily notes and medicine administration notes (MAR) for two people using the service and one person who had recently used the service.

Inadequate

Is the service safe?

Our findings

People said they currently felt safe living at the service. One person said, "My keyworker [staff member] has been very supportive." Another person told us, "[three named staff members] have been great."

People using the service and staff told us about medicines administration and recording. One person said, "The medication has been much better." The person was referring to errors in medicines administered by staff that was highlighted in the previous report.

We checked medicines storage and records. There were three boxes of a medicine in the home which had been supplied in December 2015 and February 2016. No prescriptions or records could be located of them coming into the home. The home's medicines policy and procedure stated, 'All medicines brought into the home by the resident, from whatever source, (including for example, from the resident's home, brought in by friends/relatives, medicines provided on discharge from hospital, as well as medicines prescribed on a regular basis or brought from another home) should be recorded.

The medicine recording sheet (MAR) for a person for the week commencing 9 May 2016 stated that a medicine was to be taken 100 mg take two twice per day or as directed by the hospital.' A letter from the last placement, dated 9 November 2015 and signed by a doctor attached to that service stated the same medicine to be taken 200 mg daily. This meant that the person was not receiving the medicine as prescribed and was receiving an overdose of the said medicine. A count of the number of tablets of the medicine showed that out of a total of 112 tablets originally prescribed in three boxes 91 were left . The number of tablets does not tally with either the dosage or number of times to be taken per day.

The incorrect administration of medicine and the errors in record keeping of medicines administered constitute a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. CQC is considering the appropriate regulatory response to resolve the problems we found.

Medicines were stored in a locked facility. The staff told us they had received medicines administration training. A record of the disposal of medicines no longer required was in place to keep an audit trail of the medicines.

Where risks were identified, there were no clear plans in place to manage the risks. One person was identified at risk of self-harm and frequent checks were instituted. The checks varied in timing between five and 15 minutes depending on the documentation. The staff handover log book gave different timescales in different entries about the frequency to check the person. Daily notes also showed that the checks were not completed in a consistent manner and intervals of time. Items that the person could use to self-harm had also not been comprehensively identified and where these were identified appropriate risk management plans were not in place so the risk of self-harm was minimised.

The kitchen area contained cleaning materials that were not stored in a lockable facility. A referral for one

person using the service dated 27 January 2015 stated that the person had drunk bleach in the past. The fridge also contained out of date and unlabelled and undated food. The last food hygiene inspection took place on 12 October 2007. The upstairs bedrooms and bathrooms were dirty and untidy. There was exposed electric wall light wiring in the lounge.

One person had a risk assessment dated 4 April 2016. It was unclear if the person carrying out the risk assessment was qualified to do so or the person reviewing had sufficient experience or qualifications in this field to be competent. One person had a community psychiatric assessment that was regularly reviewed. There was no support plan provided by the home to meet the person's needs. On another person's support plan reviewed on 4 April 2016 stated under the heading culture, faith and spirituality 'currently no need.'

The staff said they shared information regarding risks to individuals including any behavioural issues during shift handovers and if they occurred. The handover, a person's daily log and communication book entries conflicted in the information recorded. The impact on people using the service was that they were not receiving care and support in a safe way.

The above shows that the provider was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was six permanent staff employed by the provider to work at the home, two bank relief staff, a part time clinical lead and deputy manager. One was on maternity leave. The nominated individual oversaw four homes in the group, three of which are registered with the Care Quality Commission. The staff rota stated that there was two staff on duty during day shifts with a deputy manager nine to five and one person on call at night.

The nominated individual was also the interim manager. The part time clinical lead and interim manager were not included on the staff rota. Neither did the clinical lead and interim manager sign the visitors book so it could not be identified how much time they spent in the home. One person said the interim manager visited two or three days per week. When asked how often the interim manager was present another person told us, 'Not a lot.' This meant there was insufficient management cover.

During the morning shift on10 May 2016, there was one member of staff on shift and the deputy manager as a member of staff had called in sick. No agency cover had been provided. The nominated manager had stated, at the previous inspection on 2 March 2016 that there would be a mix of male and female staff on the day shifts as all the people using the service were female. The member of staff on duty on the morning shift and the deputy manager were both male. The staff group was not representative of the group of people using the service. One person told us, "Generally there are one male and one female on duty."

The above paragraphs show that the provider was in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The home had a new deputy manager who was aware of how to raise a safeguarding alert and when this should take place. The home was also recruiting to the post of manager with a view to registering with the Care Quality Commission.