Mrs A Kelly & Mr A Kelly

Lancaster House

Inspection report

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Date of inspection visit:
13 September 2017
20 September 2017
21 September 2017

Date of publication:
27 November 2017

Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Good**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

We carried out an inspection of Lancaster House on 13, 20 and 27 September 2017. The first day of the inspection was unannounced.

Lancaster House is a care home providing personal care and accommodation for up to 13 adults with a mental health need. The home is a large semi-detached house situated on the main bus routes close to a busy slip road leading off Eccles Old Road onto the A6. The driveway and back garden are shared with the house next door, Cairn House, which is also a care home owned by the same provider. At the time of inspection 10 people were using the service.

The home was last inspected on 25 and 27 January 2017, when we rated the service as 'Inadequate' overall. We also identified 10 breaches of the regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, including continuing breaches with premises and equipment, staffing and good governance, along with additional breaches with safe care and treatment, management of medicines, safeguarding people from abuse or improper practice, person-centred care and receiving and acting on complaints.

We took enforcement action and issued the provider and registered manager with warning notices in regards to premises and equipment and good governance, to formally request action be taken to address the overall standard or the premises and ensure quality assurance and auditing systems were in place and being utilised. We also asked the provider to take action to ensure people were actively involved in their care, ensure staff received the necessary support and professional development to enable them to carry out their roles effectively, assess the risk of and control the spread of infections, ensure the proper and safe management of medicines, ensure they acted in accordance with the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) and ensure they had an system for the identifying, receiving, recording and handling of complaints.

At this inspection we identified eight continuing breaches in four of the regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, including breaches relating to, staffing, safe care and treatment, management of medicines, person-centred care and good governance and one breach of the Care Quality Commission (Registration) Regulations 2009, due to a failure to inform the commission of notifiable incidents. We also made a recommendation in relation to following best practice in relation to the MCA and DoLS. We are considering our enforcement actions in relation to these regulatory breaches.

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

We found remedial action had been taken to address previously identified issues with the overall décor and

maintenance of the property. A schedule of works had been produced which the provider and registered manager had overseen. Bedrooms and bathrooms had been re-decorated, damaged or broken fixtures and fittings had been replaced and attempts to de-clutter communal areas had taken place. We noted work was ongoing and the hall, stairs and landing along with replacement of carpets had purposefully been left until last, to ensure all building and painting tasks had been completed.

We saw staff continued to be responsible for cleaning tasks, with checklists in place detailing what tasks needed to be completed in each room. We found the home to be reasonably clean; however some fixtures, fittings and ornaments required dusting. Cleaning equipment was stored safely and securely and Control of Substances Hazardous to Health (COSHH) forms were in place for the cleaning products in use. We noted the provider had installed paper towel dispensers in bathrooms, to replace cotton hand towels, however hand hygiene guidance was not in place and liquid soap bottles were still being used rather than wall mounted soap dispensers, which is contrary to Department of Health guidance.

We identified some issues during our review of medicines management. We saw the service continued to not use 'as required' medicine protocols or topical medicine charts. We found records of topical medicine usage were not completed consistently and we noted one person's transdermal patch had not been applied as per prescription. We also identified aspects of good practice especially around the receipt and booking in of medication when it was delivered to the home.

Each person we spoke with told us they felt safe. The home had safeguarding policies and procedures in place, although did not have a dedicated safeguarding file and log of referrals, with referrals stored electronically in email folders. Staff had been trained in safeguarding vulnerable adults and had knowledge of how to identify and report any safeguarding or whistleblowing concerns. We did note a safeguarding issue raised by the local hospital regarding a person who used the service had not been reported to the Care Quality Commission, as is required by law.

People who used the service and staff we spoke with felt there was not enough staff employed to effectively meet people's needs. We saw staff members had left and despite actively trying to recruit, the home had not been successful in replacing these staff. Whilst the reduced staffing levels had not impacted on people's feeling of safety, we did notice an impact on the support people received to complete planned tasks and activities. People continued to be encouraged to retain their independence and were free to come and go as they wished.

We looked at five care files in detail, which were stored electronically on a laptop. We found limited improvements and additions had been made since the previous inspection, with numerous gaps in information and an overall lack of detailed guidance for staff to follow, to ensure people's needs were being met. We saw mental health care plans and risk assessments had been drawn up to sit alongside the existing care plans; however these had yet to be implemented.

We found the service was working within the principles of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). Training in both areas had been facilitated, and staff had a reasonable understanding of both sets of legislation. However there was not an MCA / DoLS policy in place and some of the wording used in care plans could be seen as oppressive.

Staff told us training had improved with a number of sessions being held over the last six months, including training in mental health awareness, which considering the nature of the service, had been a noticeable omission at the previous inspection. The training matrix had not been fully updated during the inspection, however we were able to confirm sessions had been held and the registered manager updated and

forwarded the matrix to us following the inspection.

The provider's action plan following the previous inspection stated staff would receive supervision on a bi-monthly basis, however our review of staff records demonstrated this was not being done. Whilst there had been an increase in the frequency of meetings, none of the staff had completed more than three meetings since January.

People told us they enjoyed the food provided by the service and received enough to eat and drink. People could choose when and where to eat, with meals being prepared for people to eat later, if they did not wish to eat at the allocated meal time.

Throughout the inspection we noted a positive atmosphere within the home. People were animated and engaged in conversation and friendly 'banter' with each other and members of staff. People we spoke with were complimentary about the staff and the standard of care received. Resident meetings had been held, with people given the opportunity to suggest agenda items, as well as being informed about things relating to the home.

We saw a new auditing and quality monitoring system had been introduced, which had been designed by the provider. However this had not been used fully or effectively and none of the issues noted during this inspection had been identified by the registered manager or the auditing process.

We noted some issues in fire safety processes when reviewing safety procedures and checks. Not all checks had been carried out in agreed timescales and personal emergency evacuation plan (PEEPS) were still not in place.

The overall rating for this service is 'Inadequate' and the service remains 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.

Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

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

The service was not safe.

Positive action had been taken to improve the overall décor and standard of the premises, with a detailed action plan in place.

Whilst some improvements had been made, hand hygiene practices and equipment did not adhere to Department of Health or NICE guidelines.

Medicines were not always managed safely. One person had been given medicines contrary to prescription guidance and we found gaps in recordings on MAR charts.

Fire safety checks were not being completed as per required timescales and we found no record of smoke detector checks being carried out.

Is the service effective?

Requires Improvement

Not all aspects of the service were effective.

Supervision meetings were being held but not as frequently as the provider had reported on their action plan.

Training had been provided in a number of areas over the last six months, however we found new employees were not provided with a thorough induction training programme.

People enjoyed the meals provided and reported getting enough to eat and drink.

People were supported to stay well through involvement of a multidisciplinary team and attendance at GP surgery as necessary.

Is the service caring?

Good

The service was caring.

People using the service were positive about the care and support provided, telling us that staff were kind and treated them

with dignity.

Throughout the inspection we observed a positive atmosphere within the home and appropriate interactions between staff and people using the service.

Meetings were being held with people who used the service, who had input into what was discussed.

Is the service responsive?

Requires Improvement

Not all aspects of the service were responsive.

Limited updates to care files had been completed since the previous inspection. We found a number of gaps and omissions of important information.

Mental health care plans and risk assessments had been drawn up, but not yet implemented, which meant staff did not have the information they needed to provide person centred care.

Care plans and other documentation were not completed fully or consistently, meaning that contemporaneous records were not being kept.

The service had an effective system for managing complaints; people had been reminded on the process during both individual and resident meetings.

Is the service well-led?

Inadequate

The service was not well-led.

Although a new audit and quality and monitoring system had been introduced, this was not being used effectively and had not identified the issues we noted during inspection.

Meetings with staff had been completed, to ensure the dissemination of information was maintained.

Policies and procedures had been updated, although there was no robust system in place for reviewing these.

Annual questionnaires were given to people and relatives to request feedback on the service.

Lancaster 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.

The inspection took place on 13, 20 and 21 September 2017. The first day of the inspection was unannounced.

The inspection team consisted of two adult social care inspectors from the Care Quality Commission (CQC).

Before commencing the inspection we looked at any information we held about the service. This included any notifications that had been received. A notification must be sent to the Care Quality Commission every time a significant incident has taken place, for example where a person who uses the service experiences a serious injury. We checked any complaints, whistleblowing or safeguarding information sent to CQC. We also contacted the local authority and mental health commissioning team to request any information they had about the service. This was used to inform our inspection judgements.

During the course of the inspection we spoke to the owner, registered manager and two staff members. We also spoke to five people who lived at the home.

We looked around the home, including communal areas and people's bedrooms. We viewed a variety of documentation and records. This included four staff files, five care plans, five Medication Administration Record (MAR) charts, policies and procedures and audit documentation.

Inadequate

Is the service safe?

Our findings

We checked the progress the provider had made following our inspection in January 2017 when we identified a continued breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, in relation to premises and equipment. This was because the service had failed to ensure the premises and equipment were properly maintained.

Following the last inspection the provider had drawn up and sent us a 'schedule of works' document, which contained all maintenance and decorating tasks which needed to be done along with estimated timescales for completion. As part of this inspection, we completed a review of the premises with the registered manager which included checks of all communal areas, bathrooms and toilets and four bedrooms. We saw work had been carried out in line with the plan sent to us, which been updated to include additional works identified during the process. Whilst further work was required, including the replacement of some items of furniture and carpets on the stairs and landing, the provider had made significant progress and was no longer in breach of the regulations. The registered manager told us they intended to keep the plan in place to ensure the ongoing upkeep of the premises.

We looked at the procedures in place to ensure the premises were kept clean. Cleaning duties were the responsibility of the staff on shift, with checklists in place to provide guidance on how and where to clean. The home had employed a cleaner, however they had since commenced the role of live in housekeeper for the other home run by same provider as well as covering some care shifts, which meant cleaning tasks had been passed back to care staff. We noted improvements in the overall cleanliness of the home; compared to the last inspection in January 2017, however found continued issues with dusting and cleaning of some fixtures, fittings and furniture. Due to the small number of staff on shift and the needs of the people using the service, staff had limited time to spend completing cleaning tasks, which accounted for the issues noted.

We checked the progress the provider had made following our inspection in January 2017 when we identified a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, in relation to safe care and treatment, because the service did not assess the risk of, or control the spread of infections. This was because Department of Health and The National Institute for Health and Care Excellence (NICE) guidelines around hand hygiene were not being followed.

We saw paper towel dispensers had been fitted in all toilets and bathrooms, and cotton hand towels removed. Bottles of hand wash were still in place, rather than wall mounted soap dispensers, and on two days of the inspection, one of the downstairs toilets had no soap in place at all. There was still no hand hygiene guidance displayed above or near to any wash basin. The registered manager told us they had been sent posters by local authority but had not yet put them up. NICE guidance states providers should, 'educate residents and carers about the benefits of effective hand hygiene. The guidance also states that hand hygiene facilities should include as a minimum, disposable paper towels and wall mounted liquid soap dispensers. Top up/refillable dispensers should not be used as these pose a risk of contamination and cause the spread of infection.'

This is a continued breach of Regulation 12(2)(h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, in relation to safe care and treatment, because the service did not assess the risk of, or control the spread of infections.

We asked people who used the service if they felt safe living at Lancaster House. One person said, "I feel safe here. I can go to my room when I want" Another told us, "It's relaxed here, people get on. People don't argue, there are no outbursts or worries." A third stated, "Yes, I do, I love it here."

We looked at the home's safeguarding systems and procedures. The registered manager told us referrals continued to be stored electronically using a colour coded system to 'flag' any safeguarding referrals that had been emailed to the local authority. However, the home did not have a matrix or other systems in place to document progress or outcomes of any referrals. Following a review of people's care by the mental health commissioning team, a number of potential safeguarding issues were identified and passed on to the local authority. These issues had not been identified or reported by the provider. Salford Royal also raised a safeguarding concern which was investigated and the allegation of abuse substantiated. This involved the staff's response to a person who had requested medical attention, but was not listened to. The person spent several days in discomfort until action was taken and the person being supported to go to hospital. Recommendations had been put forward following the safeguarding investigation, which we noted had been put in place to ensure a similar incident did not occur again.

We looked at how accidents and incidents were recorded and whether there was a procedure in place to identify trends and track outcomes. We were told staff completed an accident form and this was then filed in either the staff personnel file or the person's care file, which was used to file correspondence and miscellaneous information about the person. We found there was no accident or incident log in place, to record when any accidents or incidents had occurred, and when we asked the provider how they analysed accidents and incidents to check for trends, they were unable to demonstrate this. Through reading the daily notes section of people's care files, we noted at least two people had had accidents requiring medical intervention. However we could find no completed accident or incident form in their care files. This meant the provider did not have an effective system in place to document, store and manage accidents and incidents as they were unable to demonstrate trends were identified or control measures implemented to reduce the risk of re-occurrence.

During the last inspection in January 2017, we found the risk management section of people's care files we looked at did not accurately assess known risks or contain a management plan to minimise or mitigate these risks. During this inspection we noted improvements had been made to these same care files, with the omissions we reported to the provider being addressed. However following the review of people's care by the mental health commissioning team, additional issues had been identified with risk assessment procedures and documentation and an action plan had been drawn up and given to the provider. We were provided with a copy of the plan and checked the provider's progress against this as part of the inspection. Whilst some items had been addressed, we found specific risk assessments for four people had yet to be drawn up and implemented.

We looked at the home's safety documentation, to ensure the property was appropriately maintained and safe for residents. Gas and electricity safety certificates were in place and up to date, although the registered manager could not locate the portable appliance testing (PAT) certificates, which we were told had been completed in April 2017.

We found seven fire drills had been completed so far this year, with all people using the service evacuating safely, either independently or following a prompt from a staff member. Call points and fire fighting

equipment had been checked weekly, however checks of escape routes and emergency lighting had not been carried out as per stated timescales and we saw no records of smoke alarm testing being completed. We were also unable to evidence a comprehensive and up to date fire risk assessment was in place although an emergency fire plan had been drawn up, which covered how to read the fire alarm panel, where each zone was located, where fire equipment was and a basic assessment of fire hazards and control measures in place.

We also noted that whilst staff had met with all people using the service and assessed their understanding of what to do if the fire alarm went off, personal emergency evacuation plans (PEEPs) had still not been put in place. The introduction of the Regulatory Reform (Fire Safety) Order 2005 places the onus on providers to ensure that everyone can evacuate safely in the event of a fire or emergency evacuation. In order to comply with legislation, a personal emergency evacuation plan (PEEP) needs to be devised by the responsible person. A PEEP is designed to ensure the safety of a specific person in the event of an emergency evacuation and must be drawn up with the individual so that the method of evacuation can be agreed. The PEEP will detail the escape routes, and identify the people who will assist in carrying out the evacuation.

This is a breach of Regulation 12(2)(a)(b)(d)(e) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, in relation to safe care and treatment, because the service did not assess the risks to the health and safety of service users, ensure they complied with statutory requirements or national guidance and ensure the premises and equipment used by the service was safe for use.

As part of the inspection we checked the progress the provider had made following our inspection in January 2017 when we identified a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, as the service had not ensured the proper and safe management of medicines.

We looked at five medicine administration record (MAR) charts and checked four people's medicines, to ensure stock levels were accurate and all medicines had been administered as prescribed. We found some examples of good practice, such as all medicine deliveries had been checked, the amounts confirmed and signed off, a specimen signature chart was in place and this tallied with the staff signatures on the MAR charts and each person had a 'ready reckoner' sheet in place, which was a visual aid designed by the service to help staff identify whether medicines were stored in a blister pack or box and the time of administration.

However we noted one person's transdermal patches, used to mitigate the symptoms of travel sickness had not been stored or administered correctly. The patches are supplied in boxes of two, however we found nine patches in one box. We were told this had been done on purpose, to reduce the number of boxes in the cupboard, however staff had not updated the packaging to reflect this. Administration instructions stated a patch should be applied every 72 hours. However when we checked the MAR chart for August 2017, we saw one had been applied on 25, 26, 27 and 28 August. We also saw only three patches had been applied between 28 August and 12 September. The person had not come to any harm as a result of the incorrect dosage however neither the staff or registered manager were aware the error had occurred until we brought it to their attention.

For people who were prescribed topical medicines, the home had not maintained a contemporaneous record of its usage and application. One person was reported to self-administer a cream; however we also saw guidance which indicated staff supported the person to do so. The senior carer told us the person applied it themselves but was observed by staff doing so, who then documented this. This process had not been followed consistently. We also noted gaps on MAR charts, where neither a signature or code had been used to indicate if the person had taken their medicines or not. We were able to confirm medicines had been

administered by checking stock levels.

A medicine fridge remained in place although was unplugged on two of the days we inspected. Fridge temperature monitoring charts were located next to the fridge but had not been completed consistently. The fridge was only used once a month to store eye drops, which needed to be kept between 2°C and 8°C until opened. Recordings on the monitoring charts showed it had regularly exceeded the required temperature level, which indicates it had not had enough time to reach the necessary temperature before being used.

The home did not have when required medicines (PRN) protocols in place, which are used to inform staff what a medicine is for, the required dose, how often it can be administered, the time needed between doses, if the person is able to tell staff they need it and if not what signs staff need to look for. This ensures 'as required' medicines are being administered safely and appropriately. The use of these was not deemed necessary by the registered manager, as all people using the service were able to ask for 'as required' medicines when they needed them.

Some prescription medicines contain drugs that are controlled under the Misuse of Drugs legislation. These medicines are called controlled drugs (CD). At the time of inspection nobody using the service was prescribed controlled drugs.

We saw medicines policies and procedures in place were up to date, although the home did not have an up to date pharmaceutical prescribing reference guide on site. Staff spoken with confirmed they had completed training in medicines management and had their competency assessed, however we found no records to evidence this.

This is a continued breach of Regulation 12(2)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, in relation to safe care and treatment, as the service did not ensure the proper and safe management of medicines.

We asked both people using the service and staff working at the home for their views on staffing levels. One person told us, "I feel there are enough staff on duty. A staff member left recently and the manager is on leave so they are understaffed at the moment, but there is always somebody on duty." Another said, "There's not enough staff, can't do the things I want to as never anyone to support me." A staff member stated, "Not enough staff here. [Manager's name] has been advertising but not had any joy yet. Have had some agency in but they weren't very good." A second told us, "We are short staffed, have advertised, but some not turned up for interviews."

We looked at a staff rotas for August and September 2017 and noted the home had ran with one staff member between 08.00am and 16.00pm, one between 15.00pm and 22.00pm and one who worked 22.00pm until 08.00am. The registered manager was on site to support between 9.30am and 17.30am Monday to Friday. During the registered manager's recent leave, the owner had provided cover.

We found there was still not a clear approach to determining staffing requirements based on people's needs. People's dependency had been assessed in their care file, but there was no overview of dependency levels to determine correct and effective staffing levels. The registered manager told us staffing levels were low at present and they had experienced problems with recruiting staff, but did not want to use agency staff, due to negative experiences in the past. As a result they were managing with the staff they had. The registered manager told us the owner helped out regularly to ensure people could attend appointments and complete planned activities.

From speaking to people and reviewing documentation, we noted all people using the service were able to access the community independently, albeit one person requested support to do so due to anxiety, and required very little support from staff during the day, however activities and goals that had been generated during key worker sessions, such as regular cooking sessions had not been completed consistently, due to staffing levels.

This is a breach of Regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, in relation to staffing, as the provider did not deploy sufficient numbers of staff to make sure people's care and treatment needs were being met.

We reviewed four staff files to check if safe recruitment procedures were in place and saw evidence that Disclosure and Baring Service (DBS) check information had been sought for all staff and was logged on each file. Staff also had a completed application form, at least two references as well as a full work or educational history documented. A DBS check helps a service to ensure the applicant's suitability to work with vulnerable people.

Requires Improvement

Is the service effective?

Our findings

As part of this inspection we checked the progress the service had made following our inspection in January 2017, when we found a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, in relation to staffing, because the provider could not demonstrate staff had received the appropriate support and professional development.

We asked staff whether they had supervision and if so how often. One told us, "I have had about three since I started, not sure how often they are. We talked about what I had done during the day, how things were working." Another stated, "We have quite a lot now, maybe every two months or so."

Following the last inspection the provider sent us an action plan which stated staff supervision would be held bi-monthly. During this inspection we noted company policy also stated meetings would be held every two months. We looked at both staff personnel files, where we were told supervision records were kept, and the supervision matrix, which was part of the providers audit tool. We could not evidence meetings had been held to agreed timescales. Of the seven staff listed on the matrix who still worked at the home, two staff had completed three supervisions since January, three had completed two meetings and the remaining two people only one. We did locate additional supervision records for two staff which had not been recorded on the matrix; however these staff had still not completed a supervision meeting every two months. This meant staff had not received a regular opportunity to formally discuss their roles, receive feedback on their performance and request additional support or guidance.

The registered manager told us that since the last inspection staff had completed training in the mental capacity act (MCA), deprivation of liberty safeguards (DoLS), infection control and mental health awareness. Safeguarding refresher training was also scheduled for the following week. Both staff members we spoke with and the training matrix confirmed this was the case, although two had been absent when MCA and DoLS training had been held and it had yet to be completed again for them. We also looked at the training provided to new staff members as part of their induction. We saw there was not a specific programme of training in place, which staff had to complete prior to working with people who used the service, instead new employee's shadowed experienced staff and completed training whenever it was scheduled for everyone else. The registered manager told us this was because they only employed people with at least an NVQ level 2 in Health and Social Care, which ensured they had a good level of knowledge and understanding. However we noted the last person to be employed did not have this qualification or a professional background in care. We were told this person was originally employed as a cleaner, but their role had progressed over time.

We asked staff for their views on the training provided at the service. One told us, "Been an improvement in training recently, compared to what it was like before." Another stated, "DoLS, infection control and medicines training, about all I have done up to now." We noted on the training matrix, this person was listed as having completed five other training sessions over the last six months.

This is a continued breach of Regulation 18 (2)(a) of the Health and Social Care Act 2008 (Regulated

Activities) Regulations 2014, in relation to staffing, because the provider could not demonstrate staff had received the appropriate support, training and professional development to enable them to carry out their duties.

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

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met.

During the last inspection in January 2017 we spoke to a person who told us their access to cigarettes and drinks was restricted by the service. The registered manager told us the person had requested this programme be in place, however we looked at this person's care file and could not find any information about such discussions, any assessments or documentation regarding the restrictive practice or completed capacity assessments to indicate the person did not have the capacity to manage their cigarette or fluid intake. During this inspection we saw the person had been assessed as having capacity, conversations discussing the cigarette and drinks programme had been documented and the person told us, "I am happy to be helped with my cigarettes and drinks, this is my choice. If they didn't they would all go at once."

Since the last inspection in January 2017, training had been provided in the MCA and DoLS. Staff told us they now had a better understanding of both as a result. However the information and knowledge had not fed into all aspects of the service. We were told every person using the service had capacity, were free to leave should they choose and as a result no DoLS applications had been made or were required, however no restrictive practice assessments had been completed to ensure people were not being deprived of their liberty. The home did not have a MCA / DoLS policy and procedure in place, which we were told was an oversight, as one had been drawn up when policies were renewed. Some of the terminology used in care plans was also oppressive. For example, "Staff to discourage [person] from going out by herself and 'escort' them when shopping or out for lunch." A second person's medicines care plan stated; "Staff to 'escort' [person] to and from clinic."

We recommend the provider and registered manager consider best practice guidance in regards to the application of the mental capacity act and deprivation of liberty safeguards for people using the service.

People using the service told us they enjoyed the food and got enough to eat and drink. One person said, "The food is alright. My favourite is stew and dumplings. I also like the brunch on Sunday's. It's a full breakfast that we have at 11.00. I have cereal in the mornings. We can have snacks when we want because we buy our own snacks." Another told us, "The food is excellent. Potatoes or chips and plenty vegetables each day. We have fish at least once a week. We discuss the food and it's put forward what we'd like and we are given it."

The home had set meal times. We asked the registered manager what procedures were in place should people not want meals at that time. We were told the meals would be cooked, left to cool, stored in the fridge and warmed up again when the person wanted it.

At the time of the inspection no one using the service required a special diet. One person was being supported with specific meal options, to help them lose weight. We saw meals were prepared by members of staff, all of whom had completed food hygiene and 'food for better business' training. A six weekly menu was in place, with two options available for lunch but just one for evening meal. However we were told and observed that alternatives were available if people did not like or want what was planned. We heard one person say they did not want pork chops, and was offered either grill steak or sausages instead. Other people made request for different types of potato dishes and alternate vegetables, all of which were provided. Individual food and fluid monitoring was not in place, instead a record of the choices people had made was recorded within a notebook, set aside for this purpose.

We had been made aware, following the mental health commissioning team's reviews of people's care, that people's access to the kitchen to make drinks was restricted during meal preparation times. The reason for this was reported to be a health and safety issue, due to the small size of the kitchen and the risk of people burning themselves. During the inspection we asked the registered manager whether this practice was still in place. They told us it was but that, "staff will make a drink for anyone who wants one whilst meals are being prepared. There is also juice available on the tables at this time and most people have facilities in their rooms for making drinks." They confirmed the concerns were to do with risk to people whilst meals were being cooked, however a risk assessment had not been completed to assess this. The manager said they would ensure a risk assessment was completed to document their concerns and control measures in place.

Our review of people's care records showed the service had continued to work with other professionals and agencies to meet people's health needs, these included general practitioners (GPs), district nurses and podiatrists. One person using the service told us, " "I see the GP, dentist and podiatry. I have no healthcare concerns." Another stated, "If unwell and need to see somebody, the staff make you an appointment straight away."

We looked at how the home sought consent from people who lived there. We did not see signed consent forms within care files. Care plans had been printed so the person had a copy and was able to sign a document attached to the care plan to indicate they consented to the content, although this process was not completed on a regular basis, to ensure ongoing consent to care and treatment. However everyone we spoke with during the inspection confirmed they enjoyed living at Lancaster House and agreed with the care and support provided.

Good

Is the service caring?

Our findings

All the people we spoke with told us they liked living at Lancaster House and had developed positive relationships with the staff. Comments included, "It's a good home to live in. I get on with everybody. I've been in worse places", "There's life here. Compared to where I was previously living. You can relax here" and "It's a good home. Got time to chat with staff at night. The staff are compatible and get on well with us."

We found there was a positive atmosphere from the moment that we arrived at the home. People who were up on our arrival were in the main communal area talking to each other. Throughout the day people were animated and engaged. Everyone looked clean and had made an effort with their appearance.

Throughout the three days of inspection, we observed people using the service communicating positively with each other, asking how each other was and what they had planned. The atmosphere in the home was vibrant and welcoming. On one of the days we overheard the provider laughing and joking with people, who were evidently familiar with the provider's family as they enquired after them. The provider spent over an hour chatting to people about a variety of subjects and all were comfortable in their presence.

However when the provider was not present, who was more often than not supernumerary to staffing levels, it was apparent staff did not have the time to spend sitting and chatting with people. Staff were friendly, polite and courteous, but interactions tended to be task or support orientated, such as asking what people had planned, what they wanted to eat and if everything was okay.

We looked at how the service involved people in making decisions about their care and the running of the home. We were told people had been consulted about the recent redecoration of the home, particularly their rooms. One person told us, "I have my own room and I'm happy with how it is decorated and things." We looked at one person's room, which was very cluttered and had not been decorated. The registered manager told us this was what the person wanted. They had always been a collector of things and their room was how they liked it to be, which helped them feel at home. The person confirmed this when we spoke with them.

We saw residents' meetings had been completed, although not as frequently as the provider had stated they would following the previous inspection in January 2017. To date three formal meetings had taken place, along with another meeting involving relatives, whereas the provider had told us they would aim to hold these monthly. We looked at the minutes from these meetings and noted the provider had discussed openly the findings from the last inspection and what the home would do to address the issues. Other agenda items had included food choices, fire procedures, key work sessions and any other things people wanted to discuss. People we spoke with told us they were happy with the frequency of the meetings and felt they could bring things up anytime and did not have to wait until formal meetings were held.

We asked people using the service if staff treated them with dignity and respect. Each person we spoke with confirmed they did, telling us staff "Knock on my door", "Ask me what I would like" and "Look after us really well." Staff had a good understanding of how to ensure dignity was maintained. One told us, "I talk to them,

ask them want they want and how they want it to be done. I try to do whatever I can for people." Another said, "Ask people before I do anything, knock on their door, make sure no-one is around, or go to their room before discussing anything private."

Many of the people living at Lancaster House had resided there for a long time and viewed this as their home. One person told us several times during each day of inspection how much they loved being there and how they had developed a life and routine for themselves. Whilst a number of the interactions with people were task focussed, it was apparent staff knew people well and were aware of their daily routines. Staff asked people about their plans, if they needed a taxi booking to take them, how family members were and when they would next be visiting them. This demonstrated the caring nature of staff towards people living at the home.

We saw that issues raised by a visiting professional about a staff members interactions with a person using the service, had been addressed by the registered manager during a supervision meeting. Expectations of how interactions should be carried out had been discussed and how even though what may be said is done so in jest, it may not always be interpreted that way.

Requires Improvement

Is the service responsive?

Our findings

As part of this inspection we checked the progress the service had made following our inspection in January 2017, when we found a breach of Regulation 17 of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, in relation to good governance, as the service failed to maintain accurate, complete and contemporaneous records. The majority of the issues noted at the last inspection related to a lack of information within care plans. We found gaps within people's care plans, which meant staff did not have the necessary information about each person's ability to function and how best to support them.

Prior to this inspection, a review by the mental health commissioning team of people's care plans had identified similar concerns, along with the fact people did not have specific mental health care plans and risk assessments in place. An action plan had been generated with the involvement of the provider and registered manager, which we were sent a copy of. During this inspection we compared progress made against the action plan. Although we saw the registered manager had met with people to discuss their diagnosis and any known triggers or stressors and used this information to create mental health care plans and risk assessments, none of these had been implemented.

We spoke with the registered manager about this who told us, "I did not want to introduce them until [social worker who completed the reviews] had agreed they were okay. I was told some of them needed changing, so wanted to make sure they were right first." The registered manager agreed that by not implementing the new care plans, even as a work in progress, staff still did not have all the information they required to support people effectively.

We looked at five care files to assess if any progress had been made with the care plans staff had access to. Care plans continued to be produced and stored electronically on the service's laptop using a system that had been devised by the provider. We noted people's care plans had not progressed significantly. Each person's care file contained the same 13 sections, which included pages for personal details, assessments, care plans, daily reports and social activity. However, the care plans were not recovery focused and goals, objectives, evaluations and outcomes were more reflective of the staff's views and not about the person. For example, one person's care plan around medicines merely stated the goal/objective was for staff to administer, whilst the evaluation/outcome stated, successful care plan, continue indefinitely. This meant that people's care plans were not person centred.

We found some care plans identified the person's mental health diagnosis but they didn't always indicate what this looked like for the person or provide guidance as to what relapse looked like or how to support the person to manage their symptoms. We found some good guidance in one person's care file that experienced auditory hallucinations. There was guidance around different ways to try to assist the person including use of distraction techniques and other examples. However in another file we noted a person had panic attacks when they went out of the home. We saw no symptoms of the panic identified, duration or techniques to utilise, or information detailing what to do and when. There was also no mention of whether anxiety management, graded exposure or therapies had been considered or explored.

Medicine care plans were institutionalised with no exploration of supporting people's independence in this area. For example, one person's plan stated she would be unable to self-medicate due to tremors. Another person's reported they regularly slept in and so would forget to take their medication. We found no consideration or exploration of assistive technology to support either person to have greater independence in this area. One person had asked for greater control of their medicines, and whilst this had been discussed with them and external professionals, a plan about how this was to be facilitated had not been drawn up.

We also found gaps in information. One person had had two falls in close succession, however their mobility care plan contained no mention of this. Whilst a risk assessment had been drawn up around falls management, this stated a falls care plan was in place, which had not been done.

This is a continued breach of Regulation 17(2)(c) of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, in relation to good governance, as the service failed to maintain accurate, complete and contemporaneous records.

Each person using the service had been allocated a keyworker, whose role was to 'provide one to one support for certain areas of need or development, with the primary focus being on social needs.' The keyworker sessions were used to generate goals and monitor progress. This ensured people had ongoing involvement in their programme. We found there had been an increase in the number of key worker sessions completed since the last inspection, with most people completing one per month, albeit some of the topics covered had been about the running of the home and policies and procedures, rather than people's goals and future plans.

Despite the increase in the frequency of meetings and improvements in the recording of people's wishes, we found actual follow through of people goals to be sporadic. Four people whose notes we reviewed had said they wanted to cook more meals for themselves. We found no plan in place about how this would be facilitated. Where a plan had been agreed we saw little evidence of completion, for example, one person's session notes dated 01 August 2017 stated they were to make their own lunches for the rest of the week. We found no record this had been done. During their next key worker session, dated 07 September 2017, it had been recorded [person] wants to make more meals, so had made lunch. Will now do this once a week. We saw no plan or records to confirm they had been supported to do so. For the most part, people had been supported on the day of the keyworker session to complete an aspect of their goal, but this had not been sustained.

We were told care files were reviewed monthly and people's care needs six monthly. Whilst review dates had been updated on the electronic care files for some people, this had not been done consistently for all, meaning we could not confirm reviews had been completed. The registered manager had a file which contained copies of care plans, along with a signature sheet which stated 'care plan explained and I agree with the content'. Whilst this evidenced people had been involved in reviewing their care, we saw the process had not been completed on a monthly basis.

This is a breach of Regulation 9(3)(d)(e) of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, in relation to person-centred care, as the provider did not ensure people were consistently involved in their care and supported to complete agreed goals.

As part of this inspection we checked the progress the service had made following our inspection in January 2017, when we found a breach of Regulation 17 of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, in relation to receiving and acting on complaints, as the service did not have information and guidance available about how to complain or have an accessible system for the identifying, receiving,

recording and handling of complaints.

We saw the complaints procedure had been clearly displayed on the notice board in the main communal area, and the complaints process had been discussed with each person individually in a minuted meeting. Complaints had also been covered as an agenda item at resident meetings. People we spoke with confirmed they knew how to complain and who to speak with. The home had a complaints file in place which contained the procedure and blank complaint forms. We were told no forms had been completed since the last inspection. A verbal complaint had been made about a staff member, which we saw had been addressed, with documentation evidencing this. We spoke to the registered manager about the accessibility of complaints forms and how people may wish to complain anonymously. The registered manager said they would look to implement a suggestions and complaints box and have complaints forms on the notice board, so people would not need to ask for one.

The service did not provide an activity schedule, with people choosing how they wanted to spend their time. People told us they were happy with this arrangement and valued their freedom and ability to do as they wished. People spent their time visiting friends and relatives, going shopping, attending day centres and activity groups. We also noted people enjoyed sitting in the communal areas and chatting with each other. We were told one staff member tended to generate and complete a range of activities with people when they were on shift. We were told, "[Staff name] tends to work late shift and does a lot of activities, pamper nights, movie nights things like that. We were also told that once a year the service arranged and paid for a holiday, which people had the option to attend.

Inadequate

Is the service well-led?

Our findings

At the time of our inspection there was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like the registered provider, 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.

As part of this inspection we checked the progress the service had made following our inspection in January 2017, when we found a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, relating to good governance, as the provider had failed to operate effective systems to asses and monitor the quality, safety and effectiveness of the service and have effective communication systems in place for people using the service and the staff.

We saw a new electronic audit system had been developed by the provider. This covered a total of 15 areas including care plans, health & safety, food safety, training, safeguarding, supervision, medication and overall premises. A rating system had been incorporated, with either a red, amber or green dot on each individual audit to indicate if action was required or all areas had been met. Whilst the auditing tool had been implemented, we noted it was not being used fully. We saw a number of blank sections on the form, particularly those relating to the premises and complaints. We were told this was due to having a separate schedule of works in place and not having received any written complaints, which we accepted. We also found there was ambiguity about the frequency with which areas needed to be checked, as this was not clearly stated on the tool.

We also found the audit tool was not robust as it had not identified any of the issues noted on inspection or those highlighted when the mental health commissioning team had carried out placement reviews of people using service. For example, despite daily MAR chart and monthly medication audits being completed, none had identified the issues with incorrect dosages or missing signatures. The supervision matrix contained an amber dot, which indicated areas required addressing, however meetings had not been scheduled to ensure all staff had completed the agreed amount. Care plan reviews had been completed, which included checking information was up to date and accurate and that records and monitoring were up to date. No issues had been identified, with the people's care plans we viewed being marked as 'green'.

During our last inspection in January 2017, we found there was not an effective system in place for the storing of documentation, records and certificates. This resulted in the registered manager having difficulty locating items we requested to view. At this inspection we saw some attempts had been made to organise the filing cabinets, however the filing system within the office was still disorganised, files were not clearly labelled and many contained out of date information. During the first day of inspection, the manager was on annual leave. Throughout that day not only did we have difficulty locating required documents, but staff and the provider also had the same issue. In regards to the provider, although they were a regular visitor to the home and was the person who covered in the registered manager's absence, they demonstrated little oversight. Anything we asked for, they advised us that [registered manager] would know, which as they were on leave was not very helpful.

This was a continued breach of Regulation 17 (1)(2)(a)(b)(d)(f) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, relating to good governance, as the provider had failed to operate effective systems to asses and monitor the quality, safety and effectiveness of the service and maintain securely records which are necessary to be kept in relation to the management of the regulated activity.

The provider and registered manager have a legal responsibility to submit notifications for certain reportable events. During the inspection we noted two instances when notifications should have been submitted but the provider had failed to do so. These were in relation to a safeguarding alert and a fall which resulted in a fracture of the foot. We are considering our enforcement options in regards to the failure to notify, which will be handled outside of the inspection process.

During the last inspection in January 2017, we identified that the service's policies and procedures required updating to ensure they covered the most recent best practice guidelines. At this inspection we saw a new policy and procedures file had been implemented, and aside from the absence of an MCA and DoLS policy, which we were told had been drafted, contained all necessary documentation. However the policies did not contain the date of completion or date for review, which we raised with the registered manager.

We asked staff whether staff meetings had been completed. One told us, "Yes, they are as and when." Whilst a second staff stated, "Yes, can't remember the exact date of the last one, but we have had quite a few." Following the last inspection, the provider had indicated on the action plan sent to us in April 2017, staff meetings would be held bi-monthly. We saw three meetings had been held since April, which was in line with what we had been told. However we noted the last meeting had been held in July, which meant the next scheduled meeting was overdue.

The staff we spoke with told us they enjoyed working at the home and felt supported by the manager. When asked if they enjoyed their job, one staff said, "I do yes. [Registered manager] is a good manager, you can go to her with anything." Another told us, "I do think [registered manger] listens to us."

We asked how people were able to provide feedback on the service and were told that annual questionnaires were sent to people, relatives and professionals. Relatives had attended a meeting at the home in July, when the questionnaires had been circulated with five returns received. The questions asked covered a range of areas including people's privacy was respected, staff were courteous and friendly, home was clean and tidy, sufficient activities were provided and the service met the physical and emotional needs of people. Relatives had been asked to rate each statement on a five point scale which ranged from strongly disagree to strongly agree. Aside from one relative who had rated the activity statement as 'disagree', the ratings for all other statements were positive.

We saw people using the service had been asked to completed quality assurance questionnaires on either the 18, 19 or 20 September 2017. We queried whether the inspection had prompted the completion of these but was told this was coincidental, and it had always been the plan to circulate them in September, even though at the previous inspection in January, we had been told questionnaires were done in April. We looked at 10 completed questionnaires, which asked people to rate statements about all aspects of the service using the same scale as the relative form. Eight of the ten people had said they agreed or strongly agreed with each statement, whilst two had disagreed the service provided activities and one had also disagreed there was enough staff on duty to support them.