Durham Careline Limited
Lyons Court Care Home

<table>
<thead>
<tr>
<th>Region:</th>
<th>North East</th>
</tr>
</thead>
</table>
| **Location address:** | Lyon's Court Care Home  
                        Stones End, Evenwood  
                        Bishop Auckland  
                        Co Durham  
                        DL14 9RE |
| **Type of service:** | Care home service with nursing  
                        Care home service without nursing  
                        Rehabilitation services |
| **Date of Publication:** | September 2012 |
| **Overview of the service:** | Lyons Court is a purpose built three storey care home that provides up to 50 places. It is in the centre of the village of Evenwood and close to local facilities. It is registered with the Care Quality Commission for the regulated activities: accommodation for persons who require |
nursing and personal care; treatment of disorder, disease or injury; and diagnostics and screening.
Our current overall judgement

Lyons Court Care Home was not meeting one or more essential standards. Action is needed.

The summary below describes why we carried out this review, what we found and any action required.

Why we carried out this review

We carried out this review as part of our routine schedule of planned reviews.

How we carried out this review

We reviewed all the information we hold about this provider, carried out a visit on 6 August 2012, observed how people were being cared for, looked at records of people who use services, talked to staff and talked to people who use services.

What people told us

We spoke to several people who lived at Lyons Court Care Home and they told us that the staff were very friendly and helpful. One person said "the staff are very good, very obliging".

People said they were happy with the staff and the care they provided. One person said "the staff are very kind, it's alright here".

We also spoke to some relatives and visitors, they told us that the home was well run and they felt able to approach the staff or manager with any concerns they had.

What we found about the standards we reviewed and how well Lyons Court Care Home was meeting them

Outcome 01: People should be treated with respect, involved in discussions about their care and treatment and able to influence how the service is run

The provider was meeting this standard. People's privacy, dignity and independence were respected.

Outcome 04: People should get safe and appropriate care that meets their needs and supports their rights

The provider was meeting this standard. People experienced care, treatment and support that met their needs and protected their rights.
Outcome 07: People should be protected from abuse and staff should respect their human rights

The provider was meeting this standard. People who use the service were protected from the risk of abuse, because the provider had taken reasonable steps to identify the possibility of abuse and prevent abuse from happening.

Outcome 13: There should be enough members of staff to keep people safe and meet their health and welfare needs

The provider was meeting this standard. There were enough qualified, skilled and experienced staff to meet people's needs.

Outcome 16: The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care

The provider was meeting this standard. The provider had an effective system in place to regularly assess and monitor the quality of service that people receive.

Outcome 20: The service must tell us about important events that affect people's wellbeing, health and safety

The provider was not meeting this standard. Events that affect people’s welfare, health and safety have not always been reported to the Care Quality Commission.

Actions we have asked the service to take

We have asked the provider to send us a report within 14 days of them receiving this report, setting out the action they will take. We will check to make sure that this action has been taken.

Where we have concerns we have a range of enforcement powers we can use to protect the safety and welfare of people who use this service. When we propose to take enforcement action, our decision is open to challenge by a registered person through a variety of internal and external appeal processes. We will publish a further report on any action we have taken.

Other information

Please see previous reports for more information about previous reviews.
What we found for each essential standard of quality and safety we reviewed
The following pages detail our findings and our regulatory judgement for each essential standard and outcome that we reviewed, linked to specific regulated activities where appropriate.

We will have reached one of the following judgements for each essential standard.

Compliant means that people who use services are experiencing the outcomes relating to the essential standard.

Where we judge that a provider is non-compliant with a standard, we make a judgement about whether the impact on people who use the service (or others) is minor, moderate or major:

A minor impact means that people who use the service experienced poor care that had an impact on their health, safety or welfare or there was a risk of this happening. The impact was not significant and the matter could be managed or resolved quickly.

A moderate impact means that people who use the service experienced poor care that had a significant effect on their health, safety or welfare or there was a risk of this happening. The matter may need to be resolved quickly.

A major impact means that people who use the service experienced poor care that had a serious current or long term impact on their health, safety and welfare, or there was a risk of this happening. The matter needs to be resolved quickly.

Where we identify compliance, no further action is taken. Where we have concerns, the most appropriate action is taken to ensure that the necessary changes are made.

More information about each of the outcomes can be found in the Guidance about compliance: Essential standards of quality and safety
Outcome 01:
Respecting and involving people who use services

What the outcome says
This is what people who use services should expect.

People who use services:
* Understand the care, treatment and support choices available to them.
* Can express their views, so far as they are able to do so, and are involved in making decisions about their care, treatment and support.
* Have their privacy, dignity and independence respected.
* Have their views and experiences taken into account in the way the service is provided and delivered.

What we found

Our judgement
The provider is compliant with Outcome 01: Respecting and involving people who use services

Our findings

What people who use the service experienced and told us
We spoke with some people who lived at the home, they said:

"The staff are very good, very obliging"
"It's alright here"
"They look after me well"

We also spoke to some relatives and visitors, they said:

"The staff are all lovely"
"The home is well run".

Other evidence
People expressed their views and were involved in making decisions about their care and treatment.

We spoke with a number of people who used the service. They told us that they were able to express their views freely. The manager told us people were provided with a pack containing information about the home. The information included an overview of the service, a service user guide and other services available to people within the
home. This information was provided to people before they decided to live at Lyons Court. This meant people were given appropriate information on what the home could offer them.

We spent time observing how staff supported people living at the home. We found staff were very respectful in their approach, treating people with dignity and courtesy. For example we saw staff sitting down and chatting to people in the lounge, they sat down next to the person so were at the same height. Staff knocked on doors before entering, ensuring people's privacy was respected.

We saw peoples' bedrooms were decorated with their own keepsakes, and some had furniture from their own homes. A new resident was due to move in so their family had taken in some personal possessions to make the bedroom more welcoming. People had choices on colour schemes and which room they wanted as their bedroom. One person said "I have brought my mirror and some pictures from home".

People were supported to remain involved in their local community. One person enjoyed going to the community centre every week; other people went on various outings to local restaurants and to see a show in a local town.

We observed mealtimes in all three of the dining areas and saw care workers supporting people in a respectful and sensitive manner when serving or helping people with their meal. If people required assistance this was provided discreetly and any requests were responded to quickly and respectfully.

People were given a choice of food at mealtimes and we found that people had the choice of eating their meals in the dining room or their own bedrooms.

We looked at people’s plans of care and we could see these had been written in an individual way for each person. They included information on how to care for peoples' individual needs but also details about preferences and interests. Staff were knowledgeable about people and were able to explain, with examples, about how they would promote people's independence and choice. All of these measures showed people were treated with respect and involved in making decisions about their care.

**Our judgement**  
The provider was meeting this standard. People's privacy, dignity and independence were respected.
Outcome 04:
Care and welfare of people who use services

What the outcome says
This is what people who use services should expect.

People who use services:
* Experience effective, safe and appropriate care, treatment and support that meets their needs and protects their rights.

What we found

Our judgement
The provider is compliant with Outcome 04: Care and welfare of people who use services

Our findings
What people who use the service experienced and told us
We spoke with several people who lived at the home, they said:

"The girls look after me well"
"The staff are very kind, it's alright here"
"(name) is a lovely girl"

We also spoke to some relatives, some said they were involved in care planning and reviews of care. One person said "the staff are fine, I've got no complaints", another said "I can speak to the staff when I need to". Other comments included; "the staff are fine, I've got no complaints", "(name) is brilliant" and "the staff seem lovely".

Other evidence
People's needs were assessed and care and treatment was planned and delivered in line with their individual care plan.

When we visited the home there were 46 people living there, and a further 2 people due to move in that day. We spent time talking with some people, and watched how staff gave them support and care. We then looked at five care records with staff to see how people's care was planned, monitored and co-ordinated.

We looked at five care records in detail. The assessments, care plans and daily notes guided staff in how to support each individual in their own way.
We saw people being involved in day to day decisions about their care; we also saw
documentary evidence that care needs assessments were compiled in discussion with people using the service and their representatives. The manager also showed us examples of pre-admission assessments; these showed that the manager met with people in their own homes before admission to gain an initial understanding of their needs and preferences.

The provider may wish to note that although there was provision for people to sign their care plans, we saw these were not always completed.

When we talked to staff we found they had a good understanding of people's histories, needs and preferences which they needed to support people. Care plans included records of appointments with and visits by health and social care professionals, such as the GP, dentist and optician. This ensured people's wider needs were supported.

We also saw staff kept a daily record of the care provided. These were generally well completed and included references to visits made by relatives, people's safety, people's welfare and daily activity. This helped to make sure people's treatment was up to date and their progress monitored. The provider may wish to note that the personal information sections in some of the care plans were not fully completed at the time of inspection.

The care plans also took into account guidance and research which helped to make sure staff were providing appropriate care. We saw one care plan had some specific instructions for staff on how to provide treatment and care for that person's specific illness.

We spoke with some residents about the activities on offer, one person said "I love playing dominoes", another preferred to watch TV and read in their room and they were supported to do this. We observed a number of activities including dominoes, a sing-a-long and looking at historical photographs. The activities co-ordinator also spent some time on a one to one basis with people; she was very knowledgeable about people and tailored her approach to suit each person. For example, some people just wanted to talk so she found out their interests to be able to have a conversation, others liked massages or their nails painted. This contributed to maintaining people's welfare and promoting their wellbeing.

**Our judgement**
The provider was meeting this standard. People experienced care, treatment and support that met their needs and protected their rights.
Outcome 07: Safeguarding people who use services from abuse

What the outcome says
This is what people who use services should expect.

People who use services:
* Are protected from abuse, or the risk of abuse, and their human rights are respected and upheld.

What we found

<table>
<thead>
<tr>
<th>Our judgement</th>
</tr>
</thead>
<tbody>
<tr>
<td>The provider is compliant with Outcome 07: Safeguarding people who use services from abuse</td>
</tr>
</tbody>
</table>

Our findings

**What people who use the service experienced and told us**
All the people we spoke with told us they felt safe living at Lyons Court Care Home. They were clear about how and who to report any concerns about their safety to.

**Other evidence**
People who used the service were protected from the risk of abuse, because the provider had taken reasonable steps to identify the possibility of abuse and prevent abuse from happening.

We saw that the provider had safeguarding and whistleblowing policies and procedures in place. Information about safeguarding was on display in the reception area of the home. This meant staff had easy access to guidance on what to do if they had concerns about a person's wellbeing.

We spoke with relatives of people who used the services at Lyons Court Care Home who told us they were confident their relatives were safe there. One relative said "I feel (relative's name) is safe living here".

The manager regularly completed a review of any safeguarding incidents and recorded the outcomes and any actions to be taken.

We spoke with four staff working in the home; they were all familiar with safeguarding procedures. The staff described clearly what action they would take in the event of a safeguarding matter coming to their attention. They were clear about their roles and
responsibilities in this area.

**Our judgement**
The provider was meeting this standard. People who use the service were protected from the risk of abuse, because the provider had taken reasonable steps to identify the possibility of abuse and prevent abuse from happening.
Outcome 13: Staffing

What the outcome says
This is what people who use services should expect.

People who use services:
* Are safe and their health and welfare needs are met by sufficient numbers of appropriate staff.

What we found

Our judgement
The provider is compliant with Outcome 13: Staffing

Our findings

What people who use the service experienced and told us
We spoke with some people who lived at the home, they said,

"It's good, they are very obliging"
"I rang the bell during the night and they came to help me"
"I have no qualms about the staff".

Other evidence
There were enough qualified, skilled and experienced staff to meet people's needs.

We talked to people who lived at the home, visitors and staff, to find out what they thought about the home. We also checked the provider's records and observed staff's care practices.

When we visited there were 46 people accommodated in the home. We looked at the number of staff supporting people at the home and found there were two nurses and eight care staff on duty. There was also an activities co-ordinator who was spending time on each floor.

The manager had recently appointed a further nine care assistants who were due to commence employment in September. Interviews were being held when we carried out our inspection to appoint additional staff with the aim of creating a bank of staff to provide cover when needed and additional 1 to 1 care.
The manager told us she continually monitored people's needs, for example around moving and handling and personal care support, and compared it to staffing levels. She said that staff were supportive when asked to do additional shifts but they also made use of bank and agency staff as necessary. This demonstrated she had calculated the number of staff required to make sure peoples' needs were met by sufficient numbers of staff.

Throughout the day of our visit we saw no instances where people did not receive the care and support they needed from staff within an acceptable period of time. We saw staff responded quickly to people's requests for assistance and staff were present in those areas where people spent their day. All of these measures showed that there was sufficient staff employed at the home to meet peoples' needs.

**Our judgement**
The provider was meeting this standard. There were enough qualified, skilled and experienced staff to meet people's needs.
Outcome 16: Assessing and monitoring the quality of service provision

What the outcome says
This is what people who use services should expect.

People who use services:
* Benefit from safe quality care, treatment and support, due to effective decision making and the management of risks to their health, welfare and safety.

What we found

<table>
<thead>
<tr>
<th>Our judgement</th>
</tr>
</thead>
<tbody>
<tr>
<td>The provider is compliant with Outcome 16: Assessing and monitoring the quality of service provision</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Our findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>What people who use the service experienced and told us</td>
</tr>
<tr>
<td>We spoke to people using the services but their feedback did not relate to this standard.</td>
</tr>
<tr>
<td>We also spoke to some relatives and visitors, they told us that they were involved in ongoing reviews and were able to speak to staff or the manager if they had any problems.</td>
</tr>
<tr>
<td>Other evidence</td>
</tr>
<tr>
<td>We saw records of the checks the provider compliance manager did to make sure the home met the required standard. These included checks of the environment to make sure it was clean and safe, health and safety, risk assessments and accidents and incidents. We saw that if any issues were identified a plan was developed with a timescale for action.</td>
</tr>
<tr>
<td>The provider had a clear policy on obtaining feedback from people using its services. This included information from sources such as comments, complaints and survey questionnaires. We saw numerous thank you cards in the entrance of the home that had been sent to the home from relatives expressing their gratitude for the care that had been delivered.</td>
</tr>
<tr>
<td>We saw that people who used the service, relatives and staff were asked for their views about their care and treatment through regular meetings and questionnaires. We saw action plans were then produced from this feedback to improve the care delivered and the experience for people using the service.</td>
</tr>
</tbody>
</table>
All these systems ensured that the provider had an effective quality assurance system and sought the views of people who used the service and their relatives.

Accidents and incidents were closely monitored in the home. In this way we saw the manager had systems in place to learn from harmful things that might happen in the home and quickly put things in place to stop them from happening again.

**Our judgement**
The provider was meeting this standard. The provider had an effective system in place to regularly assess and monitor the quality of service that people receive.
Outcome 20: Notification of other incidents

What the outcome says
This is what people who use services should expect.

People who use services:
* Can be confident that important events that affect their welfare, health and safety are reported to the Care Quality Commission so that, where needed, action can be taken.

What we found

<table>
<thead>
<tr>
<th>Our judgement</th>
</tr>
</thead>
<tbody>
<tr>
<td>The provider is non-compliant with Outcome 20: Notification of other incidents. We have judged that this has a minor impact on people who use the service.</td>
</tr>
</tbody>
</table>

Our findings

What people who use the service experienced and told us
We spoke to people using the services but the feedback did not relate to this standard.

Other evidence
We reviewed the accident book and incident report forms in people's care plans. We saw that these were completed and referred to the local safeguarding team as necessary. Action was taken to address issues of concern and records were kept up to date.

In several instances of injuries to people following abuse by other service users, the CQC was not informed using the formal notification process. This meant that we were not aware of the number and potential impact of these incidents.

Our judgement
The provider was not meeting this standard. Events that affect people's welfare, health and safety have not always been reported to the Care Quality Commission.
Compliance actions

The table below shows the essential standards of quality and safety that are not being met. Action must be taken to achieve compliance.

<table>
<thead>
<tr>
<th>Regulated activity</th>
<th>Regulation</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accommodation for persons who require nursing or personal care</td>
<td>Regulation 18 CQC (Registration) Regulations 2009</td>
<td>Outcome 20: Notification of other incidents</td>
</tr>
<tr>
<td></td>
<td><strong>How the regulation is not being met:</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Events that affect people's welfare, health</td>
<td></td>
</tr>
<tr>
<td></td>
<td>and safety have not always been reported to</td>
<td></td>
</tr>
<tr>
<td></td>
<td>the Care Quality Commission.</td>
<td></td>
</tr>
<tr>
<td>Diagnostic and screening procedures</td>
<td>Regulation 18 CQC (Registration) Regulations 2009</td>
<td>Outcome 20: Notification of other incidents</td>
</tr>
<tr>
<td></td>
<td><strong>How the regulation is not being met:</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Events that affect people's welfare, health</td>
<td></td>
</tr>
<tr>
<td></td>
<td>and safety have not always been reported to</td>
<td></td>
</tr>
<tr>
<td></td>
<td>the Care Quality Commission.</td>
<td></td>
</tr>
<tr>
<td>Treatment of disease, disorder or injury</td>
<td>Regulation 18 CQC (Registration) Regulations 2009</td>
<td>Outcome 20: Notification of other incidents</td>
</tr>
<tr>
<td></td>
<td><strong>How the regulation is not being met:</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Events that affect people's welfare, health</td>
<td></td>
</tr>
<tr>
<td></td>
<td>and safety have not always been reported to</td>
<td></td>
</tr>
<tr>
<td></td>
<td>the Care Quality Commission.</td>
<td></td>
</tr>
</tbody>
</table>

The provider must send CQC a report that says what action they are going to take to achieve compliance with these essential standards.

This report is requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider's report should be sent to us within 14 days of the date that the final review of compliance report is sent to them.
Where a provider has already sent us a report about any of the above compliance actions, they do not need to include them in any new report sent to us after this review of compliance.

CQC should be informed in writing when these compliance actions are complete.
What is a review of compliance?

By law, providers of certain adult social care and health care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The Care Quality Commission (CQC) has written guidance about what people who use services should experience when providers are meeting essential standards, called Guidance about compliance: Essential standards of quality and safety.

CQC licenses services if they meet essential standards and will constantly monitor whether they continue to do so. We formally review services when we receive information that is of concern and as a result decide we need to check whether a service is still meeting one or more of the essential standards. We also formally review them at least every two years to check whether a service is meeting all of the essential standards in each of their locations. Our reviews include checking all available information and intelligence we hold about a provider. We may seek further information by contacting people who use services, public representative groups and organisations such as other regulators. We may also ask for further information from the provider and carry out a visit with direct observations of care.

Where we judge that providers are not meeting essential standards, we may set compliance actions or take enforcement action:

**Compliance actions:** These are actions a provider must take so that they achieve compliance with the essential standards. We ask them to send us a report that says what they will do to make sure they comply. We monitor the implementation of action plans in these reports and, if necessary, take further action to make sure that essential standards are met.

**Enforcement action:** These are actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers are set out in the law and mean that we can take swift, targeted action where services are failing people.