Inspection Report

We are the regulator: *Our job is to check whether hospitals, care homes and care services are meeting essential standards.*

The Foundation of Lady Katherine Leveson

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Tel: 01564772850

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We inspected the following standards as part of a routine inspection. This is what we found:

Care and welfare of people who use services	✖ Action needed
Safeguarding people who use services from abuse	✔ Met this standard
Management of medicines	✔ Met this standard
Staffing	✖ Action needed
Assessing and monitoring the quality of service provision	✖ Action needed

Details about this location

Registered Provider	The Foundation of Lady Katherine Leveson
Registered Manager	Ms. Kelly Holder
Overview of the service	This location is registered to provide accommodation for a maximum of 30 people who require personal care. It is also registered to provide personal care to people living in the supporting housing scheme on the same site
Type of services	Care home service without nursing Domiciliary care service
Regulated activities	Accommodation for persons who require nursing or personal care Personal care

Contents

When you read this report, you may find it useful to read the sections towards the back called 'About CQC inspections' and 'How we define our judgements'.

Summary of this inspection

Why we carried out this inspection

This was a routine inspection to check that essential standards of quality and safety referred to on the front page were being met. We sometimes describe this as a scheduled inspection.

This was an unannounced inspection.

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 14 November 2013, observed how people were being cared for and checked how people were cared for at each stage of their treatment and care. We talked with people who use the service, talked with staff and talked with other regulators or the Department of Health.

What people told us and what we found

We visited the main house and the courtyard residential flats on the same site. We observed how people were being cared for at each stage of their treatment and care and how their health and well-being was safeguarded from abuse. We looked at how medication was managed and we examined how the service measured the quality of care provided to people who used the service. We spoke to staff and people who used the service.

We observed staff interacting with people with kindness. The main home had 11 en-suite flats. In addition there were a further eighteen flats separated from the main house by a courtyard. Above the residential flats were a further sixteen flats used as sheltered accommodation. We had concerns about some people's safety when walking across the cobbled flagstones which paved the perimeter of the courtyard.

One person who used the service told us, " It's nice here, it's my home, I'm happy".

We reviewed the care of four people with varying levels of need. We saw medication was stored and administered safely.

We saw there had been a significant number of falls within the service. We had concerns there were insufficient staff to meet the needs of people living in both the main house and the flats. We examined care records and saw people's needs were not always reflected in their risk assessments and care plans.

We noted the service made appropriate referrals to outside specialists on behalf of people who lived there.

You can see our judgements on the front page of this report.

What we have told the provider to do

We have asked the provider to send us a report by 19 December 2013, setting out the action they will take to meet the standards. We will check to make sure that this action is taken.

Where providers are not meeting essential standards, we have a range of enforcement powers we can use to protect the health, safety and welfare of people who use this service (and others, where appropriate). When we propose to take enforcement action, our decision is open to challenge by the provider through a variety of internal and external appeal processes. We will publish a further report on any action we take.

More information about the provider

Please see our website www.cqc.org.uk for more information, including our most recent judgements against the essential standards. You can contact us using the telephone number on the back of the report if you have additional questions.

There is a glossary at the back of this report which has definitions for words and phrases we use in the report.

Our judgements for each standard inspected

Care and welfare of people who use services ✖ Action needed

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

Our judgement

The provider was not meeting this standard.

Care and treatment was not planned and delivered in a way that was intended to ensure people's safety and welfare.

We have judged that this has a major impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

We examined the care records of four people who used the service. We found that some risk assessments and care plans had been updated and reflected people's needs. Some did not. For example, we saw one person had fallen seven times within an eight week period. One member of staff explained, " X has deteriorated and has been off their feet for four to five weeks, we now need to hoist X ". However, the manager told us , "X has been off their feet for a few days and can still mobilise with supervision". We examined the risk assessment and care plan which indicated X needed to be supervised when mobilising. This meant care being delivered conflicted with information recorded in their care plan and it was unclear how the person should be moved safely.

We looked at the care of a person identified as having skin at high risk of pressure damage. Staff explained the person should sit on a pressure relieving cushion when seated in the lounge. However we saw the person sitting on a wheel chair pad and not a pressure relieving cushion. Their care plan stated, "To be turned every two hours, all pressure areas to be creamed at this point". We examined the repositioning chart. Reposition charts are used to record how often a person is turned in bed. Repositioning reduces the risks of skin breaking down and pressure ulcers developing. The chart showed on several days the person had not been repositioned for six hours. This meant the person had been placed at greater risk of developing pressure ulcers.

We saw another person's care records identified them as having a high risk of falls. We noted their condition meant they were unable to communicate effectively and their mobility was restricted. Their falls risk assessment stated, " X is occasionally unsteady when balancing, shuffles when walking and likely to trip on uneven ground or over minor obstructions". There was no falls care plan in place to guide staff how to reduce the risk of falls.

We were told by staff the person was found on the second landing having made their own way down the first flight of stairs unsupervised carrying their walking frame with them. Staff explained "It was 11am? and I saw X about to make their way down the second flight of stairs, I saw X and stopped X just in time". We were told the person had a bedroom door sensor in place which activated if the person left their room. It was connected to the main call bell system and would ring to alert staff if the person opened their bedroom door and left the room. We checked the door sensor. It had not been activated as the bedroom door was ajar. This meant if the person had left their bedroom staff would not have been alerted and the person would be placed at further risk of falls. We asked staff at 12:45pm when they had last checked X was safe. Staff explained they did not undertake regular safety checks on X and could not be sure the last time staff checked his safety.

On the day of the inspection we saw one person eating breakfast at 10:50am. Staff explained they were late helping them to wash and dress and the person was left until last. We saw the person remained sitting in their wheelchair at the dining room table after their breakfast. Staff then moved them to the other side of the table for lunch at 12:30pm. This meant the person had not long finished one meal before being served another. The person had dementia and was unable to verbally communicate their needs. We were told by staff the same person was found by night staff outside in the courtyard a few days prior to our visit in their pyjamas at 5am. We asked the manager about this, who advised us they were not aware of the incident. . We examined the incident and accident book and noted there was no record of the incident. The person's mobility risk assessment and care plan did not include the risk that they could walk outside in the early hours of the morning. This meant there was lack of communication between staff and an inconsistent approach to recording of information which affected how staff were able to deliver care safely to reduce further incidents The manager has since carried out an investigation to address both issues of communication and record keeping.

We were told the service had an agreement with the local GP to visit the service once every six weeks. The manager explained if people required a GP before the six week visit the GP would be called out. We saw the district nurses visited the service twice weekly to nurse people with catheters and leg wounds. We saw one person was supported by the SALT (Speech and language therapist) on the day of the inspection and informed staff they were pleased with the person's progress. This meant the service had made appropriate referrals to outside health care professionals who continued to meet the needs of the people who used the service

We noted four people had lost small amounts of weight and we saw appropriate referrals to the GP requesting a dietetic assessment. We spoke with staff who were aware which people had lost weight and told us the service provided fortified foods to boost calorie intake, such as adding full fat milk, cream and cheese to their diets and marshmallows in their hot milky drinks.

All the people we saw were well groomed. We saw the service had a designated hairdressing salon and the hairdresser visited twice a week.

Safeguarding people who use services from abuse ✓ Met this standard

People should be protected from abuse and staff should respect their human rights

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.

Reasons for our judgement

We found that documents and information about signs of abuse were displayed in a folder in reception for people and their relatives to read. However, this information did not provide clear contact details for who people or their relatives should contact if they were worried about someone at risk of abuse.

People we spoke with told us they felt safe at the home. One person said, "I would speak to the manager straight away if I had any problems." Whilst some people might be aware of who to contact and how to contact them, the provider might like to note that this information should be displayed clearly in a prominent location for everyone to read.

We looked at the training records and found the majority of staff had attended a safeguarding training course or were in the process of studying via a safeguarding distance learning programme. Staff we spoke to were able to tell us basic definitions of different kinds of abuse and how to escalate their concerns if they needed to.

Two staff members we spoke with were unclear of what the MCA (Mental Capacity Act) and DoLS (Deprivation of Liberty) meant. We examined the training record and saw both of these subjects had been poorly attended by staff employed at the service. The provider may like to note that all staff should receive MCA and DoLS training to understand the mental health rights and needs of people using the service.

Management of medicines ✓ Met this standard

People should be given the medicines they need when they need them, and in a safe way

Our judgement

The provider was meeting this standard.

People were protected against the risks associated with medicines because the provider had appropriate arrangements in place to manage medicines

Reasons for our judgement

We looked at the medicines for four people. We noted that people's medicines were being managed appropriately. We looked at medicine charts and saw these were completed appropriately. We saw people had received their prescribed medication on time.

We inspected the treatment room and saw medication was being stored and administered safely. For instance the fridge was not overloaded and the fridge temperature was within the recommended range to ensure medicines remained effective. Controlled drugs were stored appropriately and staff had maintained an accurate record.

We saw records showing that medication no longer used by people was appropriately recorded and destroyed.

We saw an external pharmacy audit had been conducted at the service in August 2013 and actions highlighted by the pharmacist had been addressed. This demonstrated the service had put measures in place to improve medicines management.

We were shown the staff training matrix which highlighted staff had received appropriate medication training. The manager explained the service had recently introduced a medication competency programme and we saw certificates to support this. We spoke with staff who were responsible for administering medication. One stated, "I am very confident in my abilities to administer medication, I've had lots of training and the management have been very supportive". This meant staff had the necessary skills and knowledge in medicines management to support people who used the service.

We examined people's notes and saw each person had a list of their prescribed medication and their uses. We were told this helped staff who administered medication and all staff involved in care delivery to understand what medication people were taking and why. Staff said, "This is important because drugs can have side effects such as being drowsy or needing the toilet more, and if we know this, it helps us to care for them better".

Staffing ✖ Action needed

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

Our judgement

The provider was not meeting this standard.

There were not enough qualified, skilled and experienced staff to meet people's needs of ther people all of the time.

We have judged that this has a moderate impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

We were told by the manager the staffing levels were: One senior care worker and four care workers for the morning shift from 7am to 2.30pm. One senior care worker and three care workers for the late shift from 2pm to 9.30pm and two care workers worked the night shift from 9.15pm to 7.15am. The service had employed an additional member of staff to 'sleep in'. This meant there would be a third person available on site at night. We were told the third staff member would be woken if there was an emergency but they would not be expected to deliver routine care.

In addition the service had employed an afternoon activity coordinator. The service also employed a cook, kitchen assistant and a housekeeper. We were told the hours worked by the manager and deputy manager were in addition to these.

During the inspection we spoke with one senior carer, three care workers and the cook. Some staff told us they struggled to meet the needs of the people using the service. One staff member explained, " People have become very dependent over the last few months and need lots of help, for instance X used to walk on their own but now needs two of us to hoist X and that takes time" . Another member of staff told us, "There's not enough staff at night, two people need to be turned every two hours in the courtyard flats, that takes two of you, it means there's no one left in the main house to answer call bells or monitor people and one resident has dementia and walks about at night, X is unpredictable". We spoke to other staff. One staff member said, " Yes I think, we have enough staff, it gets very busy at times but we pull together ".

Staff told us two people who lived in the sheltered housing flats fell inside their flats at the same time a few months ago. They both called for assistance from night staff. Both night staff care workers came to their aid and waited with them until the ambulance arrived six hours later. They told us during the six hour period there were no staff available to meet the needs of the people in the main house or in the courtyard residential flats. This meant people who required hourly and two hourly night checks did not receive them. People who required two hourly repositioning did not receive care and call bells were not answered.

We were told the third staff member was also responsible for the needs of the sixteen people living in the sheltered accommodation. This meant the third 'sleeping' staff member was responsible to assist with emergency situations for up to thirty people living in the main house and in the residential courtyard flats and for the routine and emergency needs of up to sixteen people living in the sheltered accommodation at night. Since our visit the manager has told us the service is considering using the third person not as a 'sleep in' but as an extra member of staff to provide care at night.

We noted the service occasionally used a care agency to fill gaps in the staff rota when required. During the afternoon of the inspection we observed an agency care worker providing care to a person in the lounge in a way that was undignified and inappropriate. The agency care worker was standing up beside the person assisting them to drink. Standing above a person can appear intimidating and prevents interaction on the same level. The agency worker was watching TV whilst placing the spout of the beaker to the person's mouth. On several occasions the spout was directed to the person's ear or cheek because of lack of concentration by the agency worker. This was relayed to the manager who stated agency workers were always properly prepared prior to them delivering care. However, the service would provide written literature to outline the service's expectations and standards in advance. The agency worker stated they had not worked in the service before, however they had been given a verbal and hard copy handover record about the needs of the people they were expected to provide care to.

During the inspection we found mandatory training in some subjects had been well attended such as moving and handling, safeguarding vulnerable adults, food safety, and fire safety. We were told people who were administering medication had been appropriately trained to do so and we saw evidence of this.

However we noted three areas of training had been poorly attended. For example, eleven care workers had not received dementia training. The manager informed us one person using the service had dementia, and the remainder of the people using the service had some age related memory loss. However staff informed us that in their view 50% of people using the service had dementia. This meant there were a lack of clarity and understanding about people's mental health state.

We saw twenty care workers had not attended DoLS (deprivation of liberty safeguarding) training and sixteen care workers had not attended MCA (Mental Capacity Act) training The majority of staff had not attended the falls awareness training. Since our visit the manager has confirmed that courses had been arranged and staff would be attending.

Assessing and monitoring the quality of service provision ✖ Action needed

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

Our judgement

The provider was not meeting this standard.

The provider did not have effective systems in place to identify, assess and manage risks to the health, safety and welfare of people who use the service and others.

We have judged that this has a moderate impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

We looked at how the service assessed and monitored the quality of service provided. We spoke with the manager who showed us various audits conducted since their appointment in March 2013. These highlighted possible risks and identified areas for improvement. For example, the manager had organised monthly medication audits and an external Pharmacy audit in August 2013. We noted improvements highlighted by the pharmacy and saw actions addressed appropriately by the service.

We saw minutes taken from a resident's meeting with actions in place to address concerns raised. We saw examples of room audits detailing which areas of the room had been checked and any work required.

We were shown a record which showed regular checks of water outlets, emergency lighting equipment, fire alarm testing had been carried out. This meant the service routinely maintained equipment and the premises for safety.

We examined the incident and accident record. This highlighted people who had fallen. We saw the service had begun an audit of falls in July and August to highlight people at high risk of falls. This included the following detail: time of day a person fell, location of the fall and whether the person sustained any injuries. Staff told us, "We started to collect the information as its useful to understand why, to try and prevent it, but we were not able to keep it up, as we've been so busy". We saw the record had not been updated since August and there was evidence to show some people had continued to fall. This meant we could not be sure the service had implemented appropriate systems to monitor falls incidents and used the information to reduce the risk of further falls.

We asked the manager whether risk assessments had been undertaken for people who walked between the main house and courtyard flats. This was because we had been told by staff the cobbled flagstone surface was a hazard as the cobbles became slippery when wet. The manager explained no one had received a mobility risk assessment for outside

walking.

We asked the manager whether the service conducted regular checks on the cobbled flagstones which ran along the perimeter of the courtyard. We were told by staff the cobbled flagstones become dislodged and need to be regularly reset or replaced. One member of staff said, "I've tripped up a few times myself outside on the cobbles, especially when its frosty or rainy". Another staff member told us, "We have to deliver breakfast trays to flats in the courtyard, its cold and the ground is dangerous especially in the winter".

We were told a monthly check was carried out and the cobbled flagstones were reset or replaced as and when. However the service had not maintained a record of assessment or work undertaken to support this. On the day of the inspection we were shown a folder which the manager stated the service would start using to document assessments made, work required and by whom.

We were advised a person fell and fractured both knees on the cobbled flagstones in 2012 and the service was aware the surface could be hazardous.

This section is primarily information for the provider

Action we have told the provider to take

Compliance actions

The table below shows the essential standards of quality and safety that **were not being met**. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activities	Regulation
Accommodation for persons who require nursing or personal care Personal care	**Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010** **Care and welfare of people who use services** **How the regulation was not being met:** Risk assessments were not always carried out for people to protect against the risks of receiving care or treatment that was inappropriate or unsafe. Care plans and records did not always reflect peoples current needs and people at risk of falls were not always monitored appropriately to protect their health, safety and wellbeing. Regulation 9, 1(a)(b)(i)(ii)
Regulated activities	Regulation
Accommodation for persons who require nursing or personal care Personal care	**Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010** **Staffing** **How the regulation was not being met:** The service had not ensured there was sufficient numbers of suitably trained staff to safeguard the health, safety and wellbeing of people who used the service all of the time. Regulation 22.
Regulated activities	Regulation
Accommodation for persons who require	**Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010**

This section is primarily information for the provider

nursing or personal care Personal care	**Assessing and monitoring the quality of service provision** **How the regulation was not being met:** The service did not protect people against the risks of inappropriate or unsafe care and treatment by means of conducting effective operation of systems. To include conducting risk assessments for people who mobilise around the grounds and implementing appropriate systems to identify people at risk of falls. Regulation 10 (10) (a) (b)

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 by 19 December 2013.

CQC should be informed when compliance actions are complete.

We will check to make sure that action has been taken to meet the standards and will report on our judgements.

About CQC inspections

We are the regulator of health and social care in England.

All providers of regulated health and social 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 essential standards are described in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. We regulate against these standards, which we sometimes describe as "government standards".

We carry out unannounced inspections of all care homes, acute hospitals and domiciliary care services in England at least once a year to judge whether or not the essential standards are being met. We carry out inspections of other services less often. All of our inspections are unannounced unless there is a good reason to let the provider know we are coming.

There are 16 essential standards that relate most directly to the quality and safety of care and these are grouped into five key areas. When we inspect we could check all or part of any of the 16 standards at any time depending on the individual circumstances of the service. Because of this we often check different standards at different times.

When we inspect, we always visit and we do things like observe how people are cared for, and we talk to people who use the service, to their carers and to staff. We also review information we have gathered about the provider, check the service's records and check whether the right systems and processes are in place.

We focus on whether or not the provider is meeting the standards and we are guided by whether people are experiencing the outcomes they should be able to expect when the standards are being met. By outcomes we mean the impact care has on the health, safety and welfare of people who use the service, and the experience they have whilst receiving it.

Our inspectors judge if any action is required by the provider of the service to improve the standard of care being provided. Where providers are non-compliant with the regulations, we take enforcement action against them. If we require a service to take action, or if we take enforcement action, we re-inspect it before its next routine inspection was due. This could mean we re-inspect a service several times in one year. We also might decide to re-inspect a service if new concerns emerge about it before the next routine inspection.

In between inspections we continually monitor information we have about providers. The information comes from the public, the provider, other organisations, and from care workers.

You can tell us about your experience of this provider on our website.

How we define our judgements

The following pages show our findings and regulatory judgement for each essential standard or part of the standard that we inspected. Our judgements are based on the ongoing review and analysis of the information gathered by CQC about this provider and the evidence collected during this inspection.

We reach one of the following judgements for each essential standard inspected.

✓ **Met this standard**	This means that the standard was being met in that the provider was compliant with the regulation. If we find that standards were met, we take no regulatory action but we may make comments that may be useful to the provider and to the public about minor improvements that could be made.
✖ **Action needed**	This means that the standard was not being met in that the provider was non-compliant with the regulation. We may have set a compliance action requiring the provider to produce a report setting out how and by when changes will be made to make sure they comply with the standard. We monitor the implementation of action plans in these reports and, if necessary, take further action. We may have identified a breach of a regulation which is more serious, and we will make sure action is taken. We will report on this when it is complete.
✖ **Enforcement action taken**	If the breach of the regulation was more serious, or there have been several or continual breaches, we have a range of actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers include issuing a warning notice; restricting or suspending the services a provider can offer, or the number of people it can care for; issuing fines and formal cautions; in extreme cases, cancelling a provider or managers registration or prosecuting a manager or provider. These enforcement powers are set out in law and mean that we can take swift, targeted action where services are failing people.

How we define our judgements (continued)

Where we find non-compliance with a regulation (or part of a regulation), we state which part of the regulation has been breached. Only where there is non compliance with one or more of Regulations 9-24 of the Regulated Activity Regulations, will our report include a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation). This could be a minor, moderate or major impact.

Minor impact - 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.

Moderate impact - 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.

Major impact - 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

We decide the most appropriate action to take to ensure that the necessary changes are made. We always follow up to check whether action has been taken to meet the standards.

Glossary of terms we use in this report

Essential standard

The essential standards of quality and safety are described in our *Guidance about compliance: Essential standards of quality and safety*. They consist of a significant number of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. These regulations describe the essential standards of quality and safety that people who use health and adult social care services have a right to expect. A full list of the standards can be found within the *Guidance about compliance*. The 16 essential standards are:

Respecting and involving people who use services - Outcome 1 (Regulation 17)
Consent to care and treatment - Outcome 2 (Regulation 18)
Care and welfare of people who use services - Outcome 4 (Regulation 9)
Meeting Nutritional Needs - Outcome 5 (Regulation 14)
Cooperating with other providers - Outcome 6 (Regulation 24)
Safeguarding people who use services from abuse - Outcome 7 (Regulation 11)
Cleanliness and infection control - Outcome 8 (Regulation 12)
Management of medicines - Outcome 9 (Regulation 13)
Safety and suitability of premises - Outcome 10 (Regulation 15)
Safety, availability and suitability of equipment - Outcome 11 (Regulation 16)
Requirements relating to workers - Outcome 12 (Regulation 21)
Staffing - Outcome 13 (Regulation 22)
Supporting Staff - Outcome 14 (Regulation 23)
Assessing and monitoring the quality of service provision - Outcome 16 (Regulation 10)
Complaints - Outcome 17 (Regulation 19)
Records - Outcome 21 (Regulation 20)

Regulated activity

These are prescribed activities related to care and treatment that require registration with CQC. These are set out in legislation, and reflect the services provided.

Glossary of terms we use in this report (continued)

(Registered) Provider

There are several legal terms relating to the providers of services. These include registered person, service provider and registered manager. The term 'provider' means anyone with a legal responsibility for ensuring that the requirements of the law are carried out. On our website we often refer to providers as a 'service'.

Regulations

We regulate against the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009.

Responsive inspection

This is carried out at any time in relation to identified concerns.

Routine inspection

This is planned and could occur at any time. We sometimes describe this as a scheduled inspection.

Themed inspection

This is targeted to look at specific standards, sectors or types of care.

Contact us

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