Imperial Care Homes Limited

Letheringsett Hall

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 18 and 21 July 2016. The first day was unannounced.

Letheringsett Hall provides accommodation and care for up to 20 older people. At the time of this inspection 17 people were living in the home.

A registered manager was in post and had been managing the service for seven years. 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.

At this inspection we found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

The Mental Capacity Act 2005 was not well understood over and above the provision of day to day support to people to help them make routine decisions. This had resulted in concerns that the service was not acting in accordance with the legislation.

The provider had failed to ensure that a suitable evaluation of any risks presented by the legionella bacteria had taken place. The audits the service carried out were not robust and meant that suitable systems were not in place to ensure that areas for improvement were identified or acted upon.

There were usually enough staff on duty but at weekends staff were busier than during the week as they sometimes needed to fulfil functions carried out by the cleaner or kitchen assistant. This took them away from the direct provision of support to people on these occasions.

People felt safe at the home and staff were knowledgeable about indicators of possible abuse. They knew what actions would need to be taken.

Medicines were well managed and the manager had taken steps to ensure that people's medicines were stored at a safe temperature.

Staff received a good standard of training which also tested their knowledge. The manager had a robust system in place for ensuring that staff administered people's medicines safely.

People had a choice at mealtimes, although some people would have benefited from a menu or board to show what meals were being served.

Most staff were caring, but we observed some comments being made that were not respectful to people.

Care plans did not suitably reflect people's emotional requirements and how people needed to be supported. There was limited social stimulation in the home.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

There were not always enough staff deployed to meet people's needs at weekends.

People's medicines were not always stored within the required temperature range. People received their medicines when they needed them.

Risks to people's welfare were identified and mitigated as far as was possible. However, the lighting needed to be improved in some areas of the home that did not benefit from natural light.

Is the service effective?

Requires Improvement

The service was not consistently effective.

There was poor understanding and application of the Mental Capacity Act 2005.

The provider had robust training and staff support arrangements in place.

People had access to health care professionals as required.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Some staff did not exhibit a caring or patient attitude towards people.

People and/or their relatives were not involved in the development or on-going reviews of care planning.

People told us that staff respected their privacy and dignity.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People's emotional health conditions were not always identified or planned for in their care records.

People did not always have access to regular social activities.

People knew how to raise complaints and concerns and were satisfied that staff would deal with them appropriately.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

The provider had failed to ensure that the auditing system in the home was robust.

Letheringsett Hall

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.

This inspection took place on 18 and 21 July 2016 and was unannounced. It was carried out by one inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Prior to this inspection we reviewed information we held about the service. This included the Provider Information Return. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed other information that we held about the service.

Providers are required to notify the Care Quality Commission about events and incidents that occur including injuries to people receiving care and safeguarding matters. We reviewed the notifications the provider had sent us. We had requested feedback before the inspection from the local authority quality assurance team and clinical commissioning group.

During the inspection, we spoke with seven people who used the service and relatives of three people living in the home. We also spoke with the manager, a community nurse, four care staff, and the cook.

We carried out general observations and looked at the care records of five people and other information relating to their care and the recruitment records of three staff members. We also looked at records relating to how the quality of the service was monitored.

Requires Improvement

Is the service safe?

Our findings

We received mixed views on whether there were enough staff. Some people were positive. One said, "There always seems to be someone about." Another person told us, "I don't think I've seen anything that makes you think it's understaffed." However, others felt there were staffing concerns. One stated, "I do feel that they are a little bit short of carers, especially at weekends." Another person said, "Sometimes they could do with more staff. Patience is a virtue." Staff members told us that there were enough staff to meet people's needs.

The arrangements were that there was three care staff on duty on the morning shift, two on the afternoon shift and one overnight. There was always a second staff member available who was on call overnight. Often this was one of the staff members who lived on the premises. Staff told us that those who 'lived in' would be willing to help out if there was an emergency overnight if necessary, even if they were not on call. The cook worked between 9am to 1:30pm to prepare the lunchtime meal. A kitchen assistant was employed to prepare tea time meals.

We reviewed the staffing rotas for the six weeks prior to our inspection. On four of 42 days there was no kitchen assistant which meant that one of the staff on duty would be needed to prepare tea. This usually happened at weekends. In the mornings care staff assisted people to get up, made their breakfasts and cleaned their bathrooms. The cleaner did the vacuuming throughout the home and kept communal areas clean. However, the cleaner was only employed for four days a week, Monday to Thursday. This meant that on other days all the cleaning in the home had to be done by care staff. On these days, and particularly on the days where there was no cleaner and no kitchen assistant people might be waiting longer for assistance as some people had mentioned to us.

The provider had robust processes in place to help ensure the risks of employing unsuitable staff were minimised. References were taken up, proof of identity was obtained and checks were made with the Disclosure and Baring Service (DBS).

People told us that they received their medicines as necessary. One person said, "They keep my tablets and bring them to me twice a day. I'm happy, they come round regularly. And I can ask for pain relief when I need it." Another person told us, "It seems to be an important thing for staff. They've got your medications and they see that you take it."

People's medicines were received in the home weekly, in pre-packed dossette boxes made up by the pharmacy. This meant that the tablets people received regularly at a certain time of the day were sealed together in a compartmentalised container. As the service had responsibility for administering people's individual medicines they needed to ensure that the correct tablets were in each compartment. They had tablet recognition and description charts to enable them to do this and we saw how this was checked and recorded.

The fridge containing medicines requiring refrigeration was kept within an appropriate temperature range. However, the temperature of the room in which all other medicines were stored was not recorded. The first

day of our visit was a very hot day. Medicines need to be stored below 25 degrees centigrade and there was no system in place for monitoring this. On the second day of our visit a fan had been put in this room and the manager told us that they would try this out initially, commence recording temperatures and would ensure that medicines were stored within an appropriate temperature range.

All medicines were administered by staff who had received training and had their competencies checked. They had a good understanding of the medicines they were giving out. Staff were seen administering medicines in a safe way.

People living in the home that we spoke with told us they felt safe living at Letheringsett Hall. One person said, "I feel safe here, there's always a carer about."

Staff told us about the signs that could indicate that people were at risk from abuse. They were clear about what actions they would need to take if they had any concerns and who they would need to contact. We saw that people were asked whether they had any concerns about safety in the home at the last residents meeting in May 2016. No concerns had been expressed.

We looked at the arrangements in place to manage risks relating to both people and the environment. Risk assessments were in place to determine the risks to people's welfare and plans were in place to mitigate the risks as far as was possible. For example, we saw risk assessments for falls, nutrition and skin care.

The service was changing its nutritional risk assessment process. The new risk assessment considered weight loss to be a risk, but did not take into account the risk of a person not being within a healthy weight range. The manager told us they would still be recording people's body mass index (BMI) which was not required in the new risk assessment process and that they would contact a person's GP for advice if necessary.

There were risk assessments in place for environmental hazards which were suitable. However, whilst water temperatures were checked to ensure they were within a safe range that would inhibit the growth of the legionella bacteria, this did not amount to a full risk assessment for legionella. This meant that people may have been at risk because appropriate steps to determine whether there was a risk had not been taken.

Utility services and lifting equipment were inspected as necessary. However, areas of the home, including an ensuite bathroom on the top floor and main corridor on the ground floor were very dark. This was because they had no natural light and the light bulbs in use were not very bright. Better lighting was required to reduce the risk of accidents. On occasions we saw that cleaning trolleys, containing hazardous chemicals were left unaccompanied in corridors.

We looked at the arrangements that were in place for managing accidents and incidents and reducing the risk of re-occurrence. The manager explained the levels of scrutiny that incidents and accidents were subject to within the home. They demonstrated what actions had been taken to ensure people were immediately safe and what steps had been taken to reduce the risks of re-occurrence of events in the future.

Requires Improvement

Is the service effective?

Our findings

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 and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA.

The manager told us that no-one living in the home had been diagnosed with dementia. However, several people had varying degrees of cognitive impairment. People are considered to lack capacity in relation to a specific matter if they are unable to make a decision for themself due to a cognitive impairment. Under the MCA a person is unable to make a decision if they cannot understand, retain and weigh the information provided and communicate their decision.

We did not find any decision specific mental capacity assessments in the care records that we looked at or references to specific decisions being made in people's best interests. For example, blood pressure, temperature and pulse rates were recorded in respect of people on a monthly basis. We were concerned that some people would not have been able to meaningfully consent to these checks. Some people's relatives were sent a six monthly review of their family member's care arrangements. There was no evidence to indicate that people had consented to this.

One person was being supported by a dementia nurse. A mental capacity assessment for this person had last been carried out in 2010 which stated that they had capacity. However, this was general in nature and wasn't in relation to a particular decision that needed to be made. This person had a care plan in place for 'dying' which stated that their next of kin could make decisions on the person's behalf if the person did not have the mental capacity to do so in relation to hospital admissions. There was no evidence that the next of kin had Lasting Power of Attorney (LPA) for health and welfare. Therefore the service could not be sure that the next of kin had the legal authority to make decisions on behalf of their family member.

Another person had a care plan in place for 'dying'. This stated that the person did not wish to be resuscitated and that they wished their relative to make decisions about this on their behalf if they were unable to do so themselves. However, there was no evidence to indicate that the relative had the legal authority to make decisions on the person's behalf. The manager had not requested that the GP consider the person's wishes in respect of a DNACPR.

These findings were indicative of a lack of understanding of the MCA. Consequently, the provider was in breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Most people were able to make day to day decisions for themselves. Staff explained to us how they supported people to make their own decisions and how they made decisions in people's best interests when necessary. For example, one person enjoyed the company of others, but sometimes this could lead to anxiety. When this happened and the person was unable to decide what they wanted to do staff assisted the person. They moved them to a position where they could see other people, but not be with them. This often eased their anxiety.

The manager told us that no DoLS applications had been made to the local authority and that no-one was being deprived of their liberty. They said that refresher training in the MCA was due in September 2016 and that if they felt that a mental capacity assessment was needed that they would ask social workers to carry this out.

People had good access to health professionals. One person told us, "I haven't needed a doctor. But I'd just tell one of the staff and they would call one." Another person said, "I'm down to see the optician. There's a mobile optician. My eyes have deteriorated a lot." People's care records showed that there was access to a range of health professionals, including dentists, chiropodists and community nurses. People were supported with hospital appointments as necessary.

Staff told us that the training and support they received was good. The provider had robust systems in place for staff training and we saw that staff training was well organised and up to date. Most staff members had a National Vocational Qualification (NVQ) in social care. Newer staff members were completing the care certificate. This is a set of care standards that are covered in the induction training of new staff. In addition to the NVQ or care certificate there was a training system in place that also tested the staff's understanding of the topics covered. These included health and safety, infection control and dementia. Staff we spoke with were knowledgeable about their training and gave examples of how they had utilised it in the way that they supported people. Staff received supervisions every three months and annual appraisals. Staff also told us that they had many opportunities to discuss their training, development and support needs.

People were positive about the food, but some commented that they would like more variation. One person told us, "The food is fine, it's all edible but sometimes it can be a bit boring but there is enough choice I think." One person's relative told us, "The food is a bit institutional. There's not much fresh fruit, they tend to use tinned. [Family member] used to like brown bread and muesli. Here's it's white bread and cornflakes." Another person's relative said, "[Person] told me that the food is a bit old fashioned, tinned fruit and ice cream." A third person said, "It could be a little more varied. It would be nice to have fresh fruit for dessert for a change." Other comments we received about the food included, "The food is excellent, it really is." "Some of the meals are exceptional, really amazing." "Breakfast is excellent." One relative told us that their family member had been made cheese on toast when they hadn't wanted what was on offer at teatime.

We observed a lunchtime in the dining room. The table had been laid attractively with table cloths, place mats and linen napkins. People were served from a choice of drinks. However, some people may have benefited from a menu or another indication of what was for lunch as some were unsure of what they had been served. One person said to another, "Do you know what it is? They can't make pastry can they? It's awful."

Care staff made people's breakfasts and there was a variety of choice on offer, such as cereal and toast or eggs. After breakfast care staff discussed with people the options available for lunch. There was always a choice of two main meals. At the time of our visit there were people in the home living with diabetes. The cook told us about the changes they made to support these people with their dietary requirements. For

example, where most people had a lemon meringue pie, people with diabetes were offered a lemon tart instead. They told us that they fortified meals with butter and milk powder to help support those with higher nutritional requirements. A variety of snacks were available throughout the day, including some with a high calorific value. During our visit we noticed that people had drinks available within reach. This was particularly important during the hot weather that was being experienced at the time.

Requires Improvement

Is the service caring?

Our findings

People were positive about the staff who supported them. One person said, "They're very happy, caring staff and they're quite good at everything. It doesn't matter what you ask them to do, they're never grumpy." Another person told us, "We can't fault the carers at all. If they're going shopping they ask us whether we want anything." One person's relative told us, "You can't fault the staff, they are all so kind." Another person's relative said, "It's important that [family member] gets some physical affection because she responds well to it." The person later told us that staff were affectionate towards them, which they appreciated.

People told us that staff treated them with dignity and respect. Two people told us that staff always knocked on their doors before entering. One of them said, "They respect your privacy. They always knock, all of them."

However, our observations found that there was room for improvement. One staff member said to no-one in particular during lunch, "Do you feel like you're being watched?" We overheard another staff member responding to the needs of one person whilst another person was calling out for assistance. Whilst they did not raise their voice in responding to the second person we could hear them making exasperated sighs.

During lunchtime the same staff member asked one person if they had finished their meal. When there was no immediate response they took the plate away before the person had been given time to answer. One person had asked them what the pie had been. The staff member told them and asked them whether they had liked it. When the person stated that they had not enjoyed it the staff member said, "Oh well, you can't win them all." The staff member brought one person their dessert and said, "Here you go [person's name]." The person had not spoken during the meal and when they remained quiet after being served dessert the staff member said to themselves in a flippant manner, "You're welcome."

The gardens were very attractive and several people enjoyed spending time outside throughout the day. People were assisted to go outside and sit in the shade. Some people sat on cushions which had been placed on the wooden benches or chairs for them. However, one relative told us, "Because [family member] won't ask, not all staff thinks to take them out a cushion to sit on."

People's care needs were met in terms of managing and responding to their health conditions and people were involved with this. Relatives told us that detailed discussions took place prior to admission and as and when any concerns arose. One relative told us, "Even if [family member] has a rash they'll let me know. They also let me know about a minor fall [family member] had." Another said, "If [family member] is unwell, they'll tell me. They're very good with that sort of thing."

However, people told us that they were not involved in the routine reviewing of their care plans. One person said, "No-one has asked me, there's no discussion." Another person said, "They've not had a heart to heart with me to ask me what is good and what is bad." The provider had a system in place whereby a six monthly review was carried out. However, the opportunity was not taken to involve people or their relatives in this.

Two relatives told us that this was emailed out to them. One of them told us, "I feel it's a bit like an end of term report."

Requires Improvement

Is the service responsive?

Our findings

Staff we spoke with were knowledgeable about people's preferences and needs, but information available in people's care plans not did always provide staff with suitable guidance. Due to poor recording practices we were unable to determine whether some records were up to date. For example, one person's care plan for their oral health had been written in January 2014. Handwritten updates and comments had subsequently been made, but some of these were undated. Some amendments were written randomly over the page so we could not determine the order of any amendments.

The manager had advised us that no-one living in the home had been diagnosed with dementia. We were able to converse in detail with some people living in the home. However, we observed that others appeared withdrawn, were anxious, had limited communication and were quite confused. There was little recorded in care plans about emotional health conditions that people were living with, how this impacted upon their day to day lives and how staff needed to support people with this.

One person's relative told us that their family member had had depression for several years and didn't speak much. However, there was no reference to their depression in the person's care plan. This care plan had been re-written in recent months but had not been signed either by a staff member or the person. The manager told us that this was because a senior staff member was due to go through it with the person to seek their agreement.

We found that people's blood pressure, temperature and pulse rate were taken on a monthly basis and recorded. The manager told us that they did this in case it proved useful for the GP and that they knew what range they would expect individual people's results to be within. However, they were unable to provide any documented information to support this assertion. These checks were not done in response to the health needs of specific individuals. They did not form part of any care planning process and there was no evidence that people had agreed to them.

Some people were able to entertain themselves with activities such as knitting, reading or watching television. One person said, "I do knitting, crochet, read the paper. I'm quite happy with everything here." Another person told us, "I read, I love books. My relative comes twice a week and brings me books to read."

There was an activity plan on the wall for July 2016 and we saw that activities were scheduled for one hour a day in the afternoons. These included reminiscence, beauty and nails and hangman and scrabble. However records kept showed that few people participated in these activities and that some hadn't taken place since April 2016. Friday's activity was a mobile shop. In practice this was when a staff member did some shopping for people. Sunday was set aside for staff to assist people in sorting out their wardrobes and drawers which had been organised by room number.

We observed an ad hoc quiz on one morning of our inspection which was not scheduled according to the activity plan. This was being run by two staff members with five people participating. One staff member asked the questions and the other joined in the conversation that followed. This left one staff member to

support the remaining 12 people who were not taking part in the quiz.

One person told us, "There aren't really any activities." Another person told us, "Once a fortnight I do water colouring. They persuaded me to go to the daycentre which is for half a day once a week. When we got there we were given lunch, played dominoes and we stopped for an ice-cream on the way back. That was it." A relative told us, "There's not enough stimulation. Staff don't have the time to play word games with people like they used to."

People gave us examples of how staff had responded to their individual needs. One person said, "They've put a touch lamp in for me as the light switch is too far away from the bed if I need to use the bathroom in the night." Another person told us that staff had arranged a raised toilet seat for them.

One person said, "I pressed the emergency buzzer as I was worried that [another person] was having a little stroke. Four staff arrived at the same time." We saw from the person's records what actions had been taken to ensure that the person received the medical interventions required in a timely manner.

We saw that people had call bells in place close to where they were sitting, so they were able to call for assistance if they needed to. One person told us, "Sometimes I use it. They come fairly quickly." A second person said, "They're not too bad at all. Sometimes they respond in seconds." A third person told us, "Some carers work better together than others. Sometimes you have to ring again to see if they've overlooked you."

People told us that they had confidence that if they had any concerns that they would be looked into and any issues would be resolved to their satisfaction. One person said, "If I've got any complaints or moans the owner is always about, but I don't have anything that concerns me." Another person told us, "Usually I'd talk to one of the senior staff, they are very good. They sometimes come and ask me if I have any worries."

Requires Improvement

Is the service well-led?

Our findings

A system of audits was in place. However, these were not effective. These were dated on the front sheet and reviewed annually. The reviews comprised of a signature and a new date. Very few new issues were identified by these audits. These audits failed to identify any of the areas of concern that we found during this inspection visit, for example the medicines temperature storage issue. Medicines audits were done twice a year. At each of these audits one person's medicines arrangements were sampled. This meant that it could be several years before each person's medicines were audited.

An environmental audit for infection control was last carried out in June 2016. This audit had been signed off monthly with a signature and date only, since May 2010. It asked such questions as whether toilets were visibly clean, whether all wash basins were visibly clean and whether all soap and towel dispensers were full. However, no samples of rooms were carried out on a monthly basis in order to support the assertion that there were no concerns in these areas.

There had been no recent care plans audits because the manager was re-writing people's care plans. However, the manager was also responsible for carrying out care plan audits. There was no other scrutiny of the content of the care plans which should have identified the issues in relation to the MCA.

The provider carried out a monthly formal visit and report was made in relation to this. The provider spoke with a sample of people living in the home, their relatives and staff to obtain their views. There was no scrutiny of whether the audits that the manager had carried out were effective, just that they were done.

The risk assessment in place for legionella had been carried out by the manager. However, this was not a risk assessment. It was a record of routine maintenance checks on the water system, such as making sure that water temperatures were within suitable ranges. It did not assess or identify the risk of exposure to the legionella bacteria, evaluate potential sources of risk or determine the condition and suitability of storage tanks and pipework systems. The provider had failed to ensure that an effective legionella risk assessment had been carried out.

These concerns constituted a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The manager believed that people would be more open about any issues they had concerning the service, if they were spoken with on an individual basis. Consequently, staff members spoke with people on an individual basis once every six months and this was recorded as a residents meeting. People's feedback was overwhelmingly positive when people's views were last sought in January and May 2016. One of the few issues people did provide feedback on was the food. We saw that their views were asked about how staff treated them, activity provision and what improvements could be made. However, records of these meetings did not show that information was conveyed to people, for example changes in staff.

A suggestion box was in the main hallway. One person told us, "We put some suggestions in and they were

taken notice of." During our inspection we found that there was no paper or cards available in the area for people to make their suggestions on.

People told us that the service managers were approachable. One said, "We know [the provider] very well. She's extremely nice and friendly. I have a good relationship with the manager too." Another person told us, "The manager is on the ball, extremely competent." A third person said. "The manager comes around two or three times a year to ask us about the care here."

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Service users were not protected from the failure to properly implement the Mental Capacity Act 2005. Regulation 11(1)(2)(3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to implement effective systems to mitigate risks to people's welfare and asses the quality and safety of the service. Regulation 17(1)(2)(a)(b)