Lostock Lodge Limited

Lostock Lodge

Inspection report

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Website: www.lostocklodge.com

Date of inspection visit:
24 October 2016

Date of publication:
03 February 2017

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?	**Inadequate**

Summary of findings

Overall summary

We inspected Lostock Lodge on 24 October 2016.

The last full inspection took place on 8 May 2014, when we found the service was meeting the regulations we looked at.

Lostock Lodge is registered to provide personal care and accommodation for up to 32 older people and older people living with dementia. Accommodation is mainly on the ground floor and there is a passenger lift to the first floor accommodation. All the bedrooms are single occupancy with en-suite toilets. There is one lounge, one dining room, one lounge/diner and a conservatory.

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

We found three 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 the report.

We found, generally, staff were being recruited safely, however, there were no duty rotas in place to show which members of staff were on duty or in what capacity they were working. The registered manager was not using any formalised tool to calculate how many staff were needed, based on the dependencies of people using the service. This meant we could not assure ourselves there were always enough staff on duty to met people's needs.

People who used the service told us they liked the staff and found them kind and caring. We saw staff were kind and patient with people, however, we saw some practices which showed a lack of respect and overall concluded staff required additional training to ensure they supported people in a person centred way.

We found the service was meeting the legal requirements relating to Deprivation of Liberty Safeguards (DoLS), however, we felt staff required further training in relation to these safeguards and the Mental Capacity Act.

People told us they liked the meals, however, we found risk assessments and care plans did not identify what action needed to be taken in order to mitigate risks to people who were losing weight. People told us the meals were good, however, we felt people were not always aware of the choices on offer and had no control over the portion size of their meals.

People's healthcare needs were being met, however, we found medicines were not being administered and managed safely.

There were some activities on offer and an annual trip out was organised.

There was a complaints procedure in place and people we spoke with told us if they had any concerns they would tell a member of staff.

We found checks being made on the overall operation and quality of the service were poor and did not identify areas which required improvement. Residents meetings had been held and showed people were being asked for their views, however, it was not always clear what action had been taken in response.

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 always safe.

Medicines were not being administered and managed safely.

People told us there were enough staff on duty to provide care and support; however, it was unclear how safe staffing levels were being calculated.

Staff understood the safeguarding process and how to report concerns.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff training was not up to date and staff did not fully understand the Mental Capacity Act and Deprivation of Liberty Safeguards.

Records showed people had access to healthcare professionals, such as GPs, opticians, district nurses and chiropodists.

People told us they liked the meals, however, we found people were not always made aware of the choices on offer or the portion sizes.

Is the service caring?

Requires Improvement

The service was not always caring.

People told us they liked the staff and found them caring and obliging.

There were some practices which showed a lack of respect for people who used the service.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans were not always detailing what action staff needed to take to make sure people's nutrition and hydration needs were met.

The complaints procedure was on display and people told us they would tell staff if they had any concerns.

There were some activities on offer to keep people occupied.

Is the service well-led?

Inadequate

The service was not well-led.

People were not protected because the provider did not have effective systems in place to monitor, assess and improve the quality of the services provided. This was evidenced by issues identified at this inspection.

People had been asked for their views about the service through surveys and residents meetings.

Lostock Lodge

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection team consisted of two adult social care inspectors 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.

Before the inspection we reviewed the information we held about the service. This included speaking with the local authority contracts and safeguarding teams. We asked the provider to complete a Provider Information Return (PIR). 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. This document was completed and returned to us.

We spent time observing care in the lounges and dining rooms and used the Short Observational Framework for Inspections (SOFI), which is a way of observing care to help us understand the experience of people using the service who could not talk with us. We looked around some areas of the building including bedrooms, bathrooms and communal areas. We also spent time looking at records, which included eight people's care records, three staff recruitment records and records relating to the management of the service.

We spoke with five people who lived at Lostock Lodge, five relatives, two care workers, housekeeper, cook, activities coordinator the deputy manager and the registered manager.

Requires Improvement

Is the service safe?

Our findings

We asked people who used the service if they received their medicines at the right times. One person said, "I can self-medicate, they [medicines] are in the cabinet on the wall." A second person told us, "They usually stay with me whilst I take my medicine." A third person commented, "They usually stay with me whilst I take it, it depends how busy they are." A fourth person said, "Yes, I get them four times a day."

We observed the senior care staff member administering some of the morning medicines and found they were calm and patient with people, staying with them until they had taken their medicines and then signing the Medication Administration Record (MAR). However, we subsequently found two people had not taken their medicines. We saw a tablet on one person's table and when we checked with the senior staff member who had given out the medicines they confirmed it was one of the morning medicines and disposed of it. We saw tablets another person had spat out. The registered manager told us this person regularly hid medicines in their mouth then spat them out later. When we asked the registered manager if they had considered or discussed different options such as providing the medicines in liquid form they said no.

The registered manager told us three people received their medicines covertly, which means medicines were hidden or disguised in food or drink. We reviewed the care records for two of these people. Whilst we saw mental capacity assessments and best interest meetings had been recorded which stated the next of kin, GP and pharmacist had been involved, there was no evidence of a pharmacist's advice, no treatment plan, no instruction as to how to disguise the tablets and no plans to review the practice. National guidance, (Managing medicines in care homes - National Institute for Health and Care Excellence (NICE) guidelines March 2014) was not being adhered to and the provider's own medicines policy was not being followed. We discussed this with the registered manager who told us they would address this straightaway.

Some prescription medicines contain drugs that are controlled under the Misuse of Drugs legislation. These medicines are called controlled drugs (CD). We checked these with the registered manager and found these medicines were kept securely. However, we found the recording of the administration of one person's CD was inaccurate in both the CD register and on the MAR. For example, on two occasions the dates of entries recorded in the CD register which had been signed by two staff, differed from the signatures recorded on the MAR. On another occasion there was no signature on the MAR to show the CD had been administered. This demonstrated staff were not carrying out thorough checks before and after administering CDs.

We saw records were maintained of medicines returned to the pharmacist. However, although the registered manager was able to describe the process for ordering and checking medicines received they acknowledged there were no records to evidence these processes.

The registered manager told us all the senior staff who administered medicines had received medicine training and completed competency assessments and said these were updated every six months. However, they were unable to provide us with documentary evidence of recent training or competency assessments for any senior staff. We looked at the staff files for two seniors and the most recent certificate for medicine training was as part of a NVQ qualification. For one staff member this was in 2012 and the other in 2013. One

of these staff had a record which showed they had been supervised administering medicines in April 2014. The training matrix identified six senior staff, which included the registered manager and deputy manager. Only two senior staff members were shown as having received medicine training in July 2016, there were no training dates for the other four staff.

The provider had not ensured that medicines were managed safely at the home. This was a breach of the Regulation 12 (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw medicines were kept safely and securely. People's medicines were kept in locked cupboards in their rooms with their individual medicine administration records (MARS). Medicines requiring cold storage were kept in a locked medicine fridge and the temperature was monitored daily.

Detailed information about each individual was kept with the MARs which included the person's photograph, allergies and any special instructions about how the person liked to take their medicines. Arrangements were in place to make sure people who required their medicines to be given at set times received them correctly. Similarly protocols were in place for 'as required' medicines showing in what circumstances these should be administered and the minimum time between doses. Some people were prescribed topical creams for application by care staff. MARs for these were well completed and showed people received these creams as prescribed.

We looked at three staff files and found most recruitment checks had been completed before staff started employment. We saw two written references and a criminal record check had been obtained through the Disclosure and Barring Service (DBS). Application forms had been completed; there were detailed interview records and proof of identity documents for each applicant. However, the references for one staff member had not been received until a month after they had started work at the service and only one reference had been received for another staff member before they started work; the other reference had been received three weeks later. We raised these matters with the registered manager.

There were 30 people using the service on the day of the inspection. The registered manager told us the usual staffing levels were one senior care staff member and four care staff throughout the day and one senior care staff member and two care staff at night. They said they had recently increased the staffing in the evening as there had previously only been a senior and three care staff on duty between 6pm and 10pm. In addition there were cleaning and kitchen staff working daily. The registered manager and deputy manager also worked in addition to the care staff numbers. The registered manager told us the care staff also completed laundry duties and were responsible for serving and clearing the teatime meal as the kitchen staff finished at 1.30pm.

We asked people who used the service and visitors about the availability of staff. One person said, "I think so, I never ring my bell." A second person said, "Always, they answer the bell as quickly as they can." A third person told us, "They're quite good (at answering the bell). One visitor told us, "[My relative] has to wait." Another visitor said "They do have occasions when they have to call staff in." A third visitor commented, "Sometimes it seems bit sparse, but I don't know if they're at the other end ([of the building])." Staff we spoke with told us there were enough staff on duty to provide people with the care and support they needed.

No specific concerns were raised with us about the staffing levels and we did not observe any shortfalls in care, however, the registered manager confirmed there was an additional care staff member on duty during the inspection.

We were not assured that systems were in place to establish safe staffing levels. We asked the registered manager how staffing levels were determined and they said they were based on the number of people using the service. There was no tool used to calculate the staffing levels and although the registered manager said people's dependencies were taken into consideration they acknowledged there were no records to evidence this. The registered manager told us they worked to a fixed two week staff rota which we saw; however, they said this did not reflect the staff on duty each day as there were often changes due to holidays, sickness and other absences. When we asked to see rotas showing which staff had worked each day the registered manager told us they did not have these and the only way this could be determined would be by looking through individual staff time sheets and the 'cover' list which showed additional shifts care staff or agency staff had picked up.

We asked people who used the service if they felt safe at Lostock Lodge and what it was that made them feel safe. These were some of their comments, One person told us, "Yes, there's always somebody knocking about and there's someone on duty at night," Another person said, "The way people look after me, there's a lot of kindness." A third person commented, "It's all the security, you can't get in and out without a code."

We saw the safeguarding procedures were on display. Care workers we spoke with told us they had received safeguarding training and if they had any concerns about people's wellbeing they would report these to a senior member of staff or the registered manager. The registered manager had made appropriate referrals to the safeguarding team when they had identified concerns. This showed us staff were aware of the systems in place to protect people, keep them safe and how to raise any concerns.

We found some areas of the home were not clean. One person's easy chair had dried food stains on the arms and down the front of the chair. Another armchair had a pressure relieving cushion and both the chair and the cushion had dried food stains on them. The table in front of one person was sticky and dirty.

We saw pressure ulcer risk assessments were being completed by staff; however, some of the risk assessments did not have the 'score key' to identify the level of risk. We asked the deputy manager about this and they knew, for example, a score of 22 indicated the person was at high risk. We saw this person had a specialist mattress in place but the records did not indicate the setting it needed to be on. If a mattress is on the wrong setting it could cause damage rather than reducing the risk of tissue damage. We discussed this with the deputy manager who told us they would follow this up.

We asked one member of staff what would happen if the fire alarms sounded. They told us they would go to the main assembly point and wait for instructions from a senior member of staff. Later in the day the fire alarm went off we saw staff make their way to the assembly point, to be informed it was a false alarm. This showed us staff knew what action to take in the event of an emergency.

Requires Improvement

Is the service effective?

Our findings

We asked people who used the service and visitors if they felt staff had received enough training and were competent. One person told us, "Yes, I should say so." A second person said, "Perfectly confident and I'm very particular." A third person told us, "Yes, they seem to be and most of them are pleasant enough." One visitor said, "I think they work hard." A second visitor told us, "Most of them have been here a long time." A third visitor commented, "The staff are not as well up in dementia as they should be and there's a lack of empathy sometimes."

Staff files showed new staff completed induction training which the registered manager told us was based on the common induction standards. They told us staff did not complete the Care Certificate. The Care Certificate is a set of standards that social care and health workers stick to in their daily working life. It is the new minimum standards that should be covered as part of induction training of new care workers.

The registered manager provided us with a training matrix which they said showed training which was planned as well as training staff had received. Generally this showed most staff had attended training in areas such as moving and handling, safeguarding, fire safety and infection control in 2015 and 2016. However, there were some gaps where there were no training dates and other areas highlighted where staff had not received any updates for over a year. For example, three staff had not received safeguarding training since 2012; one since 2014 and four had no safeguarding training dates. The registered manager told us they had completed the train the trainer course for moving and handling and provided training for staff. We asked when they had received this training and they said three to four years ago and when we asked if this had been updated they told us an update was not required as there was no expiry date on the training.

The registered manager told us all staff received regular supervision and annual appraisals and we saw the planned programme for the year. Staff files we reviewed showed staff had received supervision and appraisal. Staff we spoke with told us each year they had one appraisal, a supervise on related to practice and a one to one session to talk about practice and professional development.

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 asked the registered manager if anyone using the service had a deprivation of liberty authorisation in place. They told us 'everyone' had one, through discussion we established applications had been made to the managing authority, but no authorisations had been made. The registered manager told us applications

had been made for all of the people using the service who were living with dementia. We asked if this had been done following capacity assessments and they told us 'safeguarding' had told them to do this, but could not give us any further information about who in the safeguarding team had told them this. On the provider information return it was stated 16 people had a DoLS authorisation in place. Staff we spoke with also told us they thought everyone had an authorisation in place.

We saw one person was subject to a number of restrictions which included where they could go in the home and the removal of a walking aid. The reason for these restrictions was recorded in their care plan; however, although a standard application for a DoLS had been made in April 2016, no consideration had been given to the need for an urgent DoLS application. We discussed this with the registered manager and advised them to contact the Local Authority DoLS team.. We contacted the deputy manager following the inspection and they assured us the urgent referral had been made. We concluded staff required more training in this area.

There was a general lack of understanding about the Mental Capacity Act 2005 and DoLS. This was a breach of the Regulation 18 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked people who used the service and visitors what they thought of the food. One person said, "It's not so bad, I don't eat meat so I try to eat what they give me. They don't bother if I leave anything, they ask if you want something else and you get a pudding. It's good quality and always warm I've no complaints about the food." Another person told us, "I don't eat lunch, the food here is better than anywhere." A third person said, "I think it's nice." A fourth person commented, "We get a bit of a choice and if we want more we can have more." One visitor said, "It's not good there's too much repeat." Another visitor told us, "Normally yes, of all the meals I've seen, I find them quite decent." A third visitor said "[Name] is doing very well with the food." A fourth visitor said, "[My relative] doesn't seem to do so bad at eating." A fifth visitor said, "There's nothing wrong with it, he's a good appetite, he enjoys his meals.

We saw in the service's statement of purpose the following statement, "We take care of people's nutritional needs by offering an appealing yet balanced daily menu of home cooked traditional food."

The cook told us new menus had started on the day of the inspection which had been designed following feedback from a recent residents' meeting. These showed one main course for lunch with sandwiches and soup for tea and a buffet tea at weekends. The cook told us there were a range of alternatives available if people did not like what was on the menu. They said a cooked option such as bacon and eggs was available for breakfast.

At breakfast time we saw people being served with cereal, porridge, toast and hot drinks. We did not hear anyone being offered a choice or asked if they wanted a cooked breakfast. The cook told us two different porridges were prepared, one which was high calorie and contained full fat milk and milk powder for people who were nutritionally at risk and another porridge made semi-skimmed milk. We observed people who were given porridge all received it from the same pot and there was no other option available.

Mid-morning and mid-afternoon hot drinks and biscuits were served but there were no high calorie snacks on offer.

The choice of lunchtime meal was butter pie or mince and potato pie with boiled new potatoes and minted peas. Care workers told us the kitchen staff got people's orders during the morning for lunch.

We saw one person had left a lot of their lunch, they told us they really disliked the minted peas. Another

person had not eaten their rice pudding and told us they did not like it.

The meals arrived on a trolley already plated up this meant no one had a choice of portion size. People were served with their plate of food and given cutlery. A care worker served hot drinks and then sometime after people had started their meal offered them gravy. We saw jugs of water on two tables and a jug of juice on the third; however, no glasses were available until raised by one of the inspection team. Some considerable time after the main course had been finished people were offered a choice of rice pudding or ice cream.

Care workers we spoke with told us if they had any concerns about people's health they would tell the senior care worker on duty, who would then take any necessary action. In the eight care records we looked at we saw people had been seen by a range of health care professionals, including GPs, speech and language therapists, district nurses, chiropodists and opticians. We saw staff had contacted one person's GP a week prior to our visit; however, the GP had not visited. We asked the deputy manager about this who told us they would contact the doctor again.

Requires Improvement

Is the service caring?

Our findings

We asked people who used the service and visitors about the staff who cared for them. One person told us, "They're very good; I've no complaints at all." A second person said, "They're wonderful to me." A third person commented, "I find them very nice, caring and obliging." A fourth person told us, "They're good, some get a bit nasty at times, they shout at you." (This person did tell us they were hard of hearing.) A fifth person said, "Most of them are alright, some people you just don't click with." One visitor said, "They keep telling the residents to sit down." A second visitor told us, "Most of them are very pleasant, but the interaction with [Name] is very limited." A third visitor commented, "They're always very busy, but they'll always try to answer anything." A fourth visitor said "I can't fault them." A fifth visitor told us, "Mostly they're OK; [Name of service user] can be very vocal/abusive to the younger ones. There's one or two that shout (use a loud voice). Mostly they're kind, but he misses the company, he says nobody comes in, nobody talks to him."

We found staff were friendly and helpful and heard them call everyone by name, including visitors.

However, we saw some practices which showed a lack of respect for people. We saw staff enter people's bedrooms without knocking on the door first. We saw staff used a towel at breakfast time as a clothing protector because they could not find an apron. We saw missed opportunities to talk to people in the lounges and dining room. We saw one person sitting in the dining room on their own, although staff came in and out only one member of staff said 'Good morning' to them. This person ate their breakfast in complete silence.

We also saw a member of staff go into then conservatory and put the radio on, without consulting with the person who was sitting there.

At lunchtime we saw one person was pushing food onto their spoon with their fingers, a carer told us, "We have those things you put round the plate (plate guards) but they push the food over the top."

We saw in one care plan for a person who was living with dementia they had been assessed as being at high risk of falls. In their care plan staff had written, "Walking without assistance, against advice." This statement assumed the person could retain this information.

The lunchtime experience varied in the different areas of the home. In the lounge/dining room we saw the tables had only been set with paper placemats, serviettes and condiments. Whereas in the other dining area tables had been set without the addition of crockery and cutlery. We asked the registered manager about this and they told us cutlery and crockery were not put on the tables because that was where people living with dementia ate their meals. We asked why tables could not be set and they told us one person used to put the cutlery in their handbag. We noted at lunch time people living with dementia were left, unsupervised by staff, in the lounge/diner. After people had finished their main course cutlery was left on their plates for 30 minutes before being cleared away. No one showed any sign of wanting to remove the cutlery or be in any danger from it being left on the table.

Staff required more training in supporting people living with dementia, dignity and respect. This was a breach of the Regulation 18 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service responsive?

Our findings

The deputy manager told us an assessment of people's needs was undertaken by staff before a place at Lostock Lodge was offered. They also told us the needs of people already living at the home were also considered and the bedroom which was available. For example, they told us the upstairs rooms would only be occupied by people who could use the emergency call bell.

We had concerns about how people's nutritional intake and weight was monitored and reviewed by staff. We saw one person had lost 3.2kgs in weight over a five week period. Care workers told us their health had declined, but their nutritional care plan had not been updated to show what action was being taken in relation to the weight loss. We looked at this person's food and fluid chart and saw the day before our visit they had eaten a bowl of porridge and had a milky coffee, but had not had anything to eat since. In their care plan we saw they had been having thickened fluids, but did not like the thickener so it had been discontinued. We saw a beaker with thickened fluids on their bedside table and asked a member of staff about this and they said the thickened fluids had re-commenced.

We saw from the care records another person had lost 6.5kgs in weight over a four month period. Again, the care plan did not show what action was needed to be taken by staff in relation to their nutritional needs. We saw from the records they were eating and drinking very little. There was no documented information about what their optimum fluid intake should be or about how their foods could be fortified to increase their calorific intake.

Another person had lost 4kgs in four months and had a Body Mass Index (BMI) of 17. Their care plan stated they were to be weighed fortnightly but the care records showed this had not happened. Their care plan showed they were at risk of urine infections and stated staff were to 'push fluids' yet there was no information to advise what their daily fluid intake should be. Food and fluid charts showed they were eating and drinking very little.

A fourth person's care records showed they had a low weight and had a BMI of 16.2. Their care plan dated 21 July 2016 stated they were to be weighed every two weeks, yet the records showed they had last been weighed in September 2016 and prior to that in May 2016. Their care plan showed they often refused to eat and drink but they liked one particular food so to give this if they refused everything else. We saw from the food and fluid charts they were eating and drinking very little and there was nothing to show the particular food they liked had been offered when other foods had been refused.

We saw another person had gained 7kgs in four months. Their care plan dated 27 July 2016 stated they were to be weighed monthly yet no weight had been recorded since March 2016. There was nothing in the care records to show how their weight and health was being monitored.

There was a lack of appropriate care planning and risk assessments related to hydration and nutrition. This was a breach of the Regulation 12 (a) & (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw the complaints procedure was on display on the notice board in the corridor. The registered manager told us they had not received any complaints and did not log low level concerns. However, when we spoke with two visitors they told us they had made complaints. As concerns and complaints had not been recorded we could not see what action had been taken to resolve issues which had been raised or the outcome.

We asked people who used the service how they spent their time. One person told us, "That's a problem I'm bored. I had a radio, but that got knocked off the table a while back. I don't know who knocked it off. We go down to the dining room after lunch; we make things and play dominoes." A second person told us, "I read the paper, do crosswords and read magazines." A third person commented, "I go back to my home and look after my birds." A fourth person said, "I do word search, crosswords, read magazines and watch TV in my room." A fifth person said, "I go out, listen to music and join in the baking."

We asked visitors what activities were on offer, one said, "Not a lot, one lady does art and I take them out every week, we sing in a choir." Another told us, "Sometimes she sits in the lounge and listens to music, she doesn't want to interact." A third said, "She doesn't read or watch television, she just sits there or sleeps." A fourth said, "Occasionally he goes to the lounge for a meal, he just sits here, sometimes he has a little walk."

The home employed an activity organiser who worked three hours a day five days a week which included alternative weekends. They were enthusiastic about their role and described the different activities which took place which included manicures, board games, and bingo and music sessions. They told us they had a planned programme of activities but said this was not displayed in the home as they found it was better to tell people verbally. They told us they spent time with people individually as well as carrying out group activities. They said they organised an annual outing for people which this year was to Chester Zoo.

On the day of the inspection we saw a small group of people were involved in making things for Halloween. However, we found there was little to occupy people in other areas of the home.

Inadequate

Is the service well-led?

Our findings

There was a registered manager in post who had worked at the service for three years. We asked people who used the service, visitors and staff about the management of the home. These were some of the things they told us, "She's wonderful." "She's alright, very nice." "Sometimes she can be a bit not bothered." "I think she's alright, I can talk to her and her daughter." (The deputy manager is the registered manager's daughter.) "She's OK, I prefer her daughter." "She's very capable, she listens." "She's alright, you can interact with her." "I don't like her; she's a bit abrupt and lacking in empathy." "[Name of registered manager] has an open door policy and there is always someone you can speak to." "[Name of registered manager] is a good manager; they are easy to talk to and cares about Lostock Lodge."

The registered manager told us they had been away from the service for six weeks and had only returned in September 2016. They also said the deputy manager had left and a new deputy had only recently been appointed.

We found there was a lack of leadership and direction at the service. For example, when we arrived at 8:05am one of the care workers told us the senior care worker had not turned up and two staff had telephoned to say they were sick. The registered manager and deputy manager were contacted and both arranged staff to cover, which resulted in more staff than usual being on duty. Although we were told staff were allocated to work in specific areas we saw staff in all areas of the home.

We saw a range of audits were in place but concluded these were not effective. For example, the laundry audits from January 2016 to September 2016 were all identical. However, some of the people we spoke with told us they had items of clothing which had gone missing.

Monthly medicine audits were carried out by the registered manager. We looked at the audits for September and October 2016 and no issues had been identified. We saw a medicine audit in July 2016 had identified some issues but there was no detail to show what these were or the action that had been taken to resolve them. The PIR we received from the provider prior to the inspection showed there had been 20 medicine errors in the previous 12 months. When we asked the registered manager about these they told us there had been no medicine errors. They said they did not know where this information had come from and that it was a previous staff member who had completed the PIR.

The registered manager told us there were no care plan audits other than the individual reviews of people's care plans in the their care files.

There were no audits of people's weights to give a picture of the management of people's weights over time. Food and fluid charts were not being analysed to assess if people had received sufficient to eat and drink.

Concerns and complaints were not being recorded; therefore, it was not possible to see if there were any common themes or trends emerging.

We saw housekeeping audits were being completed however, we found areas of the home which were not clean.

We saw kitchen audits were being completed, however, we saw following the most recent inspection by the food standards agency in August 2016 the rating had reduced from five stars to four stars

The audits in place were not effective as they had not picked up the issues we identified during the inspection or by other agencies. This was a breach of Regulation 17 (a) and (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw the provider was completing monthly visits and reporting on these visits, identifying any action which needed to be taken. We did note these visits were being made against the 'outcome' areas of the previous legislation. We showed the provider the CQC 'Guidance for providers on meeting the regulations,' which was published in March 2015 and covered the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3) (as amended). This document was sent to all too all providers, however, the provider told us they had not seen this document. However, the day after the inspection they sent an email stating the following, "Of course I have seen this document, as soon as you left I checked on my PC and I had looked at it in detail last year. I'm sorry I was slow to realise which document you were referring to. It is true that I have not revised my provider audit to reflect the new format - I suppose I felt that the existing layout still provides an effective audit tool. However, I will be re-writing it immediately."

We saw 13 completed satisfaction surveys which had been given to people using the service and had been returned in October 2016. These asked five questions about the service and gave people a choice of answers. There were no questions which gave people further opportunity to comment, for example, asking what people thought the service could improve on. The completed surveys indicated people were generally satisfied with the service which was being provided.

We saw the minutes of residents meetings which had menu/food, laundry, and activities on as standard areas for discussion. We saw 15 people had attended the last meeting on 13 October 2016. We saw one person, in relation to the menus had said, "We did have pilchards, grapefruit segments and black pudding on a couple of times but they had disappeared as an option again." When we asked the registered manager about this they said the person no longer wanted them. It is important for the registered manager to demonstrate how they have used the consultation with people who use the service and/or relatives to make changes to the service.

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 12 HSCA RA Regulations 2014 Safe care and treatment Service users were not provided with care and treatment in a safe way as risks to their health and safety because plans were not in place to mitigate risks. The management of medicines was not safe and proper. Regulation12(1) (2) (a) (b) (g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff required additional training to enable them to carry out their duties. Regulation 18 (1) (2) (a)

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes were not established or operated effectively to assess, monitor and improve the quality of the services provided or to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk. . Regulation 17 (1) (2) (a) (b)

The enforcement action we took:

Warning notice