Care Quality Commission

Mrs Joan Smith

Lowdon House

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?	Good
Is the service responsive?	Requires improvement
Is the service well-led?	Requires improvement

Overall summary

This inspection took place across two dates 05 and10 November 2015 and was unannounced.

The last inspection of Lowdon House was 22 May 2014 and the service was found to be fully compliant against the five outcomes we looked at.

Lowdon House is registered to provide support, care and accommodation for up to six residents with mental health conditions. The home is situated in a residential area close to Preston City Centre. Accommodation is provided in single rooms. There is a communal dining room and lounge.

The registered provider who was also registered manager and a second registered manager was available throughout our inspection and received feedback during and at the end of the inspection.

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.

Resident's told us that they felt safe. We found that safeguarding principles were understood by support

Summary of findings

workers and the management team. However we found that some support systems at the service were not based on current practice and did not always take into account resident's individuals needs and abilities; this resulted in an organisational safeguarding alert being made around institutionalised care and support at the service.

We looked at resident's care records and found that risk assessments had been undertaken for known risk factors and these were individualised. However we found that incidents and accidents were not always reported.

We found that resident's safety was being compromised. The service failed to protect resident's against the risk of fire. We found five fire doors had been wedged and recording around fire risk assessment was poor. This meant that resident's were at risk of avoidable harm.

We looked at staff recruitment records and found that important checks had not always been undertaken prior to a person being recruited. This meant that the provider could not evidence how they had ensured resident's were being supported by staff with good character.

The provider did not assess staffing levels on a formal basis, we asked to see a dependency assessment tool and this was not produced. Staff were deployed to undertake house work. We did not see personal support being provided for resident's on a group or individual basis other than during medicines administration.

We looked at the way medicines were managed and found significant failures. We found that unsafe systems were used which placed resident's at risk of not receiving their correct prescribed treatments. The provider acknowledged this during the inspection and implemented improved systems that would facilitate safe administration of medicines.

We observed staff use protective clothing during cleaning duties. However we found that communal bathrooms and toilets did not have sufficient hand washing facilities. This placed resident's, staff and visitors at risk of cross contamination of infection and disease.

We looked at staff training records. We found that staff had undertaken training as outlined in the providers policies and procedures. However we observed the provider undertake medicines administration and their training records showed failure to complete training and competency assessment around all mandatory courses specified in the providers policies and procedures.

Staff told us that they felt supported and had received regular supervision. Staff told us that they would benefit from training in mental health recovery, this was a core need at the service and training had not been obtained.

We looked at resident's care records and found that written consent/agreement had been requested for various reasons. The service did not have the tools in place to assess a resident's mental capacity prior to requesting written consent. The registered managers and staff were unable to demonstrate sufficient knowledge of the Mental Capacity Act 2005 or associated Deprivation of Liberty Safeguards.

Resident's were sufficiently supported to maintain their physical health. Staff escorted Resident's to appointments and maintained contact with community professionals.

The premises did not fully facilitate resident's to maintain their life skills. Independent access to the main kitchen was not allowed and resident's told us that they did not have free access to kitchen facilities that would help them maintain cooking skills.

We found that the staff team had built trusting relationships with all resident's. We observed staff interact with people in a kind way. However staff told us that they would like to be able to support people more often rather than attending to house work.

Resident's had access to advocacy information.

Resident's told us that their dignity was always considered. We saw that the provider and registered manager had built close relationships with resident's. A small family run service provided continuity for resident's who lived at Lowdon House.

We found that resident's were not always provided with support that was person centred. This was due to an organisational failure to understand best practice and models in health and social care for ways of supporting people with mental health needs including re-enablement and recovery.

Summary of findings

We saw that the service was responsive to resident's changing needs, this included referral to external health care professionals and mental health relapse rates at the service were extremely low.

We looked at care plans and found that minimal person centred detail was recorded. Care plans did not always tell us what skills the resident had and how these could be maintained or developed.

The provider did not have any records of complaints or compliments.

The provider told us that surveys were undertaken by resident's twice per year. However when we asked to see the records during the inspection they were not provided. After the inspection the provider sent us a record of what survey results had been collated in 2015. These stated that some resident's participated in surveys, however we were unable to fully analyse records because the provider did not show us original documents.

We found that the registered provider/manager was not suitably qualified to provide oversight at the service in line with current legislation and best practice. They had not undertaken mandatory training since 2004.

The service had two registered managers. The second registered manager had maintained training and updated their knowledge on a regular basis.

We observed a family run culture at the service, although this had some positive outcomes for resident's we found that conflict between the registered provider and manager prevented the service from being developed in line with current day regulation.

Staff meetings were held regularly and staff told us that communication at the service was effective. Staff told us that they felt supported by the management team. Resident's told us that they felt supported by the team and confident in the managements response should they raise concern.

Quality assurance systems were not robust. We looked at audits that had been undertaken for medicines and infection control, the audits had not identified issues found during our inspection.

We have made recommendations in relation to best practice when working with resident's who live with mental health needs to help maintain their life skills and independence, routinely listening to resident's experiences, complaints and concerns and quality assurance.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 these were in relation to person centred care, safe care and treatment and need for consent.

You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

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.

Safeguarding principles were understood by staff and the service had systems in place to ensure that resident's were protected from abuse.

Resident's care records showed that risk assessments had been undertaken for known risk factors and these were individualised. However we found that incidents and accidents were not always reported.

The service failed to effectively protect resident's against the risk of fire and cross infection.

Recruitment records showed that staff were not sufficiently screened prior to being offered employment.

Medicines management at the service was not robust. The provider took action during our inspection to rectify systems that placed people at risk of not receiving their medicines as prescribed.

Is the service effective?

Requires improvement

The service was not consistently effective.

Staff told us that they had received training in various subjects to enable them to provide safe and effective care. We looked at staff training files and saw that training had been provided in line with the providers policies.

The provider was providing support for resident's living at the service and was not suitably trained to demonstrate best practice knowledge and skills.

Staff had regular supervision and told us that they felt supported by the management team.

The service did not have the tools in place to assess a resident's mental capacity prior to requesting written consent.

We found that resident's were provided nutritious food and drinks. However due to institutionalised practices at the service resident's were given minimal opportunities to be in control of their daily diet.

Resident's were sufficiently supported to maintain their physical health.

Is the service caring?

Good

The service was caring.

We found that the staff team had built trusting relationships with all resident's who lived at the service.

We observed staff interact with resident's in a kind way. Staff were keen to develop their knowledge to help resident's lead a more independent life style.

Summary of findings

Resident's told us that their dignity was always considered.

Resident's had access to advocacy information.

Is the service responsive?

Requires improvement 

The service was not consistently responsive.

We found that resident's were not always provided with support that was person centred.

Institutionalised practices meant that resident's were not always encouraged to maintain their independence or life skills.

We saw that the service was responsive to resident's changing needs.

The service did not record complaints, concerns or compliments. Evidence of listening to resident's experience of the service was minimal.

Is the service well-led?

Requires improvement 

The service was not consistently well-led.

Quality assurance systems were not robust.

There was a family run culture at the service however this did not always have positive outcomes for resdient's. We found that the management team conflicted and this prevented positive developments within the service.

Staff meetings were held regularly and staff told us that communication at the service was positive.

Staff told us that they felt supported by the management team.

Lowdon House

Detailed findings

Background to this inspection

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

This inspection took place across two dates 05 and 10 November 2015 and was unannounced.

The inspection team consisted of three adult social care inspectors. Two inspectors on each day of the inspection.

Prior to this inspection we looked at all the information we held about this service. We reviewed notifications of incidents that the provider had sent us since our last inspection.

We also requested feedback from community professionals, such as general practitioners and mental health care co-ordinators. We received limited feedback. Comments are included within the main body of the report.

There were six resident's living at Lowdon House. We spoke with all the resident's who lived at the service, three support workers, the registered manager, and the registered provider who is also registered manager.

We looked at three resident's care records, staff duty rosters, staff recruitment files, training records, management audits, safety checks, medication records and quality assurance documents.

Requires improvement

Is the service safe?

Our findings

We spoke with residents. Resident's told us "I feel safe here". "It's my home". And "Everyone is nice".

We looked at how the provider protected people who lived at the service from bullying, harassment, avoidable harm and abuse.

We found that safeguarding principles were understood by support workers and the management team. However we found that some support systems at the service were old fashioned and did not always take into account resident's individuals needs and abilities; this resulted in an organisational safeguarding alert being made around institutional care and support at the service.

We looked at staff training records and found that safeguarding training had been undertaken. The provider had policies and procedures in place that enabled staff to access information about best practice and safeguarding referral processes.

We looked at a resident's care records who was vulnerable. The service had referred concerns about the resident to the local authority safeguarding team. Following investigation the service implemented clear risk assessments to protect the person from further incidents of abuse.

We looked at resident's care records and found that risk assessments had been undertaken for known risk factors and these were individualised. Risk assessments had been updated on a monthly basis. However we found that incidents and accidents were not always reported.

For example one resident's daily reports showed that they had fallen from bed and sustained injury to their face. An accident form was not completed, a risk assessment was not implemented and this was not formally communicated to the relevant agencies.

The registered managers were not aware of this incident.

We found that resident's safety was being compromised. The service failed to protect resident's against the risk of fire. We found five fire doors had been wedged and recording around fire risk assessment was poor. This meant that resident's were at risk of avoidable harm.

These failings in safe care and treatment amounted to a breach of regulation 12 (1) (2) (a) (b) (d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at staff recruitment records and found that important checks had not always been undertaken prior to a person being recruited in line with schedule 3 of Health and Social Care Act 2008. Four out of six employees did not have recorded criminal record checks from the disclosure and baring service. Four out of six employees did not have employment reference checks.

Two staff members told us that their criminal record checks were at home. This meant that the provider could not evidence how they had ensured resident's were being supported by staff with good character.

We discussed this with the registered manager and provider. They told us that criminal record checks had been undertaken, however not all were held at the service and some staff had taken them home. The provider acknowledged the need to improve record keeping systems at the service around safe staff recruitment.

This amounted to a breach of regulation 19 (1) (a) (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider did not assess staffing levels on a formal basis, we asked to see a dependency assessment tool and this was not produced. Staff were deployed to undertake house work. We did not see personal support being provided for resident's on a group or individual basis other than during medicines administration.

Staff told us "I wish we could do more with the people that live here". "We clean all day and seem to have forgotten about activities". And "Yes we need to support people more".

We looked at the way medicines were managed and found significant failures. We found that unsafe systems were used which placed resident's at risk of not receiving their correct prescribed treatments.

For example the service was secondary dispensing medicines from packaging into doset boxes for two resident's. This placed resident's at high risk of receiving

Requires improvement

Is the service safe?

the wrong medicines and could cause significant harm. The provider acknowledged this during the inspection and implemented improved systems that would facilitate safe administration of medicines.

We observed the provider administer medicines in an unsafe way. The provider told us that they administered medicines on a regular basis, often in the morning. The provider had not undertaken training for medicines management since 2004. The provider agreed not to participate in the administration of medicines until training and competency assessment had been obtained.

These failings in safe medicines management amounted to a breach of regulation 12 (2) (g)of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We made an organisational safeguarding alert about unsafe handling of medicines at the service.

We observed staff use protective clothing during cleaning duties. However we found that communal bathrooms and toilets did not have sufficient hand washing facilities. This placed resident's, staff and visitors at risk of cross contamination of infection and disease.

We looked at the providers audit titled 'cross infection checklist' dated 28.09.2015. The audit showed that acceptable personal hygiene standards were in place. It was evident that the service had failed to identify basic infection control failings, however on the second day of our inspection the provider had taken steps to ensure that hand washing facilities were available.

Requires improvement

Is the service effective?

Our findings

We asked resident's if they felt staff were suitably skilled to provide them support. Resident's told us "I don't really have support". "They are good at cleaning". And "The staff are nice here but I don't get much support".

We asked resident's if the support they received at Lowdon House helped them maintain their independence and if it was effective for their needs and preferences.

One resident told us "It is depressing here".
Another resident told us "I like living here, but it is boring".

We looked at care records for three resident's. We found that records did not detail how the service worked in line with best practice around mental health recovery. We asked to see information about the recovery model being followed and it was evident that this information was not available.

We looked at a resident's care records. They had a comprehensive recovery assessment and care plan formulated by the community mental health team. We asked the registered provider and registered manager how they facilitated support for the resident in line with their recovery plan. The registered manager was unable to tell us how the service supports the resident to maintain these set goals. Resident's should have access to important information which would enable their recovery and independence.

We looked at staff training records. We found that staff had undertaken training as outlined in the providers policies and procedures. Courses included; safeguarding, fire safety, health and safety, food hygiene, medicines management, Mental Capacity Act 2005 [MCA], Deprivation of Liberty Safeguards [DoLS] and Control of Substances Hazardous to Health [COSHH].

Staff told us that they would benefit from training in mental health recovery, this was a core need at the service and training had not been obtained.

Staff told us that they felt supported and had received regular supervision. We looked at supervision records and found that staff were encouraged to talk about their role at Lowdon House and what they would like to achieve.

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 to receive care and treatment when this is in their best interests and legally authorised under the MCA.

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

The Mental Capacity Act 2005 Code of Practice stipulates:

'There are a number of reasons why people may question a person's capacity to make a specific decision:

• The person's behaviour or circumstances cause doubt as to whether they have capacity to make a decision.

• Somebody else says they are concerned about the person's capacity, or

• The person has previously been diagnosed with an impairment or disturbance that affects the way their mind or brain works, and it has already been shown they lack capacity to make other decisions in their life.'

We looked at resident's care records and found that written consent/agreement had been requested from resident's for care planning, medicines, risk assessments and finances.

We found that the service did not have the tools in place to assess a resident's mental capacity prior to requesting written consent. The registered manager's and staff were unable to demonstrate sufficient knowledge of the Mental Capacity Act 2005 or associated Deprivation of Liberty Safeguards.

This failure to follow the Mental Capacity Act 2005 code of practice amounted to a breach of Regulation 11 (1) (2) (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We observed lunch time meal service. We saw that resident's were served a hot dinner of chicken pie, potatoes and vegetables. At the same time hot apple pie was served.

Requires improvement

Is the service effective?

We asked resident's who lived at the service if they were able to choose what they had for their meals. People told us that the meals were planned by the staff but they could always ask for something different.

The service did not have menus to enable resident's to make informed choice at meal times. We observed resident's make hot drinks, however kitchen facilities were not accessible unless people were supervised and these were in the staff living quarters.

We found that resident's were not able to have control over their own nutrition. Facilitation of life skills was limited due to insufficient kitchen facilities for resident's to access on an independent basis.

Resident's were sufficiently supported to maintain their physical health. Staff escorted resident's to appointments and maintained contact with community professionals.

The premises did not fully facilitate resident's to maintain their life skills. Independent access to the main kitchen was not allowed.

We recommend that the service explores best practice models of care and support in working with resident's who live with mental health needs to help maintain their life skills and independence.

Good

Is the service caring?

Our findings

We asked resident's if they were treated in a kind and caring way. We received some positive comments about the staff and about the care that resident's received these included; “I like the staff”. “Staff are very nice”. And “I can talk to staff, they listen”.

We found that the staff team had built trusting relationships with all resident's who lived at the service. We observed staff interact with resident's in a kind way. Resident's had their own space that facilitated privacy. One resident told us “My bedroom is brilliant”.

Resident's told us that their dignity was always considered. We saw that the provider and registered manager had built close relationships with resident's. As a small family run service, this was seen to provide continuity for resident's who lived at Lowdon House.

Resident's had access to advocacy information. We did not see any examples of resident's accessing advocacy services. Resident's told us they felt confident to ask staff if they needed this type of support.

The provider told us that surveys were undertaken by resident's twice per year. However when we asked to see the records during the inspection they were not provided. After the inspection the provider sent us a record of what survey results had been collated in 2015. These stated that some resident's participated in surveys, however we were unable to fully analyse records because the provider did not show us original documents.

We saw that resident's had been involved in review of their care plans and risk assessments. Whilst this was not with consideration of the resident's mental capacity, it was evident that the service engaged with resident's to encourage them to understand the plans in place for their care and support.

Requires improvement

Is the service responsive?

Our findings

We asked resident's if they felt Lowdon House was responsive to their needs. Resident's told us "I am happy here". "Sometimes I am bored but I am happy enough". "I have a job two days per week I like to get out". And "Things are fine, they listen to me if I have something to say".

We found that resident's were not always provided with support that was person centred. This was due to an organisational failure to understand up to date and best practice models of care and support for resident's living with mental health needs including re-enablement and recovery.

We observed institutional care practices that prevented resident's from maintaining their life skills and independence. For example resident's were fully supported in tasks such as cooking, meal preparation, cleaning, making their beds and laundry. The service had taken over resident's daily life routines without consideration to involve them or motivate resident's to maintain a level of independence appropriate to their abilities.

We asked staff what role they undertake at the service. One support worker told us "we don't do any support, other than house chores". Another support worker told us "We take people to their appointments, but our role is generally maintenance of the house, cleaning and cooking".

Institutionalised practices constituted to a breach of regulation 9 (1) (a) (b) (c) (3) (b) (c) (d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at care plans and found that person centred details relating to individuals was minimal. Care plans did not always tell us what skills the resident had and how these could be maintained or developed. Support workers told us that they had not received any up to date training in person centred support, and that they would like to learn more about how to provide person centred care for resident's living with mental health needs.

We discussed this with the registered provider and registered manager who agreed that modernisation at the service was needed. The registered manager told us, "Resident's used to do much more for themselves", and that "Resident's started to refuse to do things andthe staff took over the daily routines". The registered manager acknowledged that a person centred approach to mental health support was required to develop the service.

We saw that the service was responsive to resident's changing needs, this included referral to external health care professionals and mental health relapse rates at the service were extremely low.

We asked a visiting care co-ordinator for feedback about the service. The care co-coordinator agreed that the service was not providing care and support that was inline with best practice around mental health recovery. However commended the service for low levels of mental health relapse.

The provider did not have any records of complaints or compliments. The registered manager told us "Resident's do not make complaints or compliments".

We recommend that the provider considers ways to engage resident's in actively expressing their opinions and views about the service being provided.

Requires improvement

Is the service well-led?

Our findings

We asked resident's if they felt confident in the management team. Resident's told us "Yes it is like a family here, everyone cares for you" And "Yes I can always go to the managers".

Quality assurance systems were not robust. We looked at audits that had been undertaken for medicines and infection control, and these had not identified issues found during our inspection.

We found that quality assurance was not considered for all areas of service provision. During feedback the registered manager told us that they intended to improve auditing systems to help highlight areas for improvement.

A support worker told us "We are one team, everyone pulls together".

We found that the registered provider/manager was not suitably qualified to provide oversight at the service in line with current legislation and best practice. The registered provider/manager had not undertaken mandatory training since 2004 and had not updated their skills and knowledge around best practice and regulation.

The service had two registered managers. The second registered manager had maintained training and updated their knowledge on a regular basis.

We observed a family run culture at the service, although this had some positive outcomes for resident's, we found that conflict between the registered provider and manager had prevented the service from being developed in line with current day best practice and the regulatory frameworks.

Staff meetings were held regularly and staff told us that communication at the service was effective. Staff told us that they felt supported by the management team.

Meetings for resident's were not held on a regular basis. We asked resident's when was the last time they attended a meeting, a resident told us "I cannot remember". We found that the service was not actively empowering people to be involved in making decisions about the way the service was run.

We received feedback from a community care coordinator, they told us that the service worked in partnership with external agencies and were always willing to take advice and support.

The provider sent us statutory notifications to inform us of any reportable incidents at the service or changes to the way the service runs.

We recommend that the provider considers improved systems for assessing, monitoring and evaluating the quality of care at the service.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **The provider did not have effective arrangements in place to ensure that the care and treatment of resident's was appropriate, outlined to meet their needs and reflected their preferences.** **Regulation 9 (1) (a) (b) (c) (3) (b) (c) (d).**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent **The provider did not have suitable arrangements in place to ensure that the treatment of resident's was provided with the consent of the relevant person in accordance with the Mental Capacity Act 2005.** **Regulation 11 (1) (2) (3).**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **The provider did not have suitable arrangements in place to make sure that care and treatment was provided in a safe way for service users.** **Regulation 12 (1) (2) (a) (b) (d) (g).**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed

This section is primarily information for the provider

Action we have told the provider to take

The provider did not have effective arrangements in place to ensure that recruitment of staff was inline with stipulations outlined in Schedule 3 of the HSCA 2008.

Regulation 19 (1) (a) (2).