

Doobay Care (Lychgate) Limited

Lychgate 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 

Summary of findings

Overall summary

Lychgate House provides accommodation without nursing for up to 15 people who have mental health needs.

There were 14 people living in the service when we inspected on 5 July 2016. This was an unannounced inspection.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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.

People were not always provided with their medicines in a safe manner. Improvements were required around the recording and auditing of medicines, and as and when required medicines.

People's health needs were generally met. However, some of the health monitoring was not always clear.

People were not always supported in accordance with the requirements of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS). Some staff lacked awareness of what the Mental Capacity Act meant for people despite having received training. Mental capacity assessments had not been completed correctly.

Records were not always sufficiently detailed or respectfully written.

The service was at risk of isolation and the registered manager was not up to date with current best practice.

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

Procedures were in place which safeguarded people who used the service from the potential risk of abuse and staff understood the various types of abuse and knew who to report any concerns to.

There were sufficient numbers of trained staff to meet people's needs and recruitment processes checked the suitability of staff to work in the service.

People were treated with kindness by the staff who knew them well and had good relationships with people who used the service.

A complaints procedure was in place and people's comments and concerns were listened to.

There was an open culture within the service and staff understood their roles and responsibilities in providing good quality care to people.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not always safe.

People were not always provided with their medicines in a safe manner.

Staff knew how to recognise abuse or potential abuse and how to respond and report these concerns appropriately.

Staff were available to provide assistance to people when needed. The systems for the safe recruitment of staff were robust.

Requires Improvement ●

Is the service effective?

The service was not always effective.

Staff gained consent before supporting people. However, staff had a limited understanding of the Mental Capacity Act (MCA) 2005 and documentation had not been completed correctly.

Safe food hygiene practices were not always in place.

Health monitoring was not always effective. People had access to appropriate services which ensured they received ongoing healthcare support.

Staff felt very well supported and received regular supervision.

Requires Improvement ●

Is the service caring?

The service was caring.

People's privacy and independence was promoted and respected.

The positive and friendly interactions of the staff promoted people's wellbeing.

Good ●

Is the service responsive?

The service was not always responsive.

Requires Improvement ●

Care plans did not always contain sufficient detail to ensure people received appropriate care and support and records were not always written in a respectful way.

Care plans did not show how people were supported to work towards their aspirations and goals or any progress made to achieve these.

Activities were available and people accessed the community.

People knew how to complain and share their experiences of the service.

Is the service well-led?

The service was not always well led.

Audits were completed to assess the quality of the service, however these were not robust and did not always identify all areas for improvement.

The service was at risk of isolation and the manager was not up to date with current best practice regarding the Care Certificate.

The manager and provider were visible in the service and there was an open and transparent culture. Staff were clear on their roles and responsibilities.

Requires Improvement 

Lychgate 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 on 5 July 2016, was unannounced and undertaken by one inspector and an expert-by-experience who had experience of mental health services. 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 our inspection a Provider Information Return (PIR) was submitted by the registered manager. 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 spoke with 10 people who used the service and two people's relatives. We used the Short Observational Framework for Inspectors (SOFI). This is a specific way of observing care to help us understand the experiences of people who may not be able to verbally share their views of the service with us. We observed the care and support provided to people and the interaction between staff and people throughout our inspection.

We looked at records in relation to seven people's care. We spoke with the registered manager, the provider and four members of staff, including care and kitchen staff. We spoke with two relatives, one professional and also received feedback from the local authority.

We looked at records relating to the management of the service, staff recruitment and training, and systems for monitoring the quality of the service provided.

Is the service safe?

Our findings

We completed an audit of medicines to check systems were working and we found that we did not know if the stock count of medicines was correct. The medicines were not regularly counted and the balance of medicines in stock was not recorded when new medicines were delivered. This meant that we were not able to see if all medicines had been given and recorded correctly. Audits were completed on medicines, however these were not formally recorded and did not cover counting the stock which would identify any potential discrepancies so that these could be identified and acted on.

Where as required (PRN) medicines are required, there should be clear guidance to staff on what each medicine is for, when it should be given and how often and any proactive strategies to use prior to using the medicine. This guidance was not in place for all PRN medicines that were being administered. For example, a person had been prescribed diazepam and there was no guidance available on when this medicine may be required or how often it could be taken. The medicines policy did not cover the use of as and when required medicines. This meant that there was a risk that these medicines could be administered when they were not required or wanted.

Pain relieving medicines had been administered however the actual amount given, the exact time it was given and the reason for administration was not recorded. One medicine had not been administered as per the instructions on the medicines administration record (MAR). A senior member of care staff told us that the dosage of the medicine had recently been changed by the GP and the dosage at lunchtime was no longer required. This had not been amended on the MAR. This meant that there was a risk of people receiving too much medicine. The senior staff member told us that the record would be amended.

Some people had medicines profiles and some people did not. Medicines profiles provide an overview for staff of the medicines that people are taking, the reasons why and possible side effects. Where people did have medicines profiles were not always accurate. For example, one person had their dose of medicine increased. The MAR had been amended but the medicines profile had not been updated with the change. This meant there was a risk that staff could be confused about which medicines to administer due to conflicting information. Instructions on the MAR said to apply creams 'as directed'. There was no guidance available on the MAR, in the care plan or on the medicines profile on where the cream should be applied or how often. This meant that there was a risk of people not receiving the medicine in the right way.

This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Safe care and treatment.

We discussed our concerns regarding medicines with the registered manager who told us that despite the risks we had found there had been no medicines errors that they were aware of within the service. This was because although information was not written down, staff knew people well. The manager assured us that systems would be put in place to manage medicines effectively and we saw that action was being taken on the day of our inspection to reduce the risk.

Medicines were stored safely in a lockable cupboard for the protection of people who used the service. Staff provided people with their medicines respectfully and at the person's own pace. For example, we observed a member of staff administering medicines to people after their lunch, as they had requested, so it did not impact on their meal. A staff member who was responsible for administering medicines told us that they had received training to safely do this.

Systems were in place to reduce the risk of harm and potential abuse. Care staff had received up to date safeguarding training. Care staff knew how to recognise and report any suspicions of abuse to the appropriate professionals who were responsible for investigating concerns. One member of staff told us, "I would immediately report the incident, write it down accurately, inform the manager." Information was available for people using the service about how to report any concerns regarding the care they received to the local authority.

The service followed safe recruitment practices. Staff files included application forms, records of interview and appropriate references. Checks had been carried out to make sure people were of good character and suitable to work with vulnerable adults.

People felt safe living at the service. One person said, "Oh yes I feel safe, you got staff to help you whenever you need help." One relative said, "I think the home is a safe place." We saw that staff were attentive to people's needs to ensure that they were safe. For example, when a person was using a walking frame, the staff encouraged them to slow down to reduce the risk of them falling.

Risks to people's personal safety had been assessed and plans were in place to minimise these risks. This included risks associated with diabetes, poor mental health and mobility. However, different formats were in use which could be confusing. However when we spoke to staff they had a good understanding of the risk assessments. One staff member said, "They are important because then you can go back to it if there is an accident. It makes you aware of the dangers and what initiatives you can make to prevent it (the accident) happening in the future."

The risk assessments had been signed by the person and had been reviewed regularly. We saw that potential risks in people's rooms had been discussed with that person. For example, a build-up of magazines or any trip hazards. This ensured that people were encouraged to take responsibility for their own safety.

Checks had been made on equipment, including the lift, hoists and wheelchairs, to ensure they were safe to use and fit for purpose. Records showed that fire safety checks and fire drills were regularly undertaken which helped to ensure staff and others knew how to reduce the risks to people if there was a fire. The fire evacuation plan and signage were visible in the service to tell people, visitors and staff of the evacuation process in the event of a fire. We saw that concerns highlighted through a fire risk assessment had been addressed.

The registered manager assessed the staffing levels based on people's needs. Any changes in needs were discussed throughout the day so that rotas could be amended accordingly. The rotas reflected what we were told. Staff were attentive to people and requests for assistance were responded to promptly. Staff had time to chat to people and engage in activities with them. Staff told us that they felt there were enough staff to support people. However, one relative said, "I think there is enough staff although sometimes I am told there is not enough staff for [relative] to go out."

On the day of our inspection, one staff member called the service to say that they would be late for their

shift. Arrangements were made for another staff member to stay on and cover until the member of staff arrived. This showed us that there were systems in place to make sure that there were enough staff to support people living in the service and to manage any changes in the service safely during an emergency.

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 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.

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. 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, and whether any conditions on authorisations to deprive a person of their liberty were being met.

The service was not always working within the principles of the MCA and DoLS. Capacity assessments were not completed correctly and the specific decision to be made was not detailed. Where one person had capacity, the assessment said that decisions would be made in a person's best interests. This meant that the care the person received may not be appropriate. This was discussed with the manager who told us they would refresh their knowledge and complete the assessments correctly.

Staff had a mixed understanding of DoLS and MCA despite attending training in May 2016. One staff member said, "I have had training recently but I can't remember what it's about." Another staff member said, "It's about if people have the capacity to make their own choices and are safe to go out." Policies and procedures were in place covering consent to care and treatment, the MCA and DoLS (Deprivation of Liberty Safeguards).

This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Person-centred Care

People were asked for their consent before staff supported them with their care needs. For example, assisting them with their medicines and personal care.

Where bowel monitoring was identified as an assessed need, this was not always in place. The care plan stated that a bowel monitoring chart should be used. However, the registered manager told us that this information would be recorded in the person's daily report. This information was not recorded consistently and there was no guidance for staff as to what action to take should the person not have a bowel movement over a prolonged period. This meant that the person was at risk of not receiving the correct support to maintain their health

Where people required the support of healthcare professionals, this was provided. One person said, "If you

are not well you just go to a member of staff and they will ring a doctor." Records showed that people were supported to maintain good health, have access to healthcare services and receive ongoing healthcare support from district nurses, physiotherapists and opticians.

Where changes in people's wellbeing were identified, prompt action was taken to seek guidance and treatment from health professionals, such as involving occupational therapy to ensure that any equipment purchased met the needs of the people using it. This showed us that staff recognised and took appropriate action to keep people well.

Staff had received training which was relevant and gave them the necessary knowledge for their roles such as bi-polar and diabetes. One staff member said, "I have had training in challenging behaviour." We saw that staff used their knowledge from this training to effectively support people. For example, we saw staff using de-escalation techniques to reduce the anxiety of one person. One staff member said, "We try and calm [person] down by talking, encourage them to go to a quiet place if distressing other people." Staff were knowledgeable about their work role, people's individual needs and how they were met.

Each staff member had an induction on commencing employment at the service and shadowed staff to gain knowledge of the role. One staff member confirmed they had an induction and said, "I did three day's training, watching other staff and then gradually doing things myself, starting off with them watching me."

Feedback from care staff about their experience of working for the service and the support arrangements in place were positive. Staff felt supported and were provided with opportunities to talk through any issues. One member of staff told us that they had supervision once a month and a yearly appraisal. They said, "We talk a lot informally and in handovers too." Another staff member said, "I am happy with the support that is offered. We have supervisions and we have extra ones if there has been an incident." Staff meetings were held monthly providing an additional opportunity for staff to raise any concerns and receive support.

People were complimentary about the food and said that they had a choice of what to eat. One person said, "No complaints about the food dear, sometimes we get shepherd's pie, sometimes we get sausages, sometimes burgers, sometimes we get fruit and sometimes a nice pudding, we get nice food here." Another person told us, "I get to make choices, I told the cook I don't want chicken so she is going to make me an omelette, I get yogurts, fruit, strawberries." The cook had a good knowledge of what people liked and did not like and their individual needs and there were guidelines in place for people who required a soft diet and information regarding foods suitable for people who wished to lose weight. Low sugar puddings such as yoghurts and jellies were available and we saw a meal pureed ready for a person to eat as agreed in their eating and drinking assessment.

There was opened food in the fridge which was not dated and a frozen chicken defrosting on the work top in the kitchen which was uncovered. Food temperatures had not always been recorded which meant there was a risk that food may not be fully cooked before being eaten by the residents. This was raised with the cook and the registered manager who took action to rectify our concerns.

People were supported to have hot and cold drinks throughout the day. Records were in place which showed what people had eaten and drank each day; however these were not always detailed with one record saying "Pureed" rather than describing the food that had been eaten. We saw food in the fridge which was pureed together. This meant that the person would not be able to enjoy the taste of each individual food.

People had completed a survey about the food and the results were positive. We observed lunch time and

this was relaxed and calm with people enjoying their food. People had a variety of individual meals which looked appetising and fruit juice was available on each table. The support people received with their meals varied depending on their individual circumstances. Care staff encouraged people to be independent and made sure those who required support and assistance to eat their meal or to have a drink, were helped sensitively and respectfully. We heard staff offering assistance and gaining consent before helping people. For example, "Shall I cut this up this up?" and, "Shall I feed you?"

People's nutritional needs were assessed and they were provided with enough to eat and drink and supported to maintain a balanced diet. Where issues had been identified, such as difficulty swallowing, guidance and support had been sought from health care professionals, including speech and language therapists. This information was reflected in care plans and used to guide staff on meeting people's needs appropriately.

The house had a warm, friendly and relaxed atmosphere. Communal areas were clean and furnished with a variety of chairs and pictures that made it feel homely. The service has recently had an extension and some re-decoration however, the upstairs hallway does require some redecoration. This was acknowledged by the registered manager who told us that plans would be made to address this.

Is the service caring?

Our findings

People and staff appeared comfortable with each other. Staff were professional whilst also being friendly and easy going in their interactions with residents. Staff provided reassurance where needed and when residents asked for attention they were responded to quickly. Residents were positive about the staff. One person said when asked about the staff, "They are friendly and approachable." Another person said, "I like this one (home) because are staff are nice and kind and helpful." A relative said, "Best place [relative] has ever been. Here [relative] gets 1-1 (support) which is what [relative] needs."

We saw thank you cards that had been received by the service and compliments which included, "Lychgate House is a very good example of how care should be." and, "We all feel that [person] is happy and belongs at Lychgate House."

All staff demonstrated knowledge and familiarity with the needs and preferences of people in their conversations with them and demonstrated genuine affection and care when talking about residents. One staff member said, "I love working here. I love the people." We observed a staff member playing dominoes with two residents; they were respectful and relaxed together. We observed staff serving breakfast to a resident, they were polite and periodically checked the resident was happy.

During lunchtime, we saw one staff member who did not always interact with people when giving people their lunch and poured out juice for people without checking if they wanted this. This meant that people had missed opportunities for social interaction and choice. This was discussed with the manager who informed us that concerns had been discussed previously and assured us that this would be addressed with the staff member.

Staff listened to what people said and their views were taken into account when their care was planned and reviewed. One person said, "Any sort of problems you can go to them, they will answer your questions." One person's care plan said, "I prefer to have assistance from staff who are familiar and sensitive to my needs." People's views were sought through surveys which covered specific areas such as food and staff attitude. The responses had been positive. Residents meetings were held monthly and people were asked for their views at these meetings. People said they were happy and people had given feedback such as. "[Person] loves their room and enjoys their food but for breakfast wants to have shredded wheat." As a result, shredded wheat was now available.

Records showed that people had been involved in their care planning. People had signed their care plans and told us that they met with their keyworkers regularly to discuss their care. One person said, "I see my keyworker every month, we discuss problems, have a one to one, talk it out, they would try and implement anything I asked." Another person said, "I've got a keyworker, she's good at her job." This demonstrated that people were involved in their care and that their comments were listened to and respected.

People's independence, privacy and dignity was promoted and respected. This included shutting doors before supporting them with personal care. In addition, when care staff spoke with people about their

personal care needs, such as if they needed to use the toilet, this was done in a discreet manner. People's records provided guidance to care staff on the areas of care that they could attend to independently and how this should be promoted and respected. One care plan said, "I need encouragement to do as much as I can for myself. Staff must preserve my dignity at all times." One person was being supported to move onto a flat of their own. A staff member said, "People are independent and this is promoted. People get involved in things. People are included as it is their home."

Is the service responsive?

Our findings

People's needs were assessed before admission and people were involved in developing their care plans which had been signed by each person. However, paperwork was confusing and it was not always clear which documents were care plans and which were risk assessments. The manager told us that this would be rectified

Care plans reflected the basic support that each person required and preferred to meet their assessed needs. These covered mobility, likes and dislikes, sleep pattern and social needs; however these could have been more detailed. For example, one care plan for managing difficult behaviours did not cover the incidents that could trigger the person to become angry or upset or ways that the staff could support the person to prevent this from happening. This meant that staff may not have the information needed to support the person effectively and prevent them from becoming upset.

There was little evidence of people's aspirations within care plans or that people had been supported to work towards any goals. Progress sheets were linked to care plans and completed each shift by care workers. These often focused on practical tasks that had been completed and the language used was not always respectful towards people. For example, one progress record said 'toileted regularly'. The progress sheets did not cover a person's whole wellbeing such as any social activities they had been involved in or how they were feeling.

Most people were fairly independent and went out regularly. On the day of the inspection, we saw people waiting for the bus to go into town. We received mixed feedback regarding activities. One person said, "I went out yesterday to Sainsbury's, I brought two dresses, a nightdress, had a cup of tea and came home." One person said, "We play cards and dominoes, I go out, someone accompanies me." Another person said, "I never get bored, I look after the two grey cats, I feed them." However, one relative commented, "[Relative] needs things to do. [Relative] needs to be occupied and [relative] could go out more often."

An activities plan was displayed with activities which included a 'news and views' discussion, music, social morning, DVDs and church. One staff member said when asked about the activities on offer, "We go to the zoo, shopping, cinema, dominoes, cards. Any activities that we do are user led." Another staff member commented, "Colouring, word searches, every fourth Sunday church members come and sing, cards, helping in the kitchen."

The routine of the home appeared organised which suited those living there. People knew what to expect and what was going to happen next, however where the routine needed to be flexible to suit people's needs this was accommodated. For example, we saw two people eating their lunch at different times to everyone else.

Regular house meetings were held and we saw minutes of meetings where activities and the menu had been discussed. Changes had been made to the menu as a result of one of these meetings. This showed that the

service acted on people's views.

Staff were able to explain how they kept up to date when people's needs changed. When asked how they kept up to date, one staff member said, "Through team meetings, handovers and the communication book and we have a diary for appointments." A professional visiting the service said when asked about the service, "No problems, staff always talk to us and inform us about how she is getting on. Staff have done really well. If [person] is struggling with sleeping they find solutions or refer [person] for extra help."

People knew who to speak with if they needed to make a complaint. The complaints procedure was given to people in the service user guide, was on display on the wall and blank complaints forms were seen in people's files. The service had not received any formal complaints. Staff knew how to support someone if they wanted to complain. One staff member said, "Listen to the service user, take them into the office or separate room. And tell the manager."

Is the service well-led?

Our findings

The provider was failing to ensure that there were robust systems in place to ensure that the quality of care provided was safe and of a consistently good quality. As mentioned previously in this report we identified problems with medicines audits, care planning, the application of MCA assessment and decision making processes and support for people to maintain good health. Directors meetings were held three monthly and included an audit of the service. The audit covered staffing, premises and records, however these had not identified the issues we found during this inspection. Although the manager demonstrated the drive for continuous improvement through audits that had been completed, a lack of effective oversight and thorough auditing of all areas meant that there was a risk that issues would not be identified or addressed.

The registered manager had attended annual workshops which included the implementation of the Care Act but they had failed to put learning from these workshops into practice. They were not implementing current best practice in the care industry. For example, they were not aware of the Care Certificate which is the minimum standard that should be covered as part of induction training for new care workers.

The service was at risk of isolation from other similar services and the provider needs to ensure that they keep up to date with best practice and health and social care legislation to provide a quality service which continues to improve.

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Good Governance

Despite our findings, people knew who the provider and manager was and told us that they felt that the service was well-led. One person said, "The managers are nice". Another person said, "[Provider], she's alright." One staff member when asked about the the manager told us, "Yes, [manager] is very nice we all have a good relationship with her, she always listens to us." Another staff member said, "I like the atmosphere, the staff and the boss. The manager is very nice." One relative said, "I wouldn't want [relative] to live anywhere else, they take wonderful care of [relative] and are very fond of [relative]."

The service had a small staff team and the manager was very visible in the service. The manager told us that they worked alongside the staff team and were in the service a minimum of five days a week. This meant that they could speak to staff and people regularly, monitor the service and make any improvements as required. Staff meetings were held monthly and topics that had been discussed included keyworker roles, responsibilities and training.

Staff told us that the manager had an open door policy and was approachable. This contributed to the good running of the service. One staff member said, "I am able to talk to the managers about any concerns." People benefited from staff that understood and were confident about using the whistleblowing procedure if this was required.

There were policies and procedures in place to provide guidance to staff and these had been reviewed

regularly and guidance was displayed for staff in the utility room on different subjects. For example, how to deal with minor injuries.

The service worked in partnership with social work teams, district nurses, local GP services and mental health services to ensure they were following correct practice and providing a high quality service. One professional said, "Staff keep us up to date and have done really well. If they are struggling they find solutions or refer person for extra help."

We saw compliments from surveys that had been completed by relatives and people using the service. One compliment said, "We are always pleased with the standard of the home." And, "Residents are well looked after, relaxed and happy."

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 9 HSCA RA Regulations 2014 Person-centred care Mental capacity assessments had not been completed correctly and staff had a limited understanding of the Mental Capacity Act. Regulation 9 (1) (2)
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were not always provided with their medicines in a safe manner. Regulation 12 (g)
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Audits were not robust and did not always identify all areas for improvement. The manager was not up to date with current best practice regarding the Care Certificate. Regulation 17 (2) (a) (b) (f)