Barchester Healthcare Homes Limited

Lindum House

Inspection report

1 Deer Park Way
Lincoln Way
Beverley
Humberside
HU17 8RN

Tel: 01482886090
Website: www.barchester.com

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Lindum House is a care home which provides both nursing and personal care for those who may have dementia or a physical disability. It is registered to support 64 people within two units, one nursing and one residential. At the time of our inspection 51 people were using the service.

People's experience of using this service and what we found
People were not safe and did not always experience high quality care. The quality and safety of the service had deteriorated since our last inspection. The lack of provider and management oversight had not been consistently maintained. Systems and processes designed to identify shortfalls, and to drive improvement were not effective and had not identified the concerns we found during this inspection.

Risks to the health and safety of people were not consistently monitored and mitigated. This included risk associated with catheter care, skin integrity, choking and allergies. Staff had not always had sight of people's risk assessments and care plans. Medicines had not always been managed safely.

We found incidents and complaints were not used as opportunities to learn lessons. Feedback was not consistently sought from people or their relatives to help shape the service. The provider had not always fulfilled its duty of candour. We have made a recommendation regarding this.

There was not always sufficient staff to meet people's needs. People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the systems in the service did not support this practice. Staff told us morale was low.

Staff were recruited safely and had received training suitable to their role. However, the quality of training was inconsistent and best practice was not always followed by staff. Staff failed to recognise and report when people were at risk of harm. We have made a recommendation to improve staff knowledge about safeguarding and how to report poor practice.

People had enough to eat and drink but there were mixed reviews about the quality of food and the dining experience.

The provider was responsive to our findings and started to make improvements during the inspection.

For more details, please see the full report which is on the Care Quality Commission (CQC) website at www.cqc.org.uk

Rating at last inspection
The last rating for this service was good (published 20/10/2018).

Why we inspected
The inspection was prompted in part by notification of an incident following which a person died. This incident is subject to further investigation by CQC as to whether any regulatory action should be taken. As a result, this inspection did not examine the circumstances of the incident. However, the information shared with CQC about the incident indicated potential concerns about the management of risk of care and support in relation to catheter care and staffing levels. This inspection examined those risks.

The information CQC received about the incident indicated concerns about catheter care and staffing levels. A decision was made for us to inspect and examine those risks. As a result, we undertook a focused inspection to review the key questions of safe, effective, caring and well-led only.

We have found evidence that the provider needs to make improvements. Please see the safe and well led section of this full report.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

We looked at infection prevention and control measures under the safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

The overall rating for the service has changed from good to inadequate based on the findings of this inspection.

You can see what action we have asked the provider to take at the end of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for 'Lindum House' on our website at www.cqc.org.uk.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and will take further action if needed.

We have identified breaches in relation to safe care and treatment, staffing, person-centred care and good governance at this inspection.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it. And it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

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 safe. Details are in our safe findings below.	**Inadequate**
Is the service effective? The service was not always effective. Details are in our effective findings below.	**Requires Improvement**
Is the service caring? The service was not always caring. Details are in our caring findings below.	**Requires Improvement**
Is the service well-led? The service was not well-led. Details are in our well-led findings below.	**Inadequate**

Lindum House

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
Two inspectors, a specialist advisor and an Expert by Experience completed this inspection. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Lindum House is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Lindum House is a care home with nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

At the time of our inspection there was a registered manager in post, but they were not present for the inspection. There was an interim manager supporting the service.

Notice of inspection

This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We completed visual inspections of the service on all three days of inspection. We reviewed a range of records relating to twelve people's care. We reviewed information relating to the health and safety of the service and three staff files. We spoke with two visiting professionals, ten relatives and nine people who lived at the service. We spoke to twenty-one members of staff including management, housekeeping, carers, kitchen and maintenance staff.

After the inspection
We made referrals to the local authority safeguarding team and sought clarifying information from the infection control team. We discussed our findings with the provider throughout the inspection.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At our last inspection we rated this key question good. At this inspection the rating has changed to inadequate. This meant people were not always safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management

- People were at the risk of harm due to a lack of monitoring around their health needs. Health conditions were not consistently monitored or reviewed by staff to ensure people received the correct care.
- Risk assessments were not always in place or did not always contain all the required information for staff to follow to keep people safe.
- Where risks had been identified, staff did not follow best practice to minimise these risks. For example, people did not receive their positional changes as required. One person who required hourly positional changes, had only received these every two hours.
- Staff told us they did not have the time to read care plans and risk assessments, "We don't read the care plans; we rely on other staff telling us and it being on the handover."
- Care plans and risk assessments were not updated when people's needs changed. Staff did not have up to date information to ensure people received safe care. For example, one person's needs had changed following an incident. This had not been recorded.

Systems had not been established to assess, monitor and mitigate risks to the health, safety and welfare of people using the service. This placed people at risk of harm. This was a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Relatives we spoke with felt overall, their relative was safe.

Preventing and controlling infection

- Risks in relation to the spread of infection were not effectively managed. Staff did not always demonstrate knowledge of how to reduce the spread of infection and we observed poor practice which put people at risk.
- Staff were not correctly wearing Personal Protective Equipment (PPE) or following the provider's own infection control policy. For example, staff were observed with masks below their noses and were not always bare below the elbow.
- Areas of the service required redecoration as they could not be properly cleaned.

People were put at increased risk of infection due to poor practice and ineffective control measures. This was a breach of regulation 12(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The provider was responsive to the issues raised and redecoration began during the inspection. We observed an improvement regarding PPE once this had been highlighted to management.

● The majority of relatives we spoke with said they felt, the service was clean.

Staffing and recruitment
● There were not enough staff to meet people's needs. A dependency tool was used to calculate the number of staff required at the service. However, this was not consistently applied. Rotas showed that staff were not always deployed to work at the home in line with the assessed staffing levels and staffing levels had not changed in line with peoples' needs.
● People, relatives and staff did not feel there was enough staff. Comments we received included, "Often have to wait a while, there are a lot of temporary staff;" "Not enough staff, they are always stressed and rushed;" "They fit me in when they can, usually lose a morning just sat waiting." And, "[Relative] is diabetic, injections have been delayed and sometimes they don't get food at the right time."
●Staff we spoke with said, "We have no time at all to sit with people and get to know them; no time to read the care plans;" "We don't have enough staff, I can say this sincerely. We use a lot of agency workers and this poses a challenge"; and "staffing levels are shocking".

Failing to have sufficient numbers of suitably qualified, competent staff to meet people's needs is a breach of a breach of regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider was using a high level of agency staff to fill vacancies at the home. The provider acknowledged the disadvantages of this and assured us they were working hard to recruit their own staff.
● Staff had been recruited safely with the appropriate checks in place before starting work.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong
● People were not always safeguarded from abuse. The provider did not follow internal or external procedures to keep people safe.
● Staff had received training in relation to safeguarding but were unable to demonstrate how this would be applied.
● Staff told us about poor practice at the service, which put people at risk of harm, but they had failed to recognise and report this as a safeguarding concern to the management team.
● We spoke with two visiting professionals and they did not feel they could be assured the service was always safe.
● Where incidents had been reported, there was little evidence of learning from events or action taken to improve safety. Incident reports demonstrated poor practice from staff and this had not been identified or explored further.
● During the inspection we made referrals to the local safeguarding team.

We recommend the provider reviews staff training in relation to safeguarding adults to ensure they can identify, and report concerns appropriately.

● The provider took immediate action to address the areas raised.

Using medicines safely
● Medicines were not always managed safely. People did not always receive their medicines as prescribed. For example, people who were prescribed medicine to be taken with food and medicine to be taken 60 minutes before food, received their medication at the same time.
● People's topical medicines such as creams were not always managed safely. One person had cream which was prescribed twice daily, but this had only been applied once a day. Creams stored in people's rooms did

not clearly indicate when they had been opened.
● Staff who were responsible for administering medication and suitable training and their competencies regularly checked.

We recommend the provider seeks advice and guidance from a reputable source to ensure medicines are consistently managed.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
- People did not always receive person-centred care in line with good practice guidance and standards. For example, people nursed in bed were wearing both catheter leg bags and night bags.
- Staff said they did not always give people choice. One staff said, "People don't get choice in their care at Lindum House. We will ask people if they get a wash, but if they say no, we might not be able to go back to them. So, it's now or never, if that counts as choice."
- People felt they did not have choice over their care; one person we spoke with said they would prefer to have a shower but was instead given a wash in bed. Another person told us they would like to leave their bedroom everyday but was not always offered this.
- Some staff told us they did not always deliver care in line with standards due to feeling rushed. For example, in relation to moving and handling techniques.
- Relatives we spoke with felt staffing levels meant people did not always have their care delivered in line with their relative's personal needs and preferences. One relative said, "[Relative] is diabetic, injections have been delayed and sometimes they don't get food at the right time."

People did not have choice and control over their care, and care was not always delivered in line with standards, guidance and the law. This was a breach of regulation 9(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care
- People did not consistently receive access to the appropriate healthcare services. When advice and guidance had been provided by healthcare professionals, we could not always be assured that all benefits and risks had been discussed with people in a timely manner so that people could make an informed choice about their care.
- We spoke with a visiting healthcare professional who told us referrals were not always appropriate and made in a timely manner.
- Another visiting professional said the provider was responsive, "if we prescribe something, they will get it the same day. People are then getting the medication quickly."

Supporting people to eat and drink enough to maintain a balanced diet
- People had enough to eat and drink, however we received mixed feedback regarding the quality of the food provided.".

● The dining experience varied within the service. In the residential unit, we observed people offered a choice of food and enjoying their meals in a dining room with menus and music playing. On the nursing unit, people were not given choice and did not have a 'dining experience'. Instead their meals were provided to them in their bedrooms.

Ensuring consent to care and treatment in line with law and guidance
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 MCA 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. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.
● People had the appropriate legal safeguards (DoLs) in place when they were not able to consent to their care and treatment.
● Overall, relatives told us they felt involved in decisions for their relatives and had been consulted before changes had been made.
● Although staff understood the Mental Capacity Act this was not always applied in practice. For example, we observed staff not asking for consent or offering choice when providing care.

Staff support: induction, training, skills and experience
● Staff training records demonstrated staff were provided with training. However, staff failed to always use this training in practice. We observed practice relating to moving and handling, the prevention of infection, and medicines which did not reflect the training provided.
● The provider had identified the need to ensure staff were suitably supported in their roles and had started making improvements.
● Staff told us they received an induction and overall, felt supported in their role.

Adapting service, design, decoration to meet people's needs
● People had access to an outside area which was well-maintained and secure. The service had various options of where they would like to spend their time, including an area for meals, activities and quieter spaces. The service had a "wow" spa bathroom available for people which included a sensory experience.
● People were consulted and asked for their opinion regarding decoration and adaptions.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant there were times when people did not feel well-supported or care for and their dignity was not maintained. The service was not always caring.

Ensuring people are well treated and supported; respecting equality and diversity

- People were not always well-supported, cared for or treated with dignity and respect.
- People we spoke with felt low staffing levels had impacted on the quality of care provided. People felt the staff sometimes lacked in empathy and kindness. One person said, "I have noticed that they ask how I am, but they don't always wait for an answer. It's like they are just going through the motions."
- Staff did not know about people's personal histories and preferences. This was caused by a lack of staff continuity. Staff told us they do not get time to sit and talk with people about anything meaningful. A person we spoke with said, "I don't get the chance to talk to the girls, they are too busy."

Respecting and promoting people's privacy, dignity and independence

- People were not always cared for in a respectful way.
- People's confidentiality and privacy was not always respected. We observed staff discussing personal matters, multiple times, in public areas and one person told us, "Whilst I am receiving care another staff member will come to the door and talk about another resident- I get to know everything – it's very unprofessional and I wouldn't like them to do that about me."
- We raised our concerns with the provider as part of the inspection and they informed us they would address this immediately.

Supporting people to express their views and be involved in making decisions about their care

- People were not involved in decisions about their care or supported to express their views. We spoke with said they would prefer to have a shower but was instead given a wash in bed. Another person told us they would like to leave their bedroom everyday but was not always offered this.
- Staff felt they could not always provide choice and support people to make decisions about their care due to feeling rushed. One staff member said, "We will ask people if they want a wash, but if they say no, we might not be able to go back to them. So, it's now or never, if that counts as choice."

People did not have choice and control over their care, and care was not always delivered in line with standards, guidance and the law. This was a breach of regulation 9(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At our last inspection we rated this key question good. At this inspection the rating has deteriorated to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- There were shortfalls in the way the service was being led, which has resulted in the breaches of regulations identified in the inspection. Governance systems had failed to identify the areas where risk management was not effective. There was insufficient oversight to ensure risks associated with falls, choking, catheter care and skin integrity were suitably identified, addressed and mitigated.
- The provider had failed to ensure effective oversight of the service. Organisational polices were not consistently implemented. For example, they had failed to follow their own infection control policy.
- Quality assurance processes failed to identify the concerns raised at this inspection relating to catheter care, medicines and documentation.
- The provider had failed to learn and improve the service when advice was given from visiting professionals such as the Local Authority Infection Control Team.
- Feedback from people who lived at the home, relatives and key people was not always sought. No satisfaction surveys had been completed with people, staff or relatives to shape the service. Meetings had been facilitated with people, but these were inconsistent, and could not evidence change.
- Records were not always stored securely. We observed care plans stored in unlocked offices and in communal areas. Some documentation we asked for what not available.
- Records were not accurate and reflective of people's care needs and treatment. Care plans and risk assessments had not been consistently updated when people's needs had changed.

Failure to assess, monitor and improve the quality and safety of the service was a breach of Regulation 17 (1) (2) (3) (Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Action was taken in response to the inspection findings to deliver service improvements. For example, the provider made changes to their paperwork and care plans during the inspection and arranged a staff consultation exercise to ensure staff were consulted with.

- We have shared our findings with the local authority who will continue to monitor and support the service.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

- Duty of candour policy and procedures had not always been followed. Notifiable incidents had been

identified and notified to the Commission. However, written records were not available to evidence the actions staff had taken.

We recommend the provider reviews their systems to ensure duty of candour policies and procedures are always followed.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

● The leadership and governance of the service did not support the delivery of high quality, person-centred care.

● Staff told us the lack of consistent management meant they were not always confident about raising concerns and there was no regular oversight of the service; "We haven't had a proper manager for a while, not always sure who to go to, it's a bit hit and miss."

● Due to the low staffing levels and use of agency staff, staff told us the morale was low at the service. One staff member said, "Everyone has lost heart in the place, no one cares anymore - they are overworked and exhausted."

Continuous learning and improving care; Working in partnership with others

● There were various missed opportunities for the service to have learnt lessons from incidents. Incident reports and complaints were not been documented and actioned and therefore improvements were not being made and mistakes were often repeated.

● The provider told us they would usually implement additional paperwork which provided a concise overview of a person's needs where there is a high use of agency workers; but this had not been identified or implemented.

● One visiting professional who had been supporting the service told us they could not be assured the home was well-led.

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 Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care People did not always receive care and treatment which was appropriate, met their needs or reflected their preferences. This was a breach of Regulation 9 (1).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to provide care and treatment in a safe way for people. This was a breach of Regulation 12 (1). The provider was in breach of Regulation 12 (a) (b) as they failed to assess the risks to the health and safety of people receiving care and treatment; and to do all that is reasonably practicable to mitigate such risks. The provider was in breach of regulation 12 (h) as they failed to assess the risk of and preventing, detecting and controlling the spread of infections.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The provider failed to ensure there were sufficient Numbers of suitably qualified, competent, skilled and experienced persons must be deployed. This was a breach of Regulation 18 (1).

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 Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity. This was a breach of Regulation 17 (2) (a). The provider failed to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity. This was a breach of Regulation 17 (2) (b). The provider failed to maintain securely an accurate, complete and contemporaneous record in respect of each person, including a record of care and treatment provided and decisions taken in relation to care and treatment provided. This was a breach of Regulation 17 (2) (c).

The enforcement action we took:

We have served a warning notice to the provider.