KRG Care Homes Limited

Lound Hall

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

Lound Hall is registered to provide nursing and personal care to a maximum of 43 older people, some of whom were living with dementia. At the time of our visit there were 29 people using the service.

The inspection was unannounced and took place on 8 January 2018. We carried out this urgent focussed inspection following concerns about people's safety and welfare from Suffolk County Council and the Clinical Commissioning Group (CCG).

On 31 October and 1 November 2017 we carried out an urgent comprehensive inspection in response to concerns about people's safety and welfare. We were so concerned about what we found we took urgent action to stop the service admitting people. We also placed conditions on the registration of the service which requires them to send us regular information about the improvements being made. In January 2018 we received further concerns about a lack of improvement in the service and continuing risks to people's safety and welfare. As a result we undertook an urgent focused inspection to look into those concerns. This report only covers our findings in relation to those topics. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Lound Hall on our website at www.cqc.org.uk

The service had a registered manager in place. 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.

People were put at the risk of significant harm in the absence of clear records and assessments which reflected all current areas of risk and how these should be managed to protect the person from harm. Basic care plans had been implemented for people; however, these did not provide adequate information for staff around meeting people's specific complex needs.

Information received from the CCG demonstrated that there were continuing failures in the safe management of medicines.
Whilst some training had been carried out since our inspection, action was still needed to ensure that staff had the appropriate training and competencies to meet people's complex needs safely.

There was a continuing failure of the management team to ensure that effective systems were in place to monitor the quality of the service. Limited progress had been made following our previous inspection and we were concerned that the management team had not identified risks to people and taken action to protect them. This was despite us providing clear information on the areas of risk following our inspection on 31 October and 1 November 2017 and the support provided by Suffolk County Council and CCG.

The service had assessed the dependency of people using the service and increased the staffing level. They did not have enough employed staff to cover all the shifts but had organised for agency staff to cover the

deficit.

On the day of this inspection a new member of staff had started work at the service. They had been employed to be part of the management team and to facilitate and oversee improvements at the service.

Following our inspection we liaised with Suffolk County Council and the CCG to ensure that appropriate support was given to the service to keep people safe whilst improvements were made. We continue to work closely with other agencies to monitor the service and identify if there are further risks to people's health, safety and welfare.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

There remained significant shortfalls in risk management and systems in place to protect people from harm.

Care plans in place did not contain enough information to inform staff on how to meet people's complex needs.

Information from the CCG demonstrated that medicines management at the service remained poor.

The service did not have enough employed care staff nor nursing staff to cover the required shifts. However, they were using agency staff to address this shortfall.

Is the service well-led?

Inadequate

The service was not well-led.

The provider and management team had failed to make significant improvements in a timely way.

There remained significant shortfalls which put people at the risk of potential harm. Systems in place to monitor the quality of the service had been ineffective in identifying these shortfalls.

Lound Hall

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. We undertook an urgent unannounced focused inspection of Lound Hall on 8 January 2018. This inspection was in response to further concerns about people's safety and welfare. The team inspected the service against two of the five questions we ask about services: is the service safe and is the service well led. No significant improvements were identified in the remaining key questions through our ongoing monitoring or during our inspection activity so we did not inspect them. The ratings from the previous comprehensive inspection for these key questions were included in calculating the overall rating in this inspection

This inspection was carried out by one inspector and an inspection manager. We reviewed the care records for four people, records relating to medicines and records relating to the management of the service. We spoke with the provider, the provider's consultant, the quality assurance manager, nursing staff, staff from Suffolk County Council and the Clinical Commissioning Group (CCG).

Inadequate

Is the service safe?

Our findings

At our last inspection on 31 October and 1 November 2017 we rated the service 'inadequate' in this key question. We found the service was in breach of regulations 9, 10, 11, 12, 13, 14, 16, 17, 18 and 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The service needed to make urgent improvements to medicines administration practices, staffing levels, recruitment procedures, care planning and the management of risks. Improvements were needed in other areas such as Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) practices, delivering personalised care, activities and maintaining people's dignity and respect. We carried out this urgent focused inspection on 8 January 2018 because of information from Suffolk County Council and the Clinical Commissioning Group (CCG) which indicated continuing serious shortfalls which put people at risk of potential harm. During this inspection we found that the service had not made all of the urgent improvements that were required to keep people safe. The rating in this key question remains 'inadequate'.

Following our previous inspection basic care plans had been put in place. However, the service had not ensured that care plans for people's specific and complex medical needs were detailed enough. This meant there was not sufficient information for staff to be able to deliver safe care to people. For example, two care plans in place for people with Parkinson's disease only stated the medicines they were taking and did not specify what other support they required, such as support to ensure they mobilised safely. Care plans for those unable to verbally communicate lacked information about how they may communicate in other ways, such as with facial expressions. This meant there was a risk that new staff may not recognise when someone was trying to communicate a need, such as a need for pain management. Some people still did not have care plans in place for assessed areas of risk. For example, two of the people whose records we reviewed were assessed as at risk of pressure ulcers but there were no care plans around reducing this risk. This was particularly concerning as the service was using a significant number of agency care and nursing staff who did not know people's needs and relied on care plans for this information.

Action had still not been taken to implement appropriate measures to ensure people did not use the stairs without support. This meant there remained a risk people living with dementia could attempt to use the stairs unsupported and fall.

Information and reports received from the CCG demonstrated to us that the management of medicines in the service remained poor. A report following a visit by the medicines optimisation team at CCG on 2 January 2018 identified that there remained gaps in some medicines administration records which meant that it was unclear whether people had received their medicines as prescribed. The CCG identified that there were not adequate stocks of some medicines to last until the next order of medicines was completed. This had not been independently identified by the service which meant there was a continuing risk that the service would run out of medication for people. There were additional concerns about the availability and use of prescribed barrier creams. Records did not always demonstrate that these were applied in line with the instructions of the prescriber and in some cases prescribed creams were not available to be applied.

At our previous inspection we told the service they did not have enough staff to meet people's needs.

Following that inspection they increased the staffing level, but they told us they did not have enough permanently employed staff to cover all the shifts required. The service has demonstrated to us that they have appropriate arrangements in place to use agency staff to cover these shifts.

This was a continued breach of Regulation 12: Safe Care and Treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

At our previous inspection on 31 October and 1 November 2017 we identified shortfalls in the service which meant people were not consistently provided with safe, effective care which met their needs. The service was rated Inadequate overall and placed into special measures. We found the service was in breach of Regulations 9, 10, 11, 12, 13, 14, 16, 17, 18 and 19 of the Health and Social Care Act 2010 (Regulated Activities) Regulations 2014. We took urgent action to stop the service admitting people. In addition we placed conditions on the service's registration requiring them to provide us with regular information about the improvements being made.

We carried out this urgent focused inspection in response to concerns about people's safety and welfare. The purpose of this inspection was to ascertain whether people were safe living in the service and whether we needed to take further action to reduce the risk of harm to people.

At this inspection we identified continuing failures of the provider and management team to protect people from potential harm. Limited progress had been made to ensure people's safety and to ensure that they received care that met their needs. This was despite significant support and guidance from Suffolk County Council and the CCG. A quality assurance manager had just started working at the service on the day of our inspection. We were told their role was to oversee and facilitate improvements to the service.

Effective systems were not in place to identify shortfalls in the service, such as shortfalls in records, care planning or risk management. For example, at our last inspection we told the management team they needed to implement an effective system to identify where records indicated people were not being repositioned appropriately. At this inspection we found that the repositioning records for one person at high risk of developing a pressure ulcer contained 51 occasions in December 2017 where records indicated the person may not have been repositioned appropriately. This had not been identified by the management team which meant that no action was taken to ensure this person's safety and welfare.

At our last inspection we told the management team they needed to implement an effective system to monitor the performance of staff completing duties delegated to them. Despite care planning being a high risk area and a priority, the management team did not carry out appropriate checks on the quality of care plans being developed by nurses to ensure they contained all the necessary information. This meant that at this inspection we identified that care plans did not contain sufficient information for staff to deliver people with safe and effective care.

At our last inspection we told the management team they needed to implement a system to assess the competency of the staff team to ensure they had the skills and knowledge to provide safe care to people. At this inspection we found that this system had not been effectively implemented and there were concerns over the competency of two members of nursing staff which had not been identified by the management team. During our visit we were told of concerns about the conduct of one member of staff, who we were told was being supervised at all times. However, we identified that this member of staff was carrying out duties unsupervised which had not been identified by the provider or management team who were present at the

service. When we made the provider aware of this we were told they would take action to ensure the staff member was supervised fully in future.

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