Valuecare Ltd

Lathbury Manor Care Home

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 well-led?	**Requires Improvement**

Summary of findings

Overall summary

Lathbury Manor Care Home is a residential care home providing personal care for up to 29 people including people living with dementia. At the time of our inspection 26 people were using the service.

People's experience of using this service and what we found
The provider had re-established monthly meeting and audits. However, they lacked sufficient evidence to demonstrate detailed analysis of incidents had taken place, to improve the quality and safety of people using the service.

Risk assessments and care plans had insufficient information on how to safely manage people's expressions of distress that had placed people at risk of harm.

All staff received induction and ongoing training that included supporting people expressing distress/agitation.

We have made a recommendation about training on the use of physical intervention.

People received an appealing and nutritious diet. However, the way in which staff supported people at mealtimes, required enhancing to make the mealtime experience more pleasant for people.

Staff received training on the safe administration of medicines. Systems were followed for ordering, receiving, storing and the administration of medicines.

There were sufficient staff available to meet people's needs. The provider followed safe recruitment practices.

A maintenance and refurbishment programme was in place and some refurbishments had taken place since our last inspection. Further refurbishment work was planned.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

Timely action was taken to ensure people received support from healthcare professionals.

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.

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

Rating at last inspection and update
The last rating for this service was requires improvement (published 30 November 2021) and there were breaches of regulation. The provider completed an action plan after the last inspection to show what they would do and by when to improve.

At this inspection we found the provider remained in breach of regulations.

This service has been rated requires improvement for the last two consecutive inspections.

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

Why we inspected
The purpose of this inspection was to check if the provider had met the requirements of the warning notice we previously served, to check they followed their action plan and to confirm they have met legal requirements. This report covers our findings in relation to the key questions Safe and Well-Led which contain those requirements.

When we inspected more information was required on how the provider followed the principles of the Mental Capacity Act, so we widened the scope of the inspection to include the key question Effective.

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

We have found evidence that the provider needs to make improvements. Please see the Safe, Effective and Well-Led sections of this full report.

Please see the action we have told the provider to take at the end of this report.

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 five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.
Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.
Details are in our effective findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.
Details are in our well-led findings below.

Lathbury Manor Care Home

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
The inspection was carried out by two inspectors and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Lathbury Manor 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. Lathbury Manor Care Home is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was a registered manager in post. The registered manager was also the nominated individual for the service. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

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 also sought feedback from Milton Keynes Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

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 spoke with three people living in the service and five relatives about their experience of the care provided. We spoke with six members of staff including the provider, registered manager, deputy manager, senior care staff, care staff and catering staff.

We looked at three files in relation to staff recruitment. A variety of records relating to the management of the service, including audits and quality assurance checks, were reviewed. We reviewed a range of records. This included specific areas of four people's care and medication records.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

Requires Improvement

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 requires improvement. At this inspection the rating has remained requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management

At our last inspection the provider had failed to have effective systems in place to record and monitor management oversight of people's safe care and treatment. This was a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12

● One person said, "I have mixed feelings about feeling safe." They told us of two incidents involving another person using threatening behaviour towards them. One incident, when the person was pushed by the other person and fell against a wheelchair causing cuts to their legs. The other incident when they tried to stop the person from taking food from their dinner plate; the person shouted at them and attempted to hit them. Records showed that staff had recorded both incidents on the incident reporting system.
● The person said, "I like to have my meals in the dining room but am now very wary of coming downstairs on my own." We spoke with the provider who said they would arrange for a staff member to support the person when coming downstairs into the dining room.
● The risk assessment for the person that had pushed the person over stated there was a risk of potential harm to self/others due to being unable to control behaviour, and for staff to intervene as soon as they noticed the person getting into an altercation with other people. In addition, their care plan, instructed staff to sit the person with others at the dining table and made no reference to the possibility they may take other people's food.
● Following the inspection, the provider sent us a revised dietary care plan for the person that informed staff to maintain close observations at meal times, to divert the person from taking food from other people's plates and support the person to eat with dignity.
● A relative told us, they had witnessed an incident when two people had an altercation in the hallway, and a staff member had to hold one person to stop them from physically harming the other person. Records showed that staff had recorded the incident on the incident reporting system.
● Following the inspection the provider sent us a Challenging Behaviour care plan they had put into place following the first day of the first day of the inspection. That informed staff to try to avoid the person coming into contact with people they do not get along with and to use diversional tactics when the person became agitated.
● During the inspection we reviewed the risk assessments for another person who at times had displayed emotional distress placing them and others at risk of physical harm. The assessment informed staff to

intervene as soon as they noticed [Person] getting into any altercations with other people, but did not specify any potential triggers that may cause the person to become distressed, placing them and others at risk of harm, or how staff were to intervene to ensure the safety of the person and others.

The provider had not made sure risk assessments had detailed information for managing risks associated with behaviours that had the potential to cause harm to self and others. This was a continued breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Risk assessments were in place and followed by staff for moving and handling, nutrition, hydration and pressure area care. People with limited mobility; at increased risk of developing pressure damage had pressure relieving equipment in place. People at high risk of falls had specialist beds and floor sensor mats in place. People at risk of choking had modified diets provided.

Systems and processes to safeguard people from the risk of abuse
● During the inspection the provider showed us records in relation to safeguarding incidents they had brought to the attention of the safeguarding authority and to CQC. However, following the inspection, the provider submitted incident reports to CQC that we identified several people had been subjected to harm or placed at risk of harm from others. Following the inspection, we informed the safeguarding authority of the incidents so they could be addressed directly with the provider on a case by case basis.
● Staff received safeguarding training. One staff member said, "If I ever suspected or witnessed any form of abuse, I would not hesitate to report it immediately to my manager."

Learning lessons when things go wrong
● Monthly incident audits and management meetings took place, but they lacked detailed analysis of individual incidents, to effectively mitigate the risks of repeat incidents, to improve the safety of people using the service and demonstrate lessons were learned.

Using medicines safely
● Systems were followed for ordering, receiving and storing medicines. An electronic medication system was used for recording the administration of medicines. Records showed that medicines audits took place.
● Medicines were administered by staff that were trained to do so. Protocols were in place for medicine prescribed to be taken 'as required' and for medicines administered in a way different from the prescribed method, to ensure it was given safely and in line with best practice guidance.

Staffing and recruitment
● There were sufficient staff available to meet people's needs.
● The provider followed safe recruitment practices. Disclosure and Barring Service (DBS) checks were completed on all new staff employed at the home. The DBS provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

Preventing and controlling infection
● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was supporting people living at the service to minimise the spread of infection.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was responding effectively to risks and signs of infection.

● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.

Visiting in care homes
● We were assured the provider was facilitating visits for people living in the home in accordance with the current guidance.

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 comprehensive 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.

Supporting people to eat and drink enough to maintain a balanced diet

- During the inspection, we observed in the dining room a person took approximately half the amount of food from another person's dinner plate, which went unnoticed by staff within the room. We brought our observation to the attention of a staff member who offered the person another meal. Although the person declined saying, "I don't eat much anyway, they [Person] can't help it." However, this had placed the person at risk of not eating their meal, and of having a very poor mealtime experience.
- Following the first day of the inspection the provider updated the dietary needs care plan for the person who had taken the food from the other person's plate, to inform staff to maintain close observations at mealtimes.
- The social aspects of mealtimes can play a significant part in most people's lives. The way in which staff support and assist people at mealtimes, is crucial in ensuring all people receive an appealing and nutritious diet and having a pleasant mealtime experience.
- People's dietary needs were assessed, and referrals had been made to healthcare professionals when further dietary advice was required. One person told us they had plenty of drinks throughout the day, and we saw they had juice and water on their side table within reach.
- People said the meals were nice, and they were provided with a choice of meals. A relative told us their family members food needed to be cut up smaller or given a softer diet as they had noticed their family member was not eating so well and had lost a little weight. They confirmed that staff had kept them up to date.

Staff support: induction, training, skills and experience

- All staff received mandatory training and ongoing refresher training. Dementia training and 'Challenging Behaviour' training was included in the training programme.
- The service provides care for some people that at times displayed their distress in ways which could place them and others at risk of harm. During the inspection we were made aware of an incident involving staff holding one person to prevent them from harming another person. The use of physical intervention was not included in the staff training programme.
- Following the inspection, we were provided with records of several incidents of physical aggression between people using the service when staff had to intervene to prevent incidents from escalating further.

We recommend the provider seeks guidance on the use of physical intervention following best practice, based on current legislation, to ensure staff have the qualifications, competence, skills and experience to keep people safe.

● All new staff undertook an induction programme and worked alongside more experienced staff before they worked independently.
● One member of staff said, "I feel really well supported [manager], is always willing to offer further support if needed." Records showed that staff supervision was monitored on a monthly basis and reviewed in the provider monthly management meetings.

Adapting service, design, decoration to meet people's needs
● The home had been adapted with lifts and disabled access toilets for the purpose of providing care.
● A maintenance and refurbishment programme were in place and some refurbishments had taken place since our last inspection. Further refurbishment work was planned, to include the replacement of some carpets.
● People's bedrooms were clean, personalised with people's personal belongings, such as small items of furniture and memorabilia.
● There was a pleasant garden space, with outdoor seating for people to use, that included a garden tearoom, with a small kitchen facility. This addition to the garden, provided people, their relatives and friends with a sheltered outdoor space when visiting.
● A fishpond provided a pleasant garden feature. The provider had completed a risk assessment, which had assessed the likelihood of people using the service entering the pond area, at low risk.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care
● Lathbury Manor is a small care home, providing care for people with a range of needs, including people living with advanced dementia. The provider was mindful when assessing the needs of new people coming into the home, they were balanced with the needs of people already living at the home.
● People's health was monitored to prevent any deterioration in health. Referrals were made to the appropriate health professionals as required, such as, the GP, speech and language therapist, dietitian, occupational therapy and memory service and their recommendations and advice were followed.
● Important information was available regarding people's healthcare needs, in the event of people requiring emergency hospital care.

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.
● Staff received training in the MCA and had access to information and guidance to help support their practice.
● Where required, DoLS applications were made in people's best interests to ensure their rights were

protected. People were encouraged to make decisions about their care and their day-to-day routines and preferences.

● Where required, best interest decisions were recorded, for people who lacked capacity to consent to medication.

Requires Improvement

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 requires improvement. At this inspection the rating has remained requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

At our last inspection effective systems were not in place to record and monitor management oversight of people's safe care and treatment. This was a breach of regulation 17 Good Governance of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17

● Monthly management meetings and audits had been re-introduced that included reviewing incident reports. The provider told us in their action plan that audits would be completed in detail and analysis of incidents discussed during management meetings. However, we found they lacked enough evidence to demonstrate detailed analysis of incidents had taken place, to improve the quality and safety of people using the service.
● One management meeting recorded three people had displayed 'aggressive behaviours' towards other people living at the home and staff. However, no record was available of any discussion or analysis of the incidents, or any steps taken to prevent recurrences.
● We saw one person had raised a serious complaint. Of which, there was mention the provider had spoken with the staff involved and planned to speak with the person. However, no record was available to demonstrate any further action had been taken in response to the complaint.
● Following the inspection, the provider submitted several records of accidents and incidents. On review of these records we identified the provider had not always notified CQC as required by law, in reporting events of alleged abuse and serious injuries.

Systems and processes were not operated effectively to enable the provider to identify where quality and/or safety were being compromised and to respond appropriately and without delay. This was a continued breach of regulation 17 Good Governance of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider had displayed the CQC ratings from the last inspection on their website and within the home, as required by law.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● At the last inspection the provider told us they planned to re-establish relatives and resident meetings. A management meeting in May 2022 recorded that relative/resident involvement meetings/forums needed to be arranged. However, these meetings were yet to take place. The provider said the planned relative's event earlier this year had to be cancelled due to a COVID outbreak and they were looking to plan another event towards Halloween and Christmas.

● The provider said they used a website care review system to seek feedback from people using the service and relatives. They also said they were open to people and relatives approaching them directly with any feedback. However, this approach did not sufficiently evidence how the provider seeks and acts on feedback from all people using the service, relatives' and stakeholders, to continually evaluate the service and drive improvement.

● One relative said, "I'm old school, I would rather be given a questionnaire from time to time, rather than put something on the website." Another relative said, "Not aware, not to my knowledge of any resident / relatives meetings taking place, I've never had a questionnaire, or I don't remember being given one." We saw since April 2022 eight people had placed reviews on the provider website, that were in the main positive.

● One relative said, "Communication could be improved, we often find out about changes that have happened with [family member] in passing, when talking with staff.

● People and relatives told us the manager and staff member were approachable. One relative told us, the provider had contacted them in response to incidents and complaints. Another relative said, "They [Manager] come up to me a couple of times, just mentioning what has been happening and they ask for suggestions, such as what they think [Family member] might like to eat, as they don't eat as much now."

● Staff meetings took place to give staff opportunities to discuss issues and receive information and updates regarding the service.

Working in partnership with others; 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

● The management team and staff worked in partnership with health professionals involved in monitoring and providing care and treatment for people using the service.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not made sure risk assessments had detailed information for managing risks associated with behaviours that had the potential to cause harm to self and others. This was a continued breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes were not operated effectively to enable the provider to identify where quality and/or safety were being compromised and to respond appropriately and without delay. This was a continued breach of regulation 17 Good Governance of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.