Ladymead Care Home Limited

Ladymead 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 well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Ladymead Care Home is a residential care home providing personal and nursing care to 22 older people at the time of the inspection. The service can support up to 27 people.

Ladymead Care Home accommodates 27 people in one adapted building.

People's experience of using this service and what we found
There were not always enough staff available to meet people's needs. People had to wait for staff to assist them. Not all people had access to a call bell, to attract staff attention so had to call out to staff. Some staff had left recently, and the manager was leaving and working their notice.

Risks to people's health and well-being were not always assessed and mitigated. When people had exhibited behaviour than may harm themselves, this had not been assessed and ways found to reduce the risk. When assessments showed that people were at risk of skin damage, ways to limit this had not been implemented. Risks about the home environment were not always mitigated, such as the closing of fire doors.

When things went wrong, lessons were not always learnt. Staff had not recognised all incidents appropriately and had not made records or referrals when needed. When people made allegations of abuse to staff, these were not always responded to appropriately.

People did not always receive their medicines safely. Staff had not always overseen people taking their medicines, when this was needed. Records of medicines given was not always completed accurately. When people were prescribed medicines 'as required', the time these were given, the dosage, reason and result were not recorded.

The home was not always clean. Infection control was not consistently well managed. The operations assistant recognised that cleanliness and the management of infection control required improvement.

Quality assurance systems had not assisted the management team to recognise and address areas needing improvement. Records did not always reflect people's needs clearly and accurately.

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

Rating at last inspection
The last rating for this service was requires improvement (published 16 August 2019).

Why we inspected
We received concerns in relation to the management of medicines, infection control, staffing, the

management of risks to people and people's nursing care needs. As a result, we undertook a focused inspection to review the Key Questions of Safe and Well-led only.

We reviewed the information we held about the service. No areas of concern were identified in the other Key Questions. We therefore did not inspect them.

The overall rating for the service has remained requires improvement. This is based on the findings at this inspection.
We have found evidence that the provider needs to make improvement.
You can see what action we have asked the provider to take at the end of this report. Following the identification of these concerns the provider informed us they had taken action to mitigate the risks to people. We will follow this up at the next inspection.

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

Enforcement
We have identified breaches in relation to safe care and treatment, safeguarding service users from abuse and improper treatment, staffing and good governance at this inspection.

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

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 for 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 return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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 well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-Led findings below.

Ladymead 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 Care Act 2014.

Inspection team
The inspection was carried out by two inspectors.

Service and service type
Ladymead Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service did not have a manager registered with the Care Quality Commission. This means that the provider was legally responsible for how the service is run and for the quality and safety of the care provided. There was a manager in post at the time of the inspection, but they were working their notice period. The operations assistant assured us that recruitment would take place for a replacement manager.

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. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We used all of this information to plan our inspection.

During the inspection

We spoke with five people who used the service about their experience of the care provided. We spoke with six members of staff including the operations assistant, the manager, care manager, care workers and the chef.

We reviewed a range of records. This included five people's care records and some medication records. A variety of records relating to the management of the service were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at care plans and risk assessment records and other records sent to us by the provider.

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 the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same.

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.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong

● The provider had not ensured that safeguarding concerns were recognised and reported to the appropriate authorities. We found three examples of incidents which had not been documented as incidents or recognised and escalated as safeguarding concerns. As such, no action had been taken to prevent reoccurrence of the incidents and safeguard people.
● For example, we had been advised that one person's behaviour had changed, and this put them at risk of harm. There was no written record of this change, or what action staff had taken to reduce the risk and a safeguarding referral had not been made to the local authority.
● The person was referred to their GP the following day. We spoke to the member of staff who made the referral. They explained another member of staff had told them what had occurred and so they had referred to the GP. They had not taken any further action to reduce the risk of reoccurrence. The manager and operations assistant had not been made aware of the incident. When asked about how the ongoing risk to the person would be managed, we were told it would be communicated verbally through the staff team and that there was reference in the person's care plan file. We queried how agency staff would be aware of this as they had reported that they did not know the whereabouts of care files and were told that there would be reference in the person's daily notes. There was no reference to this in the person's daily notes and it had not been included in the morning handover meeting, so staff may not be aware of the increased risk to the person.
● During the inspection we heard one person make an allegation to a member of staff about physical abuse. The member of staff, instead of taking the allegation seriously, suggested an alternative version of events to the person. The staff member did not record or report the allegation in line with the provider's policy.
● We asked the provider to take urgent action to ensure that incidents were appropriately identified, recorded and reported. The manager told us that they would report the incidents mentioned above, to both the local authority and CQC, by the next day. This notification was received by CQC.

The provider had not ensured people were protected from abuse and improper treatment. This was a breach of Regulation 13 Safeguarding service users from abuse and improper treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Agency staff told us how they would report any concerns, such as bruises or skin tears. They said, "We tell the person in charge straight away, in case they think it was caused by us. Then we record it."

Assessing risk, safety monitoring and management

● Risks to people were not always recognised and supported. For example, one person had displayed behaviour which increased the risk of potential harm to their well-being. This had not been recognised, assessed and mitigated. A referral to the person's GP had been made but other relevant risks, such as their environment and emotional well-being had not been considered, assessed and mitigated.

● Following the inspection, the operations assistant sent a care plan relating to the person's mental health support needs. This did not mention the specific risk of harm, any triggers or what may pose a risk in the person's environment. When asked about this, the risk assessment was rewritten to include these elements.

● Risks about people's skin integrity had not been assessed and mitigated. Staff used a Waterlow assessment tool to ascertain the level of risk of a person's skin deteriorating. However, when a risk was identified there were no plans about how staff could reduce the risk of the person's skin deteriorating, such as using specialist mattresses and equipment. This left people were at risk of developing pressure sores.

● Following the inspection, the operation assistant told us that they had reviewed the Waterlow assessment for all people who were identified as medium or high risk.

● Risks around people's eating and drinking had not always been considered. We saw that one person ate lying in a semi prone position, which is likely to increase the risk of choking. This risk had not been recognised or assessed. Following the inspection, the operations assistant sent us an eating and drinking plan for this person, which included the need for them to now be 'well sat up in bed.'

● Known risks were not appropriately monitored. Some people had charts in place to record their fluid intake or times of repositioning. Records were not completed accurately, we found gaps in records. The recording of drinks given to people and taken during the day were not kept so staff could not tell that people were drinking enough to keep well hydrated. One person, who used a catheter, did not have their fluid output monitored. When someone uses a catheter, monitoring of their output can help identify any issues.

● Following the inspection, the operations assistant sent us reviewed catheter management plans. This did not include the monitoring of any fluid output. When asked about this, this was updated to include monitoring of fluid input and output.

● We asked the provider to take urgent action to ensure that risks to people were assessed and mitigated. The manager advised they would review people's care plans and risk assessments, beginning with people highlighted during the inspection.

●There was a strong smell of urine in some people's rooms. We discussed this with the management team who said they would seek GP reviews for those people to check for infection. Following the inspection, the operations assistant told us the whole home would be having a deep clean.

● Environmental risks were not always assessed and mitigated. For example, there were fire doors throughout the building, with door guards in place to close in the event of the alarm sounding. One of these had been propped open preventing the door from closing in the event of a fire. There were doors marked 'fire door keep locked' that were not locked. The carpet on the stairs was ripped creating a trip hazard. When we identified this to the manager and operations director they took action to tape the loose carpet.

The provider had not ensured that risks to the health and safety of people had been assessed and mitigated. This was a breach of Regulation 12 Safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People had personal emergency evacuation plans in place reflecting the assistance they would need to leave the building in the event of an emergency.

Staffing and recruitment

● People were not always supported to attract staff attention when needed. Not all people had call bells to

help them communicate to staff that they needed assistance. One person told us, "I just make a noise, that's how I see it, look there is nothing here. (call bell)" When we asked the person if staff responded to them when they called out they said, "Sometimes, not often."

● We found one person calling out from their bedroom whilst distressed. There was no call bell available to this person to use, so they could attract staff support. We located a member of staff to assist the person, who advised us there was a call bell in the person's room. This could not be located. When raised with the manager and operations assistant a call bell was located and provided to the person.

● Another person, who required staff support to move, did not have access to a call bell. This had been placed out of their reach.

● We asked the provider to take urgent action to ensure people could call staff for assistance. The operations assistant assured us that they would ensure all people had access to a call bell that night. For those unable to use a call bell, that they would have checks every 20 to 30 minutes which would be recorded by staff.

● Following the inspection, the operations manager sent us a template of hourly monitoring charts. These had been put in place for people who preferred to stay in their rooms, who were unable to use the call bell system. They told us that they had also addressed with staff the need to respond to people's needs in a timely way. They told us that people were being reassessed to see if they were able to use a call bell to signal to staff that they needed assistance.

● People did not always feel confident using call bells to request staff assistance. One person told us they did not like to use their call bells as staff got cross. Another said, "I can't do that, they will tell me off" when we suggested they use their bell.

● We asked the provider to follow this up. The operations assistant told us he would speak to all people living at Ladymead Care Home to reassure and encourage people to use them.

● People who did have call bells had to wait for staff to support them. The operations assistant told us that call bells should be responded to within five minutes, but people were often waiting in excess of this. For example, one person required staff assistance to use the bathroom. We spoke to them when they had just used the call bell to request staff support. The person waited 30 minutes for staff to assist them.

● We asked the provider to take urgent action to ensure that people's call bells were responded to in a timely way. The manager advised they would be reviewing people's dependency needs and increasing staff as appropriate. We will follow this up at the next inspection.

● The manager told us they were struggling to recruit staff. They said, "The staffing here is awful, I just can't get the staff and I can't leave the people, so I work the shifts. I'm doing days and nights this week. I'm exhausted." .

● People told us that when staff were available to them, they received support. One person said, "They're good the staff, nice if they had a few more." We saw that staff interactions with people were kind and person centred, however they were rushed. One agency member of staff told us, "I wish we had more time."

● The manager told us that some staff had recently left the service so they were using some staff employed through an agency. On the day of the inspection, there was the care manager, one directly employed care worker and three agency care staff providing personal and nursing care to people.

● Whilst agency staff interacted well with people, there was a concern that they did not know people well. For example, agency staff did not know where they could locate people's care plans to find specific information about their care needs.

● We asked the provider to take urgent action to ensure agency staff had information about people. The manager told us that new staff, including agency staff, would have an orientation form to complete at the start of their first shift which would include this information.

The provider had not ensured that sufficient numbers of staff were deployed to meet people's needs. This was a breach of Regulation 18 Staffing of the Health and Social Care Act 2008 (Regulated Activities)

Regulations 2014.

Using medicines safely

● Medicines were not always safely managed. We found that one person had been left a tablet in a medicine pot. Nursing staff, when supporting a person with their medicines, should ensure that all medicines have been taken and swallowed. The member of staff had not followed the provider's medicines policy which stated they should 'Offer the individual a drink and ensure that the tablets are swallowed.' And to 'Never leave medicines or tablet on locker tops or tables if the individual is unable or unwilling to take the medication.'

● People did not receive their medicines in a timely way. On the day of the inspection we were told that medicines had started being given to people at 7:30am. Morning medicines were still being given until 11:20am. One person we spoke to told us that they were in pain. However, as they had not yet received their morning medicine they had not been offered pain relief medicine. We spoke to the member of staff giving medicines about the delay in people receiving their medicines. They told us, "It doesn't matter." The member of staff later completed an incident form about the delayed medicine round.

● Some people were prescribed medicines 'as required' (PRN). The reason for giving these and the effect had not been recorded on the reverse of the medicine administration record (MAR). This meant that, as the time of the medicine being given was not recorded, there was a potential risk of there not being enough time between doses of such medicines. There were clear protocols in place for people prescribed PRN medicines, to inform staff why they would need the medicines, the dose and how often people could take it.

● Records about medicines were not kept accurately. We sampled five people's medicines records over two days and there were gaps in the recording of medicines being given for all five people, so staff could not be sure that people had been given the medicines they had been prescribed.

● People had topical creams stored in lockable metal cupboards in their bedrooms. These cupboards were found to be unlocked. The medicines in them were accessible to anyone in the home.

● Staff competency to give people their medicines had been assessed. However, we observed that staff practice was always in line with the provider's policy.

The provider had not ensured the proper and safe management of medicines. This was a breach of Regulation 12 Safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection

● The prevention and control of infection was not well managed. We saw soiled clothing being left on the floor in the hallway, rather than being placed in a laundry bag. Items given to people were not always clean, for example a bowl left on the side in a person's bedroom had unidentifiable debris stuck to the side.

● Furniture which was wet or unclean was not always cleaned in a timely way. For example, one person had been supported with their continence and was sat in an armchair in their bedroom. However, their soiled bed linen has not been stripped from the bed.

● The operations assistant recognised that the cleanliness of the home needed improvement. Following the inspection, they told us they had arranged for a cleaning company to visit the home and complete a deep clean of all areas.

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 the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same.

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.

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 provider had not ensured that staff recognised, reported and recorded all incidents and safeguarding concerns. The provider had not acted on the duty of candour, to be open and honest with people when something went wrong as incidents had not always been appropriately recorded or reported. For example, a person had made an allegation about staff supporting them to move, not in line with their assessed needs. This had not been recognised and reported as an incident. This meant that discussions with people or their relatives had not taken place and actions to reduce the risk of reoccurrence had not been identified.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

● There was not a registered manager in post at the time of the inspection as required. The manager in post was working their notice and was therefore not planning to register with CQC. The operations assistant advised us that recruitment for a new manager was underway.

● People told us they were concerned about the service. One person said, "I've been here four years, three were good. Last year has been terrible, the new manager came in and he said he was going to sort it out." The person told us that some staff had recently left suddenly and that the activities coordinator had recently left. The manager confirmed this.

● Staff did not always protect people's confidentiality. For example, one person was told that staff would be delayed coming to support them because another, named, resident had 'had an accident'.

● The service were using staff from an agency, whilst they recruited more permanent staff. Agency staff told us they received an induction to the service and were supported by the nurse and permanent staff. We asked an agency member of staff where we could find care plans for people living in the home, and they did not know. They did not have access to detailed information about people and their care needs.

● Following the inspection, the operations assistant told us they would be basing themselves at the home three or four days a week. They advised that the provider would visit the home regularly to ensure improvements were made and sustained.

● We observed a handover meeting on the morning of the inspection. This included an overview of people's recent presentation and whether they had any appointments or specific needs for the day ahead.

●The provider was displaying the most recent inspection rating within the home.

Continuous learning and improving care

● Quality assurance had not assisted the management team to identify and address the shortfalls found during this inspection. For example, the operations assistant had last completed an audit of care plans, with the sample size of one, in May 2019. This had not assisted the recognition of the issues we found during the inspection.

● Quality assurance audits did not include any way of checking how quickly call bells were responded to. The operations assistant recognised this was an area in need of improvement and made contact with the call bell provider to arrange a way of reporting and monitoring.

● There was not sufficient oversight of accidents and incidents to prevent reoccurrence. When incidents or accidents occurred and were recorded by staff the detail was limited. For example, when people sustained an injury or fell, records did not include an account by any witnesses or the person, or what action had been taken to prevent it happening again. There was no detail recorded of managerial oversight or acknowledgement of the lessons learnt following incidents to prevent reoccurrence.

● The operations assistant recognised that the quality assurance systems were not effective. They told us they would be doing audits differently in light of the feedback we gave.

● There had been an incident at the end of 2018 which lead to concerns about the accuracy of records kept and oversight of records. We found that lessons had not been learnt from this and poor record keeping continued.

● Records did not always reflect people's needs. For example, one person was being supported by staff due to a specific health need. Staff told us there was a short-term care plan in place to encourage more fluids for this person. However, the person's care plans did not reflect this, or that they experienced any such difficulty.

● Records did not always reflect people's ongoing needs and how staff should meet these. When people had wounds, there was no guidance available for staff on what treatment for the wound was needed. Records showed the action which had been taken, but not the plan for further treatment, such as when a dressing should be next changed.

● Records held conflicting information about people's risks. For example, one person had specialist guidance about drinking from a speech and language therapist. Staff told us they could drink water at a normal consistency. However, their care plan included conflicting information about this. Records showed that the person could not take fluids orally, needed them thickened and also reflected the guidance given by staff. This meant there was a potential risk that the person would be supported to drink in a way that was assessed as unsafe for them.

● Records were not always completed in a timely way. One person sustained an injury during the inspection. Whilst their injury was attended to and dressed, this was not recognised as an incident by staff. No incident form record was completed. When this was raised with the manager and operations assistant they agreed this should have been documented and said they would address this with staff.

The provider had not ensured good governance. This was a breach of Regulation 17 Good governance of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We asked the provider to take urgent action to ensure records were accurate and consistent. The operations assistant told us they would review people's record and speak to staff about ongoing monitoring. Where there was conflicting information, they told us they would seek clarity with health care professionals and make staff aware of any changes through handover.

● The operations assistant told us that they would be shortly moving to an electronic care planning system, which they saw as a way of improving record keeping and management of risk. They assured us that this change would not impact on the immediate improvements required.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● There was a suggestion box available, so that people, their relatives and staff could suggest improvements to the service. Meetings were held with people and surveys had been sent to monitor satisfaction.

Working in partnership with others

● Staff worked in partnership with other professionals. For example, we saw the GP visited people during the inspection.

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 ensured that risks to the health and safety of people had been assessed and mitigated. The provider had not ensured the proper and safe management of medicines.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider had not ensured people were protected from abuse and improper treatment.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not ensured good governance. This

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had not ensured that sufficient numbers of staff were deployed to meet people's needs.