# Larchwood Care Homes (South) Limited

# The Old Rectory

## Inspection report

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18 July 2016

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## Ratings

| | |
|---|---|
| Overall rating for this service | Inadequate |

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

# Summary of findings

## Overall summary

The Old Rectory is a care home that provides accommodation and personal care for up to 60 older people including care and support for people living with a diagnosed dementia. There were 41 people in the service when we inspected on 14 and 18 July 2016. This was an unannounced inspection.

The registered manager was on leave at the time of inspection and an interim manager was in post. 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.

There was not a culture in the service which promoted a holistic approach to people's care to ensure all physical, mental and emotional needs were being met. Robust and sustainable audit and monitoring systems were not in place to ensure that the quality of care was consistently assessed, monitored and improved

Quality assurance systems had failed to identify the issues we identified during our inspection. The provider had failed to demonstrate that there were sufficient financial or practical resources to drive forward improvements and for these to be sustained.

There were not enough staff on duty to meet people's care and support needs. People told us that they often had to wait for assistance when using their call bell. There were a high incidence of falls in the service and we were concerned that at times this was due to a lack of staff being available.

People were at risk due to poor monitoring of environmental factors and essential maintenance not taking place when needed. Risks to people injuring themselves or others were not always appropriately managed.

People's medicines were not being managed effectively to protect them from the associated risks of not receiving prescribed medicines. Staff had not been proactive in seeking professional advice when there were concerns relating to peoples medicines.

The provider had not ensured the service was being run in a manner that promoted a caring and respectful culture. Although staff were attentive and caring in their interactions with people, they were not supporting people in a consistent and planned way.

Staff had not always taken appropriate action to protect people who had conditions which may put them at risk. They did not always respond appropriately and in a timely manner to all of people's needs.

Care plans were lacking in information to assist staff in meeting the specific needs of people living with dementia. There was little detail to guide staff how to support people with the things that interest them,

details of social activities they enjoyed or details of their life history and people of importance to them.

Staff were aware of their responsibilities with regard to safeguarding people from abuse and knew how to report concerns. However, they did not recognise or understand the wider aspects of safeguarding people from risk as identified in this report.□

Training and development was not sufficient in some areas to show that people's healthcare conditions were fully understood by staff. Records showed that where there had been cause for concern regarding the conduct of staff there had been little or no action taken.

Staff demonstrated a lack of knowledge regarding the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS.) However, staff understood the importance of gaining people's consent and we observed that they asked people's permission before they provided any support or care.

Relatives had been updated regarding recent changes and asked for their opinion. However, there had not been the same opportunity for the people living at service.

During this inspection we identified a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special Measures'.
The service will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key
question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their 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?

**Inadequate**

The service was not safe.

There were not enough staff on duty or deployed effectively to meet people's care and support needs.

Risks to people injuring themselves or others were not appropriately managed.

There was poor monitoring of the environment and essential maintenance to ensure risks to people were minimised.

People's medicines were not being managed effectively.

### Is the service effective?

**Inadequate**

The service was not effective.

Staff training and development was not sufficient and did not always reflect the needs of people being cared for.

People were supported to maintain access to appropriate services which ensured they received ongoing healthcare support.

### Is the service caring?

**Requires Improvement**

The service was not consistently caring.

The provider had not ensured the service was being run in a manner that promoted a caring and respectful culture.

Although staff were attentive and caring in their interactions with people, the routines of the service did not support them to do this in a consistent way.

### Is the service responsive?

**Inadequate**

The service was not responsive.

Care plans were mainly task focused and not personalised to individual's needs. Information was inconsistent and did not

support staff to understand fully what people needed.

Staff did not always respond appropriately and in a timely manner to  people's needs

## Is the service well-led?

**Inadequate**

The service was not well led.

Robust audit and monitoring systems were not in place to ensure that the quality of care was consistently assessed, monitored and improved

The culture in the service did not reflect the provider's own aims and objectives. There was a lack of focus to ensure staff worked together to achieve positive outcomes.

The provider had failed to demonstrate sufficient support to the interim manager to ensure improvements could be made.

# The Old Rectory

**Detailed findings**

## Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This unannounced inspection took place on 14 and 18 July 2016 and was carried out by one inspector, an expert by experience and a specialist advisor. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The specialist advisor had knowledge and experience in dementia care.
Before the inspection the provider completed a Provider Information Return [PIR]. This is a form which asks the provider to give some key information about the service, what the service does well and improvements they plan to make.
We reviewed information we had received about the service such as notifications. This is information about important events which the provider is required to send us by law. We also looked at information sent to us from other stakeholders, for example the local authority and members of the public.

We spoke with the interim manager, deputy manager and regional manager for the service. We also spoke with eight other members of staff, including care and catering staff.

We spoke with 10 people who used the service, six relatives and three health care professionals. We also observed the care and support provided to people and the interaction between staff and people throughout our inspection.

To help us assess how people's care needs were being met we reviewed six people's care records and other information, for example their risk assessments and medicines records.

We looked at three staff personnel files and records relating to the management of the service. This included recruitment, training, and systems for assessing and monitoring the quality of the service.

Inadequate

# Is the service safe?

## Our findings

There were not enough staff on duty to meet people's care and support needs. A person told us about the time they had to wait when using their call bell, "It varies from two or three minutes to not far off an hour. Sometimes I just wait and wait, the mornings are the worst. I can't always wait that long." A visitor said, "[Staff] don't seem to know everyone, there is a lack of time, they are rushed off their feet."

People were at risk of harm should they try to mobilise independently. A family member said, "There have been occasions when the floor is left unattended. There will be people trying to get up in the lounge and there is no one there." A person told us how they had needed urgent assistance the previous day but had had to wait a considerable amount of time for a member of staff to respond to their need.

On the first day of our inspection staff were looking for a person who was missing when we arrived. They were later found in an unlocked, unoccupied bedroom. Staff were unclear how long they had been missing for. Minutes of staff meetings and our discussions with staff confirmed they felt there were not enough of them on duty in order to meet people's needs in a timely manner.

Adjustments to staffing levels had not been made when risks increased due to the failure of the fire alarm system. On the second day of our inspection, the fire alarm had been out of operation for a period over 24 hours. The system was only partly fixed and although smoke detectors were operational, internal and external doors remained unsecure. This was not fully resolved for another two days. People told us that other people who lived in the service walked around the building at night, often coming into others' bedrooms. They told us that staff did not always notice this. No additional staff had been made available during this time and there was an unassessed risk that staff would be unable to sufficiently monitor where people were throughout the night to ensure people safety.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Risks to people were not fully assessed to protect people as far as possible. For example staff delayed reporting for a day that a person who had epilepsy, had experienced a seizure. It was recorded in the persons daily notes that, "[Person] is quite stiff today following [their] seizure yesterday." Records did not demonstrate what action (if any) had been taken at the time, how the person was being monitored (in case of a reoccurrence or delayed impact) or how this incident had influenced the way care was being provided. A lack of medical intervention or any additional support did not fully protect the person. Where people were using bed rails, no risk assessments were in place to demonstrate their suitability and safety. It was not always clear why the rails were in use and if the risks had not been fully considered or actions documented as to how the risks would be minimised. Equipment such as hoists and other moving and handling equipment were stored in unlocked bathrooms which could cause harm to people if they attempted to use these inappropriately.

People were not always provided with a way of calling for assistance when they needed it. We asked a person how they would call for help as we could not see a call bell in their bedroom. They shrugged their shoulders to indicate they didn't know. A member of staff who entered the room told us, "I don't know where [their] bell is. But we would notice if [they] needed us." No consideration had been given to how this person would be able to request assistance if they were unable to verbally call for help and/or there were no staff nearby.

Essential maintenance was not taking place when needed. A Health and Safety audit carried out on 15 April 2016 showed that several areas had been identified as needing attention, including water quality issues, insufficient lighting levels, uncovered radiators, unsuitable flooring, trip hazards and stairs in poor condition. The action plan was blank and staff could not demonstrate that any of these issues were now resolved. A water systems legionella risk assessment and survey dated 31 March 2016 highlighted 37 required actions to ensure that the water quality was safe. 28 of these were given high priority with an expectation that action be taken within three months. At the time of inspection there was no documentation provided to show any action had been taken. Following inspection the provider told us that testing had been carried out and that required work was due to commence.

People raised concerns with us about the cleanliness of the service. One person told us, 'My commode in here [person's bedroom] has never gone for a deep clean. It's rinsed and wiped, but it needs to be cleaned properly. Sometimes they don't even have time to rinse it well….' A relative explained how they often had to clean their relative's phone, walking frame and commode because they didn't feel these were done satisfactorily. They added that when they visited they made the bed and opened the windows as it was often hot and stuffy in their relative's bedroom.

No bins suitable for the disposal of clinical waste were seen in any of the bathrooms or toilets. A member of staff told us that continence aids had to be bagged up and taken to the sluice room. This practice meant that there was a potential risk of spread of infection.

People were not always receiving their medicines at prescribed times which could be detrimental to their health and well-being. The medicines administration records [MAR] showed they were to be given at 'breakfast, lunch, tea and bed' with no specific times stated. There was no documentation to show if any consideration had been given to the importance of medicines needing to be given at a specific time. For example people with Parkinson's need their medication at particular times to try and avoid associated risks such as falls or disorientation.

Two people had out of stock of medicines prescribed to be administered when required. This included medication for pain relief. The deputy manager was unable to explain why this was the case and told us that they would be receiving a delivery in three days' time. There were no plans in place to address pain relief in the intervening period. We fed this back to the management team who took action to ensure the medication was obtained.

MAR for one person showed they had refused their eye drops every evening for over two months, but had accepted them during the day. Records did not show and staff could not tell us if this situation had been explored or discussed with the persons GP. A relative of another person expressed concern that their relative didn't always receive their eye drops, which needed to be administered four times daily. They told us, "[Relative] gets very anxious about it, and is often a bit worked up when we arrive. We even get phone calls at home about it from [relative].' If people do not receive their medication as prescribed they are placed at potential risk that their condition could deteriorate. Staff had not been proactive in seeking professional

advice when there were concerns relating to peoples medicines.

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

Staff were aware of their responsibilities with regard to safeguarding people from abuse and knew how to report concerns. However, they did not recognise or understand the wider aspects of safeguarding people from risk linked to poor care practices as identified in this report.

Inadequate

# Is the service effective?

## Our findings

There was a lack of effective systems to demonstrate people had enough to drink. None of the fluid charts seen in people's care records showed a target amount to be consumed and where intake was seen to be low there was no documentation to demonstrate if any action being taken. A relative expressed concern about the amounts of fluid that their relative consumed and told us, "[Relative] wouldn't ask for a cup of tea, but I wish [they] had more. [They] have four a day, and that's not enough in my opinion." The interim manager explained that very few people achieved what would be considered an acceptable amount of fluid and a significant number of people's intake was too low. They had plans to address this through staff training and further monitoring. However we remained concerned about this situation in the interim period.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Staff training and development was not sufficient in some areas to show that people's healthcare needs were fully understood and recognised and consistently met by staff. For example, staff cared for people with epilepsy and diabetes but they had not received training about these subjects to enable them to care for them more effectively.

Staff had not been supported to develop and enhance their understanding in order to provide improved quality of care and support to people. Staff told us they had requested training specific to their role and had been promised over a year ago that this would be arranged, however this had still not occurred. As a result they felt unable to fulfil their potential in their role.

The interim manager acknowledged that more training was needed, particularly in relation to dealing with behaviours which could be challenging. A visiting professional spoke to us about the level of understanding which staff had regarding dementia and commented, "I think some people are better trained than others."

Records showed although formal supervision of staff was taking place, where there had been cause for concern regarding the conduct of staff there had been little or no action taken. This meant that there had been a failure to promote good practice and a culture had developed where staff were providing task focussed care and failing to use their initiative to deal with situations as they arose. The interim manager felt that staff were willing to learn given the opportunity and had plans to provide additional training and support in order to assist staff with their learning and development.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as

possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. Records showed that applications had been made under DoLS to the relevant supervisory body, for some people living in the service who did not have capacity to make their own decisions. The interim manager told us there were other people for whom it was likely that a DoLs application would be needed and assessments in relation to this still needed to be completed. For these people, the appropriate safeguards were not in place to ensure that decisions made on their behalf were in their best interests. Staff demonstrated a lack of knowledge regarding the MCA and were unclear how this should affect their practice. They told us that MCA assessments were carried out by senior staff and they didn't get involved. Despite the lack of awareness of MCA and DoLs, we observed that staff asked people's permission before they provided any support or care.

There were mixed views about the food provided. One relative told us, "Food has been a big issue, a big concern. It has improved but it's not to where it should be. They have changed menus recently, there is more fresh than frozen." People told us that they had a choice of food and that alternatives were made available to them if they wanted something different to what was on the menu. A person told us, "If I don't like something I get them to do me an omelette." We observed staff asking a person who had not eaten any of their meal if they would like something else. They explained the different options available and helped them to choose an alternative.

In the Redwood dementia unit, a lack of communication and team working resulted in a chaotic and extremely slow lunch time experience. People were left for a considerable time with no food and one person had to ask three times for a cold drink. Staff assisted one person into the dining area using a wheelchair but a lack of planning meant that they were unable to negotiate the wheelchair between the people already seated. The person had to sit in an easy chair and use a tray table instead. The angle they sat at meant that they struggled to eat independently. This was not a relaxed and dignified experience them.

Peoples nutritional needs had been acknowledged and the cook demonstrated an understanding of people's dietary requirements. They were aware that food needed to be fortified for some people to prevent the risk of malnutrition. The cook told us, "I always put loads of marg in the mash and cream in sauces. The seniors deal with milkshake shots [to supplement and fortify peoples diet.]" We saw that these shots were recorded daily in people's care records.

People had access to health care services and received ongoing health care support where required. Visits from health care professionals had been recorded in people's files. A visiting support worker from the local authority confirmed that, "There are regular contacts with the dieticians, the links with GP's seem to be good."

Requires Improvement

# Is the service caring?

## Our findings

The provider had not ensured the service was being run in a manner that consistently promoted a caring and respectful culture. A visitor told us, "I think they [staff] genuinely do care but it is difficult when they are under pressure." Although people said staff were caring and kind, staff had not been equipped with the appropriate knowledge to help them to understand the needs of people. Care staff were not supporting people in a consistent and planned way. This, therefore, placed people at risk of receiving inappropriate and poor care.

We observed that time spent with people was largely limited to when staff were assisting in some way and was task focussed. A visitor commented, "Sometimes [people] look a bit sorry for themselves. They [staff] don't have time, they are so busy." This demonstrated that although staff were caring, their daily routines did not promote a culture which supported people with all of their physical, psychological and emotional needs.

People told us that they felt that their choices, independence, privacy and dignity was promoted and respected. A person told us, "They treat me very well, they don't tell me what to do. They're very understanding." A visitor said, "They [staff] have always knocked when they've come in room when I've been here." However, there was a lack of importance placed on ensuring peoples records remained confidential. Some people's care records were stored in one of the dining rooms. A senior member of staff confirmed that there had been an issue with confidentiality because care plans were often left out rather than being stored appropriately.

Minutes of relatives meetings showed that they had been updated regarding recent changes and asked for their opinion. However, there had not been the same opportunity for the people living at service. Several people told us that they were never asked for their opinions, and that they could not remember having any resident's meetings. One person told us, "I think this is a good idea, having someone to ask us what we think. No, it doesn't normally happen."

However, people told us that they felt staff mostly listened to what they said and their views were taken into account about how they wished to spend their day. A relative told us, "[Relative] will say, I don't want to get up, they'll go back later to try and encourage [relative]." A member of staff told us that this was something they had been working on and said, "If they want to get up, they get up. If they want to stay, they can but we do encourage them [to get up]. Before, we used to get everyone up as quickly as possible." This demonstrated that when the appropriate support and encouragement was given from the management and provider, staff were able to make changes in order to deliver a better quality of care.

Inadequate

# Is the service responsive?

## Our findings

Care plans were lacking in information to assist staff in meeting the specific needs of people living with dementia. A member of staff told us they didn't think that there was anybody living with dementia on the unit they were working, but the list of people we had been given indicated that there were at least two. There were no details to alert staff to any potential triggers which could upset people or guidance as to how they could support them at these times. There was little detail which could help staff understand people's needs. For example their life history and people of importance in their lives. People's records did not demonstrate how they, and their families if appropriate, had been involved in planning their care. Care plans were mainly task focused and not personalised or centred on individual's needs, wishes, choices and preferences about how they wished their care to be provided and how they chose to live their daily lives. Without these details the service was unable to demonstrate person centred care in a holistic way to ensure people's whole well-being.

A statement at the bottom of assessment forms said they should be completed within 48 hours of admission. However large sections were blank including those entitled anxiety, interaction, thoughts, ability to accept medicines, comprehension, behaviour, breathing, eating and drinking , communication, mobility, maintaining safety, hygiene and sexuality.

Records included inconsistent information. For example, one person who had a pressure ulcer we saw the frequency with which they should be assisted to reposition themselves was recorded differently in three parts of their care records. Without a consistent approach, the person was at risk of their ulcer deteriorating.

Staff did not always respond appropriately and in a timely manner to people's needs. A relative told us how they had needed to point out that a bedroom carpet had been soiled for some time and needed cleaning. They commented, "It shouldn't take someone like me to point it out." A visiting professional said, "Staff don't always use their initiative. There was a [person] whose leg had been injured, there was blood dripping down and no one seemed to notice,"

Attempts had been made to create a dementia friendly environment but the effect was chaotic and its impact had not been fully considered. For example, reminiscence objects were not easily accessible to people, The effect was cluttered rather than therapeutic and staff did not have the time to use these objects to engage with people in a meaningful way. In the Redwood unit we observed that a large television was on very loudly for much of the day which made conversation difficult. It was unclear whether people had chosen the programmes. In another lounge, a television was on with several people watching, but the sound was on mute at the same time as a radio was on playing loud music. No staff explored or considered what people wanted.

The service employed an activities co-ordinator who was keen to arrange activities appropriate to people's needs, interests and wishes. They tried to get people involved but were hindered by the impact of other events in the service. For example, they told us, "This afternoon we should have had a big sing-a-long in the lounge, but the lift is broken, so I've had to do a little bit on each floor." People told us that it was not always

communicated to them what activities were taking place each day so they often missed out. One person said, "We don't get told, or get given a notice about things.".

Some resources which were available were not used effectively. For example there was a themed traditional tea room which was a relaxing space for people to socialise and reminisce together. However, the interim manager told us that it was never used as staff had not been able to find a way to include this into people's daily routines.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

The activities co-ordinator had started to liaised regularly with families to get them involved. A group of relatives had held a gardening day to work on the grounds of the service together. There was a summer fete being planned which families were also involved in organising.

There was a complaints procedure in place which was displayed in the service, and explained how people could raise a complaint. Records of previous complaints showed that they had been investigated and responded to. A relative told us,"[Interim manager] said [they] will be writing to me about the concerns I've raised. They have responded to concerns, once you have mentioned it they get it done." This showed that people were confident that the interim manager would listen and respond to any concerns they raised.

Inadequate

# Is the service well-led?

## Our findings

The provider was failing to ensure that there were robust systems in place to ensure that the quality of care provided was safe and of a consistently good quality. This had led to a lack of effective oversight and governance, to ensure people were living in a safe environment, supported by adequate numbers of staff, competent in their roles and deployed in a way which met people's needs. There was confidence from people, relatives, staff and healthcare professionals in the interim manager. A health care professional told us, "I think [interim manager] is working hard to change things." A relative said, "[Interim manager] seems to be very much on the ball. [They] will listen to you and take on board what you are saying. I've got every faith in [them]. However this did not extend to the provider's senior leadership team who supported the interim manager. Whilst there was an appetite for improvement it lacked focus, direction and drive to achieve the level of quality needed to meet people's fundamental needs.

The provider was not running the service in line with their own aims and objectives which stated that, "They [people] need a home where individuality is emphasised, with staff who have time to give attention to small detail" However staff were not always clear on their roles and responsibilities or how they contributed towards the provider's vision and values. Therefore the service was struggling to demonstrate that it had a positive culture which fully reflected the best interests of the people it served.

The interim manager acknowledged that peoples care records were insufficient and told us they had a planned to address it. However it was unclear who was able to support them with carrying out the task of updating, reviewing and making 41 care records fit for purpose. It was also unclear how long this task would take and how risks would be mitigated while records were being updated.

Audits carried out by senior members of staff had failed to identify the issues we identified during our inspection, including shortfalls relating to medicines, infection control, inconsistencies in care records and the absence of information to be able to support people with all of their physical and psychological needs. This meant the provider had missed opportunities to protect people from the risk of receiving inconsistent, inappropriate or unsafe care.

Following our inspection we asked the provider to submit an action plan detailing how they proposed to address the shortfalls we had identified. The plan submitted gave little details of how the proposed action would impact on people and how the leadership would ensure that any action taken was effective. The response raised further concerns about the level of understanding the provider had about their role and responsibility to ensure effective governance and quality assurance systems. The majority of the actions were recorded as the responsibility of the manager, including monitoring and recruitment. The plan failed to demonstrate sufficient input from the provider including financial and practical resources to support the interim manager to do this work, drive forward improvement so they could be fully embedded and sustained. There was a risk that this would result in continued non-compliance with regulations and poor quality care for people.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations

2014.