

Mr & Mrs Murphy C Hampton and Ms C Hampton

Lakenham Residential 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

Lakenham Residential Care Home is a residential care home providing accommodation and personal care to 23 people in one adapted building at the time of the inspection. The service can support up to 25 people.

People's experience of using this service and what we found

At the time of our inspection, several people were being cared for in their bedrooms because five people had a chest infection, which was not COVID-19 related. They were isolating to prevent the spread of infection. As a result, it took a long time for everyone to receive their meal at lunchtime as staff were having to change how lunch was served, which required a different approach to the deployment of staff. We observed that some people were waiting for their lunch for up to 45 minutes, which resulted in their food being cold and unappetising. We raised our concerns with the manager and provider, who admitted this was not at all acceptable and they would address the shortfalls as a matter of priority. By the second day of our inspection, two warming plates had been ordered to ensure food remained at the right temperature.

On the first day of our inspection, we observed a person in a bedroom a distance away from the others. The door was closed, and they had no call bell so could not be heard if needed assistance. There was no television or radio on for company. The person's legs were not elevated, and they had no covering on their legs or feet and we were unsure when they last had a drink or had eaten. We were unable to establish when they had last been checked on by staff. We raised this with the manager, who informed us that normally the person would spend their days in communal areas, but today this had not happened and that it had been an oversight due to short staffing.

We asked them to address these concerns as a matter of priority, which they agreed to do. We received an email the following day from the provider who had held a meeting with staff about the importance of people being regularly checked and ensuring they have fluids available to them. They also informed us that the person had received appropriate support as cited in daily records. By the second day of our inspection, comfort charts were now in place for staff to complete to ensure regular checks on people in order for their needs to be met in a timely manner.

No one had any pressure damage at the time of our inspection. However, mattress settings were not being checked in line with people's weights to ensure people's skin integrity. As a result, by the second day of our inspection individualised weight charts had been implemented which indicated the setting for the mattress and these checks were added to the comfort charts to ensure people were receiving safe care and support.

Medicines were safely administered. Medicines administration records were appropriately signed by staff when administering a person's medicines. However, we found gaps in the controlled drug book, which require double signatures when these medicines are administered. There were four occasions when this had happened, with only one staff member signing. The deputy manager informed us that they were chasing up and reminding staff to ensure they signed appropriately the administration of controlled drugs.

Audits were undertaken to ensure people were receiving their medicines as prescribed. The checks also ensured medicines remained in date. However, these audits had not picked up the issues we found with the signing of controlled drugs.

We have made a recommendation to further strengthen medicines administration practices in line with best practice guidance.

Staff were recruited safely, and appropriate checks were carried out to protect people from the employment of unsuitable staff. However, despite interviews and discussions regarding gaps in employment history taking place, these were not documented.

We have made a recommendation to further strengthen recruitment practices within the home.

There was a range of quality monitoring systems in place which were used to continually review and improve the service. However, the audits did not pick up on our concerns raised in relation to people not receiving person-centred care which met their needs and reflected their personal preferences, people not receiving care and support in a safe way and medicines management as detailed in the safe domain. These concerns were addressed by the service once we raised them.

A new manager was in post and was developing their skills to become the registered manager. To further develop their skills, they were working with the local authority Quality Assurance Improvement Team (QAIT). The QAIT team offers advice and support to providers to meet the quality standards and requirements of regulators and local authority. This would also enable them to further develop robust audits to ensure the quality and safety of the service.

People told us they felt safe living at Lakenham Residential Care Home, and that staff were kind and caring. Concerns raised with the manager and provider regarding people's specific care and support needs were addressed by the manager and provider in a timely manner.

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.

Staff had received up to date safeguarding training in order for them to understand what good practice is, how to report concerns and keep people safe. Staff knew the procedure to follow if they witnessed abuse. Policies and procedures relating to safeguarding reflected current best practice and provided staff with the relevant details should they wish to raise a concern outside of the organisation.

The management and staff had people's safety and wellbeing as their focus. Risks associated with people's health and wellbeing were assessed prior to admission and on an on-going basis once resident in the home. Where risks were identified, there was guidance in place to reduce the risk of harm. Care plans contained information in line with and addressed people's assessed needs, and how to reduce or prevent them. This enabled clear oversight and enabled changes in a person's physical or mental health to be escalated, including to the community nursing team.

Mental capacity assessments had been undertaken specific to additional measures required to keep people safe. For example, regards to the need for a pressure mat to be in place due to a person's risk of falls.

There was evidence that learning from incidents and investigations took place and appropriate changes

were implemented. For example, when a person's physical health needs had changed, their care plans and risk assessments had been updated and involvement of other health and social care professionals was requested in a timely way.

Staff told us they were short staffed on occasions but were confident it was a safe service. They were doing the best they could to ensure people had their care and support needs met, picking up extra shifts when needed. The provider and manager confirmed they had experienced difficulties with staffing, largely due to staff leaving, recruitment difficulties, last minute staff sickness and staff needing to self-isolate. They were working to address this and provide a safe service. The provider was actively recruiting for staff on an ongoing process via various advertising sources.

We were assured that infection prevention and control measures were sufficient and in line with current UK government guidance.

A system was in place to record complaints. Complaints were acknowledged and responded to in an appropriate time frame and other professionals informed and involved where appropriate.

We continue to receive statutory notifications in relation to safeguarding events and serious injuries in a timely manner.

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 good (published 5 October 2017).

Why we inspected

We had received concerns around new admissions processes and the home's ability to meet people's specific care and support needs. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

We inspected and found there were concerns in relation to person-centred care, safe care and treatment and governance arrangements. Please see the Safe and Well-led sections of this full report.

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. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

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

The overall rating for the service has changed from good to requires improvement This is based on the findings at this inspection. You can see what action we have asked the provider to take at the end of this full report.

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

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?

The service was not always safe.

Details are in our safe findings below.

Requires Improvement ●

Is the service well-led?

The service was not always well-led.

Details are in our well-Led findings below.

Requires Improvement ●

Lakenham Residential 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.

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 on the first day and one inspector on the second day.

Service and service type

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

Notice of inspection

This inspection was unannounced on the first day and announced on the second day.

What we did before the inspection

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 took this into account when we inspected the service and made the judgements in this report. Prior to the inspection we reviewed the information we held about

the service and notifications we had received. A notification is information about important events which the service is required to send us by law.

During the inspection

We spent time observing the interactions between people and staff. We spoke with five people living at Lakenham Residential Care Home and seven members of staff, which included the new manager and provider. We also toured the premises, looked at infection control practices and medicines management.

We reviewed a range of records. This included three people's care records and medication records. We looked at two staff files in relation to recruitment and various policies and procedures were reviewed. A variety of records relating to the management of the service, including specific audits/reports relating to the quality and safety of the service to ensure people received safe care and support specific to their individual needs.

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.

After the inspection

After our visit we sought feedback from relatives, health and social care professionals and staff to obtain their views of the service provided to people. We received information from three additional staff, three relatives and one health and social care professional. We continued to seek clarification from the provider to validate evidence found.

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 good. At this inspection this key question has now deteriorated to 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.

Staffing and recruitment

- At the time of our inspection, several people were being cared for in their bedrooms because five people had a chest infection, which was not COVID-19 related. They were isolating to prevent the spread of infection. As a result, it took a long time for everyone to receive their meal at lunchtime as staff were having to change how lunch was served, which required a different approach to the deployment of staff. All the care staff delivered meals to people in their bedrooms. There were two people eating their lunch in the dining room. We established that normally most people ate in the dining room, so it was easier for people to receive their meals in a timely manner. We observed that some people were waiting for their lunch for up to 45 minutes, which resulted in their food being cold and unappetising. We were told that if need be, food was microwaved to ensure it was at the right temperature for people. However, the microwave was not used at any time during our observations of lunchtime and people received cold food on that day.
- We raised our concerns with the manager and provider, who admitted this was not at all acceptable and they would address the shortfalls as a matter of priority. By the second day of our inspection, two warming plates had been ordered to ensure food remained at the right temperature.

People were not always receiving person-centred care which met their needs and reflected their personal preferences. This was a breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Staff advised they were short staffed on occasions but were confident it was a safe service. They were doing the best they could to ensure people had their care and support needs met, picking up extra shifts when needed.
- The provider and manager confirmed they had experienced difficulties with staffing, largely due to staff leaving, recruitment difficulties, last minute staff sickness and staff needing to self-isolate. They were working to address this and provide a safe service.
- The provider was actively recruiting for staff on an ongoing process via various advertising sources.
- Despite the challenges of staffing, people were able to engage in a range of activities. Activities were on offer at least once a day. Activities included, cooking, ball games, skittles and tennis. Every two weeks there was an events afternoon, which included a pub afternoon, where a local brewery was contacted who lent a beer pump, and non-alcoholic drinks were served. There was also themed bingo. Other examples included, a circus afternoon and significant events were celebrated, such as St Patricks day.
- Staff were recruited safely, and appropriate checks were carried out to protect people from the employment of unsuitable staff. However, despite interviews and discussions taking place regarding any gaps in employment history, these were not documented.

We recommend the provider documents interview questions and answers to further strengthen recruitment practices within the home.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

- On the first day of our inspection, we observed a person in a bedroom a distance away from the others. The door was closed, and they had no call bell so could not be heard if needed assistance. There was no television or radio on for company. The person's legs were not elevated, and they had no covering on their legs or feet and we were unsure when they last had a drink or had eaten. They told us their legs were cold and the manager proceeded to put a blanket over their legs. We were unable to establish when they had last been checked on by staff. We raised this with the manager, who informed us that normally the person would spend their days in communal areas, but today this had not happened and that it had been an oversight due to short staffing. We asked them to address these concerns as a matter of priority, which they agreed to do.
- We received an email the following day from the provider who had held a meeting with staff about the importance of people being regularly checked and ensuring they have fluids available to them. They also informed us that the person had received appropriate support as cited in daily records. By the second day of our inspection, comfort charts were now in place for staff to complete to ensure regular checks on people in order for their needs to be met in a timely manner.
- No one had any pressure damage at the time of our inspection. However, mattress settings were not being checked in line with people's weights to ensure people's skin integrity. As a result, by the second day of our inspection individualised weight charts had been implemented which indicated the setting for the mattress and these checks were added to the comfort charts to ensure people were receiving safe care and support.

People were not always receiving care and support in a safe way. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Risks associated with people's health and wellbeing were assessed prior to admission and on an on-going basis once resident in the home. Where risks were identified, there was guidance in place to reduce the risk of harm. Risk management considered people's physical and mental health needs and measures to manage risk were as least restrictive as possible. For example, where a person was assessed as being at risk of falls prior to admission, there was detailed information to follow to help reduce risks and there was timely involvement of relevant professionals, and monthly fall reviews were undertaken to identify themes if a fall occurred.
- Care plans contained information in line with and addressed people's assessed risks, and how to reduce or prevent them. This enabled clear oversight and enabled changes in a person's physical or mental health to be escalated, including to the community nursing team.
- Mental capacity assessments had been undertaken in relation to specific decisions. For example, where a person required a pressure alarm mat to reduce their risk of falls.
- The management and staff had people's safety and wellbeing as their focus. One staff member commented, "if a person's physical or mental health deteriorated, I would always involve their GP. If they had any falls and if the falls are getting more frequent, I would request a referral to the falls team to ensure we can reduce the person's risk. I would contact the mental health team and they can liaise with GP as well as involving family members."
- Fire safety checks were completed on a daily, weekly, monthly and annual basis by staff employed by the service and by external contractors. Fire alarm, fire extinguishers and electrical equipment checks were completed regularly. Staff had received health and safety and fire safety training to ensure they understood their roles and responsibilities.
- There was evidence that learning from incidents and investigations took place and appropriate changes were implemented. For example, when a person's physical health needs had changed, their care plans and

risk assessments had been updated and involvement of other health and social care professionals was requested in a timely way.

Using medicines safely

- Medicines were safely administered. Medicine's administration records were appropriately signed by staff when administering a person's medicines. However, we found gaps in the controlled drug book, which require double signatures when these medicines are administered. There were four occasions when this had happened, with only one staff member signing. The deputy manager informed us that they were chasing up and reminding staff to ensure they signed appropriately the administration of controlled drugs.
- Audits were undertaken to ensure people were receiving their medicines as prescribed. The checks also ensured medicines remained in date. However, these audits had not picked up the issues we found with the signing of controlled drugs.
- Medicines were kept safely in a locked medicine trolley. The trolley was kept in an orderly way to reduce the possibility of mistakes happening. However, room temperature checks were completed at night and not in the daytime. The trolley was kept in a large, warm room and the validity of the temperature would not have reflected daytimes. The deputy manager agreed to change the time of temperature checks to ensure medicines were being stored at the correct temperature.

We recommend the provider strengthens medicines administration practices in line with best practice guidance.

- Appropriate arrangements were in place for obtaining medicines. The home received people's medicines from a local pharmacy each month. When the home received the medicines, they were checked, and the amount of stock documented to ensure accuracy.
- Staff received medicine training and competency assessments to ensure they were competent to carry out this task.

Systems and processes to safeguard people from the risk of abuse

- Staff had received up to date safeguarding training in order for them to understand what good practice is, how to report concerns and keep people safe.
- Staff knew the procedure to follow if they witnessed abuse. Comments included: "If I suspected abuse had occurred my first port of call would be to see the manager or go to proprietor/owner. Outside of the organisation I would contact the local authority, CQC or the police. We safeguard people in the home by ensuring we have up to date training and also by having the relevant paperwork such as risk assessments in order to keep them safe."
- Policies and procedures relating to safeguarding reflected current best practice and provided staff with the relevant details should they wish to raise a concern outside of the organisation.
- People told us they felt safe living at Lakenham Residential Care Home, and that staff were kind and caring. Comments included: "The staff look after me very well" and "The staff are so caring and kind." A relative commented: "The care is very good. (Relative) has had a few falls due to her condition, we are always kept informed and a physiotherapy referral has been made. They ensure she has all the mobility aids that she needs. The staff are kind and conscientious. The manager is always very approachable. I have no concerns."

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 meeting shielding and social distancing rules.

- 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 accessing testing for people using the service and staff.
- 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.
- We were assured the provider was facilitating visits for people living in the home in accordance with the current guidance.

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 good. At this inspection this key question has now deteriorated to 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

- There was a range of quality monitoring systems in place which were used to continually review and improve the service. The provider had a programme of audits and checks they undertook each year. These audits reviewed people's care plans and risk assessments, incidents and accidents, staffing, medicines, infection control and health and safety. This enabled any trends to be identified to ensure the service was meeting the requirements and needs of people being supported. Where actions were needed, these had been followed up. For example, care plans and risk assessments were updated, and external health professionals were involved where appropriate. However, the audits did not pick up on our concerns raised in relation to people not receiving person-centred care which met their needs and reflected their personal preferences, people not receiving care and support in a safe way and medicines management as detailed in the safe domain.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate safety was effectively managed. This placed people at risk of harm. This is a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- A professional commented: "I haven't got any concerns. I recently met with (deputy manager) who deals with medications at Lakenham and she seems very knowledgeable and person-centred in her role." However, the audits did not pick up on our concerns raised in relation to mattress settings and medicines as detailed in the safe domain. These concerns were addressed by the service once we raised them.
- There was no registered manager in post when we inspected. A new manager was in post and was developing their skills to become the registered manager. To further develop their skills, they were working with the local authority Quality Assurance Improvement Team (QAIT). The QAIT team offers advice and support to providers to meet the quality standards and requirements of regulators and local authority. This would also enable them to further develop robust audits to ensure the quality and safety of the service.
- The service had notified the Care Quality Commission (CQC) in full about any significant events at the service. We use this information to monitor the service and ensure they respond appropriately to keep people safe. The provider had displayed the rating of their previous inspection in the home, which is a legal requirement as part of their registration.

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

- Staff spoke positively about communication as a staff team. Comments included, 'I always feel supported by other staff and management. I have always been able to raise any concerns with no problems and they (management) listen to concerns raised.' Staff confirmed they were kept up to date with things affecting the overall service via team meetings and conversations on an on-going basis. Additional meetings took place on a regular basis as part of the service's handover system which occurred at each shift change.
- The service was open, honest and transparent with people when things went wrong. The management team recognised their responsibilities under the duty of candour requirements and followed the service's policy.
- There were regular opportunities for people, and people that matter to them, to raise issues, concerns and complaints. This was through discussions with them by staff on a regular basis and people having access to complaint forms. The complaints procedure set out the process which would be followed by the provider and included contact details of the provider and the Care Quality Commission. This ensured people were given enough information if they felt they needed to raise a concern or complaint.
- Systems were in place to record complaints. Complaints were acknowledged and responded to in an appropriate time frame and other professionals informed and involved where appropriate.
- We continue to receive statutory notifications in relation to safeguarding events and serious injuries in a timely manner.

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

- People's views and suggestions were taken into account to improve the service. Surveys had been completed by people using the service and relatives. The survey asked specific questions about the standard of the service and the support it gave people. Where suggestions had been made these had been implemented. For example, external work to the home and recruitment of more staff. The manager and provider recognised the importance of continuously improving the service to meet people's individual needs. This included the gathering of people's views to improve the quality and safety of the service and the care being provided.
- The home had received several compliments about the care and support provided by staff. These included: 'We thank you so much for looking after all the residents, you are doing an amazing job' and 'Just to say that you are very much in our thoughts and that we are praying for your protection, your strength and courage in this terrible adversity. Thank you, dear staff, for all that you do and are doing. You are stars.'
- People's equality, diversity and human rights were respected. The service's vision and values centred around the people they supported. The organisation's statement of purpose documented a philosophy of maximising people's life choices, encouraging independence and people having a sense of worth and value. On this inspection we found that the organisation's philosophy was embedded in staff practice at Lakenham Residential Care Home.

Working in partnership with others

- The service worked with other health and social care professionals in line with people's specific needs. Staff commented that communication between other agencies was good and enabled people's needs to be met. Care files showed evidence of care professionals, such as GP's and nurses, working together. Regular reviews took place to ensure people's current and changing needs were being met.

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 9 HSCA RA Regulations 2014 Person-centred care People were not always receiving person-centred care which met their needs and reflected their personal preferences. Regulation 9 (1)
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were not always receiving care and support in a safe way. Regulation 12 (1)
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate safety was effectively managed. This placed people at risk of harm. Regulation 17 (1) (2) (a) (b)