Croft Carehomes Limited

# Laughton Croft Care Home with Nursing

## Inspection report

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## Ratings

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

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

# Summary of findings

## Overall summary

About the service: Laughton Croft Care Home with nursing is located near the town of Gainsborough in Lincolnshire. It is registered to provide care for up to 36 older people or people living with dementia. On the day of our inspection, there were 29 people living in the service. The service had two units, Emerald which was predominately for people who required registered nursing care and Ruby for people living with dementia or a mental health problem.

People's experience of using this service:
Systems and processes were in place to safeguarded people from the risk of abuse, but these were not always effective. People did not always have their risk of harm assessed and reviewed. There were not always sufficient numbers of staff on duty to look after people, especially at weekends. People received their medicine from staff who were not always competent to do so. The service was not clean and some areas were in need of refurbishment and repair. Lessons were not learnt when things went wrong.

There was a lack of effective leadership. The clinical governance systems did not identify and address areas of the service that required improvement.

The service met the characteristics of Inadequate in both areas that we inspected. More information is in the full report.
Rating at last inspection: At our last inspection in October 2016 we rated the service as Good. The inspection report was published on 04 January 2017.

Why we inspected: The inspection was prompted by concerns we had received about the intermittent breakdown of the hot water and central heating boiler. Several areas in Ruby were without heating and hot water. Staff carried open containers of hot water from the kitchen to people's bedrooms and people were provided with portable heaters. We were concerned about the management of risk of trips from trailing electrical appliance cables, contact from hot surfaces, scalds from carrying open containers of hot water in corridors and hypothermia from the lack of heating. In addition, we had received information of concern about a medicine error and about a person who had left the service unsupervised and was found by passers-by on a busy main road. We were concerned about the overall safety of people who lived at the service.

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

## 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.

Details are in our Safe findings below.

### Is the service well-led?

**Inadequate**

The service was not well-led.

Details are in our Well-Led findings below.

# Laughton Croft Care Home with Nursing

**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. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection was prompted in part by concerns we had received in the previous month about the intermittent breakdown of the hot water and central heating boiler in the area of the service called Ruby. Several areas of Ruby were without heating and hot water. These included the kitchen, toilets, bathrooms and bedrooms. In addition, we were told that staff were carrying open containers of hot water from the kitchen water boiler to bedrooms. People were provided with portable heaters with cables trailing on the floor.

The information shared with CQC about the incident indicated potential concerns about the management of risk of trips from trailing electrical appliance cables, contact from hot surfaces, scalds from carrying open containers of hot water in corridors and hypothermia from the lack of heating. This inspection examined those risks.

Inspection team:
The inspection team was made up of one inspector and an assistant inspector.

Service and service type:
Laughton Croft Care Home with Nursing provides residential and/or nursing care to older people, people who misuse drugs and alcohol and people living with a learning disability, mental health problem or dementia.

There was a manager in post. However, they were not registered with the Care Quality Commission. This was because the manager left their post before their application to be registered with CQC was processed. A registered manager and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

What we did:
Before our inspection we gathered and reviewed other information we held about the service such as notifications (events which happened in the service that the provider is required to tell us about) and information that had been sent to us by other agencies including the local authority contracting and safeguarding teams and the local clinical commissioning group.

Due to the short notice of our inspection we did not request a Provider Information Return (PIR). A PIR is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

During our inspection 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 speak with us. We spoke with the manager, one registered nurse, a member of care staff, the cook, the laundry assistant, the maintenance person and four people who lived at the service. We also spoke with one visiting relative.

We looked at a range of records related to the running of and the quality of the service. These included risk assessments and room temperature recordings for the areas affected by the boiler breakdown. Four staff recruitment and induction files, staff training information and arrangements for managing complaints. We looked at the quality assurance audits that the registered manager had completed. We also looked at care plans and daily care records for nine people and medicine administration records for 13 people who lived on Ruby.

Following our inspection, we spoke with the registered provider by telephone and requested additional information about the service. The registered provider told us that work on the boiler would be completed that day. We also requested an action plan, to advise us of the action the provider would take to make immediate improvements to the service.

Inadequate

# Is the service safe?

## Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm

Inadequate: People were not safe and were at risk of avoidable harm. Some regulations were not met.

Systems and processes to safeguard people from the risk of abuse
• We found evidence that people were at risk of neglect. For example, one person was in their bed until late morning. This person had not yet received personal care. Their personal clothing and bedding were soiled with food stains. Their lower body was uncovered. We could see that their incontinence pad and pants were soiled and their legs were bare. There was a piece of toast lying on their bed and a cold cup of tea out of their reach. The television was switched on, but the person was unable to see the screen as the bathroom door was open into the bedroom and obscuring their view. We brought our concerns to the manager's attention, who asked a member of care staff to attend to the person's personal care needs. The person's care plan stated that they required assistance to eat and drink.
• In house systems to safeguard people from the risk of harm were ignored. An external door, leading to the open grounds was propped open with a fire extinguisher. A sign on the door read, "Please ensure door kept locked at all time." This exit door was accessible to people who lived on Ruby. This also highlights that lessons were not learnt from the previous incident when a person had left the service unsupervised.
• We found that recently appointed staff had received safeguarding training as part of their induction. However, the maintenance person, who had been employed by the provider for over three years, told us that they had not received safeguarding training. It is a legal requirement that all staff receive safeguarding training that is relevant and suitable to their role on induction and training should be updated at suitable intervals

Failure to safeguard service users from abuse and improper treatment was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• A recently employed member of care was aware of the signs of abuse. They told us how they would escalate their concerns and would not hesitate to whistleblow to CQC or the police.
• Staff had access to policies and procedures on safeguarding and whistleblowing.

Assessing risk, safety monitoring and management; Using medicines safely
• The manager did not complete a risk assessment when the problems with the boiler were first identified at the beginning of November 2018. We therefore requested a risk assessment prior to our inspection. The risk assessments, dated 29 November 2018 were not personalised and did not identify the level of risk or address the issues to ensure that people, visitors to the service and staff were protected from the risk of burns and scalds. We found that a portable heater in one person's bedroom was too hot to touch. There was a not protective guard or warning notice to alert the person of the risk of contact burns. Another person had a fan heater in their bedroom. We looked at their risk assessment and found it was generic and had another resident's name on it.
• Prior to our inspection we requested that the manager take two hourly room temperature recording of the

premises until the boiler was in good working order. Records showed that the recordings were inconsistent. For example, when we checked records, the last temperature recorded on the day of our inspection it was at 6.25 am that morning. We did not see any thermometers in the service. The manager told us that they only had one thermometer and moved it from room to room. The maintenance person told us that there had been problems with the heating since they switched the boiler on at the end of the summer. A registered nurse said, "It has been a difficult time. The issue of heating has been raised at meetings since the end of the summer." The registered nurse also told us about the impact this had on people who lived at the service and said, "[People] have been pretty upset. They want to be clean. It has been hard for them. We have had ladies crying as they wanted to have baths." A member of care staff told us, "I was working on Ruby and changed the residents in the bathroom as it was warmer than their bedrooms. We had three heaters that had blown as on all the time."

• One person, living with dementia had recently left the service unsupervised and was found by passers-by on a busy main road. Nursing and care staff on duty at the time were unaware that the person had left the premises, until they were safely returned to them by the passer-by. We read the incident investigation notes. Staff had observed that the person was standing at the exit door reading a map, that they were agitated and told staff that they were leaving. The person was known to be at risk of absconding and had a Deprivation of Liberty Safeguards (DoLS) in place as they were at risk of becoming lost and disorientated. The person no longer resides at the service at the request of their family.

• Following the incident, no measures had been put in place to reduce the risk of a reoccurrence, other than to change the key pad code on the door leading from Emerald unit to the reception area. On the day of our inspection, we noted that the front entrance door from the grounds into the reception area was unlocked. A registered nurse told us that the grounds were unsafe, and people could not access them unsupervised. The grounds had open access onto woodland and farmland with water courses running through them. The registered nurse suggested that a perimeter fence would help to keep people safe.

• A similar incident had been reported to CQC in the past. A person had left the service by climbing out of a window. They were found in a nearby bog and brought back to the service by the police.

• The manager completed an accident and incident log once a month. However, they did not have a clear picture of recent events as they had omitted to complete the log for the previous month. We therefore looked at the accident and incident log for October 2018. Eight falls and six incidents had been recorded. However, there was no breakdown of the level of individual risk. We found that when a person experienced a fall that their risk assessment was not updated.

• We walked about Ruby with the manager and identified several environmental hazards. For example, a broken pane of glass on a corridor door was taped up, a fire extinguisher had come loose from the wall and the electrical fuse cupboard was unlocked.

• Portable appliance safety testing (PAT) on several electric items, such as portable heaters and radios had expired; some were due for re-testing three years ago.

• One person did not have a lead from their call buzzer that they could use when in bed to summon assistance from staff. The wall mounted call buzzer was not situated near their bed. The manager told us that the persons was capable of getting out of bed at night if they needed assistance. The manager did not consider the potential risk of harm to the person if they had to call for help at night.

• The manager told us that while there was an issue with the lack of hot water on Ruby, that if a person wanted a bath they were assisted to use the bath on Emerald. However, we found that the bath did not drain and had dirty standing water in it. The bathroom was accessible to people who lived on Emerald. Action had not been taken to assess the risk of preventable accidents or incidents from the standing water.

• There were no systems in place for staff to log any jobs for the maintenance person. We shared our observations of the environment with the maintenance person and they were unaware of the areas in need of attention that we had identified.

● Prior to our inspection we asked the manager to investigate an avoidable medicine error. The medicine error was due to the manager not following the correct procedure when carrying out a pre-admission

assessment in another care setting. The manager had not looked at the person's medicine administration record (MAR chart) or the medicines they were prescribed prior to admission. We noted that the pre-admission assessment required any prescribed medicines associated with 'mental health issues' to be recorded. In response to this the manager had written, 'see MAR sheet'. The person was prescribed medicine for a mental health condition.
• The registered nurse who admitted the person from another care setting did not have a second competent member of staff to check the medicines with them. The registered nurse was responsible for completing a MAR chart, and recorded the medicines sent with the person, rather than the medicines they were prescribed. This resulted in the person receiving a higher than prescribed dose of an antipsychotic medicine.

• When the error was identified the manager and registered nurse did not liaise with the person's GP, or discuss the handover procedure with the previous care provider. The responsibility for this was passed onto the community psychiatric nurse and the investigating safeguarding authority officer.
• We found no evidence following the incident that the registered nurse involved had their competency to manage medicines safely assessed. In addition, this nurse was responsible for assessing the competency of other registered nurses and senior care staff who administered medicines.
• Topical medicines were not correctly labelled. One person had a skin cleansing spray. It did not have the person's name on it and staff had not recoded the date when it was opened.

Failure to suitably assess risks to the health and safety of people who received care and treatment and to do all that was reasonably practical to reduce such risks was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection
● Several areas of the location were not clean and the internal and external environment needed decoration. There was a strong smell of urine in the corridor of Ruby and in individual bedrooms.
• We found broken and damaged furniture in several bedrooms.
• One bedroom had mould in the built-in wardrobe. There had been a leak in the roof space above the wardrobe. A storage area above the wardrobe had been taped shut. This bedroom was occupied and the person could not store their belongings in the wardrobe. We saw that their belongings were in several suitcases and plastic carrier bags on their bedroom floor. Following our inspection, the person was assisted to move to another bedroom.
• This was not an isolated incident. We found mould in another person's en-suite toilet.
• The staff toilet was dirty and there was a risk of cross contamination. We found a build-up of limescale on the sink, the backing tiles were cracked and staff were at risk of injury from a loose toilet seat. The minutes from a relatives meeting held in November 2018, recorded their concerns that they were at risk of slipping off the broken toilet seat.
• The sluice was not fit for purpose. Access to the sink was blocked by a vacuum cleaner and two deep cleaning machines. There were two mop buckets of dirty water sat by the sluice sink. When we enquired about them we were told that these had been used to drain the radiators. The mop buckets had not been used for their intended purpose or cleaned after use. The sluice sink was dirty and there was a build-up of limescale.
• One person had three disposable urinals on their bedside table. The person had drinks and snacks on their table. We found that staff would empty the urinals when they were all full. There were training wires across their bedroom floor from a portable heater, this trip hazard had not been risk assessed. Their bedroom floor was heavily soiled and sticky. Their en-suite toilet was soiled, the sink was dirty and the plug had a build-up of grime. This person had a leaking radiator and there was a plastic container under it to collect water. The manager did not know how long their bedroom had been an infection control risk.
• Staff did not dispose of clinical waste safely. The clinical waste bin in the grounds was not locked and was

overflowing. We saw used personal protective equipment lying on the ground in the garden. In addition, old and soiled mattresses, broken furniture and other household items were on the ground.
• One bathroom was used to store the clean linen trolley, three soiled linen trollies and a wall dispenser for personal protective equipment. There was no domestic or clinical waste bin in the bathroom and staff had deposited used single use gloves and aprons and paper towels on top of the clean linen trolley. The bath was damaged and the bath hoist was heavily soiled with a build-up of grime.
• There were three oxygen cylinders for collection stored at the previously mentioned insecure exit. We brought to the manager's attention that the used oxygen tubing and nasal cannula were remained attached. This imposed an infection control risk to anyone who may pass through this area.

Failure to ensure that the premises and □equipment were clean, suitable for their purpose and properly maintained was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
● We looked at the personal files for four members of staff. We found that references had not been received for a registered nurse. The manager was unable to tell us why the registered nurse had been employed without references. The application form, references and interview record for manager were unavailable in the provider's head office.
•There was a recent high turnover of staff, including the office administrator, care staff and a housekeeper. This had resulted in staff carrying out duties that were not defined by their role. For example, on the afternoon of our inspection, the activity coordinator was working a late shift as a member of care staff.
• At the time of our inspection there were only two registered nurses and two senior care staff employed. Several shifts were covered by agency staff. A member of care staff commented on this and said, "The residents need continuity. They need to know your face."
• The manager told us that one person's relative had recently complained about the lack of care staff to look after their loved one. To reassure the relative, the manager provided them with access to the secure electronic record system for their loved one. This meant that the relative could see when their loved one had received care. However, there was no record that the manager had discussed permitting the relative to have access to their loved one's electronic care records.
•Concerns about staffing levels at the weekend were voiced by another relative.

Failure to establish and operate effective recruitment procedures is a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Learning lessons when things go wrong
• The manager's investigation into the recent medicine error demonstrated that robust processes were not in place to learn lessons from when things went wrong. When asked what actions had been taken to ensure lessons had been learnt, we were advised by the manager that they would ensure an up to date MAR chart on transfer. However, they did not tell us how this would be achieved or who would be accountable.
• We requested a copy of the lessons learnt notes following the medicine incident. However, we were informed by the manager that these had not been necessary. They told us, "I did not blame or take any action with my own staff. It was not their fault."

Inadequate

# 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

Inadequate: There were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care. Some regulations were not met.

Planning and promoting person-centred, high-quality care and support with openness; and how the provider understands and acts on their duty of candour responsibility; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Continuous learning and improving care

● There was a lack of effective leadership. The manager and provider were unaware of the poor standards of care people received, the environmental risks and hazards and the overall maintenance of the service.
• The manager was vague about most aspects of care in the service. The manager was unsure of how many people had a Deprivation of Liberty Safeguards (DoLS) authorisation in place. They were unable to find several documents that we requested to help us inform the outcome of our inspection.
• We noted that the office was disorganised, and there were several unopened items of mail. In addition, we found unopened recorded delivery letters in the policy and procedure folder. These letters contained the conditions of Deprivation of Liberty Safeguards (DoLS) authorisations. These authorisations are legal documents and help to inform the care people receive to keep them safe from harm and abuse
• We noted that the administrator's computer in the office was left unlocked when not in use. There was a risk that confidential and sensitive information could be accessed.
• The manager told us that they carried out a daily walk-about of the service, but did not keep a record of their observations. However, they had not identified the risks and hazards we found, such as the mould in the wardrobe or broken and damaged furniture.
• We spoke with one person who was cared for on a specialised air-flow mattress. The alarm had been sounding for 48 hours as there was fault with the air pressure. We raised this with the manager who told us that a replacement mattress had been delivered the previous day, but staff had not yet got around to replacing the faulty mattress. This meant that the person's skin was at risk of developing pressure damage. The person's care plan did not record the faulty mattress or action staff were to take to rectify the problem.
• We discussed the problem of the boiler with this person. They told us, "I'm fairly comfortable, but it's not the best. It has been cold most of the time, especially in the mornings. They [care staff] give me an extra blanket if out want one."
• We were informed that one bedroom was unoccupied. When we entered the bedroom, there was a stale smell of urine, and personal belongings. The bedroom had been occupied for over a week and the manager was unaware. The wardrobe door was broken and the radiator was damaged with sharp edges. The person was unable to hang their clothes in the wardrobe as it was used to store spare pillows and duvets. The person was incontinent of urine, but was not provided with protective pads as they were waiting to be assessed. There was no personal protective equipment (PPE) in the en-suite that staff could access when

providing personal care. We later observed that there was no PPE in any of the shared toilets or en-suites.
• We looked at the care records for nine people. We noted that one person who moved into in the service in September 2018 did not have care plans to inform staff of their care needs and support. We also found that people who had recently moved into the service had not given their consent to care and treatment, for staff to store and administer their medicines, to share their personal information and to have their photograph taken. Systems were not in place to support staff to provide people with high quality person centred care.
● There were significant weaknesses in the clinical governance practices. The manager had not completed the CQC notification of the medicine incident correctly. They had recorded that the person had been admitted to hospital as an outcome of the error. We later found that this was written in error and the person had not been admitted to hospital.
• Staff had access to policies and procedures. However, the admission policy did not provide guidance on the process for undertaking a pre-admission assessment. We also found that medicine policy did not advise two staff to safely check new medicines into the service.
• The admission assessment document was last reviewed in June 2011 and did not follow current best practice guidelines and legislation. We looked at the assessment for the person involved in the medicine incident. We saw that some sections were completed with little or no detail, the information was inaccurate and were not a true assessment of their physical, social and psychological care needs. Furthermore, the manager omitted to record if the service could meet the person's care and support needs, and did not sign and date the completed document.
• The concerns we identified in the recruitment of the registered nurse had not been identified by the provider or the manager.
• The registration certificate for the previous manager was on display at the entrance to the service, although they were no longer registered with CQC or employed by the service. We asked the current manager to remove the registration certificate as people living at the service or their relatives may find this information misleading and inaccurate. The provider's registration certificate was not on display.
• Some staff had lead roles relevant to their area of interest. Two members of care staff were the infection, prevention and control leads and were supported by the local authority as infection, prevention and control ambassadors. We were told that they shared their new-found knowledge with other staff. We did not find evidence that their knowledge had a positive impact on our walk-about of the service.
• We found that other areas that would have benefited from a lead person did not have one in place. For example, dementia care, safeguarding and the Mental Capacity Act 2005.
• Confidential records were not always securely stored. We found hand written records unattended on a table in the lounge. These records contained personal information about peoples' care and support.
● We found that the service did not always consider people's equality characteristics as identified in the Equality Act 2010. When we asked if anyone living in the service was in a relationship or was lesbian, gay, bi-sexual or transgender, the manager said, "There are no relationships and we don't ask about LBGT on admission. It's not on the form. It's not something you think about with that generation [older people]."
• Written information shared with people was not up to date and did not address their needs. For example, when a person moved into the service they were provided with a copy of the "Information Booklet". However, this was dependent on their reading and cognitive ability. The booklet was not available in alternative formats such as easy-read or languages other than English. The information in the booklet was last updated in December 2015 and referred to a previous manager, a Care Act that had been replaced by the Health and Social Care Act 2008 and the description of the service did not reflect our findings.
• One person did not speak English as their first language. Their communication care plan did not refer to this or record their first language or preferred method of communication.
• The manager held head of department meetings at 11am on a Monday, Wednesday and Friday morning. However, this was not carried out the day before our inspection [Wednesday], as the plumber was visiting. We saw from the minutes of the meetings held on 12, 19 and 31 November 2018 that staff had raised the problems with the boiler. Comments included, "The home is too cold" and "[Manager] to speak with [Name

of director]." The minutes were hand-written and not all meetings were minuted. Staff who attended did not receive a copy of the minutes.
• Staff shared information with each other in the daily diary. This acted as a reminder to staff when a referral was due to be made to a health professional or if a person was due to be weighed. In addition, staff shared information on a shift handover sheet. However, we found the content of this lacked detail about the care and welfare of people, as staff described people as "settled" or "fine".
• We found that staff previously had a communication book to share information with each other. However, this went missing in May 2018 and had not been found. This was a concern as it contained personal information about people who lived in the service.
• A member of staff told us that communication between members of staff was, "awful". They put this down to the use of, "a lot of agency staff".
● Staff were provided with supervision sessions and appraisals to identify their strengths and weaknesses and look at areas for future learning and development. However, we found the approach to this was inconsistent. For example, we noted that a registered nurse had not received an appraisal since May 2016. We looked at their personal file and found that their registration with the Nursing and Midwifery Council (NMC) had expired in February 2016 and its renewal had not been checked by the provider. The manager checked this information at our request and the nurse had valid registration until February 2019.
• Audits were undertaken as part of the provider's governance system and measured the standards and quality of the care people received. We found when an area for improvement was identified, that there was not a relevant action plan that identified who was responsible for actions or a realistic time frame to complete the actions.

Failure to provide systems and processes that assess, monitor and improve the quality of the service is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

• An anonymous concern was shared with us on 28 November 2018 about the lack of hot water and heating in one area of the service. This had been ongoing since 01 November 2018. The manager and registered provider did not notify us until we raised this with the manager on 30 November 2018.

Failure to notify CQC of an event that prevents the service provider's ability to carry on the service safely is a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

• The manager submitted significant issues about the service to the directors once a month. These included CQC notifications, complaints and safeguarding incidents. The director for quality and care visited the service once a week and discussed incidents and events with the manager. The director for care held regular meetings for all mangers employed by the provider to discuss incidents and learn from each other.

•It is a statutory requirement that a provider's latest CQC inspection report is clearly displayed at the service and on their website. This is so that people who lived in the service and those seeking information about the service can be informed of our judgments. The rating from the previous inspection was displayed in the main reception area and on their website

Working in partnership with others
● The provider was a member and director of the Lincolnshire Care Association (LinCA). LinCA provides members with regular newsletters, workshops and networking to enable them to keep up to date with current best practice initiatives. The manager told us that they attended these meetings.