Majesticare (Lashbrook) Limited

Lashbrook House

Inspection report

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17 October 2019

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06 November 2019

Ratings

Overall rating for this service	Requires Improvement
Is the service safe?	**Inadequate**

Summary of findings

Overall summary

About the service
Lashbrook House is a residential care home providing personal and nursing care for up to 46 people aged 65 and over at the time of the inspection. At the time of the inspection there were 41 people using the service.

People's experience of using this service and what we found
The provider had made some improvements to the service. However, not all the requirements of the warning notice had been met. Risks relating to pressure damage and behaviours that may challenge were still not managed effectively to ensure people were safe. Following the inspection the manager took prompt, effective action to address the remaining issues.

Improvements had been made for people who were at risk of choking to ensure risks were managed. High risk medicines were managed effectively and people received these medicines as prescribed.

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

The last rating for this service was requires improvement (published 9 October 2019) when there were multiple breaches of regulations.

Following our last inspection, we served a warning notice on the provider and the registered manager. We required them to be compliant with Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 by 6 September 2019.

Why we inspected
This was a targeted inspection based on the warning notice we served on the provider and the registered manager following our last inspection in relation to Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. CQC are conducting trials of targeted inspections to measure their effectiveness in services where we served a warning notice.

We undertook this targeted inspection to check they now met legal requirements for Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This report only covers our findings in relation to the safe care and treatment in the service. The overall rating for the service has not changed following this targeted inspection and remains requires improvement. This is because we have not assessed all areas of the key questions.

Follow up
Following the inspection we met with the provider to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the 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?

Inadequate

The service was not safe.

Details are in our safe findings below.

Lashbrook House

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. This was a targeted inspection. CQC are conducting trials of this type of inspection to follow up services where CQC have issued a warning notice.

Inspection team
This inspection was carried out by one inspector.

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

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Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection-
We spoke with 2 people who used the service about their experience of the care provided. We spoke with six members of staff including the manager, nurses and care workers.

We reviewed a range of records. This included five people's care records and multiple medication records.

Inadequate

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 inadequate. At this inspection this key question has remained the same. We have not changed the rating as we have not assessed all of this key question area. We will assess all of the key question at the next comprehensive inspection of the service

The purpose of this inspection was to check if the provider had met the requirements of the warning notice in relation to Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found that whilst some improvements had been made the provider had not met all the requirements of the warning notice and were still in breach of the regulation.

The remaining breaches found at our last inspection in this key question will be reviewed at our next scheduled inspection. This is to allow the provider time to make and embed their improvements.

Assessing risk, safety monitoring and management
At our last inspection the provider had failed to ensure risks relating to pressure damage and behaviours that may be seen as challenging were managed effectively. At this inspection we found these risks around behaviour and pressure damage continued to not be managed safely.
• Systems in place to support people who were assessed as at risk of pressure damage were not always effective. One person was at high risk of pressure damage. The person's records identified the person had a pressure sore. There was no information relating to how the pressure sore was being managed. Guidance relating to managing the risk of further pressure damage was not being followed.
• Where people were at risk due to behaviours that may challenge, there were not always effective systems in place to ensure the risks were managed. One person's records showed they could become anxious. The care plan guided staff in how to support the person. However, records showed there had been two incidents where people were at risk due to the person's behaviour. No action had been taken to analyse the triggers of the incidents and no investigation had been completed.

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

• Following the inspection, the manager took prompt action to address the issues found. Immediate steps were taken to review all pressure equipment in the service and ensure it was set appropriately for individuals. Health professionals were contacted for advice and guidance relating to the pressure damage identified.
• The manager raised safeguarding alert in relation to the risk of harm to people as a result of behaviours that challenge. Health and social care professionals were involved in reviewing people's care to ensure their behaviour was being appropriately managed and to offer support and guidance to staff.
• Risks related to choking had been reassessed and there were clear plans in place to guide staff in how to support people. This included guidance in relation to the International Dysphagia Diet Standardisation

Initiative (IDDSI) to ensure guidance was in line with current best practice. There was photographic guidance for staff in how to position people to reduce the risk of choking and clear information relating to the action to take if a person was choking. The service had contacted Speech and Language Therapy (SALT) to review people's needs and ensure the information was accurate and up to date. Staff knew the support people required. People received food and drink in line with their care plans.

Using medicines safely
At the last inspection the provider had failed to ensure high risk medicines were managed safely. At this inspection we found improvements had been made.
• People's care plans contained information to guide staff in how to monitor and manage side effects of high-risk medicines. For example, one person was prescribed medicine to control diabetes. The care plan contained details relating to this medicine and possible effects of the medicine on the person. Care plans also included patient information leaflets and guidance on the signs and symptoms relating to a deterioration of the health condition.
• Where people were prescribed medicines that required administration at specific times, there was information in care plans detailing the prescribed intervals required. Care plans also included information relating to the reason for the time specific nature of the medicine and the possible impact of not administering the medicine in line with the guidance. Medicine administration records (MAR) for these medicines showed the medicines were administered at consistent times.