Farrington Care Homes Limited

# Lyme Regis Nursing Home

## Inspection report

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Date of inspection visit:
05 April 2023
11 April 2023

Date of publication:
06 June 2023

## 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
Lyme Regis Nursing Home is a residential care home providing personal and nursing care to up to 27 people. The service provides support to older people with a range of nursing needs; some of the people living in the home are living with dementia. At the time of our inspection there were 23 people using the service.

People's experience of using this service and what we found
The home had recently had a change of manager. A new manager started their employment on the second day of our inspection. They were visiting the home on our first visit. The new manager spent time meeting people and modelling good person centred care during our visits.

People were not always supported to have maximum choice and control of their lives and staff did not always supported people in the least restrictive way possible and in their best interests; despite the policies and systems in the service supporting this practice. We have made a recommendation about the implementation of the Mental Capacity Act (MCA) code of practice.

A program of audits had been developed and completed. However, these audits and the oversight in place had not identified all the areas of concern identified during our inspection. Areas for development that had been identified and addressed previously had not been maintained.

Environmental risks were not always managed sufficiently to protect people. Fire doors were not working effectively at the start of our inspection and some parts of the home were not clean and secure. The manager and provider were responsive to our concerns. Risks to people were regularly reviewed. However, we identified some risks had not been assessed appropriately and the oversight of risks associated with safe eating and drinking was not sufficient. We also identified specific risks to people due to care plans not being followed. We heard from people who had been distressed by the way risks were managed. The manager and clinical lead began to address these issues during our inspection.

There were enough safely recruited staff to meet people's needs, we did note the communal area was sometimes not supervised by staff when people were spending time there.

People received their medicines safely. Accidents and incidents were managed appropriately. Each accident or incident was reviewed by the clinical lead to ensure staff had taken appropriate action.

People were supported by staff who had received safeguarding training and understood how to report concerns. Two people raised concerns with us about situations that had caused them distress. We shared these with the new manager, and they responded to these appropriately.

People and their relatives were positive about the home and the way staff cared for people.

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

Rating at last inspection
The last rating for this service was requires improvement (published August 2022).

Why we inspected
We undertook a targeted inspection to follow up on specific concerns which we had received about the service. The inspection was prompted in part due to concerns received about consistent oversight. A decision was made for us to inspect and examine those risks.

We inspected and found there was a concern with the oversight of eating and drinking and effectiveness of fire doors, so we widened the scope of the inspection to become a focused inspection which included the key questions of safe and well-led. The manager was responsive and put measures in place to reduce risks during our 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.

Enforcement and recommendations
We have identified breaches in relation to the management of risk and the management of the home.

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

We have made a recommendation about the implementation of the Mental Capacity Act Code of Practice.

Follow up
We will meet with the provider following this report being published 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 continue to monitor information we receive about the service, which will help inform when we next inspect.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

**Is the service safe?**

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

**Is the service well-led?**

Requires Improvement

The service was not always well-led.

Details are in well-led safe findings below.

# Lyme Regis Nursing 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 Health and Social Care Act 2008.

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
This inspection was undertaken by two inspectors and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Lyme Regis Nursing Home is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Lyme Regis Nursing Home is a care home with nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was a manager registered with CQC, they had left the service in the two weeks prior to our visit.

Notice of inspection

This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service. We sought feedback from the local authority's quality team. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with 10 people and spoke with, or received feedback from, the relatives of 9 people. We spent time observing the support people received in communal areas. 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.

We also spoke with 11 staff including the manager, the clinical lead, a nurse, and care staff and cooks and maintenance staff.
We received feedback from the quality monitoring team and spoke with a visiting professional.

We reviewed a range of records. This included documentation related to 7 people's care and 9 people's medication records. We looked at a variety of records relating to the management of the service, including training records, incident records, 2 staff recruitment files, a sample of quality assurance processes.

After the inspection visits the manager sent us details of actions they had taken as a result of our feedback.

Requires Improvement

# Is the service safe?

## Our findings

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

At our last inspection we rated this key question requires improvement. The rating for this key question has remained 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.

Assessing risk, safety monitoring and management

● Some environmental risks were not adequately managed. During our first visit, we identified fire doors did not all close automatically. This put people and staff at risk of unnecessary harm. The senior team and provider were responsive to this concern however, one fire door on a person's bedroom did not fully close when the alarms were tested during our second visit.

● The door to a cleaning storeroom, and both the kitchen and kitchen storeroom were not kept closed when unattended. This put people at risk of harm as these rooms all housed equipment or products that could be dangerous. The kitchen door was also left open which meant there was a door out of the building that was not easily observed by staff. This put people who wanted to leave the home but could not leave without supervision at risk of harm.

● Staff in the kitchen did not have up to date information about people's dietary needs. A white board in the kitchen to guide staff about people's diets, did not contain all of people's dietary requirements. A folder of people's dietary requirements in the kitchen was not up to date and contained information about people who were no longer at the home and did not contain everybody's dietary needs. This put people at risk of receiving the wrong diet or consistency.

● Staff who served people their food did not always have up to date information about their dietary needs. A member of staff who was delivering breakfasts had not been made aware that one person was diabetic and as a result their breakfast had not been prioritised.

● Risks were not always mitigated appropriately. Two people had bed rails and told us they did not want them. There was no evidence that their ongoing consent to this restriction had been sought. Two people had no means of calling for staff and could not reach their drinks. Staff told us they had moved the table for one of these people to stop them spilling their drinks. One of these people was thirsty and told us after 10am they had not had a drink since the previous evening. This response was not reflected in their care plans, was a restrictive measure in place without their consent, and put them at risk of dehydration as their fluid intake was not being monitored.

● When people's care plans identified they were at risk of dehydration or not eating sufficiently, recording was not always in place to monitor their intake. This put people at unnecessary risk.

● People had detailed care plans related to risk management, however, these plans did not always reflect the care provided to people or what the care staff should provide to keep people safe. One person needed a modified diet for safety. This had been added to a separate review that also stated the care plan remained relevant. It was not reflected in their care plan and this had placed the person at risk of receiving food and drink that was not safe for them. Another person had a care plan that related to pain management that did not reflect their ongoing difficulties with this, and another person was not being supported with their continence as described in their care plan. This meant their needs were not being reviewed and put them at

risk of harm.
● There was mixed feedback related to some aspects of risk management. One person, and a relative told us they had observed a lack of focus on maintaining mobility. The person told us they sat for too long and the relative told us they were concerned that people seemed to sit all day. We observed people asked to sit down when they stood up, we also noted people were not offered the choice to move to a dining table and ate their lunches in the chairs they were sat in, missing an opportunity for movement in their day. This lack of movement increased the risk that people's mobility might deteriorate.

Systems and processes in place had not protected people from receiving unsafe care and treatment and prevent harm. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The manager and clinical lead were responsive to issues raised during our inspection. They started to address the concerns related to the fire doors immediately and began to update care plans that did not reflect people's needs. They addressed a person's pain management concerns immediately. The manager also introduced champion roles to develop and support staff understanding. We have not been able to check that these changes have been embedded at this inspection.
● Relatives told us they felt the service was safe. One relative commented, "Yes it's all very good and safe. If anything happens to (relative) they inform me straight away. "

Preventing and controlling infection
● We were not assured that the provider was promoting safety through the hygiene practices of the premises. The kitchen and kitchen store were not clean and cleaning records were not completed on our first visit. Records were improved on our second visit but the storeroom remained dirty. One person was left in a bed with a dirty sheet after they had been supported with continence care.

This failure to ensure good hygiene standards contributed to a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The manager took action to improve this following our inspection and an inspection by Environmental Health shortly after our inspection awarded them a 5 star rating. We have not been able to check the sustainability of these actions at this inspection.

● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was supporting people living at the service to minimise the spread of infection.
● 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 responding effectively to risks and signs of infection.
● 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.

Visiting in care homes
● The home was open to visitors in line with current government guidance.
● Relatives were welcomed in the home during our visits. One relative told us, "The (staff) are all kind and polite."

Systems and processes to safeguard people from the risk of abuse

● Most people told us they felt safe and well looked after. A person told us, "They are all very kind."

● Two people told inspectors about experiences that had caused them distress. We shared these with the manager and they responded immediately. One of these situations was reported to safeguarding on the day of our visit.

● Staff had completed safeguarding training. Staff we spoke with understood how to identify and report safeguarding concerns and were confident that action would be taken if they reported any concerns.

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 MCA 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 Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)

● Capacity assessments had been undertaken to determine if people could weigh up information and make specific decisions, these were usually undertaken by a member of staff who worked at night. This did not reflect good practice as it meant people's ability to make decisions was not supported by offering support to do so at varied times of the day. We highlighted this with the new manager and clinical lead who told us they would review this.

● We found the appropriate legal authorisations were in place to deprive a person of their liberty.

We recommend the provider implement good practice guidance on enabling people to make decisions about their care and support in line with the MCA Code of practice.

● Following our inspection we received information that the practice of night staff undertaking MCA assessments that did not relate to the person's care at night had ceased. A group supervision was provided for nursing staff and training sourced for the nurses to ensure their competence. We have not been able to check the effectiveness and sustainability of these actions at this inspection.

Staffing and recruitment

● There were enough staff deployed in the home to meet people's needs although we did note short periods of time where no staff were present in a communal lounge where people were sitting. One person told us, "I just ring the bell and the staff come." Another person commented that they might have to wait but they also explained they understood the pressures being felt by social care nationally.

● Staff rotas showed that a nurse was on duty on all shifts and through the day supported by 4 care staff and at night 2 staff. They were also supported by the clinical lead, activity person, housekeeping, maintenance person, the cook and kitchen assistant. Relatives and people told us they thought the staff had the training they needed.

● Recruitment folders had a checklist, which demonstrated relevant checks were being undertaken to ensure new staff were recruited safely. This included references from previous employers and Disclosure and Barring Service (DBS) checks. These provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

Using medicines safely

● Medicines were safely managed and administered by trained nurses. We observed staff taking time supporting people with their medicines, in a kind and calm way.
● Two people fed back positively about how safely their medicines were managed. One person said, "They are very good with the medicines, I would soon say if they were not."
● Medicine Administration Records (MAR) were signed to confirm whether or not prescribed medicines had been given.
● A laminated sheet in front of each person's MAR had an up to date photograph of the person, any known allergies they had and gave clear guidance about how the person liked to take their medicines.
● Handwritten medicine administration records (MAR) charts were signed and checked by two staff members to ensure the entries were accurate.
● Staff had clear directions on a body map chart about where and what topical cream to apply.
● Medicines were stored safely. There were suitable arrangements for ordering, receiving and disposal of medicines, including medicines requiring extra security.
● Fridge temperatures and the temperature of the medicine room where medicines were stored were monitored to check medicines were stored at recommended temperatures.
● Staff administering medicines wore a red tabard reminding people not to disturb them, to minimize the risk of making a medicine error.
● Where people were prescribed 'as required' medicines, there were individual protocols in place to guide staff in their use.

Learning lessons when things go wrong
● The manager, clinical lead and providers responded immediately to areas we discussed at the inspection.
● Staff were recording accidents, incidents and near misses at the home. The clinical lead reviewed these each month to look to see the actions staff had been taken and whether any lessons had been learnt.
● Some of the concerns identified on this inspection related to risk management issues that had been raised with the providers by both the local authority quality monitoring team and previous CQC inspections. These concerns had been addressed at the time but the improvements had not been sustained.

Requires Improvement

# Is the service well-led?

## Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At our last inspection we rated this key question requires improvement. The rating for this key question has remained 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

- Audits and monitoring processes were not always effective in ensuring the quality and safety of the service and the care people received. An audit had been undertaken of fire doors two days before our first visit that did not find any concerns. The nurses' walk rounds undertaken between our two visits did not identify the need to clean the kitchen storeroom. This walk round had also noted that toilet paper had run out the night before our second visit. This was not addressed until the afternoon when we asked the clinical lead if this had been rectified.
- Some of the shortfalls identified on this inspection had previously been addressed following a local authority quality monitoring visit. The actions had been taken but ongoing monitoring had not been effectively embedded and this had resulted in the issues reoccurring.
- Systems implemented to enhance the quality of people's experience of care were not always effective. One person had been expressing pain regularly to nurses and this had not been picked up as an omission and addressed on two occasions when they had been resident of the day. The oversight of people's care had not highlighted the need to ensure they were supported appropriately to engage in decisions about their care.
- Records were improving but did not always reflect accurately people's experience. One person was recorded as being repositioned at a time when this had not happened.

The provider had failed to ensure robust quality assurance systems were operated effectively to continually assess, monitor and improve the quality and safety provided. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- There was a clear management structure within the home and staff all commented that they felt able to discuss any queries with the clinical lead, they told us the new manager was approachable. Staff all told us they felt very well supported. One member of staff said, "I have felt very welcome here."
- The new manager had visited the home before commencing employment hand had started to highlight areas for development to add to the home's action plan.
- The provider had worked to ensure staffing levels were maintained despite the challenges facing the care sector.
- The provider was involved in the oversight of the home and visited regularly. They had appointed a consultant who had been working to support quality improvement within the home.

● Actions were taken immediately to rectify issues identified during the inspection.
● There were oversight systems in place to monitor the improve the quality and safety of the care people received. There were examples of these processes leading to improved quality and safety. Topical medicines were now monitored closely, and this was effective. The oversight of admissions had led to improvements in developing care plans for people when they moved in.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● People, relatives and professionals described a caring staff team, and this was reflected in the way staff spoke about people. We observed a staff member not talking to people when they undertook tasks near them or offering them choice early in our first visit. This was addressed quickly, and we did not see this repeated.
● Relatives and people commented on changes in the management of the home. They were not all clear who was in charge and who they could speak to. We received comments such as, "I don't know who the manager is, and I think there could be some improvements in the management of the home. I have not been informed of any of the changes in management." The new manager and provider were in the process of communicating recent changes. Following the inspection we received a copy of a letter, sent by the provider, introducing the new manager to people living in the home and their families.
● Relatives were happy with the care their loved ones received and made comments such as, "Very welcoming, nurturing, warm, kind and calm."
● During our visits, the new manager spent time with people, observing care provision and modelling person centred practice. This led to positive outcomes for people, and training opportunities for staff during our visits. They also introduced champion roles to help focus staff knowledge and skill development.
● Staff attended regular meetings and a handover meeting at the beginning of their shift to share information about people. They told us this meant they were kept up to date with any changes in people's needs. We observed improvements to this handover process during our inspection.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
● The clinical lead reviewed all accidents and incidents and ensured people and their relatives were kept informed.
● The registered manager and clinical lead had submitted statutory notifications to CQC as required.
● The manager understood their responsibilities regarding duty of candour and took an open and transparent during the inspection process. They, and the clinical lead, acted promptly on the feedback provided and supplied all information requested.

Working in partnership with others
● The manager told us they kept up to date with good practice and we saw examples of this being implemented during our visits.
● The local authority were positive about the responsiveness of the provider and manager to the findings of the inspection.

This section is primarily information for the provider

# Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>The provider did not have systems in place to protect people from receiving unsafe care and treatment and prevent possible avoidable harm or risk of harm. |

**The enforcement action we took:**

We served a warning notice requiring the provider to become compliant with this regulation within a specified time frame.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>The provider had failed to ensure robust quality assurance systems were operated effectively to continually assess, monitor and improve the quality and safety provided. |

**The enforcement action we took:**

We served a warning notice requiring the provider to become compliant with this regulation within a specified time frame.