Larchwood Care Homes (South) Limited

Lauriston House

Inspection report

Lauriston House Nursing Home
Bickley Park Road
Bromley
Kent
BR1 2AZ

Date of inspection visit:
15 March 2016
18 March 2016

Date of publication:
11 May 2016

Ratings

Overall rating for this service	Good

Is the service safe?	Requires Improvement
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

We carried out an unannounced comprehensive inspection of this service on 02 and 03 June 2015. Following that inspection we received concerns in relation to the care delivery and the management of the service. As a result we undertook a focused inspection on 15 and 18 March 2016 to look into those concerns. This report only covers our findings in relation those topics. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Lauriston House on our website at www.cqc.org.uk. As the comprehensive inspection took place more than six months before the current inspection, we have not revised the overall rating for this service.

Lauriston House provides nursing and personal care for up to 39 people, some of whom have dementia. At the time of this inspection the home was providing nursing care and support to 35 people.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

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

People's medicines were not managed safely. Appropriate information was not always available for the safe management of medicines and systems were not always in place for the safe recording of people's medicines. Staff training and competency assessments were not completed for all staff to ensure they had the appropriate skills and knowledge for the safe management of medicines. Medicines errors had not been identified and reported promptly. Systems and processes in place for auditing medicines were not robust in identifying issues to improve on the quality of the service.

CQC is currently considering appropriate regulatory responses to address these breaches in legal requirements. We will report on this at a later date.

Staffing levels were not always appropriate to meet people's needs in a timely manner. The provider had a complaints policy in place however this had not been followed in all cases to ensure that complaints and concerns raised were address appropriately. The provider had monitoring checks in place but these were not effective in identifying the concerns we found at our inspection. Records were not always kept to demonstrate that the care delivery was in line with the care and treatment planned for.

We found that some other areas required improvement. Each person using the service had a care and treatment plan in place which included guidance on how they should be cared for; however relatives felt more could be done to meet people's personal care needs. The provider had a part-time activities

coordinator in post however people and their relatives told us there was not enough to do at the home. There were systems in place to monitor the safety of the premises and equipment used within the home; however this required improvement because faulty equipment was impacting on the care delivery.

People told us they felt safe living at Lauriston House Nursing Home and we found that the provider had safeguarding adults and whistleblowing policies in place and staff were aware of action to take to protect people in their care. There were safe recruitment protocols in place. Assessments were undertaken to identify the level of risk to people and appropriate actions were in place to prevent or mitigate these risks.

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.

People's medicines were not managed safely. Staffing levels were not always appropriate in meeting people's needs in a timely manner.

Staff were aware of their responsibility to safeguard people that they cared for. Risk to people had been identified with relevant action plans to mitigate these risks.

There were safe recruitment protocols in place and there were systems in place to monitor equipment used within the home, however this required improvement.

Is the service responsive?

Requires Improvement

The service was not always responsive.

The provider had a complaints policy in place and people and their relatives knew how to make a complaint. However people's complaints and concerns were not always handled in line with the provider's policy.

There was a part-time activities coordinator in post; however activities available were not always sufficient to meet people's needs.

Each person using the service had a care and treatment plan in place which included guidance on how people should be supported; however relatives felt more could be done to ensure people's personal care needs were met in a timely manner.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

The provider did not always have an effective system in place to assess and monitor the quality of the service and audits did not identify the issues we found at our inspection. Appropriate records were not always being kept of the care delivery including records of monitoring charts.

People could express their views through residents and relatives meetings however relatives told us these meetings were not always effective as it was mostly not advertised with advance notice given therefore only a few relatives attended it.

People were not complimentary of the management team because they felt their views were not taken into consideration.

Lauriston House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008.

This focused inspection took place on 15 and 18 March 2016 and was unannounced. The inspection was carried out in response to information of concerns we had received in relation to the care delivery and the management of the service. The team inspected the service against three of the five key questions we ask about services: is the service safe, is the service responsive and is the service well-led.

Before the inspection, we reviewed information we held about the service including complaints, safeguarding, whistleblowing and any notifications the provider had sent us. A notification is information about important events which the provider is required to send us by law. We also contacted the local authority to obtain their views about the home.

The inspection team consisted of two inspectors on both days of the inspection. At the inspection, we spoke with nine people using the service and 10 relatives. We interviewed nine staff in total including the registered manager, four registered trained nurses, two care workers, one domestic staff and an activities coordinator. The area manager was also present at our feedback session on the first day of the inspection. We looked at seven care plans and we looked at records relating to staff recruitment, training and competency assessment for the safe management of medicines. We also looked at other records used in the management of the service such as policies and procedures, audits, residents and relatives meetings, staff rota, weekly activities planner, health and safety and equipment maintenance records and the complaints log.

Requires Improvement

Is the service safe?

Our findings

People's medicines were not managed safely. Staff told us that only trained registered nurses administer medicines to people using the service. The registered manager informed us that all staff had received medicines training. Training records for staff authorised to administer medicines showed that four of eight staff had received medicines training in 2015. A training matrix showed only 44% of staff were compliant with medicines training. Medicines competencies for staff were also not undertaken in line with the provider's annual policy. Competency assessments were last completed by staff in 2013. Therefore staff were not appropriately supported to manage medicines safely.

Medicines were not administered safely. We found four medication administration records (MAR) that were photocopied and handwritten and the signature section was not legible and blackened-out due to the poor quality of the photocopied charts which meant staff could not see if medicines were signed for as given. The handwritten MAR charts were also not clear and did not provide instructions for staff on when to administer these medicines. The provider's medicines policy stated, "Where a printed MAR sheet is not possible the nurse will update the Service Users MAR Sheet as necessary ensuring it includes the instructions from the prescription and is signed and dated. A second person must sign the MAR to witness the change made and check the details are correct to match the prescription." The handwritten MAR charts were signed by only one member of staff which showed that staff were not following the provider's policy.

People were at risk of receiving medicines inappropriately due to the lack of information. For example, a person's care plan stated that their medicines were required to be crushed due to swallowing difficulties. We reviewed the person's MAR chart and found that there were no instructions recorded for staff to crush their tablets. In another instance, a person's MAR chart stated they should have pain relieving injections; however there were no instructions about when this should be administered.

We checked the balances of medicines available against the MAR charts on both floors and we found a medication error which had not been reported. The medicines were signed for as given but were still in the container and this had not been identified and reported. This meant that people were at risk of not receiving their medicines as prescribed by healthcare professionals.

Medicines audits undertaken in January and March 2016 had failed to identify the issues we found at our inspection such as the lack of information on administering medicines safely. Therefore the processes in place to mitigate risk were not adequate in ensuring that people's medicines were managed safely.

These issues were a breach of Regulation 12 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

We looked at the medicines folders for the home which were clearly set out and easy to follow. They included individual medication administration records (MAR) for people using the service, their photographs, details of their GP, information about their health conditions and any allergies. The majority of

medicines were administered to people using a monitored dosage system (blister packs) supplied by a local pharmacist.

People and visiting relatives told us they felt there should be more staff on each shift for people's needs to be met in a timely manner. One person said, "They get me up late." Another person told us, "They are short of staff. Yesterday it was 11am before I got help to wash and dress". Another person commented, "Staff say do this do that and I can't keep up. Staff are off hand and people don't talk to you… all a rush!" Another person said, "Some carers are inpatient because they have too much to do and can be a bit abrupt." A relative commented, "Sometimes I do hear the bell ringing and you can see that the staff are off on their feet…there never seem to be enough staff." Another relative said, "Staffing is the main issue here. There have been times when only two carers are on shift."

There were two floors to the home, the ground floor and the garden suite. The registered manager told us the four carers and a trained nurse worked on the ground floor and the garden suite was managed by three carers and a trained nurse and in addition an administrative staff. We looked at the staffing rota and found that the numbers of staff planned to be on shift matched the number available on the first day of inspection. However, on our second day of inspection, the ground floor was managed by only three carers and a trained nurse instead of four carers and a trained nurse and there was no administrative staff on duty. The registered manager told us another member staff was meant to start at 11a.m.; however we were informed that the staff member due to attend at 11a.m. was only booked to undertake "paperwork only" not to provide care and support to people. All staff members told us they felt there should be more staff on duty. They said that the morning shifts were busy and staff did not get their breaks. They told us that people were frequently late having their breakfast and getting out of bed in the morning.

We asked the registered manager how their staffing levels were calculated. They told us, "We have the required numbers, the ratio we have is one [staff] to five [residents]…this is the guidance even in hospitals." They were unable to tell us if people's dependency level was taken into consideration when planning the numbers of staff or shift patterns to ensure people's needs were met in a timely manner.

We found that staffing levels were impacting on the care and support people received. For example on the garden suite eight out of 17 people needed support with meals and six were non mobile which meant it took staff a longer time to meet people's needs. On our first day of the inspection we observed people were being supported to have breakfast at 11 a.m. Staff informed us lunch was planned for 12.30 p.m. and people had started to congregate from 12 noon, however some people did not receive their lunch until 2.00 p.m. and staff told us this was their "usual routine" because of the staffing levels. People's care plans did not record that they preferred to have a late breakfast or lunch. In another instance a relative arrived to take their loved one out at 11.30 a.m. and told us, "It's concerning she is still in bed at this time." Also staff informed us that one person went out every Friday for a social event and was transported to the location by the provider's own transport system. We found that the person refused to go out on that day because they were not supported to be ready before their transport arrived. A care plan we looked at stated a person's finger nails should be cut by trained nurses and a staff member we spoke with confirmed this but told us there was never enough time to support the person with this. On the second day of our inspection, we noted that a person's call bell rang for 5 minutes 53 seconds before it was answered. This meant that the staffing arrangements in place were not meeting people's needs in a timely manner.

The registered manager informed us that vacant shifts were first offered to permanent staff and then to the bank staff. They told us that agency staff were never used. Staff confirmed this and told us they that permanent staff covered all the vacant shifts. Staff also said they felt more permanent staff were required as there were times that they experienced staff shortages. These issues showed that the staffing arrangements

in place were not reviewed continuously and adapted to respond to the changing needs and circumstances of people using the service.

These issues were a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People using the service told us they felt safe and relatives said they felt their loved ones were safe living at the home. The provider had safeguarding and whistleblowing policy and procedures in place. All staff said they had received safeguarding training and were aware of the whistleblowing procedure. Staff said they could raise any concerns with the manager. We saw whistleblowing information displayed on the staff notice board to ensure information was easily accessible when required.

Assessments were conducted to identify the level of risk to people's care needs. Risk to people had been identified in areas such as falls, skin integrity and pain. Risk assessments were used to develop care plans which included relevant guidance for staff on how to prevent or minimise the risks. For example where people were at risk of poor skin integrity, appropriate equipment was in place for the prevention of pressure ulcers and these were monitored daily by the nursing team. People's weight was monitored each month and daily food and fluid charts were in place where risk assessments had identified a risk of poor nutrition or hydration.

There were safe recruitment protocols in place. Staff told us they went through recruitment and selection process before they started working at the home. Staff recruitment records contained completed application forms, two references, criminal records checks, proof of identification and evidence of the right to work in the United Kingdom were in place to reduce the risk of unsuitable staff being employed.

There were systems in place to monitor the safety of the premises and equipment used within the home. Weekly fire tests and checks were carried out to ensure equipment was working. Legionella tests had also been carried out to ensure the water supply was safe for use. However we found that the home had one lift out of use and the working lift had a faulty call button which meant the lift could not be called from the lower floor or the garden suite. Staff told us the lift had been "out of order for a long time" and that it was repaired about three weeks ago but the faulty call button was not detected. The home had two standing hoists but one was faulty hence one standing hoist was being transported between both floors. On the second day of our inspection we found that the call bell system was not working on the garden suite and staff were not aware of this. We brought these issues to the attention of the registered and they told us all faulty equipment had been reported and showed us documentation to confirm this. However, these issues required improvement as faulty equipment was impacting on the care and support people received.

Requires Improvement

Is the service responsive?

Our findings

People and their relatives told us they knew how to make a complaint if they were not happy with the quality of the service provided. One person said, "I will speak to the staff." Another person commented, "I will speak with the manager". Relatives told us they knew how to make a complaint however their complaints were not listened to or acted upon.

The provider had a complaints policy in place which included the complaints procedure, recordings, timescales, investigations and appeals. The registered manager informed us that they had received few complaints from people using the service and their relatives. The complaints log showed that where relatives had made written complaints to the provider, their complaints were responded to. However people's verbal complaints and concerns were not recorded and acted upon in line with the provider's complaints policy.

Visiting relatives told us that they had made verbal complaints to the manager and these were not addressed. For example a relative told us they had complained to the manager about the cleanliness of the cups at the home. They told us they had not received any response from the manager and the cleanliness of the cups had not changed. The registered manager informed us they recalled this incident and did not regard it as a complaint because they took immediate action to ensure all the cups were washed by kitchen staff. The area manager confirmed that the registered manager had not followed the provider's complaint procedure by either recording or informing the complainant of any actions they had taken or planned to take. Another relative sent us e-mail correspondences they had sent the registered manager which demonstrated that not all issues raised with the registered manager in their e-mail had been acted upon in line with the complaints policy.

These issues were a breach of regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

People and their relatives told us that the activities provided at the home were not sufficient in meeting their needs. One person said, "The activities are really not suitable for me, they are like for children." Another person said, "I would have gone out if something interesting was happening, but this is why I am in my room at this time." Relatives told us that more could be done to stimulate people appropriately. One relative said, "The activities are appalling because there is one activities coordinator who is part-time for all residents." Another relative said, "The activities coordinator is very good but struggles to support every one as there are so many people confined in their room."

The provider had a part-time activity coordinator in post who was responsible for organising activities for all the people living at the home. A weekly activities programme included sing along, quiz, home baking, walks and art and crafts. We saw that eight people engaged in a board game and people were engaged in socialising and engaging with each other. However, people who could not mobilise and were confined to

their rooms told us they sometimes felt lonely as there was nothing to do and no one to talk to. One person said, "I did not want a television, I want to talk to people, I feel lonely, nobody comes in here very much to chat with me." A relative commented, "Staff have no time for stimulation of people." Staff said they needed more time to talk to residents. In the morning we saw people sitting idle either in the communal areas or their bedrooms without any effective stimulating activities to engage them.

The activities coordinator told us additional support would be appreciated as there were many residents that needed one-to-one support because they were confined in their rooms due to their health conditions. We found that although there were some level of activities being provided this did not meet people's needs and required improvement.

Each person using the service had a care and support plan in place which covered areas such as personal care, nutrition, mobility and dexterity. People's care plan included guidance for staff on how to support them to ensure their needs were met and people's care plans were reviewed monthly to ensure their changing needs were met. For example where people had a bath or a shower, this was clearly recorded to demonstrate the care and support they had received. However, some relatives felt more could be done to improve people's personal care needs for example in areas such as fingernail care and regular change of clothing.

Requires Improvement

Is the service well-led?

Our findings

The provider had systems in place to monitor the quality of the service but these were not consistently effective because the systems in place did not identify the issues we found at our inspection in areas such as safe management of medicines, staffing and complaints.

Relatives told us that the level of cleanliness at the home and equipment had to be improved. The provider had domestic staff in place responsible for the cleanliness of the home. However we found that some areas of the home were not clean including the kitchen area on the ground floor, the medicines room and some people's bedrooms. For example we saw food particles in a person's bedroom and their relatives told us that was always the case. We noted that the plastic cups or beakers used to serve people drinks although clean had discoloured. We brought all these issues to the attention of the registered manager and they told us that although we found some aspects of the home unclean their view was that the home was generally clean and without odour compared to other nursing homes. We requested a copy of the home's cleaning schedule but were not provided with one. The provider was unable to demonstrate to us any monitoring checks that had been put in place to ensure that the cleanliness of the home was maintained or improved at all times.

These issues were a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

We found at least eight call bells that were not in reach of people using the service. Call bell risk assessments were part of the care planning process. Where it was considered unsafe for some people to use the call bell, appropriate measures were included in their care plans to ensure their needs were met. For example, two people's care records stated that hourly checks should be undertaken as they were not able to use the call bells. However, we did not find any records of the hourly checks being completed. We brought these issues to the attention of the registered manager and they told us, the checks were only necessary at night. We did not find any records of hourly check being undertaken at night time either. Therefore the lack of appropriate recording and monitoring of the care delivery puts people at risk of inappropriate care and treatment because their needs may not be met when required.

The provider's quality assurance processes had failed to identify or act on the other concerns we found at inspection, to improve the quality of the service for people. For example, the provider had not monitored the quality of the activities being provided to the home or taken action to improve the quality of the service in respect of the activities offered. The provider had not assured themselves that there were sufficient staff to meet people's needs at all times and taken action to improve the quality of the service.

These issues were also a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

Two relatives meetings were held in 2015 and we were shown a copy of minutes of the residents' and relatives meetings. Discussions included laundry care, meals, activities and refurbishment work. Relatives

told us that these meetings were usually not announced or advance notice given and therefore only a few relatives attended it. In the September 2015 the minutes of the meeting showed that only four relatives attended the meeting with seven apologies and therefore we could not confirm that all relatives were informed in a timely manner and their views sought effectively to improve the quality of the service and this required improvement

At the time of our inspection there was a registered manager in post who had given notice to vacate their post by beginning of April 2016. Relatives knew who the registered manager was and told us they felt the home was not well-led. For example people said communication between the manager and relatives was poor and needed to improve. A relative commented, "The manager is going but they haven't told me… through hearsay I asked him and he said yes." Another relative said" We never see the manager on this floor."

Staff had mixed feedback about the management team. However, all staff agreed they needed more staff support on both floors and also for activities. The local authority told us they felt the service was functioning well however some areas required improvement.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints Effective systems were not in place in identifying, receiving, recording, handling and responding to complaints to ensure people's views were taken into consideration and acted upon. Regulation 16

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have an effective system in place to assess, monitor and improve the quality and safety of the service provided and mitigate the risks relating to the health, safety and welfare of service users. Regulation 17

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing People were put at risk of unsafe care and treatment because adequate staffing arrangements were not in place to ensure their needs were met in a timely manner. Regulation 18

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People who use the service were not protected against the risk of unsafe management of medicines.

The enforcement action we took:

Warning Notice