Valuecare Ltd

Lathbury Manor Care Home

Inspection report

Northampton Road
Lathbury
Newport Pagnell
Buckinghamshire
MK16 8JX

Tel: 01908615245
Website: www.lathburymanor.com

Date of inspection visit:
03 November 2021
04 November 2021

Date of publication:
30 November 2021

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
Lathbury Manor is a residential care home providing personal and nursing care to 27 people aged 65 and over at the time of the inspection. The service can support up to 29 people.

People's experience of using this service and what we found
Quality assurance checks and audits of key areas of the service had lapsed. The main monthly audit completed by the manager did not identify required actions and improvements. The provider could not assure themselves that systems to assess, monitor and improve the quality and safety of the service were undertaken and implemented effectively.

The provider could not assure themselves of the quality and safety of care provision to people living in the service. Records of management oversight of people's care records were inconsistent. This included recording of accident, incident, falls and safeguarding follow up as well as oversight of people's individual care records.

People had a range of care plans and risk assessments in place. Processes to ensure these were reviewed regularly were in place but required strengthening.

Recent high turnover of staff meant a high reliance on agency staff at the time of inspection. This meant people did not always receive care from people who knew them well. However, there were enough staff on shift to ensure people's care needs could be met.

Some areas of poor practice were found with infection prevention and control measures and these were rectified immediately by the provider.

Safe recruitment processes took place and gaps found in staff files were addressed during the inspection. An electronic medicines system was used effectively. People received their medicines safely.

The provider was fully supportive of the inspection process and acknowledged the concerns found. The provider took swift action during and following the inspection to immediately rectify issues they identified, and we brought to their attention. Since the inspection the provider has re-established quality assurance processes which had lapsed, and are committed to ensuring these are embedded and sustained.

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

Rating at last inspection
The last rating for this service was good (published 19 February 2021).

Why we inspected

We received concerns in relation to aspects of people's care, the approach of the manager and high staff turnover. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

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

The overall rating for the service has changed from good to requires improvement. This is based on the findings at this inspection.

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

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to how the service was run and people not always receiving safe care and treatment.

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

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 return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not always safe.	**Requires Improvement**
Is the service well-led? The service was not always well-led.	**Requires Improvement**

Lathbury Manor Care Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was carried out by one inspector 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
Lathbury Manor is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager who was not yet registered with the Care Quality Commission. This means the provider is legally responsible for how the service is run and for the quality and safety of the care provided. The manager was not present during the inspection. Since the inspection the provider has applied to become registered manager of the service.

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. The provider was not asked to complete a provider information return prior to this

inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We used all of this information to plan our inspection.

During the inspection
We spoke with three people living in the service and nine relatives about their experience of the care provided. We spoke with ten members of staff including the provider, deputy manager, senior care staff, care, kitchen and office staff. We also requested and received feedback from some staff via email. 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 reviewed a range of records. This included specific areas of seven people's care and medication records. We looked at three staff files in relation to recruitment. A variety of records relating to the management of the service, including audits and quality assurance checks, were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training and supervision data, and updates on action taken by the provider.

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 the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Systems and processes to safeguard people from the risk of abuse; Assessing risk, safety monitoring and management; Learning lessons when things go wrong

- Systems to safeguard people from the risk of abuse were in place but required strengthening. A tracker to monitor safeguarding incidents was incomplete. This placed people at heightened risk of abuse as robust systems were not in place to record, monitor and review safeguarding incidents.
- When accidents, incidents and falls happened, staff recorded these on accident and incident forms. However, the recording of follow up and review actions was not always effective. It was unclear whether appropriate actions were taken to ensure people's safety and reduce the risk of recurrence.
- The system to regularly review incidents, accidents and falls had lapsed. This meant there was no process in place to analyse if there were any trends or patterns, take actions where necessary and learn lessons if needed.
- People had a range of risk assessments in place to support their safe care, but these were not always updated in a timely manner. For example, a person had developed pressure wounds but their skin integrity risk assessment was still showing as low risk and they had no skin integrity care plan. This meant staff did not always have guidance to support them provide safe care.
- Hospital grab sheets were available, but we observed these were not used in practice. These provided essential basic information about a person and were used to support consistent care, for example when someone was admitted to hospital.
- Health and safety checks were not always undertaken to keep people safe from potential physical harm. For example, we found a wheelchair in front of a fire door, and the fire door covered by a curtain. This would delay exit in the event of an evacuation. The manager had not undertaken weekly fire alarm checks during the previous seven weeks when the usual staff member was unavailable. The provider took immediate action to rectify these issues.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate safety was effectively managed. This placed people at risk of harm. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded immediately during and after the inspection. They took prompt action to review and analyse safeguarding issues and recent accidents, incidents and falls. Follow up action was taken where necessary. During the inspection the provider and deputy manager updated people's care records where any gaps were found and began a full audit to identify all areas which required improvement.

● Staff received training to recognise abuse and protect people from the risk of abuse. People told us they felt safe living in the service. One staff member told us, "Yes people are safe, we make sure of that."
● When people had care needs which required daily monitoring, for example, regular repositioning or filling in food and fluid charts, we saw these were consistently completed by care staff.
● When people's needs changed or new risks emerged, action was taken to ensure people received appropriate care. For example, we saw referrals to the dietitian, falls clinic and memory service were made promptly when required, and their recommendations and advice were followed.
● A 'resident of the day' scheme was in place which meant people's care needs were reviewed and updated on a monthly basis. This helped ensure key issues were identified and monitored regularly.

Staffing and recruitment
● There were sufficient staff available to ensure safe care could be delivered to people. Due to recent staff turnover, there were a higher number of agency staff working in the service. One staff member said, "Every day we have different agency staff who don't know the residents. I find that stressful, so it must be stressful for the residents too." The provider was making all efforts to fill current vacancies.
● Where staff had advised of health issues, which may impact upon their ability to perform their roles, there was no evidence of follow up to consider whether adjustments were needed to ensure they remained well at work. The provider took immediate action when brought to their attention.
● The provider followed safe recruitment practices. This meant checks were carried out to make sure staff were suitable and had the right character and experience for their roles. For example, references with previous employers, and checks on staff identity and if they had any previous criminal convictions.

Using medicines safely
● People received their medicines safely. Medicines were administered by staff who were trained to do so. Protocols were in place for medicine which was administered 'as and when needed' to ensure it was given appropriately.
● Systems were followed for ordering, receiving and storing medicines. An electronic medication system was used which reduced the risk of errors due to the cross checks and safeguards in place. Regular audits took place.
● We identified the pharmacy did not always add specific prescribing instructions to the electronic system for staff to follow. The provider and deputy manager followed this up immediately with the pharmacy during the inspection.

Preventing and controlling infection
● Infection prevention and control audits had lapsed which meant the issues we found had not been identified. This included the visitor sign in process not being consistently effective and the disposal of used PPE not always being safe. The provider took immediate action during the inspection to rectify the issues found.
● We were assured that the provider was meeting shielding and social distancing rules.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was accessing testing for people using the service and staff.
● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
● We were assured the provider was facilitating visits for people living in the home in accordance with the current guidance.

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 the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- Quality assurance and audit processes in some areas of the service were ineffective. A monthly home audit contained scant information without supporting evidence. For example, no infection control audits, mattress checks or evidence of oversight of kitchen, domestic or health and safety/environmental checks were available. The monthly home audit did not identify the issues we found. The provider could not assure themselves that systems to assess, monitor and improve the quality of the service were effective.
- Processes to ensure management oversight of people's care records including risk assessments and care plans, daily monitoring charts, accidents, incidents and falls were in place but not used effectively. The issues we found had not been identified prior to the inspection. This put people at higher risk of unsafe care, or care which did not meet their needs.
- Regular analysis of accidents, incidents and falls had lapsed. This included oversight of tracking of safeguarding referrals, making notifications to CQC, ensuring relatives were informed when an incident occurred, review of investigations and learning lessons when an incident occurred. The provider could not be assured appropriate action was always taken and this placed people at a higher risk of abuse and unsafe care.
- DNACPR (Do Not Attempt Cardiopulmonary Resuscitation) forms were not readily accessible to staff in the event of a medical emergency. Some were in need of a review. The provider took immediate action to rectify this.
- Staff and relatives shared mixed views about the management of the service. We also reviewed the last staff survey results which also contained mixed feedback. One staff member told us, "It's been very hard. I was going to leave. I feel things are going to be brighter. I have confidence [the provider] will take it forward in the right way."
- The provider could not be assured staff were sufficiently supported to perform their roles optimally, particularly when there were a number of newer and agency employees in the service. Levels of staff supervision, which provides the opportunity to review performance and discuss support needed, were lower than the expected levels. Some issues with training had not been identified prior to the inspection. Improvements were needed with the staff induction and oversight of recruitment processes.

We found no evidence that people had been harmed however, people were at risk of harm due to failures in management and provider oversight of the service. This was a breach of regulation 17 (Good governance) of

the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded immediately during and after the inspection. The provider undertook a full audit of all areas of the service to identify issues which required improvements and developed an action plan to support this. The provider acknowledged the concerns found, and has worked at pace with the deputy manager to re-establish and embed effective processes and oversight of the service.

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

- Relatives and/or representatives were not always informed when an incident took place or something went wrong. This was confirmed by feedback we received. One relative told us, "I had a call from the safeguarding team about an incident and I didn't know anything about it, so I called Lathbury."
- Systems were in place to support open and transparent working but were not always used effectively. The provider was committed to re-establishing good practice in this area.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

- Team meetings did not regularly take place for all staff which meant opportunities to discuss issues and receive information were missed. When there was a high turnover of staff it was important to have a forum for information to be shared and discussed. Since the inspection a full team meeting has been held by the provider.
- Meetings for relatives and people living in the service had been limited due to the pandemic restrictions. The provider planned to re-establish these in the near future.
- The management team and staff continued to work in partnership with health professionals involved in monitoring and providing care and treatment for people using the service.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Effective systems were not in place to record and monitor management oversight of people's safe care and treatment. This included individual care records, accident, incident and falls follow up, tracking safeguarding issues, physical safety risks, and infection prevention and control practice.

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 17 HSCA RA Regulations 2014 Good governance The provider could not assure themselves the service was well run. Quality assurance and audit processes to assess the quality of care and drive improvements of the service had lapsed or were not effective.

The enforcement action we took:

We issued a warning notice which gave the provider a short timescale to make improvements.