Care UK Community Partnerships Ltd

Lennox House

Inspection report

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Ratings

Overall rating for this service	Inspected but not rated

Is the service safe?	**Inspected but not rated**

Summary of findings

Overall summary

About the service:
Lennox House is part of the Care UK Community Partnership Company. It provides residential care and nursing care for up to 87 older men and women at purpose-built accommodation in a residential area of North London. At the time of our inspection there were 38 people living at the home.

People's experience of using this service:
We found the provider had made improvements in the specific areas we looked at.

There was evidence of recent effective liaison with the local safeguarding team and the wider multi-disciplinary team. Reports of potential abuse had been referred to the local authority safeguarding team. Relatives gave consistently good feedback about the quality of care. They told us people were safe and protected from avoidable harm.

There were examples of good practice in relation to diabetes care. People received diabetes care that matched with their needs. Those at 'high-risk' of hypoglycaemia (low blood sugar levels) were identified and received targeted interventions. This was also true of pressure ulcer care.

The medicines administration records we reviewed showed people were receiving their medicines as prescribed. Medicines errors were being recorded and investigated. Monthly medication audits were completed. They showed improvement in how medicines were being managed with action plans developed for issues identified.

The provider ensured that lessons were learnt from accidents and incidents. We found that following each untoward event, risk assessments and risk management plans had been reviewed and updated. Actions to reduce the risk of similar incidents and accidents occurring had also been taken.

Infection risks to people using the service had been assessed and managed. The provider had reviewed and harmonised infection prevention and control practices with current guidance.

We noted there had been input from the local authority and the wider Care UK support structure to improve quality of care. This was continuing at the time of the inspection. As a result, it was too early for the provider to be able to demonstrate that these processes were fully embedded and that these improvements could be sustained over time, including when support from the local authority and Care UK was withdrawn. However, it should be noted the recent appointment of a new clinical lead, manager and new permanent staff had been viewed positively by staff. The new manager was described in complimentary terms by staff in relation to his leadership.

Rating at last inspection:
The last rating for this service was inadequate (published 25 March 2020) and there were three breaches of

regulations. At that inspection we identified breaches in relation to the quality and safety of people's care, lack of suitably qualified staff and quality assurance.

Why we inspected:
We undertook this targeted inspection to check on specific concerns we had about the quality and safety of people's care. The overall rating for the service has not changed following this targeted inspection and remains inadequate.

CQC have introduced targeted inspections to follow up on Warning Notices or to check specific concerns. They do not look at an entire key question, only the part of the key question we are specifically concerned about. Targeted inspections do not change the rating from the previous inspection. This is because they do not assess all areas of a key question.

Follow up:
We will continue to monitor information we receive about the service until we 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?

Inspected but not rated

Inspected but not rated.

At our last inspection we rated this key question inadequate. We have not reviewed the rating at this inspection. This is because we only looked at the parts of this key question, we had specific concerns about.

Lennox 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 to check on specific concerns in relation to safe care and treatment.

Inspection team:
The inspection team consisted of three inspectors, one specialist advisor, a medicines inspector and two Experts by Experience, who phoned people's relatives. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service. One inspector visited the site, and another coordinated the inspection from home. A third inspector was on stand-by to assist if needed.

Service and service type:
Lennox 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.

The service did not have a manager registered with the Care Quality Commission.

Notice of inspection:
We gave the service 48 hours' notice of the inspection visit to make sure sufficient arrangements in relation COVID-19 were in place. We also wanted to ensure arrangements were in place for the inspection team to speak with people and their relatives remotely.

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. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key

information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection:
We spoke with 15 relatives of people using the service about their experience of the care provided. We observed care to help us understand the experience of people who could not talk with us. We spoke with 11 members of staff including the provider, manager, operations support manager, deputy manager, senior care workers, care workers and nursing staff.

We reviewed a range of records. This included seven people's medicines records, five protocols for medicines to be taken 'when required', two topical administration charts, covert medicines records, medicines audits, medicines errors and medicines policy. We also looked at multiple care records, which covered a range of areas, including pressure ulcer care, diabetes care and falls.

A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection:
We continued to seek clarification from the provider to validate evidence found. We looked at diabetes care data and quality assurance records. We contacted two professionals who regularly visit the service.

Inspected but not rated

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. We have not changed the rating of this key question, as we have only looked at the part of the key question, we have specific concerns about.

The purpose of this inspection was to check improvements were being made in the specific areas.

We will assess all of the key question at the next comprehensive inspection of the service.

Systems and processes to safeguard people from the risk of abuse
• The provider had developed systems to help protect people from the risk of harm and abuse. The provider acknowledged the systems had not been operated effectively, which meant safeguarding alerts had not always been raised in a timely manner. However, there was evidence that recently the provider had started to work effectively with the local authority safeguarding team to address any historic or new concerns.
• The provider told us there was more effective liaison with the local safeguarding team and the wider multi-disciplinary team. Notably, we found evidence of good partnership working in three recent safeguarding concerns. Reports of potential abuse had been referred to the local authority safeguarding team. In each case immediate action was taken to assess any risk and to enhance the safety of the respective individuals. We had been notified of safeguarding concerns.
• Staff had appropriate knowledge and competencies in relation to safeguarding procedures, including identification of abuse, requirement to report and internal reporting structures. They were aware they could contact the local authority safeguarding team and CQC when needed.
• Relatives gave consistently good feedback about the quality of care. They told us people were safe and protected from avoidable harm. One relative said, "My relative has lived at the home for a few years. We think this is a place of high-quality service and care. There is an open culture. They never hide any problems. They call us if my relative is not feeling well, if she needs new medicines, if they think it would be good to see a GP, or any other professionals. It is reassuring they are on board." This view was repeated by other relatives we spoke with.
• Although we were reassured improvements were being made, it was too early for the provider to be able to demonstrate that these processes were fully embedded and that these improvements could be sustained over time.

Assessing risk, safety monitoring and management
At our last inspection of the service we identified several deficiencies in the provision of diabetes care. These included, inadequate monitoring of blood glucose, which increased the risk of hypoglycaemia (low blood glucose) and hyperglycaemia (raised blood glucose). There were also insufficient communication channels to facilitate specialist input. At this inspection we saw that improvements had been made.

• People with diabetes received diabetes care that matched with their needs. Each person had an individual care plan, agreed between the individual, GP and the provider. This outlined their needs, and included a

nutritional assessment, an assessment of the risk of pressure ulcer development, eye and foot care, and specialist health professional input. We spoke with a healthcare professional who recognised improvements had been made.
• People at 'high-risk' of hypoglycaemia were identified and received targeted interventions. Several approaches were taken to reduce the risk of hypoglycaemia. This included, recognition of specific signs and symptoms, frequent blood glucose monitoring and staff training.
• There were examples of good practice in relation to diabetes care. One person was switched to a nutrition-based therapy when it was determined their current treatment increased the likelihood of hypoglycaemia. This was delivered in combination with other multiple interventions, including routine blood glucose monitoring. Blood glucose target ranges and frequency of monitoring were documented, including action to be taken in the event of high or low blood glucose. Notable positive impact included achievement of good blood glucose control in relation to one person in the weeks preceding this inspection.
• Commenting on diabetes care, a relative told us, "Initially, we had teething problems, when my relative moved to Lennox House. My relative's chronic condition is now being managed well."
• We discussed with the manager a list of outcome measures that could be used to assess the impact of care delivered including, frequency of hypoglycaemia, hospital admission rates, and the impact on quality of life and wellbeing. The manager told us this would be implemented.
• There were measures in place to help prevent pressure ulcers. At the previous inspection, relevant guidance had not been followed. We could not be assured people were being repositioned as frequently as directed, which placed them at greater risk of pressure ulcer development. At this inspection we saw that improvements had been made.
• Risk assessments for the development of pressure ulcers had been carried out and documented using a "Waterlow risk assessment' tool. This is a validated tool and therefore supported staff in making clinical judgement when assessing pressure ulcer risk.
• Person-centred care was central to the prevention and management of pressure ulcers. Each person's assessment considered good care in relation to several areas, including skin care, nutrition, mobility and incontinence. Treatment plans ensured all the contributory causes were addressed.
• Three people had developed pressure ulcers since January 2020. In all three, appropriate action had been taken. For example, where appropriate, pressure relieving air mattresses were in place. Moving and handling assessments had been completed and where relevant, a repositioning plan and turning regime was clearly documented and being followed. Body mapping and pictures were available in care files.
• We concluded that improvements had started to be made to relevant areas since our last inspection. However, it was too early for the provider to be able to demonstrate that these processes were fully embedded and that these improvements could be sustained over time.

Using medicines safely
• The medicines administration records we reviewed showed people were receiving their medicines as prescribed. Handwritten amendments were double signed by a second member of staff to ensure they were correct. Daily stock balances of medicines were completed. Staff described how they would manage medicines administration for medicines which needed to be given at specific times.
• Protocols for medicines which had been prescribed to be taken 'when required' were available so staff were aware when these medicines should be given.
• Some people were receiving covert medicines (medicines given without their knowledge). Records showed that their mental capacity had been assessed and best interest decisions were completed to ensure this was appropriate.
• Medicines errors were being recorded and investigated. Monthly medication audits were completed. They showed improvement in how medicines were being managed with action plans developed for issues identified. Staff explained how the medicines ordering process had recently been reviewed with the GP and supplying pharmacy to rectify some of these issues.

Learning lessons when things go wrong

• The provider ensured that lessons were learnt from accidents and incidents. For example, we looked at witnessed and unwitnessed falls of four people who used the service. We found that following each event, risk assessments and risk management plans had been reviewed and updated. Actions to reduce the risk of similar incidents and accidents reoccurring had also been taken. For example, we saw on two occasions that the occupational therapist had been contacted to undertake an assessment and provide a walking aid and cushions to reduce the risk of falls.

• The provider monitored trends of accidents and incidents and analysed when particular incidents had occurred. On one such analysis we saw that the provider documented that most accidents had happened during the morning hours and as a result of these findings the provider had updated the person's risk assessment and increased the number of wellbeing checks for this person.

• The manager had also advised us that they discussed accidents and incidents during team meetings, to ensure that everyone working in the service was aware of these and the team was clear of what action was to be taken to minimise the risk of such accidents and incidents happening in the future. Minutes viewed confirmed that these discussions had happened.

• Commenting on accidents and incidents at the home, a relative told us, "My relative had many falls at home. We were in and out of hospitals but since moving to Lennox House this has reduced."