Care Quality Commission

Lymewood Care Limited

Lymewood Nursing Home

Inspection report

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Ratings

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

Overall summary

We previously carried out an unannounced comprehensive inspection of this service on 29 Jul, 6, 10 and 26 August 2015. At this inspection we took enforcement action in relation to four breaches of regulations by serving four warning notices and made requirements for four other breaches.

At the time of this inspection on 8 September 2015, the timescales for the provider to meet the timescales set in the warning notices had not passed, nor had the period of time for the provider to respond to the warning notices or the draft inspection report of 29 July, 6, 10 and 26 August 2015.

This inspection was carried out because we were concerned about the staffing situation at the home. In addition, we had received information of concern that people who were at risk of choking were not receiving safe care to prevent this known risk. The team inspected the service against one of the five questions we ask about services: is the service safe?

This report only covers our findings in relation to this. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for (Lymewood Nursing Home) on our website at www.cqc.org.uk

Lymewood Nursing Home is registered to provide accommodation for up to 37 adults who require nursing or personal care. The home offers its service to people who have dementia or mental health needs. At the time of this inspection there were 30 people living at the home.

The service does not have a registered manager in post. The current manager had been in post for six weeks but has resigned and is due to leave in October 2015. 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.

As a result of the previous inspection, and the number of concerns about the service, a whole home safeguarding

Summary of findings

process continues. This is through multidisciplinary safeguarding strategy meetings which include representatives from Dorset and Devon health and social care agencies. The service is being monitored daily through a combination of visits by social services staff, the safeguarding nurses, the community nursing and local mental health team. Reviews of the people's care are being carried out to check if the home is able to meet their needs. Placements to the service remain suspended by health and social care commissioners. The provider voluntarily agreed not to admit anyone new to the home.

Concerns remain regarding the staffing arrangements at the home. This was because some staff had left and because of the high reliance on agency staff. There were still some gaps in the rota where staff had not yet been found to cover upcoming shifts. We asked the provider to provide further assurances that the staff rota was completed and up to date. Staff on duty were kind, caring and considerate to people they were providing care but some staff had a more in depth knowledge and understanding of people's needs than others.

There remains a risk of people not getting their care in a timely way because of the numbers of staff on duty at times. On the day we visited three people had received their breakfast late and two people had to ask for lunch on two occasions before it was provided. Because of the lack of continuity of a stable permanent staff group, there remains the risk that people's current needs were not always known or identified in a proactive way.

We followed up concerns raised with us about ten people with possible swallowing/choking risks. This was to check whether the food and drink offered to those people was of the appropriate consistency. Also, to check whether staff had the knowledge they needed to safely care for those people.

Of the ten people we looked at, four people had known swallowing/choking risks. Each of those four people had a swallowing assessment completed by a speech and language therapist (SALT). Their care plans included instructions for staff about any dietary modifications needed and about positioning the person safely for eating and drinking. We observed three people having lunch in their rooms; each person was assisted to eat/drink by care staff. All three people were given food of the appropriate consistency as recommended by their SALT assessment. Each person was appropriately in an upright position and staff gave the person time to swallow each mouthful of food/drink before offering more food. Two people's drinks were thickened to an appropriate consistency in accordance with their care plan.

An experienced care worker was supervising an agency care staff to assist one person with their lunch whilst they assisted a second person. However, an agency staff assisting a third person with a choking/swallowing risk was unaware of this risk. The staff handover sheet in use included information about people's dietary modifications but it did not include any information about choking risks. A fourth person with a choking risk was refusing to accept the dietary modification recommended by the SALT and remained at risk. However, the person's mental capacity assessment showed they had capacity to weigh up the risks and benefits of this decision.

Kitchen staff had the appropriate information about people with choking risks being on pureed diets and knew how to prepare foods of the appropriate consistency. Three people had recently been identified as having possible swallowing/choking risks and urgent SALT assessments had been arranged. However, those people did not currently have any dietary modifications. We encouraged the provider and manager to seek further advice about managing those people safely whilst awaiting a SALT assessment.

The remaining three people we looked at did not have choking risks but were on modified diets due to other reasons, such as not being able to chew. However, communication between staff about which people had swallowing difficulties/choking risks was not always effective, which meant some staff did not receive the information they needed to safely care for each person.

We looked at fluid and food charts of four people. These were being completed most of the time, but there were some gaps in the records. This meant we were not sure whether these were recording omissions or whether those people had not received some meals/drinks. This could put people at increased risk of malnutrition or dehydration.

The overall rating for this service is 'Inadequate' and the service remains in 'Special measures'.

Summary of findings

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

Since this inspection the provider voluntarily decided to close the home and the remaining people moved out on the 25 September 2015.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate 

The service was not safe.

We could not improve the rating for safe from inadequate because there were still concerns regarding staffing at the home.

Staffing numbers and continuity continued to put people at risk.

People with choking risks were being offered food and drink in accordance with their care plan. However, some staff were not always aware of which people had choking risks.

Some people with suspected swallowing difficulties/choking risks were awaiting assessment but did not have modified diets. We asked the provider to seek advice about this.

People's food and fluid charts were not always completed. This could be recording omissions or mean people had not received some meals/drinks. This put people were at increased risk of malnutrition or dehydration.

Lymewood Nursing Home

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 checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 8 September 2015 and was unannounced.

The inspection was undertaken by two adult social care inspectors. Prior to the inspection we looked at staff rotas sent to us by the provider and compared those to more up to date rotas at the service. We received information from the safeguarding monitoring team and from nursing staff, looked at the staff handover sheet and the list of modified diets in the kitchen. From these, we identified the ten people whose care we looked at. Those people were identified to us as having modified diets, some of whom had swallowing difficulties and choking risks.

We met ten people and two relatives at the service. We observed three people being assisted to eat their lunch by staff, and spoke to catering, nursing and care staff about their nutritional and hydration needs. We looked at ten people's care records, their 'wardrobe care plans' (displayed inside their wardrobe in their room) and at all relevant food and fluid records. We spoke with 15 staff which included two provider representatives, the manager, two nurses, care staff, the cook and a housekeeper. This included an agency nurse and two agency care staff.

Prior to the inspection we received information from health and social care professionals visiting the service daily in a monitoring role. Health and social care professionals were also at the home at the time of the inspection.

Inadequate

Is the service safe?

Our findings

At the last inspection the service was not meeting the regulations 18 (Staffing) and 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we looked at the staffing levels at the home and risks to people from choking. We did not look at other aspects of the regulations. We will look at these at our next inspection.

We looked at the staffing rotas for the week commencing 3 September 2015. We had been sent a copy by the provider on 5 September 2015. We were concerned as there were gaps on the rota which had not been completed to ensure there were sufficient numbers of staff on each day.

We had been informed that on Saturday 5 September there was only one qualified nurse was on duty instead of two, as recorded on the rota. The provider told us the agency nurse who had been booked had not turned up for work. The manager came in to assist, and another agency nurse was booked. Staff were actively contacting various agencies to try to ensure cover, but this was being hampered, as some agencies were unable to find the required staff. Also, more gaps in the rota had occurred as some staff went off sick at short notice or had left. We asked the provider for further assurances that the staff rota was completed and up to date and for this to be sent to us.

The manager had handed in their notice and was leaving in October 2015.There were four permanent qualified nurses who worked at the home during the day shifts. Three of these were part time workers, and there was a reliance on agency nurses to cover some shifts. On some shifts there were no permanent qualified members of staff on duty, but cover was provided by agency staff. On the whole, agency nurses employed had worked at the home before and so had some knowledge of the people using the service and the way the home was run.

At the inspection there were two qualified nurses (one was an agency nurse who had worked at the home before) and six care workers on duty. The manager, trainer, provider, housekeeper and other domestic staff were also on duty.

Care staff told us that it was very busy when working with six care workers and that it was much easier when there were eight staff on. Two staff commented that the service needed to be more organised and staff needed more instruction about what needed to be done. The provider asked us if they must have had eight care workers on duty, and we explained that they needed to assess this; they had not spoken to the staff about how the shift had gone and if they could meet people's needs.

Some staff we spoke with had a more in depth knowledge and understanding of people's needs than others but staff did not have sufficient information about people's needs on the day we visited. For example, three people did not have their breakfast until late morning because the staff thought a kitchen assistant, who was not working that morning, was helping them with their meals. At lunchtime, two people had to ask on two occasions for their lunch before they received it.

The care staff said they had a handover before they started work and were told who were on modified diets, who needed help with positioning, and with moving and handling. Staff did have copies of handover sheets and they had helped to some extent, but some information was not always handed over to the right person to action. Staff were expected to attend handover, but were not paid for this time.

There remains the risk of people not getting their care in a timely way because of the numbers of staff on duty at times. Because of the lack of continuity of a stable permanent staff group, there remains the risk that people's current needs are not always known or identified in a proactive way.

The staff on duty were kind, caring and considerate to people they were providing care for.

One agency care worker said that they enjoyed working at the home. They had worked at a number of care homes and thought that the staff at Lymewood were lovely, very helpful, but that more staff were needed.

We followed up concerns raised about ten people with possible swallowing/choking risks. We checked whether those people were receiving food and drink of the appropriate consistency. Also, whether staff had the knowledge they needed to safely care for those people.

Of the ten people we looked at, four people had known swallowing/choking risks. Each of those four people had a swallowing assessment by a speech and language therapist (SALT). Their care plans included instructions for

staff about any dietary modifications needed and instructions about positioning the person safely for eating and drinking. We observed three people having lunch in their rooms, each person was assisted to eat/drink by care staff. All three people were given food of the required consistency and were appropriately positioned in an upright position. Staff gave each person time to swallow each mouthful of food/drink before offering more food. Two people's drinks were thickened to an appropriate consistency in accordance with their care plan.

An experienced care worker was supervising an agency care staff to assist one person with their lunch whilst they assisted a second person. However, an agency staff assisting a third person with a choking/swallowing risk was unaware of this risk. Another agency care worker described how they had supported a person who needed help with their meals and was at risk of choking. They explained how they ensured they gave the person their meal slowly, with time between each small spoonful and explaining what they were doing. They explained about positioning the person carefully and recording their intake. They said this process needed to take as long as it needed, which was around 40 minutes. The staff handover sheet included information about people's dietary modifications but not about any choking risks.

A fourth person was refusing to accept the dietary modifications recommended by the SALT team and remained at risk. However, the person's mental capacity assessment showed they had capacity to weigh up the risks and benefits of this decision. They were due to be reassessed by the SALT team on 10 September. Kitchen staff had information about special diets which included people on soft/pureed diets and knew how to prepare foods of the appropriate consistency.

Two nurses and three care staff had undertaken appropriate speech and language (SALT) training. Six of the eight staff we spoke with about swallowing/choking risks, demonstrated a good knowledge of people with swallowing difficulties and choking risks and the importance of positioning. We asked the provider to send us with further details of which staff have undertaken SALT training.

Information relating to the risk of choking was not always adequate. For example, in one person's room, instructions on the person's chart showed their drink needed to be thickened to a 'syrup' consistency. However, there were no instruction about how to achieve this and the drink we saw was not the correct consistency. The care staff also recognised this and made the person a new drink of the appropriate consistency. In contrast, in another person's room, there were instructions for staff about how to make the person's drink to the appropriate consistency.

An agency nurse had identified a person who experienced difficulty in drinking the previous evening and was coughing. They recommended the person had a speech and language therapy (SALT) assessment, which was documented in their records. The nurse in charge was not aware of this concern. This showed communication between staff about new risks identified and actions needed was not always effective. Once the nurse was made aware, they ensured this person was added to the list of people needing SALT assessments.

The safeguarding monitoring team had identified two other people who needed SALT assessments and these were was due to take place on 10 September 2015 . This meant there were three people who may have swallowing/choking risks but who did not currently have any dietary modifications. We encouraged the provider and manager to seek further advice about managing those people risks.

The wardrobe care plans in people's rooms were out of date about people's current dietary needs. For example, three people's wardrobe care plans said each person was on a soft diet, when they were on a pureed diet, and there were no SALT instructions in the room about people's positioning needs.

We concluded three people on modified diets did not have any choking risks but needed this for other reasons. For example, one person was unable able to chew because they did not have any teeth, another person was reluctant to open their mouth and a third person did not like lumpy foods. A fourth person who was previously on a soft diet had reverted to a normal diet.

We looked at fluid and food charts of four people. These were being completed most of the time, but there were some gaps in the records. We were not sure whether these were recording omissions or whether those people had not received some meals/drinks. This meant those people could be at increased risk of malnutrition and dehydration. The fluid records were not being totalled at the end of each shift, so staff were not checking whether people had

sufficient fluids each day. We discussed this with the provider and a health care professional who recommended the amount of fluid each person needed, and asked that staff check this at the end of each 24 hour period.