Larchwood Care Homes (South) Limited

Highfield

Inspection report

Bekesbourne Lane
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Date of inspection visit:
04 November 2016
08 November 2016

Date of publication:
15 December 2016

Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service caring?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

The inspection was unannounced and took place on 4 and 8 November 2016. It was carried out in response to information of concern which had been received and was a focused inspection. We planned to look at whether the service was safe and well-led. However during the inspection, we became aware of issues about caring; so we gathered evidence about this area too.

The service is a nursing home for up 34 older people some of whom may live with dementia type illnesses, physical and or sensory impairments. The home is located in a rural setting outside the village of Bekesbourne. There were 23 people in residence at the time of inspection.

This service was last inspected on 2 and 3 June 2016 when it was rated as 'Requires Improvement' overall. There was a registered manager in post. A registered manager is a person who is 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.

Risks to people had not been properly assessed or minimised. This included environmental risks, those associated with being unable to reach call bells; and risks from medicines being poorly managed.

There were not enough staff deployed to meet people's needs effectively and recruitment processes did not ensure that only suitable staff were taken on.

Accidents and incidents had not been consistently reviewed by the registered manager so that preventative actions could be considered. Not all staff understood their responsibilities around keeping people safe from abuse or neglect, and advice had not always been sought from the local authority when people had unexplained injuries.

Most staff were kind and respectful but not all staff acted to meet people's needs appropriately. People's independence was not actively promoted and some people stayed in bed all the time; when they could have been supported to get up. There was a lack of consideration about older people's needs and of those of people living with dementia. Their experiences could have been improved with more thought.

There had been a lack of effective leadership in the service for the last two months. This had resulted in the development of a poor culture amongst staff and to people receiving a reduced standard of care in some cases. The provider had reacted to the situation, but at the time of our inspection, support mechanisms put in place for the registered manager and staff had not produced sufficient improvement.

We identified a number of breaches of Regulations. The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'. 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.

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.

There were not enough staff to consistently meet people's needs.

Risks to people from the environment, fire, the unsafe management of medicines and weight loss had not been adequately reduced.

Accident and incidents had not always been properly managed in order to keep people as safe as possible. Staff were not all clear about safeguarding processes.

Recruitment processes were not sufficiently robust to ensure only suitable staff were employed.

Is the service caring?

Inadequate

The service was not consistently caring.

People were not supported to be independent where possible.

People's needs were not always met appropriately.

End of life wishes had not been documented.

Most staff were kind and respectful but others did not engage with people.

Is the service well-led?

Inadequate

The service was not well-led.

There had been no proper leadership or direction from the registered manager for around two months. The provider had put in extra support for the manager but this had not happened soon enough.

Risks to people had not been adequately assessed, monitored or minimised through management checks.

A poor culture and low morale was evident during the

inspection; which had negatively impacted on people's care.

Highfield

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 focused and carried out in response to concerns received from a number of sources; including the local authority, commissioners and the public. We checked whether the provider was 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 4 and 8 November 2016 and was unannounced. The inspection team comprised of one inspector a specialist advisor. A specialist advisor is someone who has clinical experience and knowledge of working with people who are living with dementia and have nursing needs.

At inspection we met and spoke with twelve people who lived in the service and observed interactions between people and staff. We also spoke with four relatives and a visitor. We observed staff carrying out their duties and how they communicated and interacted with each other and the people they supported. We also spoke with the registered manager, regional manager, peripatetic manager, two nurses, five care assistants and kitchen staff.

We looked at twelve people's care and health plans and risk assessments, medicine records, three staff recruitment records, staff rotas, accident and incident reports, servicing and maintenance records and quality assurance surveys and audits.

We last inspected this service on 2 and 3 June 2016 when it was rated as 'Requires Improvement' overall and we found five breaches of Regulations.

Inadequate

Is the service safe?

Our findings

People and relatives told us that they felt the service was safe. One relative said "I'm so relieved X is safe here; I could no longer cope at home" and another said "I don't have any worries when I go home-I know Y is well looked-after". However, our findings did not reflect the positive feedback we received about safety.

At our last inspection we highlighted that there were not enough staff deployed to consistently meet people's needs. At this inspection, the situation had not improved. The information of concern we had received suggested that there were too few staff on shift and that people did not always receive attention when required. Our observations showed that some people waited for up to 45 minutes to receive support to eat their lunch. On the first day of our inspection only seven people out of 23 ate in the dining room. Two care staff helped people there; but this left another 16 people requiring staff to deliver meals and support them to eat in many cases. There were two care staff allocated to this duty; which meant they had to support eight people each. This caused delays in people receiving their meals.

Many people remained in bed throughout the days of our inspection; even though the peripatetic manager said they did not all need to do so. We had highlighted this as a concern at our last inspection, but the situation had not changed. Most people needed two staff to support them with their care. Staff told us that people were got up out of bed "On rotation" because there were not enough staff to enable every person to get up each day. One person we spoke with said "I wish they'd get me up and out more-I get fed up being just here [their room]". Other staff told us that although people always received a wash; baths and showers were limited because of staffing shortfalls, and they had little time to spend speaking with people.

The registered manager told us that staffing numbers had reduced since our last inspection because there were now fewer people living in the service. The peripatetic manager told us that there were five care staff and one nurse in the mornings and four care staff plus a nurse in the afternoons. This was despite the registered manager having assessed people's dependencies; concluding that six care staff were needed mornings and afternoons.

There had been a number of occasions when rotas showed even the reduced staffing levels had not been met in the previous six weeks. The registered manager said the service had frequently been run on just four care staff and a nurse in the mornings and afternoons. We read a significant event form completed by staff when there had been just one nurse and one care assistant on duty overnight on 10 to 11 October 2016. Staff reported that they had changed continence pads but had been unable to wash people. This level of staffing had not been safe and meant that people's needs had not been appropriately met.

In addition, there had been a number of allegations made about some staff which had resulted in several of them being suspended from work or specific duties while investigations were conducted. This had impacted on the ability of the remaining staff to effectively meet people's needs. For example: the morning medicines round was not completed until 10:45am on the first day of our inspection. Staff said that this was because there were not enough trained staff available to split the round into two halves to make it more time-effective. We observed the nurse administering medicines being distracted by staff needing assistance with

other tasks. This was not safe as it provided an opportunity for errors to happen. Although agency staff had been brought in to cover some shifts, this had not always been possible and meant that assessed staffing levels had fallen short. More staff were deployed on the second day of our inspection and the regional manager assured us that staffing levels would be better matched to people's needs going forward.

The failure to ensure sufficient staffing is a continued breach of Regulation 18 (1) of the Health & Social care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection we reported that sluice rooms doors had been left unlocked and that the service generally required maintenance to ensure it was safe and comfortable for people. At this inspection we found that sluice doors remained open throughout the inspection, and areas of the home were very cold. One bathroom in particular felt extremely chilly and the registered manager told us this was only used by one person for the toilet sited there. However, this room was not warm enough for a frail, older person to be using on a regular basis.

There was a small, quiet communal lounge but this was being used for staff training for part of one day of the inspection. We rarely saw people seated there but they congregated in armchairs and wheelchairs in an area directly adjacent to the front door of the service. This meant that people were exposed to draughts every time the front door was opened, and their TV watching and other activities were frequently interrupted by visitors such as the postman and staff walking through that area. We observed a visitor to the service opening the front door and allowing visitors in without checking their ID or asking them to sign in. We brought this to the attention of the regional and registered manager; but continued to see this happening.

There was a large dip in the flooring of the communal hallway. This had hazard tape around it but there was a significant drop in the floor level; which had posed a risk to people, visitors and staff. This was given a temporary repair following day one of our inspection and the regional manager said a programme of repairs and refurbishment were planned for the near future.

There were gaps in checks made of fire equipment in the service. For example, quarterly 'Essential fire checks' had not been carried out since June 2016 and there was a ten-week gap between the recording of weekly fire checks. Interim maintenance staff had then identified in October 2016 that smoke seals on fire doors in the home had failed safety checks. 50% of these had been replaced at the time of our inspection, but this left remaining risks that fire doors would not function in the way they were intended to. We referred our concerns to the Kent Fire and Rescue Service. Water temperatures had not been checked in August or September 2016 which meant that people's safety had not been protected by proper checks and maintenance.

The failure to ensure that premises were secure, maintained and suitable for purpose is a continued breach of Regulation 15 of the Health & Social care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection medicines had not always been safely managed. At this inspection we continued to have concerns about this. Morning medicine rounds took until 10:45 am to complete on one day and there was a risk that there would not be appropriate, safe gaps between people's doses. This risk was increased because medicines administration records (MAR) did not record the times that medicines were actually given and only showed 'Breakfast, lunch, tea and bed'. We also found that MAR were confusing because the key showed that the letter 'R' should be entered whenever a person refused their medicines. However, one agency nurse had used 'R' to denote their signature. It was not possible to see whether people had refused medicines, or if the MAR had been signed by the agency nurse. This created a risk that frequent refusals might go un-noticed so that people missed more of their medicines than they should.

Handwritten additions to MAR had not always been signed by two staff to confirm that the entries made were correct, and there were gaps on MAR where staff should have signed to show that medicines had been given. The registered manager said that agency nurses were responsible for many of the errors we noted. However, not all of these had been picked up in audits carried out in the service and robust action had not been taken to prevent recurrences which placed people at risk of not receiving their medicines as prescribed to them.

The failure to manage medicines safely is a continued breach of Regulation 12 of the Health and Social Carer Act 2008 (Regulated Activities) Regulations 2014.

Individual risks to people had been assessed but actions designed to minimise them had not always been put into practice. For example; two people's call bells were out of their reach when we visited them in their rooms. Risk assessments about this stated that call bells should be 'Easily reachable', but this did not always happen. One person told us they called out to staff if their call bell was not accessible but added "Nobody comes anyway".

Some people had been assessed as at risk from not eating enough. Weight records however, showed a confusing picture; with significant differences between them. For example; one person's care plan record stated they had gained 3.2kgs between August and September 2016 when the monthly weights book showed they had lost 1.3kgs in the same period. Another person's care plan stated they weighed 70.2kgs in September 2016 but had no later record of their weight. However, the monthly weights book for this person showed a loss of more than 7kgs between September and October 2016.There was no evidence that dietician advice had been sought about this. We found several more anomalies between weight records and the regional manager instructed that every person was weighed again during the inspection. This exercise showed that 14 out of 23 people had lost weight since their last documented weigh. The registered manager made a number of referrals and re-referrals to the dietician during our inspection but the management of people's nutrition and weights had been unsafe because it had not highlighted when people needed professional input to maintain their health and well-being. We raised our concerns about this with the local safeguarding authority.

The failure to minimise known risks to people is a breach of Regulation 12 of the Health & Social care Act 2008 (Regulated Activities) Regulations 2014.

We read reports of accidents and incidents but saw that these had not been consistently signed off by the registered manager. There were often no records to show what preventative actions had been taken to stop recurrences. Two people had large unexplained bruises which staff had reported to the registered manager. In one case the bruise had been photographed, but aside from this there had been no further action other than to file the information away. The registered manager confirmed that she had not spoken to the local authority to check if safeguarding referrals should be made to them. Not all staff we spoke with were knowledgeable about safeguarding people from abuse or neglect; and newer staff in particular were unclear about the correct steps to take to protect people.

The failure to ensure that people are protected for abuse and neglect is a breach of Regulation 13 of the Health & Social care Act 2008 (Regulated Activities) Regulations 2014.

We checked three recruitment files to see how the provider had ensured that suitable staff were employed. In two out of three cases, references had not been obtained until after staff had started work in the service. The provider could not be sure that applicants were suitable until these references were received. Documentation to evidence the right to work in the UK had not been signed as seen until after staff had

commenced employment; and there was no recent photo on one staff file. Pre-employment checks had not been sufficiently thorough to give the provider assurance about staff's eligibility to work.

The failure to operate a robust recruitment system is a breach of schedule 3 or Regulation 19 of the Health & Social care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service caring?

Our findings

At our last inspection we found the service to be caring. At this inspection we observed kind and gentle interactions between some staff and people, but there were occasions when staff did not act appropriately to meet people's needs.

For example; we watched and listened as one staff member supported a person to eat. There was no conversation or verbal interaction whatsoever. The person was living with dementia and found it difficult to speak, but the staff member made no attempts to offer encouragement or engage with them. There was no eye contact or any words of kindness offered; and the event of a mealtime was treated as a task rather than an opportunity to spend quality time with the person.

Another person was seen huddled in their bed with only a sheet over them at 9:00am They appeared to be cold. Their care charts recorded that a 'Full bed change' had happened at 7:20am that morning, but no blankets had been provided. We brought this to the immediate attention of the peripatetic manager who brought blankets to the person who said "I feel rotten". The peripatetic manager told us that they could only suggest that staff had been called away while they were remaking this person's bed and had forgotten to return with warmer bed covers. Staff were observed to be very busy throughout our inspection, but it showed a lack of consideration to leave this person without proper bedding for more than an hour and a half. We had to ask staff to offer blankets to people sitting in the front reception area. Some people had bare legs and there was a cold draught every time the front door was opened. Not everybody accepted blankets, but staff had not anticipated that people might need them; until we intervened.

There were areas of the service that were poorly lit and dingy. This did not provide a pleasant environment for people and we noticed one person trying to read a magazine and holding it at different angles to try to catch the light. They gave up on this in the end, but people's experiences could have been improved by more thought to their needs and comfort. There was little signage or adaptation to help people living with dementia to identify where they were in the building. Menus were placed at head height on a wall and in small print; even though all people used wheelchairs and so would be unable to see them. The picture menu board in the dining room had photos which did not correspond to the meals on offer. Picture boards are designed to help people living with dementia to make their own choices and to understand what was available. We asked the cook about this and they said that the menu board came with limited photos, so they had put up those they felt were nearest to what was on the menu that day. However, a bowl of salad was shown when fish and chips was for lunch and the dessert picture was not representative of that on offer. The picture cards used to show to people individually; to help them choose their meals had not been updated and were from the summer menu; when autumn options had replaced these. This was not helpful in supporting people to maintain a degree of independence in choosing their own meals.

Many people were nursed in bed. The peripatetic manager said that at least 13 out of 23 people spent all their rime in bed. We asked whether it was necessary for all of these people to remain in bed and were told by staff and managers that some people were able to get up with support, but lack of staffing often prevented this. We heard about two people who could leave their beds with staff support, but had only been

up and out of their rooms once each in the previous eight days. Staff said that some people were got up on one day, but then the next day they were left in bed because it was another person's "Turn" to be up. This did not promote independence or afford people dignity. We spoke with one person who was in bed throughout the two days of the inspection. They said "I'm not being looked after properly. I'd like to be up more".

The failure to meet people's needs is a breach of Regulation 9 of the Health & Social care Act 2008 (Regulated Activities) Regulations 2014.

We looked to see how people were cared for at the end of their life. Staff told us that they had completed specialist training in this area; called the Gold Standards Framework. However, the training folders for this that we were shown had not been completed. There were no end of life care plans in the files we reviewed nor any information about people's wishes regarding their final days. This meant staff could not be sure that people's final choices would be respected when the time came. We spoke to a relative whose loved one had passed away at the service. They had only praise for the staff and the way in which they had cared for their partner at the end of their life. They told us "They couldn't do enough and I will always be grateful".
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Staff were respectful when they spoke with people. We observed staff knocking on people's bedroom doors and calling out before entering; and calling people by their preferred names. Relatives we spoke with were positive about the care their loved ones received. One relative said "As far as I know, things are very good here" and another told us "I can't fault the staff, they are marvellous". A further relative said that they visited frequently and that staff made them feel welcome.

There were some playful interactions at lunchtime when two staff laughed and joked with people as they supported them with their meals. Staff were affectionate with people and some used terms of endearment such as "You look lovely, my darling" and "Let me help you with that, love"; which people seemed to enjoy. One person told us "I love them all, the girls".

Inadequate

Is the service well-led?

Our findings

The service had experienced an unsettled and troubled period in the two months prior to this inspection. There had been a spate of allegations made about and between staff which had resulted in a number of investigations; and ill-feeling and unrest across the staff and management team.

This had translated into poor staff morale and a culture of 'back- biting' .One staff member told us "The harmony is gone; we used to all work as a team, but that is finished". We read minutes of a recent team meeting in which another staff member remarked that they could 'Feel the tension and bad atmosphere' and did not want to return to work after being away. The registered manager had been personally affected by the on-going problems surrounding staff; and she conceded that she had lost focus and drive. Staff told us that registered manager was approachable and committed but that they had "Been struggling" with the problems in the service of late. The lack of proper leadership had allowed careless attitudes to quickly develop amongst some staff; to the detriment of people. For example; using menu photos that did not correspond to the food on offer, leaving a person without warm bedding and not engaging a person who needed support to eat.

Several staff had been suspended from work or suspended from specific duties while disciplinary investigations were undertaken. This had left the staff team lacking in skills and numbers at times; which had negatively impacted on people's care. Medicines rounds were taking too long because there were not enough qualified staff to assist with the task, baths and showers were limited and people were not consistently given the opportunity to get up out of bed. Agency staff were frequently used to cover the staff rota; but this resulted in a lack of continuity of care for people; and had created other problems, such as high numbers of missed MAR signatures.

Important safety checks had not been carried out because the staff who had been responsible for them were suspended. However, the registered manager had not ensured these checks were completed by other staff. Auditing of people's weights was incomplete and inaccurate with some weight losses being recorded as gains and gains shown as losses. The regional manager had visited and highlighted weight losses in their monthly audit in August 2016. They had instructed the registered manager to carry out analysis to determine why the losses were occurring; but this had not happened. The registered manager said they had not been able to follow up on action plans because staff shortages meant they had often needed to work 'on the floor'; even covering a night shift while they were supposed to be on leave. This had left people exposed to risks to their health, safety and well-being.

The failure to assess, monitor and mitigate the risks to people is a breach of Regulation 17 of the Health & Social care Act 2008 (Regulated Activities) Regulations 2014.

Oversight by the provider had not established the extent of the problems at the service soon enough to protect people from deteriorating care. The provider had recognised that the registered manager needed support; and a peripatetic manager had been in place for around a week before our inspection. They had started to introduce new documentation and they were observing and advising staff about their practice.

The provider had also increased monitoring of the service; with the regional manager visiting at least once a week to check that progress was being made. However, at the time of our inspection, these measures had not been in operation long enough to have made a significant difference to the standard of care people were receiving.

Some of the records made by staff and the registered manager were inaccurate. People's weights were documented in several places and the information often differed between records. This had not been picked up prior to our inspection and resulted in people being inconvenienced by having to be weighed on the day; so that a true picture could be seen. Records about people's food and fluid intake were sometimes scant and incomplete because they did not always note the times that people ate and drank. MAR charts held confusing information because agency staff had been allowed to use a signature which looked the same as the code used for refusals.

The failure to maintain complete and accurate records is a breach of Regulation 17 of the Health & Social care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager told us that a recruitment drive was underway and that four care staff and a registered nurse were booked in for interviews. They hoped that new staff coming would resolve staffing issues and also bolster morale on the team.