Archers Healthcare Limited

Lower Farm Care Home with Nursing

Inspection report

126 Grimston Road
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Tel: 01553671027

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service: Lower Farm Care Home with Nursing 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. At the time of our inspection the service was providing nursing and/or personal care to 39 people.

People's experience of using this service:
Although the provider had made some improvements in Safe and Well-Led, these were not enough to ensure people always received safe and consistent care. Both key questions remain rated as Inadequate.

People were still not always fully protected from risk, particularly the risks posed by the environment. Where the provider had assessed risks, systems designed to monitor and manage these risks were not always robust.

Electronic and paper recording systems did not work in tandem and oversight of how people's risks were being managed was not good.

Medicines were not always managed safely and this had the potential to place people at increased risk of harm.

The lack of effective auditing, alongside confusing records and poor assessment of risk, meant that concerns remained with regard to the safety and leadership of the service.

New systems to improve communication within the service required further development so that important information about people's care was clear to all staff.

You can see what action we told the provider to take at the back of the full version of the report.
Rating at last inspection: At the last comprehensive inspection the service was rated Inadequate (report published 21 November 2018.)

Why we inspected: Following the last inspection we received an action plan outlining how the service would make the required changes to improve the service and to address the six breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 identified during that inspection.

We carried out this inspection to check that the improvements with regard to the breaches of Regulations 12 (Safe Care and Treatment) and 17 (Good Governance) had been made and sustained. We had also received information of concern which led us to continue to question the safety of the service and the quality of the leadership.

Follow up: We have issued further requirement notices for breaches of regulation as a result of this

inspection. We will require the provider to send us another action plan and will meet with the provider to discuss their failure to make the required improvements and to discuss how they plan to ensure significant improvements are made and maintained. Failure to achieve this will result in CQC considering a more robust regulatory response which may include a notice of proposal to cancel the service's registration.

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.

Details are in our Safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our Well-Led findings below.

Lower Farm Care Home with Nursing

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 had received concerns relating to the safety and leadership of the service. This focused inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Act, to look at the quality of the service, and to provide a rating for the service under the Care Act 2014.

Inspection team:
One inspector, an inspection manager, a medicines inspector and an expert by experience carried out this inspection. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. Our expert had experience of caring for older people.

Service and service type:
Lower Farm Residential Care Home with Nursing 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. Lower Farm can accommodate up to 46 people in one adapted building.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection:
This inspection was unannounced.

What we did:
Before we carried out our inspection visit we looked at information we held about the service. This included

notifications relating to significant events the service is required to tell us about. We also sought feedback from the local authority safeguarding and quality monitoring teams as well as the local clinical commissioning group. This information helped us to target our inspection activity and highlight where to focus our attention.

During the inspection we spoke with nine people who used the service, one relative, two directors (one of whom also carries out nursing shifts at the service) , the registered manager, the care co-coordinator, one senior care staff member and two care staff. We reviewed seven care plans, eighteen medication administration records and looked at two staff files which documented recruitment procedures and ongoing support for staff. We also reviewed rotas, staff training records and other documents relating to the safety and quality of the service. We carried out a SOFI observation. This is a structured observation that helps us understand the experiences of people who are not able to communicate with us easily.

Following our inspection we gathered further information from the service relating to people's safety and sought further feedback from local authority and CCG colleagues.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm

People were not safe and were at risk of avoidable harm. Some regulations were not met.

Assessing risk, safety monitoring and management; Using medicines safely

● Staff demonstrated an understanding of the need to reduce the risk of avoidable harm. However, records to monitor people's eating, drinking and repositioning were not always completed or were completed in different places in the electronic record and sometimes also in a paper record. This meant that staff and the provider could not be assured that risks relating to pressure care and nutrition were being clearly recorded and well managed.

● For example, one person's care plan stated that they should have a 'regular' change of position. However, records did not document what 'regular' meant. When people require a change of position to help reduce the risk of pressure ulcers, this is usually specified in their care plan as taking place every two or four hours for example. We noted that from the 2 January to 8 January the person had only three changes of position documented over a 24 hour period for two of the days and only four documented changes of position on three days. We found records of position changes in three separate places in the electronic record but we still identified gaps in recording. This meant we could not be assured that the person was being moved as regularly as they needed to be to reduce the likelihood of developing a pressure ulcer. The person had a pressure ulcer on their foot. Staff were also unaware of what setting the person's pressure mattress setting should be on, with a senior staff member telling us, "I don't actually know. It used to be in the paperwork." Records supplied to us since the inspection show that staff carry out a daily mattress check but senior staff were not able to show us this on the day of our inspection.

● Fluid records were not robust. One person's fluid record showed that they had had a good intake of fluid over five days but their output was very low, sometimes as low as 200mls. The registered manager was not able to clearly identify what action had been taken in response to the low output, although the person's catheter had been replaced by the nurse as part of the person's routine care and the output increased significantly. The failure to monitor the person's fluid levels accurately placed them at an increased risk of contracting an infection.

● The provider did not put comprehensive measures in place promptly to ensure all known risks from the environment, were reduced as much as possible. However, following our inspection, locks and alarms were fitted to all external doors to ensure staff would be alerted should a person living with dementia leave the building and place themselves at risk from the nearby main road. An upstairs kitchen was not locked and contained items which could harm people. We asked the provider to ensure action was taken to keep people safe regarding these matters.

●Staff were trained to administer medicines and followed safe procedures, although additional information was needed to guide staff when giving medicines which were only needed occasionally (PRN). People told us that staff stayed with them when administering medicines and made sure they took them safely. However, some medicines were administered up to two hours later than scheduled by the prescriber. This increased the risk of adverse side effects and of the medicines not being effective.

●Medicines were not always in stock for people to take. One person who used the service told us, "I don't always get my meds on time. For the last couple of nights I have been getting my tablets (at) 20.30 when I should have had them at 18.30. They sometimes run out of the antibiotics I need which doesn't help my current condition."
●The provider demonstrated that, although they had made attempts to ensure medicines were available, systems were not robust enough to make sure people had the medicines they needed to remain healthy and well.

This was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse

● The provider had systems in place to protect people from the risk of abuse. Staff had an understanding of how to report any concerns they had which related to abuse and knew how to spot the signs that might indicate that someone was being abused or was at risk of abuse.
● The provider had reported, as required, any safeguarding concerns to the local authority and CQC without delay. However, there had been no notification to CQC relating to people failing to receive their prescribed medicines when stocks were unavailable. The local authority require a safeguarding referral when this happens and CQC would then need to be notified.
● The provider had put actions in place to manage a serious safeguarding incident which affected the service. However, measures still left people open to an element of risk

Staffing and recruitment

●Feedback about staffing levels was mixed. People who used the service told us that there were enough staff in the day saying things like, "If I press my buzzer they generally turn up in reasonable time." We received more negative comments about nightime staffing. Three people said other service users wandered into their rooms at night uninvited. Four of the nine people we spoke with commented that staff take a long time to attend to them at night. Typical comments were, "If I press the buzzer for help they don't always turn up quickly, particularly at night," and, "In the afternoon or at night they can be slower. They appear to be short staffed later in the day."
●We observed a relative searching for a staff member to help their relative. They said to us, "Why is it you can never find a carer when you want one?"
●The provider had reviewed their dependency tool to try to reflect people's needs more accurately than it had at our previous inspection. However, people's impression was that there remained times of day when staff were not visible and did not attend quickly.
●Staff gave us mixed feedback about staffing levels with some saying they were better and were enough to meet people's needs, while others expressed concerns. One staff member said, "There aren't enough staff….[the provider] expects one nurse to do upstairs and downstairs drugs. It cannot be done. I'm not fast but I do it properly. If I start at 20.30 I don't finish until 23.00."
●The provider recruited new staff safely and carried out all appropriate checks designed to ensure people were safe to work in this setting.

Preventing and controlling infection

●The service was clean. Staff received training relating to infection control and appropriate stocks of protective equipment such as gloves and aprons were available to staff. We observed good infection control

practice when staff provided care and support.
● However, we also noted that bread and fresh vegetables were stored outside the service alongside firelighters in a Perspex fronted cabinet. The cabinet was not closed and this would have allowed access to mice and rats. We asked the provider to ensure food was removed from this cabinet and placed inside.

Learning lessons when things go wrong

●At our previous two inspections we noted that people who used the service potentially had access to an unfenced pond. The provider failed to take comprehensive action to address this known risk after each of these inspections. At this inspection the pond had been fenced but the gate was not secure and concerns remained. The provider remedied this in the days after our inspection visit. Additionally, the provider had failed to fully address our previously raised concerns about access to the main road from external doors. This was also resolved after this inspection visit. We found the provider was still not proactive in their attitude to reduce risk and did not analyse and review potential risk and near misses and learn lessons from incidents relating to these risks.

Inadequate

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

There were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care. Some regulations were not met.

Planning and promoting person-centred, high-quality care and support; and how the provider understands and acts on duty of candour responsibility

●Systems designed to ensure consistent and safe care were not sufficiently robust. Some records were not fit for purpose because they presented a potential risk of staff being unclear about the care required. Important information was held in various different locations which was confusing for staff and significant risks were not clearly highlighted.
● Care plans contained a lot of information but did not always reflect people's current needs or continued to contain contradictory information. For example, one person had a 'nil by mouth' notice in their room but their care plan stated 'can have oral thickened fluids'.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

●We found that the registered manager did not have complete oversight of the nursing practice at the service. A new system had been introduced so that nurses carried out assessments and created care plans for new nursing clients rather than the registered manager, who was not a qualified nurse. This was an improvement. However, the registered manager themselves told us they found managing the nursing staff could be a challenge. This had been further complicated by a poor relationship between the senior management team and the clinical lead who had direct responsibility for the nursing care.
●Relationships between the registered manager, one of the directors who worked as a nurse and the clinical lead, were not good and this provided further obstacles to improvement at the service.
●Although the provider had made appropriate notifications to CQC, a serious incident had not been appropriately notified to the Nursing and Midwifery Council.

This was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

●The provider consulted people who used the service, and their relatives, about the running of the service. There were monthly resident committee meetings and monthly resident meetings as well as a quarterly relatives meeting. These gave people the chance to raise concerns and share issues. An annual survey was

sent out to gather people's opinions.

Continuous learning and improving care

●Although a system of audits was in place and one of the directors carried out regular nursing shifts at the service, we found that the electronic recording system was confusing to staff, with information recorded in a variety of places. This meant that the provider did not have accurate oversight and some staff struggled to find the information they needed quickly to have a complete picture of a person's current needs. In addition, we found some records contained contradictory information. This had the potential to place the person at risk because the provider had not carried out effective audits to ensure care plans reflected people's current needs.

Working in partnership with others

●Although we saw good evidence of partnership working with local district nursing services, GPs, occupational therapists and speech and language therapists, amongst others, care plans put in place by them were not always followed or accurately recorded. For example, a senior carer told us that a nurse practitioner had visited a person the previous day and they had overheard them saying that the person would be encouraged to get up. This was not recorded on the person's care plan. The person's weight was not recorded either and so staff did not know what setting the pressure mattress should be set on. When we met with this person we saw that they were in bed and had a current pressure ulcer on their foot, which was being treated by the district nurse. We could not be assured that recording systems were robust enough to ensure that important information from professionals was always handed over effectively.

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
Treatment of disease, disorder or injury	The provider failed to ensure that risks relating to health and safety had been assessed and mitigated and had also failed to ensure the safe management of medicines. Regulation 12 (1), (2) (a) and (b).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	The provider failed to ensure that systems were operated effectively to assess, monitor, and improve the quality and safety of the service. Regulation 17 (1), (2) (a).