Care Quality Commission

Larchwood Care Homes (South) Limited

Sherford Manor Care Home

Inspection report

Wyvern Road
Taunton
Somerset
TA1 4RA

Tel: 01823337674

Date of inspection visit:
20 February 2017

Date of publication:
07 April 2017

Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Requires Improvement**
Is the service effective?	**Inadequate**
Is the service responsive?	**Inadequate**

Summary of findings

Overall summary

This focused inspection took place on 20 February 2017. It was carried out by two adult social care inspectors and was an unannounced inspection.

Sherford Manor specialises in providing care to people who are living with dementia and/or who have mental health needs. The home is registered to provide accommodation with nursing care to up to 105 people. Given the configuration of the home, the maximum number of people they accommodated was 77. At the time of this inspection there were 63 people living at the home. Sherford Manor consists of four separate units. The Rose and Sunflower units provided care and support for people who required assistance with personal care needs. Redwood and the Sutherland Unit provided nursing care.

There was a registered manager in post. 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 and associated Regulations about how the service is run. The registered manager was on long term leave so was not available for this inspection or the previous inspection. The home was being managed by the provider's regional manager and three of the provider's peripatetic managers.

We carried out a comprehensive inspection of this service on 7 and 8 December 2016. Breaches of legal requirements were found as people were not protected from receiving unsafe care and treatment and were not protected from avoidable harm. People did not receive care and treatment which met their individual needs and preferences and the service failed to ensure people were provided with opportunities to make choices in their day to day lives. There were ineffective quality assurance systems in place to make sure any areas for improvement were identified and addressed.

After the comprehensive inspection, we used our enforcement powers and served three Warning Notices on the provider on 22 December 2016. These are formal notices which confirmed the provider had to meet the legal requirement in respect of safe care and treatment and person centred care by 30 January 2017. They had to meet the legal requirement in respect of effective quality assurance systems/good governance by 20 June 2017.

We undertook this focused inspection to check the provider had taken action to meet the legal requirements relating to the two warning notices we issued for safe care and treatment and person centred care. Therefore this report only covers parts of three of the five key questions we report on; Is the service safe? Is the service effective? And Is the service responsive? The ratings for the three questions and the overall rating for the service therefore remains unchanged. The requirement notices issued at the last inspection will be followed up at our next inspection, so are not included in this report. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for on our website at www.cqc.org.uk.

We found some action had been taken to improve the safety of the people who lived at the home. Care plans for people who had diabetes, those who were at risk of choking and those who were at high risk of falls had be reviewed and re-written so they provided more detailed information about how to minimise risks. We observed people were supported by staff in accordance with their plan of care. People had access to the specialised equipment they required.

Some action had been taken to ensure people received care which met their assessed needs and preferences. The majority of the care plans we read now contained information about a person's life history and preferred daily routine. This meant staff had information which helped them support people This helped staff to understand what was important to people and of the things they liked to do. For example one person had certain preferences about their appearance and we observed staff had supported them in accordance with their preferences.

At our two previous inspections; March 2016 and December 2016 we found care plans were bulky and contained a lot of historical information which made it difficult to locate the current needs and preferences of the people who lived at the home. At this inspection we found that no progress had been made. We were not provided with a timescale for completion. This meant the provider had failed to meet the requirement of the warning notice to become compliant by 30 January 2017.

Staff had received training in how to care for people who were living with dementia and the provider had employed the services of an external trainer to improve the skills and knowledge of staff. However we met with the trainer who explained they had gone back to the basics of dementia care with staff and whilst they acknowledged some improvements in the knowledge and understanding of staff, further improvements were needed to ensure a change in culture throughout the staff team. We saw staff did not always recognise opportunities for engaging/involving people who were living with dementia. For example we observed a staff member laying a table for lunch. There was a person sat at the table but they did not involve them until prompted by us.

At our last inspection we found activity staff had not received training about supporting people who were living with dementia this inspection the provider's regional manager told us since the last inspection one of the activity workers had left and they were in the process of recruiting a replacement. The remaining activity worker had received training in caring for people who were living with dementia. The activity worker was not present for this inspection and no planned activities took place. We were therefore unable to establish that the provider had complied with this part of the warning notice.

At our last inspection one of the care plans we read told us the person was "at low risk of social isolation" because they "liked to interact with other residents and staff." However, the daily records for the person showed they had spent the majority of their time with no social interaction. We followed this up at this inspection and again found staff recorded entries as before and there was no evidence that the person had engaged in any social interaction or activities. We observed the person throughout the day and saw they spent the majority of their time sat in the lounge area on Rose unit. The television was on but they were not watching it. This meant the provider had failed to meet the requirement of the warning notice to become compliant by 30 January 2017.

People had not yet been provided with opportunities to express a view about the care and support they received however the provider's regional manager told us letters had been sent to people's relatives inviting them to attend a person centred review with their relative however we were not provided with a timescale for completion. This meant the provider had failed to meet the requirement of the warning notice to become compliant by 30 January 2017 .

Pictorial menus had been introduced which meant people could make an informed decision about the meals they wanted. Tables were nicely laid for lunch however we noticed on Rose and Redwood units, tables had been laid for lunch following breakfast . This could be confusing for people who lived with dementia. People were provided with drinks and snacks throughout the day. Improvements were needed to improve the appearance of pureed diets as those we saw did not appear appetising. This meant the provider had failed to fully meet the requirement of the warning notice to become compliant by 30 January 2017.

The legal requirements had not been fully met; the provider had therefore not fully complied with our Warning Notices.

Following our last inspection in December 2016 we placed the service in special measures because the overall rating for the service was inadequate. Following this focused inspection we have not changed the rating for the service because some parts of the warning notices were not met and because further time is needed to demonstrate the improvements made can be sustained. Also we only focused on the issues within the warning notices and only looked at parts of three of the five domains; Is the service safe? Is the service effective? And is the service responsive?

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?

Requires Improvement

The service was not always safe

Some improvements had been made Risk assessments and care plans had been updated to reduce the risks of people receiving unsafe or inappropriate care. However there has been insufficient time to measure the impact on people who lived at the home and whether this improvement can be sustained. Also we did not focus on all of the key lines of enquiry for this domain

Is the service effective?

Inadequate

The service was not always effective.

The rating for this domain has not been changed because some parts of the warning notices had not been met. Also we did not focus on all of the key lines of enquiry for this domain.

Is the service responsive?

Inadequate

The service was not always responsive.

The rating for this domain has not been changed because some parts of the warning notices had not been met. Also we did not focus on all of the key lines of enquiry for this domain.

Sherford Manor Care 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 was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008.

This focused inspection took place on 20 February 2017 and was unannounced. It was carried out by two adult social care inspectors.

After the comprehensive inspection in December 2016, we used our enforcement powers and served three Warning Notices on the provider on 22 December 2016. These are formal notices which confirmed the provider had to meet the legal requirement in respect of safe care and treatment and person centred care by 30 January 2017. They had to meet the legal requirement in respect of effective quality assurance systems/good governance by 20 June 2017.

We undertook this focused inspection to check the provider had taken action to meet the legal requirements relating to the two warning notices we issued for safe care and treatment and person centred care. Therefore this report only covers parts of three of the five key questions we report on; Is the service safe? Is the service effective? And Is the service responsive? The requirement notices issued at the last inspection will be followed up at our next inspection, so are not included in this report. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for on our website at www.cqc.org.uk

At the time of this inspection there were 63 people using the service. People were living with dementia which meant some people were unable to tell us about their experiences of life at the home. We therefore used our observations of care and our discussions with staff and visitors to help form our judgements. 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 looked at eight care plans and spoke to seven members of staff. The provider's regional manager and three of their peripatetic managers were available throughout our inspection. We also met with an external trainer.

Requires Improvement

Is the service safe?

Our findings

At our last comprehensive inspection of the service on 7 and 8 December 2016 we found a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the service was failing to prevent people from receiving unsafe care or treatment and prevent avoidable harm or risk of harm. This related to the management of people's diabetes, those people who had been assessed as being at high risk of choking and those who had been assessed as being at high risk of falls. We issued a warning notice for this breach which required the provider to become compliant by 30 January 2017.

At this inspection although we found improvements had been made regarding the issues within the warning notices, the rating remains requires improvement because further time is needed to demonstrate the improvements can be sustained. Also we only focused on the issues within the warning notice and did not look at all of our key lines of enquiry within this key question.

At our last inspection we found the care plan we read for one person who had diabetes did not contain sufficient information for staff about how to manage their care, treatment and associated risks. For example there was no clear information about the person's eating and drinking needs. The care plan stated "Type II diabetes" and "likes all foods especially pudding." There was no information about what were acceptable blood sugar levels for the person and there was no information about the signs, symptoms or action to take in the event of a hypo or hyper-glycaemic attack. We also found staff were not following the plan of care for another person who had diabetes. The care plans stated "staff should ensure your [the person's] diet does not contain high levels of sugar as you have type 2 diabetes." Records of the person's daily intake showed that they had been given foods high in sugar. For example one day breakfast consisted of porridge followed by bread and jam. On the same day after lunch they had been given cake and cream and after tea they had cake and custard. This continued throughout the week. They had also been give biscuits as snacks throughout the day.

At this focused inspection we found care plans for the management of people with diabetes had been re-written and provided information about how to manage their care, treatment and associated risks. There was information about the signs and symptoms of hyperglycaemic (high blood sugar levels) and hypoglycaemic (low blood sugar levels) attacks. There was also information about the action to be taken in the event of the attacks. Where there was an assessed need, we observed people were provided with a suitable diet which was low in sugar.

At our last inspection we found staff were not following one person's care plan who had been assessed as being at high risk of choking. The person's eating and drinking care plan stated that "oral suction must be available when eating." We observed the person being assisted with their lunch however; the suction machine was in its original packaging in the office. This meant the suction machine was not assembled or ready for use which could place the person at significant risk if they aspirated. At our last inspection we also found one person who had been assessed as being at high risk of choking was being assisted with their meal by a member of staff who did not have the skills or training to carry out the task. At this focused inspection

we read the care plans for two people who had been assessed as being at high risk of choking and we observed staff supporting these people in accordance with their plan of care. For example we spoke with a member of staff who was assisting one person with their lunch. They were knowledgeable about the person's preferences and of the consistency their food and drink should be served at. The other person's care plan stated they required a suction machine to be available in their bedroom. We observed this to be in place. Care plans had been re-written for people who had been assessed at being at high risk of choking and now provided clearer information for staff. Staffs had received, or were due to receive training in the management of people with dysphagia, which is a difficulty in swallowing.

At our last inspection we found the risks to people who had been assessed as being at high risk of falls, were not well managed. For example we observed one person used a wheeled frame to assist them to mobilise. When the person was sat in the lounge, the person's frame was removed by a member of staff which meant the person did not have access to it when needed. We read the person's care plan. They had been assessed as being at high risk of falls however the care plan made no mention of the person using a wheeled frame. At this inspection we found improvements had been made. Care plans had been re-written and included information for staff about how to reduce the risk of falls and the equipment people needed to ensure their safety when mobilising. We saw people had the mobility aids to hand as detailed in their plan of care.

Inadequate

Is the service effective?

Our findings

At our last inspection we found a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the service failed to ensure people received care and treatment which met their individual needs and preferences. The service also failed to support people to make choices. (This failure formed part of the warning notice we issued for the breach of Regulation 9.)

The service also failed to ensure staff had the knowledge and skills to care for people who were living with dementia. (This failure formed part of the warning notice we issued for the breach of Regulation 12.) These two warning notice were required to be complaint by 30 January 2017

At this inspection we found some improvements had been made however .further improvements were needed. Where action had been taken to improve the service further time is needed to demonstrate the improvements can be sustained. Also this report only covers parts of three of the five key questions we report on; Is the service safe? Is the service effective? And Is the service responsive? Therefore, the rating for Is the service effective remains inadequate.

At our last inspection the lunchtime experience did not promote a sociable or pleasant experience for people. People did not know what was for lunch and menus were not in suitable format for people who were living with dementia to be able to understand what was for lunch. This meant people were unable to make an informed choice. Meals were plated by staff from a hot trolley. This meant people had no control over portion size or what vegetables they wanted and did not provide people with opportunities to maintain a level of independence. On Sutherland unit tables were not laid for lunch. People were provided with their cutlery when staff gave them their meal. There were no drinks on the table for people to help themselves to and people were only given a drink when they had finished their meal.

At this inspection we observed lunch being served on Sutherland, Redwood and Rose units. The lunch time menu was available on each dining table and had been produced in a suitable pictorial format. We saw staff showed this to each person just prior to lunch being served so people could make an informed choice. Staff continued to plate people's meals from a hot trolley but we did hear staff asking people if they wanted more or less food. On Rose and Redwood units we observed that tables had been laid for lunch by 1045am. This could be confusing for people who were living with dementia. On Sutherland unit tables were laid for lunch just prior to the meal being served. There was a person sat at one of the tables however staff did not recognise an opportunity to ask the person if they wanted to help. When we pointed this out the person said they would like to help and appeared to enjoy the interaction. People were offered a choice of drinks throughout the meal.

Some people required a pureed diet and on the first day of our last inspection we found catering staff had pureed the vegetables together which had resulted in an unappetising grey coloured mush. We discussed this with the provider's director at that inspection who addressed this with the catering staff. However at this inspection we found the pureed meal again did not look appetising. A chicken and mushroom pie had been pureed and had resulted in a grey mush. It had been served with pureed cauliflower, mashed potatoes and

peas. The white colour of the potatoes and cauliflower meant it was difficult to distinguish one from the other. We discussed this with the regional manager and two peripatetic managers at the time who agreed with our findings, expressed their disappointment and told us they would address this.

At our last inspection we found staff did not always have the skills and knowledge to care for people who were living with dementia. For example 17 care staff told us they had completed an on-line dementia awareness programme which was described as 'very basic.' Six care staff had not yet completed this training. Our observations at that inspection showed people with dementia were left for long periods without any interactions from staff or any form of stimulation. On Redwood Unit lounge chairs were arranged in a circle with little room to move around or for staff to sit and chat to people. Many people were able to interact with us and other people however we did not observe staff assisting or offering people to sit together so they could chat. At our last inspection we met with a member of staff who was providing one to one support to a person who was living with dementia and had very complex needs. We asked the member of staff if they had access to the person's plan of care and whether this provided them with enough information about the person's needs, risks and preferences. The member of staff found it difficult to understand our question and did not understand what we meant by a care plan. The member of staff was not a permanent member of staff and had been supplied by an agency. This demonstrated the skills and knowledge of staff were not always considered when supporting people.

At this inspection we found staff had received training about how to care for people who were living with dementia. The provider had employed an external trainer who carried out a programme of Dementia Care Mapping (DCM) throughout the home. This is an established approach to achieving and embedding person-centred care for people living with dementia, and is recognised by the National Institute for Health and Clinical Excellence (NICE). We met with the trainer who explained they had gone back to the basics of dementia care with staff and whilst they acknowledged some improvements in the knowledge and understanding of staff, further improvements were needed to ensure a change in culture throughout the staff team. Staff were positive about the training. One member of staff said "The training really made me think about people and how we can give them more choices in their lives." However, more time is needed to ensure the skills and knowledge of staff are embedded. During this inspection we observed occasions where staff failed to recognise opportunities to involve people in their day to day lives. For example, on Rose and Redwood units we observed that tables had been laid for lunch by 1045am. This could be confusing for people who were living with dementia. On Sutherland unit tables were laid for lunch just prior to the meal being served. There was a person sat at one of the tables however staff did not recognise an opportunity to ask the person if they wanted to help. When we pointed this out the person said they would like to help and appeared to enjoy the interaction.

At our last inspection we looked at the induction training records for a member of staff who was working on one of the units. We found records were incomplete and the staff member had not been signed off as being competent in a number of tasks. At this inspection we found that action had been taken to address this. We met with another member of staff who had just started working at the home. They told us they had been allocated a mentor and felt well supported. They explained they were only shadowing experienced staff and would not carry out any tasks until they had been trained to do so.

Inadequate

Is the service responsive?

Our findings

At our last inspection we found a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the service failed to ensure people received care and treatment which met their individual needs and preferences. The service also failed to support people to make choices. We issued a warning notice for this breach which required the provider to make improvements by 30 January 2017.

At this inspection we found some improvements had been made however further improvements were required to become fully compliant with the warning notice. Where action had been taken to improve the service further time is needed to demonstrate the improvements can be sustained. Also this report only covers parts of three of the five key questions we report on; Is the service safe? Is the service effective? And Is the service responsive? Therefore, the rating for Is the service responsive remains inadequate.

At our last inspection we found care plans did not contain sufficient information about people which would help the staff to provide people with care and support which met their needs and preferences. When we spoke with staff they were unaware of people's life history. At this inspection the majority of the care plans we read contained a life history book which provided information about people's life, family work history and hobbies. Care plans that had been up dated gave personal information about the individual. For example we saw staff had recorded what time people liked to get up and their preferred drinks. Staff were able to tell us about people's interests, family and preferences.

At our two previous inspections; March 2016 and December 2016 we found care plans were bulky and contained a lot of historical information which made it difficult to locate the current needs and preferences of the people who lived at the home. At this inspection we found that no progress had been made. The regional manager told us the registered nurses and senior care staff on the units had been allocated a number of care plans each to update and ensure historical information was removed. However, we were not provided with a timescale for completion. This meant the provider had failed to meet the requirement of the warning notice to become compliant by 30 January 2017.

One of the care plans we read at the last inspection told us they were "at low risk of social isolation" because they "liked to interact with other residents and staff." When we read the daily records for the person over a seven day period these showed they had spent the majority of their time with no social interaction. Entries detailed times and included "bed", "eat" and "communal chair." At this inspection we again found staff recorded entries as before. We discussed this with the regional manager at the time as the daily record booklet which staff completed required staff to enter codes to reflect what the person was doing throughout the day. The codes did not cover any social stimulation/activities, only activities such as 'awake', 'chair', 'walking', 'sleeping', eating.' The regional manager told us they would look into this to ensure more information about a person's well-being and how they had spent their day was recorded. We observed the person throughout the day and saw they spent the majority of their time sat in the lounge area on Rose unit. The television was on but they were not watching it.

At our last inspection it was not clear how people who lived at the home were provided with opportunities to express a view about the care and support they received. Care plans did not contain information about person centred reviews which would involve and seek feedback from each person who lived at the home. At this inspection we found no evidence in people's care plans that they had been involved in reviewing their plan of care. However; the provider's regional manager told us that each unit were in the process of writing to people's relatives to invite them to attend a person centred review with their relative.

We found some improvements had been made to ensure people's care plans reflected their assessed needs. At our last inspection one of the care plans we read had not been updated to reflect the recommendations of a health care professional and we observed the person did not receive support in accordance with the recommendations. At this inspection we found action had been taken to address this.

At our last inspection we found people did not always receive the care and support detailed in their plan of care. We met with one person whose care plan detailed how they liked to look and how they got comfort from a particular cuddly toy. The person looked unkempt and staff had no knowledge about the cuddy toy or its whereabouts. At this inspection we found improvements had been made. The person was presented in accordance with their preferences and their cuddly toy was in their bedroom.

When we met with the two activity workers at our last inspection they told us they had not received any training in dementia care or how to provide meaningful activities for people living with dementia. At this inspection the provider's regional manager told us since the last inspection one of the activity workers had left and they were in the process of recruiting a replacement. The remaining activity worker had received training in caring for people who were living with dementia. The activity worker was not present for this inspection and no planned activities took place.