De Vere Care Limited

Lehmann House Residential and Nursing Home

Inspection report

Lehmann House
Chapel Lane, Wickham Market
Woodbridge
Suffolk
IP13 0SG

Tel: 01728733733

Date of inspection visit:
28 November 2019

Date of publication:
01 January 2020

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
Lehmann House Residential and Nursing Home is a residential care home providing personal and nursing care to 34 On the day of this inspection five people were being supported over two units.

People's experience of using this service and what we found
Our previous inspection of 5 and 7 November 2019 had identified concerns regarding the governance of the service. At this inspection we found the provider had begun to make changes this this included the appointment of a new nominated individual to the management team.

We found ongoing concerns with the management of risks to people from receiving care and support. Individual issues relating to infection control had been addressed but we found further infection control concerns.

Due to action by the local authority there had been a large reduction in the number of people using the service between this inspection and our previous inspection of 5 and 7 November 2019. The provider had adjusted staffing numbers because of this. However, we were not fully assured that staffing levels at this inspection fully met the needs of those living in the service.

Our previous inspection found that medicines were not safely managed. At this inspection we found ongoing concerns with the administration of medicines.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection (and update)
The report for the last inspection has not yet been published and is still subject to factual accuracy comments by the provider.

Why we inspected
We received concerns in relation to staffing and the overall management of the service. As a result, we undertook a focused inspection to review the Key Questions of Safe and Well-led only.
We reviewed the information we held about the service. Ratings from previous comprehensive inspections for those Key Questions were used in calculating the overall rating at this inspection.
The overall rating for the service has not changed. This is based on the findings at this inspection. We have found evidence that the provider needs to make improvement. Please see the Safe and Well-led sections of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Lehmann House Residential and Nursing Home on our website at www.cqc.org.uk.

Enforcement
We have identified breaches in relation to people's safety, the level of staffing, infection control and the overall management of the service at this inspection.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will continue to monitor information we receive about the service until we return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

Special Measures
The overall rating for this service is 'Inadequate' and the service therefore remains in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the 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.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well-led..

Details are in our safe findings below.

Lehmann House Residential and Nursing Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
The inspection was carried out by two inspectors

Lehmann House Nursing and Residential Home 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.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We took this into account when we inspected the service and made the judgements in this report. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection
We spoke with two people who used the service and observed care and support being provided in

communal areas. We spoke with three members of care staff. We also spoke with the service care director and the interim manager

We reviewed a range of records. This included three people's care records and medication records. We looked at three staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We liaised with the local authority regarding action they had taken.

Inadequate

Is the service safe?

Our findings

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

At the last inspection this key question was rated as Inadequate. At this inspection this key question has remained the same. This meant people were not safe and were at risk of avoidable harm.

Systems and processes to safeguard people from the risk of abuse; Assessing risk, safety monitoring and management

At our last inspection the provider had failed to robustly assess and manage safeguarding and risks related to the provision of people's care and support. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found that risks were still not effectively managed

● At this inspection systems and processes had not been established to protect people from abuse and manage risk.
● A safeguarding investigation carried out by the local authority substantiated failings in the service. It raised concerns regarding the ability of the service to follow and implement safeguarding plans in response to identified risks.
● Accidents and incidents were not always recorded or investigated appropriately. A body map dated 4 November 2019, recorded that a person had been found by staff with scratches on their right ankle and right arm. There was no accident or incident record relating to these scratches and therefore, this had not been investigated.
● Where risks had been identified, actions to mitigate the risk were not carried out. For example, one person had been identified as at risk of not drinking enough. They had been put on a fluid chart to record their daily fluid intake. The chart showed the person had not reached their recommended fluid intake for the five days preceding our inspection visit. On one day they had only drunk 300mls when their recommended intake was 1900mls. Records did not demonstrate what action the service had taken to increase this person's fluid intake. We raised concerns with the interim manager about this person's hydration during our inspection visit and were told that they would contact the person's GP.
● Where people were on bowel monitoring due to risk associated with their continence charts were not always completed. For example, the last recording on one person's chart was 15 November 2019. This meant that the person may not have had a bowel movement for 13 days prior to our inspection visit. Ineffective monitoring put the person at risk of faecal impaction.
● Mental capacity assessments were not always completed appropriately to ensure that the service did not deprive people of their liberty without appropriate authority. For example, for one person their physical disability was given as reason for them not having the capacity to make a decision.

Systems were either not in place or robust enough to demonstrate safeguarding and risks to people were effectively managed. This placed people at risk of harm. This was a continued breach of regulation 12 (Safe

Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

At our last inspection the provider had failed to ensure there were enough staff to support people safely. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found changes had been made to staffing levels. However, we had ongoing concerns regarding the management and deployment of staff.

● A director of the provider company told us they were reviewing how the service arrived at staffing levels. They advised a staffing tool was being developed from recognised staffing tools.
● The interim manager told us the staffing level was three care staff and one nurse during the day and one member of care staff and one nurse at night.
● Following action by the local authority the number of people living in the service had significantly reduced since our last inspection. However, on the day of our inspection the service was still using two units split over two floors. There were three people were living in the first floor unit and two people in the ground floor unit. Of these five people, four required two people to support them to transfer and two required close supervision.
● This number of staff deployed in this way over two units on two different levels meant that we could not be assured that there would always be a member of staff available to support people in an emergency or in the communal areas. The nurse was responsible for administering medicines and other nursing duties which would leave one carer available in one of the units. We also observed periods of up to 15 minutes during the day when there was no member of care staff available in communal areas.

● At 9am we visited one person in their bedroom. They were in bed but were at a very dangerous angle, nearly falling out of bed. We activated an alarm in the room. This person's daily record showed that staff had last visited this person at 7.10am. This person had previously fallen from their bed. We activated an alarm in the room to alert staff that the person needed assistance. Despite the person having fallen before and therefore being at high risk of falling from the bed there were no arrangement in place for appropriate equipment or increased observations.
● We observed periods of time of up to 15 minutes where there was no member of care staff in the communal areas. This meant that staff were not available to ensure people were safe.
● On the day of our inspection visit, one member of care staff had called in sick for the morning shift. This meant that there were two care staff and one nurse on duty when we arrived at the service at 8.30am. The nurse, who was also the interim manager, was engaged in administering medicines which left two care staff over two units. The interim manager had contacted another of the provider's services and a member of care staff came from that service arriving at Lehmann House Residential and Nursing home at 9.05am.
● The director and interim manager told us they were considering moving everybody into one unit in the near future, but this had not yet taken place due to the need to consult with people and their relatives regarding a move.
● No new staff had been recruited since our last inspection visit where concerns had been identified. Therefore, we were unable to determine if staff were now being recruited safely.

Using medicines safely

At our last inspection the provider had failed to robustly assess and manage the risks relating to the administration of medicines. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found that some improvement had been made but there were still concerns with regard to the management of prescribed

medicines.

● Records relating to the application of prescribed topical creams were kept in a folder in each lounge. For two people there was a record of what the cream was for and where it should be applied. However, the record of application was blank which meant we could not be sure they were receiving their medicine as prescribed.

Systems were either not in place or robust enough to ensure people received their medicine as prescribed. This placed people at risk of harm. This was a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Medicines continued to be stored securely.

Preventing and controlling infection
At our last inspection the provider had failed to robustly assess and manage the risks relating to infection control. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection the director showed us they had addressed the individual concerns identified, but we identified further concerns relating to infection control.

● There had been no infection control audit since February 2019.
● In the ground floor sluice room, we found a towel which care staff confirmed they were using to dry their hands. The paper towel dispenser was empty. Use of a single towel raises the risk of the transmission of infection.
● There was lime scale build up on pipes in the sluice room and staining on the floor in the laundry as described in our previous inspection report.

Systems were either not in place or robust enough to demonstrate safety was effectively managed. This placed people at risk of harm. This was a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The care director outlined to us new audits being implemented to reflect an improved clinical overview.

Learning lessons when things go wrong
● There was little evidence of learning from events or action taken to improve. For example, with regard to infection control the service had remedied the individual concerns but had not looked at the shortcomings which led to the concern.
● Accidents and incidents were not always reported appropriately. When they were reported the investigation into why the accident or incident occurred was poor.
● The care director told us that improvements were planned. These included a weekly managers report, a home action plan, new audits, audit templates, staffing reviews and rota management, appropriate recruitment procedures, and a new nominated individual.

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.

At the last inspection this key question was rated as Inadequate. At this inspection this key question has remained the same. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- There was a cultural issue in the home where the relationship between staff and the provider had broken down. Staff continued to tell us they did not feel the service was well-led and had little confidence in the management team. They told us that following our previous inspection visit and action by the local authority, a staff meeting had been held but that they had found out more information from the press. The provider told us that a staff meeting was held to inform staff of developments but that some staff were on holiday. They also told us they had been in communication independently with staff who had not been at the meeting.
- This was further demonstrated when staff told us they did not have any wipes to use during personal care and that they had not been available for a number of days. They had looked where they were usually kept and having found none available had carried on without. They had not approached any of the management team to ask if wipes were available. We asked the director and interim manager why these were not available. The care director found wipes, and these were distributed to the units. The management team blamed the care staff stating they had not looked for them. They did not recognise that it may be their systems and poor staff morale which could be the cause.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- Reporting of incidents in the service continued to be inconsistent. We found an incident recorded in a person's care plan with no corresponding incident report. Poor reporting of individual incidents meant it was not possible to effectively monitor performance and risk.
- The management team dealt with individual issues identified by us but did not take a whole service view and address the root cause of concerns. At our previous inspection we found there had been no infection control audit since February 2019 and infection control concerns were identified. At this inspection the individual concerns we had previously identified had been addressed but auditing and monitoring had not been put in place and we found further concerns with infection control.
- Investigations into accidents and incidents were not robust and did not identify what happened and the root cause of the incident. For example, one incident record recorded a person had a bruise to their eye and elbow. The report stated the person said they, "Got stuck in a building." The report had been closed with no further investigation. We spoke with the interim manager who had assumed the bruise was due to a fall

without any further investigation recorded.
● Another report regarding a medication error stated that the director had told a nurse what to do following a medicines error. When we asked the director about this they told us they had not given the nurse any advice and this should not have been recorded. The report did not contain any investigation into why and how the error had occurred. Both of the above reports had been filed and were not subject to any further investigation.

The above demonstrates a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Good governance.

● Since our last inspection visit the provider has revised their senior management team. The nominated individual was planning to step down and a new nominated individual had been recruited.
● Our previous inspection had raised concerns with regard to the overall management of the service. The provider has told us how they plan to address the governance issues.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong; Working in partnership with others
● Our previous report identified concerns with how the service worked with the local authority. Feedback from the local authority since this inspection is that the relationship is still proving challenging for both sides.
● We were not made aware on the day of inspection of any events which required the service to act on the duty of candour.