Mr & Mrs A Cousins

Levanto Residential Care Home

Inspection report

7-9 The Riviera
Paignton
Devon
TQ4 5EX

Tel: 01803554728

Date of inspection visit:
28 June 2022

Date of publication:
05 January 2023

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
Levanto Residential Care Home (hereafter referred to as Levanto) is a residential care home providing accommodation and personal care to up to 20 people. The service provides support to older people who are living with dementia. At the time of our inspection there were 16 people using the service.

Accommodation is provided over the first and second floors, with the registered manager and deputy manager's office being on the third floor. The second floor is serviced by chair lifts. Some bedrooms have ensuite facilities. There are two communal lounges and a dining room. There is a small veranda at the front of the property with comfortable seating.

People's experience of using this service and what we found
We completed our last inspection at Levanto on 16 June 2022. During that inspection we identified breaches in relation to safeguarding, safe care and treatment, premises and equipment, person-centred care, dignity and respect, consent, staff training and recruitment, complaints, notifications and governance and leadership. We raised safeguarding alerts in relation to eleven people and the local authority responded by initiating a large-scale safeguarding adults enquiry.

Following our last inspection, a member of staff had contacted us to raise concerns about a medicines error. They had reported this to the registered manager but were concerned that no action had been taken. During this inspection we found three people had new and unexplained bruising, and staff raised further concerns about one person's safety at night, and the impact of their behaviour on others. The registered manager had not recognised or reported any of these concerns as safeguarding concerns and had failed to investigate the medicines error. We notified the local authority of our concerns relating to five people.

Medicines were not being managed safely and stock was not being controlled. Some people had more medicines than they should have, one person had medicines missing and there was a large amount of paracetamol in the home that had not been recorded on people's medicines records. Care plans did not contain sufficient information to enable staff to meet people's needs safely and staff did not take action in response to people's declining health. Infection control continued to be poorly managed and no action was taken to prevent the spread of infection when four people displayed symptoms of infectious disease.

Staff told us managers were more present in the home since the last inspection, however, the culture of the service still meant staff were still reluctant to raise concerns. One said they felt it had been difficult to raise concerns because some staff members "hold a grudge, and never forget it". Managers had not identified the additional concerns we identified during this inspection. Changes in the senior staff team had led to confusion over what staff were responsible for and this had impacted on people.

Following the concerns raised after our last inspection, at this inspection we saw the local authority had begun to take action to mitigate some of the risks identified. For example, they had begun to assess people's

needs, had provided equipment to support people to mobilise safely and had provided agency staff both day and night.

Changing the culture of a service takes time. Due to the short time span between our last inspection and this inspection, it would not have been reasonable to expect the provider to have made any significant progress in regard to this. The provider had begun to make some changes, for example introducing a choice at mealtimes. The registered manager had reflected on the last inspection report, and now acknowledged that they had failed to keep their own skills and knowledge up to date and this had impacted on their ability to identify shortfalls within the service.

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 last rating for this service was inadequate (15 July 2022).

At this inspection we found the provider remained in breach of regulations.

Why we inspected
The inspection was prompted in part due to concerns received immediately after our last inspection about medicines, people's wellbeing and the management of Levanto. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating. The overall rating for the service remains inadequate based on the findings of this inspection.

Following our last inspection, the local authority took action to reduce the risks to people. This included providing equipment to help people mobilise safely and providing agency staff who were trained to use the equipment. The agency staff were in place 24 hours per day at the time of this inspection. The provider was working with the local authority to make improvements, and at the time of this inspection that work was ongoing, with assessments beginning to be completed for people living at the service.

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

Enforcement
We have identified continued breaches in relation to safe care and treatment and good governance.

We cancelled the providers registration.

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The overall rating for this service is 'Inadequate' and the service 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? The service was not safe	**Inadequate**
Is the service well-led? The service was not well led	**Inadequate**

Levanto Residential Care 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 Health and Social Care Act 2008.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
This inspection was conducted by two inspectors.

Service and service type
Levanto is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Levanto is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. 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. At the time of our inspection there was a registered manager in post.

Notice of inspection

This inspection was unannounced.

What we did before the inspection
We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We reviewed the information we had received about the service since the last inspection. We used all this information to plan our inspection.

During the inspection
We spoke with ten members of staff including the registered manager, who is also the provider. We reviewed a range of records including four peoples' care notes that had been completed since our last inspection. We sampled care plans and reviewed six peoples' medicines records and medicines stock. We spoke with eight people living at the service and made observations within the communal areas. We spoke with four health professionals. Following our site visit we spoke to a further seven members of staff on the telephone. Because we had spoken with 12 peoples' family members during the course of our previous inspection, 15 days prior to this inspection commencing, we did not contact family members for any further feedback during this inspection.

We raised our on-going concerns about the safety of the service with the local authority during our site visit.

Inadequate

Is the service safe?

Our findings

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

At our last inspection we rated this key question inadequate. The rating for this key question has remained inadequate. This meant people were not safe and were at risk of avoidable harm.

Systems and processes to safeguard people from the risk of abuse

At our last inspection systems and processes were not operated effectively to protect people from abuse and neglect. This was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 13.

- A member of staff had contacted us to raise concerns about a medicines error. Four tablets, which had been signed as being administered to one person, were found in a waste bin. They had reported this to the registered manager but were concerned that no action had been taken.
- The registered manager did not initially investigate the medicines error, speak to the staff member about it or recognise that it was a safeguarding concern.
- After we raised our concerns about this, the registered manager investigated the medicines error. They told us the outcome of this investigation was 'inconclusive as one member of staff is saying one thing and the other one is saying another'. This outcome failed to consider that the tablets had been inappropriately disposed of, and the medicines record had been signed to say they had been administered.
- At the time of this inspection three people had new, unexplained bruises. The registered manager told us they were not aware of all the bruises, and they had not recognised that the one they were aware of could constitute a safeguarding concern.
- Four staff raised concerns about one person's safety at night, and the impact of their behaviour on others. One staff member said this person, "Goes into other people's rooms, wakes them up, moves furniture around in the lounges and tried to walk upstairs. They've had numerous unwitnessed falls and unexplained bruising."
- A second staff member told us one person "clashed really badly" with the person who walked around at night, but they had, "Never seen them hit [gender]." Staff were concerned they were not always able to supervise these people when they were assisting other people elsewhere in the building, which put them at risk of harm. One staff member said, "We have been lucky so far."
- We notified the local authority of our concerns relating to five people.

Systems and processes were not operated effectively to protect people from abuse and neglect. This was a continued breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Following the concerns raised after our last inspection, at this inspection we saw the local authority had begun to take action to mitigate some of the risks identified. For example, they had begun to assess peoples' needs, had provided equipment to support people to mobilise safely and had provided agency staff both day and night.

Using medicines safely

At our last inspection medicines were not managed safely. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

● A new medicines cycle had begun eight days prior to our inspection. No stock had been carried forward on people's medicines records, which meant it was difficult to check if stock levels were correct because it was not clear if any medicines had been carried forward.
● When we compared medicines in stock to the records, we found four people had more medicines in stock that records indicated there should be. For example, one person had 23 tablets in stock when the administration record indicated there should only be 20. This meant staff could not be sure people had had their medicines as prescribed.
● Six people were prescribed paracetamol that had not been recorded on medicines administration records. In total, there were over 1100 paracetamol in stock with no stock control.
● Ten anti-depressant tablets were missing from one person's stock. We were advised that these had been found 13 days later.
● When we asked the registered manager what action they had taken regarding tablets being found in a waste bin, they told us they didn't have a system for recording medicines errors, and they were "a bit uncertain about how to approach it".

Medicines were not managed safely. This was a continued breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff were working with the local authority to improve medicines management.
● A new lockable medicines refrigerator had been ordered.

Assessing risk, safety monitoring and management

At our last inspection risks were not well assessed, monitored or managed and people were at risk of harm. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

● At our last inspection we found care plans did not contain sufficient information to enable staff to mitigate risks to people. This remained the case at this inspection.
● Staff did not always take action in response to people's declining health. For example, one person's care records showed they had been feeling unwell for the five days prior to our inspection including very minimal intake or output of fluid. No healthcare advice had been sought.

● Health professionals had assessed one person as requiring a puree diet to reduce the risk of choking. During our inspection we observed them being assisted to eat chopped up pasta and salad, which was not in line with their recommended diet. This person had also lost 30% of their body weight over the previous 14 months, there was no evidence they had been referred to a dietitian.
● A second person had been reported as being unwell in the six days prior to our inspection. Staff had called paramedics on one occasion, however, no follow up was made with the person's GP when they continued to feel unwell in the following days.
● Where people required regular repositioning to reduce the risk of pressure damage, records showed that there were still gaps of three to four hours. A health professional we spoke to confirmed best practice to prevent pressure damage is two hourly turns.
● At our last inspection we noted that the evacuation chair was not stored appropriately. The provider had taken action and it was now secured at the top of the stairs, however, staff on duty were not aware of this and did not know where to find it. This potentially put people at risk in the event of an evacuation.

Risks were not well assessed, monitored or managed and people were at risk of harm. This was a continued breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The local authority had assessed two people's mobility and provided information to enable the agency staff members to mobilise them safely. Assessments for the people identified at highest risk were ongoing at the time of our inspection.
● One person, who had been identified as being at risk of choking at our last inspection, was now having their drinks thickened with the appropriate thickener prescribed for them.

Preventing and controlling infection

At our last inspection the risk of infection was not well managed. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

● During our last inspection we identified concerns in relation to infection prevention and control. These included poor mask wearing practice, no cleaning schedules and the use of hand towels in communal bathrooms rather than paper towels in line with good practice.
● During this inspection we saw no changes had yet been made. No cleaning schedules had been put in place, hand towels were still in use and we observed one staff member frequently wear their mask under their chin and a second staff member not wear a mask at all.
● During the morning handover we observed night staff inform the registered manager that two people had had loose bowels overnight, and a third had vomited. Shortly after this handover, a fourth person was unwell with both sickness and loose bowels. No action was taken to prevent the spread of infection and records from previous days showed people continued to be supported in communal areas after being unwell.

The risk of infection was not well managed. This was a continued breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Visiting in care homes

● There were no restrictions on visiting at the time of this inspection.

Staffing and recruitment

At our last inspection systems and processes to ensure staff were recruited safely were not operated effectively. This was a breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 19.

● No staff had been recruited since our last inspection and sufficient time had not passed for the provider to address the concerns identified.

Systems and processes to ensure staff were recruited safely were not operated effectively. This was a continued breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The local authority had provided agency staff both day and night to ensure there were staff with the sufficient knowledge and skills on duty.

Learning lessons when things go wrong
● Sufficient time had not passed since our last inspection for the provider to implement systems to review safeguarding concerns or incidents.
● Despite the concerns identified during our last inspection, the provider continued to fail to take appropriate action in relation to concerns about poor practice when they were made aware of them.

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 our last inspection we rated this key question inadequate. The rating for this key question has remained inadequate. 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

At our last inspection we found the culture of the home was not positive, open, person-centred and people did not experience good outcomes. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

● Staff told us that managers were more present in the home since our last inspection, however, this had not had an entirely positive outcome. One staff member said it made them feel "uneasy", another staff member said you could, "Cut the atmosphere with a knife."
● Staff had continued to contact CQC with concerns because they did not have confidence that the registered manager would address them. One staff member told us if they had a concern they, "Wouldn't go to [registered manager] but would go straight to CQC. It's been going on too long."
● One staff member told us "things don't get seen by management". They felt it had been difficult to raise concerns because some staff members "hold a grudge, and never forget it".
● The registered manager had failed to be open about a medicines error. They had not informed the deputy manager who was overseeing medicines administration, had not investigated the error or informed the local authority safeguarding team. They maintained to CQC there had been no medicines errors until they were informed that a staff member had disclosed it to us.

The culture of the home was not positive, open, person-centred or inclusive and people did not experience good outcomes. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● Changing the culture of a service takes time. Due to the short time span between our last inspection and this inspection, it would not have been reasonable to expect the provider to have made any significant progress in regard to this. The provider had begun to make some changes, for example introducing a choice at mealtimes.
● The registered manager had reflected on the last inspection report, and now acknowledged they had failed to keep their own skills and knowledge up to date and this had impacted on their ability to identify

shortfalls within the service.
● At the time of this inspection the registered manager and senior staff were working with the local authority to make improvements at the home and local authority staff reported that they had seen some positive improvements and felt staff were working well with health professionals.

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

At our last inspection we found managers did not understand quality performance, risks and regulatory requirements. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

● Minimal progress had been made since our previous inspection. Managers had not identified the additional concerns we identified during this inspection, for example, that people's health was declining or that one person was eating food which put them at risk of choking.
● There had been some changes amongst the senior staff team, which resulted in different managers leading the staff team. One staff member told us, "No one knows what they're doing, [registered manager] doesn't know where anything is, it's embarrassing." A second member of staff said things had been "all over the place".
● Staff told us this had impacted on people living at the service. For example, one staff member told us, "No one had a bath in four days last week. [registered manager] just said to leave it."
● We observed one person in a communal lounge at 7.30am. Night staff told us they had had their medication at 7am and were waiting for their breakfast at 8am. We saw this person in the same place at 11.30am. The care staff on duty thought the kitchen staff had given them breakfast, and the kitchen staff had not done so because they had not been asked to.

Managers did not understand quality performance, risks and regulatory requirements. This was a continued breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The registered manager told us they had a staff meeting booked where they would communicate the changes being implemented to the staff team.

Continuous learning and improving care; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others.

At our last inspection we found there were no systems in place to support continuous learning and improving care, and the service did not work in partnership with others; This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

● There had not been sufficient time since our last inspection for the provider to make any significant progress or implement systems that would support continuous learning and partnership working.
● We found further evidence during this inspection staff were still not following health care professionals'

advice. For example, one person was being given food that put them at risk of choking despite healthcare professionals advising they should have a puree diet.

There were no systems in place to support continuous learning and improving care, and the service did not work in partnership with others; This was a continued breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- The provider continued to fail to recognise where incidents may require disclosing under the duty of candour. For example, informing one person's family with regards to a medicines error, and a second person's family with regards to unexplained bruising.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Systems and processes were not operated effectively to protect people from abuse and neglect. Medicines were not managed safely. Risks were not well assessed, monitored or managed and people were at risk of harm. The risk of infection was not well managed. Systems and processes to ensure staff were recruited safely were not operated effectively.

The enforcement action we took:

We cancelled the providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The culture of the home was not positive, open, person-centred or inclusive and people did not experience good outcomes. Managers did not understand quality performance, risks and regulatory requirements. There were no systems in place to support continuous learning and improving care, and the service did not work in partnership with others.

The enforcement action we took:

We cancelled the providers registration.