Greenleaf Healthcare Limited

Livesey Lodge Care Home

Inspection report

Livesey Drive
Sapcote
Leicester
Leicestershire
LE9 4LP

Tel: 01455273536

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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

We undertook this unannounced, focussed inspection on 25 October and 2 November 2018. The inspection was prompted, in part, by information shared with the Care Quality Commission which indicated potential concerns regarding the health, safety and wellbeing of people using the service. This inspection examined these concerns and potential risks to people's safety. We inspected the service against two of the five questions we ask about services; 'Is the service Safe?' and 'Is the service Well Led?' This is because the service was not meeting some legal requirements in these areas and the information shared was relevant to these two key questions.

Livesey Lodge Care Home is a single storey, purpose built residential home which provides care to older people including some people who are living with dementia. The service is registered to provide care for up to 24 people. At the time of our inspection there were 20 people using the service.

Livesey Lodge Care 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.

Our last comprehensive inspection of this service was carried out on 15 May 2018. Two breaches of the legal requirements were found and we issued a warning notice. We found staff were not consistently following policies and procedures to ensure the safe management and administration of medicines, including those related to infection control. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Safe Care and Treatment. We also found the provider did not have effective quality assurance to monitor the quality of the care provided and ensure people received good care as a minimum standard. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Good Governance.

We rated the service as 'Requires Improvement'. The provider submitted information stating what they intended to do to address the shortfalls. You can read the report from our latest comprehensive inspection by selecting 'all reports' link for Livesey Lodge Care Home on our website at www.cqc.org.uk.

At this inspection we found the provider had made some changes, but overall there was little improvement in the overall safety or governance of the service and the provider continued to be in breach of the regulations of the Health and Social Care Act 2008.

The overall rating for this service is 'inadequate' and the service is therefore in 'special measures.' Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If no 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.

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.

There was a registered manager in post who was also the provider. 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 2008 and associated Regulations about how the service is run.

People's safety was being compromised in a number of areas. Risks associated with the premises had not been effectively assessed or monitored. The provider had not taken action to protect people from the risk of burns or scalding from excessively hot surfaces and water temperatures. Maintenance was not provided in a consistent or timely manner to ensure the premises were safe and fit for their intended purpose.

The provider had not ensured sufficient numbers of suitably competent, skilled and knowledgeable staff were always available to keep people safe and meet their needs. The provider had adjusted staffing levels in response to concerns from external agencies, but had not used any recognised dependency tool or assessed people's dependency levels. They were unable to demonstrate staffing was sufficient to meet people's current needs. Staffing rotas were not an accurate reflection of staff deployment within the service.

Safe systems were not consistently in place to ensure people received their medicines as prescribed. Medicine errors were not identified or reported in a timely manner.

Risks associated with people's care and health conditions had been assessed but records did not always reflect people's current needs or demonstrate staff were following guidance in records. People were not always supported to move safely around the premises.

The provider had not adequately monitored the service to ensure it was safe. The provider had begun to undertake audits on areas of the service relating to hygiene, cleanliness and decor. Audits and checks had not identified the areas of concern we found during our inspection. The provider had not made adequate arrangements to ensure the effective leadership and governance of the service.

The provider had not made the significant improvements required since our last inspection to meet the requirements of the regulations and to keep people safe from harm. The provider demonstrated that lessons were not learned and our findings showed improvements were not made to provide a safe and well led service.

We found continued breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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.

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.

People were at risk from harm as the provider had not ensured the premises and equipment were safe and well maintained.

People did not always receive their medicines safely or as prescribed.

The provider did not always ensure sufficient numbers of qualified, experienced staff were deployed to keep people safe.

Risks to people's safety were not always effectively managed.

Is the service well-led?

Inadequate

The service was not well led.

The provider had not taken action to remedy the breaches of regulation and improve the quality of the service to ensure people received safe care.

Records and systems were not adequate, sufficient or accurate enough to demonstrate that the service was well led.

Livesey Lodge 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 checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

We undertook an unannounced focussed inspection of Livesey Lodge Care Home on 25 October 2018 and 2 November 2018. This inspection was done to check that improvements to meet legal requirements planned by the provider after our comprehensive inspection in May 2018 had been made. The team inspected the service against two of the five key questions we ask about services; is the service safe and is the service well led? This is because the service was not meeting some legal requirements.

The inspection visit on 25 October 2018 was undertaken by two inspectors. One inspector returned to complete the inspection on the 2 November 2018.

Before the inspection, we reviewed information we held about the service, which included notifications they had sent to us. A notification is information about significant events or incidents within the service that the provider is required to send us by law. We also spoke with commissioners from the local authority, responsible for funding some of the people using the service, to obtain their views about the care provided at the service. We used this information to plan this inspection.

During the inspection, we spoke with four people who used the service, two relatives, the registered manager, the provider, the deputy manager and four care staff. We reviewed care records and associated risk assessments for three people. We reviewed records relating to the day to day management of the service, including staffing, medicines and quality assurance. We also undertook observations to review the care and support people received in communal areas.

Inadequate

Is the service safe?

Our findings

At our previous inspection in May 2018, we rated the service as requires improvement in the safe domain. This was because staff did not follow safe medicines management and infection control practices and risks were not always managed so people were protected from avoidable harm. These were breaches of Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014. Following that inspection, the provider told us about the action they were taking to rectify the breaches. At this inspection, we found the provider had not made all the improvements required to rectify the breaches to ensure people received safe care.

At this inspection we found risks within the premises had not been effectively assessed or managed to ensure the premises and equipment within it were safe for people. On the first day of our inspection we found most radiators in communal areas and in people's rooms did not have protective covers on. This is important to protect people from the risk of burns through coming into prolonged contact with hot surfaces. We found a number of radiators in communal areas were extremely hot to touch. We also found radiators were very hot to touch in some people's rooms. Many of these radiators were covered by furniture, such as armchairs, that were placed in front of them. However, this presented a risk of entrapment and burns if people were to fall in this area. Radiators near the laundry area had damp clothing drying over them, with the result that wallpaper had peeled away over the top of the radiator. We raised this as an immediate concern with the provider who told us they would take immediate action to address concerns.

We also found fluctuations in water and heating temperatures within the premises. We ran hot water in the wash hand basins in two toilets and one bath in an assisted bathroom in the premises for over one minute. Temperatures ran either cold or luke warm, including the bath water. The provider told us they had recently commissioned work to improve the boilers and they would take action to ensure temperatures were regulated throughout the premises.

On the second day of our inspection, we found radiator protective covers had not been fitted to any radiators. Many radiators remained very hot to touch. We observed staff manually adjusting the temperature of individual radiators. They told us they had to do this due to fluctuations in heating temperatures throughout the premises and because one person using the service regularly adjusted these controls as they walked around the premises unsupervised. We found no action had been taken to reduce the risk for the person in coming into contact with hot radiators.

The provider had systems in place to check the temperature of radiators. However, these had not been carried out regularly or consistently. Records showed there was a gap in temperature testing for the months of August and September 2018. Records did not demonstrate if testing was for surface temperature or output from radiators. The provider showed us evidence that they had ordered a small number of radiator covers, but was unable to confirm a date of fitting. The provider had not assessed or taken reasonable action to mitigate the risks for people and protect people from the risk of burns in the event of prolonged exposure to unprotected, hot radiators.

On the second day of our inspection, we sampled water temperatures in toilets and one assisted bathroom. We found the hot water in the bath was extremely hot and exceeded 52 degrees Celsius. The provider had a safety sign in the bathroom which instructed staff that water temperatures should not exceed 43 degrees Celsius and staff should use a floating thermometer to check the water temperature before supporting people into the bath. Temperatures should be recorded in the 'bath book'. Staff told us the bath was in daily use and were unable to produce the floating thermometer or record of temperatures. People were at immediate risk of scalding through immersion in excessively hot water temperatures. We raised this as an immediate concern with the provider who told us they would instruct the maintenance person on site to ensure water temperatures were safe.

The provider had not ensured there were always sufficient numbers of staff deployed, who had the skills and qualifications to keep people safe. The provider informed us that they had recently increased staffing numbers in response to concerns from the local authority following their visit to the service. They told us staffing levels had been increased to three staff for morning, evening and nights. They told us the deputy manager and registered manager/provider were supernumerary to the rota. The increase in staffing was provided by agency staff. The provider did not have systems in place to ensure agency staff had the skills and experience needed to support people to meet their needs, which increased the risks to people's safety and wellbeing.

We observed care and support provided in the lounge, dining room and conservatory. We saw people were left without supervision for periods of time, ranging from five to fifteen minutes. Staff were busy supporting people with personal care needs or attending to tasks, such as meals or laundry. There were no calls bells available for people to use in communal areas. Some people required regular staff support to reduce risks to themselves and to others. For example, one person was disorientated and repeatedly approached other people in the lounge, standing over them and trying to converse with them. We saw other people were annoyed by this and did not want this interaction, which increasingly frustrated the person. The person's care plan recorded that they had been assessed as requiring support and staff intervention to reduce the risk of behaviours that challenge. This was confirmed by staff who we spoke with. There were no staff members available to intervene and support the person for fifteen minutes.

Staff told us they struggled to meet people's needs at times. Comments included, "Things have been really difficult. The provider has increased the staffing in the last two to three weeks. It has made some difference but staff are required to do other roles as well, such as cleaning, so we don't get to spend much extra time with people. I think it has improved consistency though as we mostly have regular agency staff work here," "Although there has been extra staffing, there are still some shifts where there are only two staff on. Rest breaks are a problem as we are supposed to have an hour when we work a long day but we can't really as when we sit down, people come over and talk with us or approach us. There is nowhere for us to take a break. The domestic is responsible for activities but hasn't much time to do them as it's within their cleaning hours. We haven't got time to spend doing activities or even talking with people as we are constantly attending to people's personal care needs. The agency is good but only if they send staff who work here regularly. New agency don't have an induction, we have a list of names and needs we give them. We do our best for people, some of it in our own time," and "The rotas are not an accurate reflection of staffing; there are times it goes below that. A number of people take two staff to provide the support they need. We struggle and it is embarrassing and shouldn't happen. We don't have time to do our paperwork."

We reviewed staffing rotas from 15 October to 4 November 2018. Although records confirmed the information given by the provider, they were not an accurate record of staff who had worked in the service. For example, on the evening of 24 October 2018, a staff member had cancelled their shift which left two staff working in the service supporting 22 people. It was evident based on the records we viewed that two staff on

a shift were not enough. For example, we found records required to monitor people were having sufficient amounts to eat and drink had not been completed for the shift. Staff told us they were unable to provide the care or supervision people needed as they had to spend some time with a person who required their support. Many of the people using the service required staff support to ensure their safety and reduce the risk of falling whilst moving around the premises. Others required staff support to intervene and reduce their anxiety or support their orientation and to provide personal care. This put people at risk because there were not enough staff to meet their needs or keep them safe.

On the second day of our inspection, the provider informed us that they had reduced the number of night care staff from three to two staff members. They told us this was because they had asked staff and felt there was a low level of need during the night. The provider had not completed any dependency tool. This is important to demonstrate they had used a systematic approach to determine the number of staff and range of skills required to meet people's needs and keep them safe. Following our inspection, the provider sent us a copy of a dependency assessment they had completed to determine staffing required during the night time. The assessment covered people's needs in relation to continence, number of turns (support to reduce the risk of pressure sores) and sleep disturbance. However, the assessment did not reflect current best practice guidance through a recognised staffing dependency tool. The assessment did not consider the different levels of skills and competence required by staff to the meet the current needs of people using the service, or include the level of support each person would require in the event of an emergency evacuation at night.

People were not always supported to move safely around the service. One person required staff support and equipment to transfer in the form of a hoist and sling. Their risk assessment provided guidance on the use of the hoist. However, staff were unable to tell us what size sling had been assessed as being safe and appropriate for the person. One staff member told us two people were supported to use the hoist and they shared the slings between them.

We observed staff supported one person to move using the hoist. The person became very distressed as staff attempted to put the sling in place and staff were visibly struggling to fit the sling in the correct position. Staff did not offer any reassurance or explanation to the person at this stage. Once the person was in the hoist, staff raised the person excessively high and a distance of over one metre in order to transfer the person to a wheelchair. Staff did not demonstrate a good understanding of safe transfers and the correct position of equipment to support safe, comfortable transfers for people. We saw staff moved the person in their wheelchair backwards from the room. There were no footplates on the wheelchair which resulted in their feet being dragged on the ground. Other supported moving, such as assisting people to use walking frames and to get up from chairs and armchairs, was carried out safely.

People were not consistently protected by safe systems for managing their medicines. The provider told us auditing of the medicines system had commenced and staff checked the system regularly. However the provider did not record the outcome of their audits and was not able to demonstrate procedures they had put in place to ensure staff checked the medicines systems systematically. We randomly sampled three people's medicine administration records (MARs). We found missing signatures for all three people. Staff were unable to explain why signatures had been missed for two people. One person's medicine was critical to enable them to manage a health condition. We had to intervene to prevent staff from signing records retrospectively as a full audit and investigation was required to identify if these errors were recording errors, or if medicines had not been administered for people. Staff explained that the third person had not received their prescribed eye drops for two days because the eye drops had got 'lost'. Staff believed the drops had been discarded by accident, though there was no evidence of this. Staff had ordered replacement stock upon discovering the error. The person required the eye drops to manage a serious eye condition, which

resulted in very sore and uncomfortable eyes. No action had been taken to identify if the person had experienced adverse effects as a result of the missed medicine. We raised these concerns with the provider who told us they would follow up these errors and areas of concern.

On the second day of our inspection, we reviewed the three MARs with missing signatures. We found one chart had been signed retrospectively by staff. There was no explanation or audit to demonstrate if this was an administration or a recording error. Missing signatures remained on the second chart where the person's medicines were critical for their health condition. The provider told us the medicines had not been administered. They had not taken any action to safeguard the person's health and well being by consulting with medical professionals to identify any possible adverse effects as a result of the missed medicines, and actions they needed to take as a result of the missed dose. They had not notified relevant external agencies to alert them to the medicines error. This is important to enable external agencies to evaluate risks and ensure action is taken to prevent the risk of further harm. This demonstrated people were at risk from not receiving their medicines as prescribed. Following our inspection visit, the provider took appropriate action to notify external agencies and seek healthcare advice to ensure the person had not experienced adverse effects as a result of this incident.

On the first day of our inspection, we found liquid medicines and eye drops had not been dated with the date of opening. This is important as these medicines had a limited shelf life once opened. On the second day of our inspection, we saw staff had recorded the date of opening on these medicines.

The above evidence supports continued breaches of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People shared their views about their safety in the service. Comments included, "I used to be terrified at night when I lived on my own. It doesn't worry me a bit here. I feel safe because the staff are around I've settled in and I'm very happy," "I can't say I've noticed any difference with staffing recently. I think they have enough," and "Things I wasn't very happy about before have been sorted out. I have seen changes in the last couple of weeks; things have improved for the better. Staff are less erratic, which helps people. There are a lot of agency staff, some are better than others. You get some that don't know what they are doing and you have to keep telling them. They are not much use. The regular agency staff are fantastic."

Staff demonstrated some understanding of their responsibility to protect people from abuse. One staff member said, "In the time I've worked here, I've never seen any poor care or staff being unkind." Staff told us they had completed training in protecting people from abuse, which was confirmed in the training records we reviewed. However, some staff demonstrated limited understanding in reporting concerns outside of the service.

The provider's safeguarding policy detailed types of abuse, responsibilities and procedures for responding and reporting suspected or actual abuse. The policy included contact details for relevant external agencies, including the local authority safeguarding team, action on elder abuse and the Care Quality Commission. Records showed the provider did not always follow their policy. For example, an incident form recorded that a person had sustained an injury to their leg, alleging that another person had kicked them. Staff had recorded a skin tear and evidence of bleeding. However, records did not demonstrate the incident had been investigated or analysed to prevent the risk of further incidents. The provider had not made a safeguarding referral to alert relevant external agencies of a potential safeguarding incident. This meant agencies were unable to take action to ensure the provider had appropriate measures in place to keep people safe.

Risks to people's safety were not always effectively managed. People's care plans included risk assessments

which identified areas where they may experience potential harm, and the measures staff needed to take to keep people safe. However, in some cases records did not reflect people's current needs and measures were not consistently followed by staff. For example, reviews of one person's risk assessments stated they were nursed in bed. We saw the person sitting in the communal lounge and staff confirmed the person was not nursed in bed. Our review of the person's daily care records confirmed they were not nursed in bed. A second person had a risk assessment in place which had been completed in October 2018, relating to them regularly declining personal care and the impact this had on their health and wellbeing. The risk assessment clearly identified strategies and approaches for staff to follow to enable the person to accept and engage in support with their personal care. Records completed two days after the risk assessment had been implemented, demonstrated staff had not followed these strategies or interventions.

It was evident that lessons had not been learned and improvements had not made following our last inspection.

We observed staff followed procedures to reduce the risk of infections for people. Staff wore gloves when administering medicines and changed gloves and aprons between tasks, such as personal care. Gloves, aprons and hand sanitisers were available throughout the premises. Clinical waste and soiled linen was appropriately bagged, though the laundry was very cluttered and congested on the second day of our inspection. Staff told us faults had developed with the washing machine and tumble dryer which they had raised with the provider to action. The provider had systems in place to ensure water storage was annually tested to reduce the risk of people being exposed to the legionella bacteria; this was confirmed in records we reviewed. The provider told us staff followed cleaning schedules to ensure water outlets, such as shower and sinks, were appropriately cleaned. However, they were unable to produce evidence of legionella procedures or that staff followed these as part of routine domestic duties.

Inadequate

Is the service well-led?

Our findings

At our last inspection in May 2018 we found systems to monitor, assess and improve the quality of the service were not effective to ensure the care provided was safe. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We issued a Warning Notice and the provider wrote to us stating how they intended to address these shortfalls.

At this inspection we found the provider had not made the improvements to meet the requirements of the regulations.

There were systematic and widespread failings in the oversight and monitoring of the service which meant people did not always received safe care to maintain and improve their well-being. Despite the previous inspection identifying significant shortfalls in governance systems, we found that insufficient progress had been made to the auditing and governance of the service.

The provider had begun to undertake some audits and checks on areas of the service which were hygiene and cleaning and the environment. These had been completed in September 2018. Hygiene and cleaning audits had reviewed cleaning standards in communal areas and in people's rooms. These identified if areas were clean and free from odours. These audits had found no areas that were unsatisfactory. Environment audits recorded areas as 'good, acceptable or poor'. There was no supporting information or processes to demonstrate the standards that the provider was reviewing against. Environmental audits reviewed the state of décor, floorings and furnishings throughout the premises. Audits had not identified the areas of concern we found during our inspection visit. There were no audits of care records, staffing and staff deployment, accidents and incidents or medicines. The provider had failed to ensure procedures were in place that could be followed to ensure all areas of the service were audited and safe.

The service had a registered manager in post who was also the provider. Staff did not feel supported by the registered manager. Comments included, "The registered manager is not pleasant to staff; never says 'good morning' or 'thank you'. It doesn't take anything to thank your staff, particularly when they work hard," "They [registered manager] will tell us the problems are our fault. They tell us, we have enough of everything, we just don't work properly," and "There has been no change in leadership or governance since the last inspection. I don't think [name of provider] understands the local market place or the competition. There has been little improvement."

Records of staff meetings held in October 2018 showed a common theme of staff recruitment was discussed at each meeting. Many of the staff lived locally and felt the provider had not made efforts to attract local workers. Minutes of meetings showed the provider had discussed outcomes from inspections and quality audits from external agencies and advised staff on the areas that they needed to improve in.

People were not meaningfully included in the running of the service. Surveys had been sent out to people to which the replies were positive and commented on improvements to meals. One person told us, "They [provider] have made some improvements. How long they will last, who knows?" However, the provider had

not explored ways in which people who could not share their views through this forum, could contribute to the running of the service and be involved in their care. There were no records of recent relative meetings being held. This meant there were limited opportunities to gather feedback to improve the service for people.

The provider did not have systems or methods in place to continuously learn, and therefore improve the service. For example, the information we supplied following the last inspection and day one of this inspection visit had not been actioned and improvements had not been made. The provider demonstrated limited knowledge and understanding of their role and legal responsibilities in driving and sustaining improvements in the service. For instance, they did not demonstrate awareness of their responsibility to notify external agencies, including the Care Quality Commission, of potential safeguarding incidents to ensure appropriate action was taken to protect people from the risk of harm.

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

Commissioners from local authorities had carried out several visits to the service and as a result, made a number of requirements of the provider to improve the safety and care provided.

The provider had displayed a copy of the last inspection report in the service, which is a legal requirement.

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 The provider had not done all that is reasonably practicable to assess and mitigate risks for people using the service. The provider had not ensured that sufficient numbers of staff were always deployed and the qualifications, competence, skills and experience to provide care and treatment and keep people safe. The provider had not ensured that the premises and equipment within it were safe to use for their intended purpose. The provider did not have sufficient systems and processes in place to ensure the proper and safe management of medicines.

The enforcement action we took:

Urgent Notice of Decision to Impose Conditions on the Providers' Registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not established or operated effective systems and processes to assess, monitor and mitigate risks relating to the health, safety and welfare of people using the service.

The enforcement action we took:

Provider meeting