Careconcepts Limited

Marion Lauder House

Inspection report

20 Lincombe Road
Wythenshawe
Manchester
Greater Manchester
M22 1PY

Tel: 01614373246
Website: www.careconcepts.co.uk

Date of inspection visit:
18 May 2021
20 May 2021
26 May 2021

Date of publication:
01 September 2021

Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service caring?	**Good**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Marion Lauder Nursing Home is a care home providing personal and nursing care to 62 people aged 65 and over at the time of the inspection. The service can support up to 79 people.

The care home accommodates people across four units. One of the units specialises in providing residential care to people living with dementia.

People's experience of using this service and what we found
Actions staff needed to take to reduce some risks were reflected in electronic care plans, but the system did not always accurately reflect the risks posed to people. Referrals were made to other health professionals, but these were not always done in a timely manner. Premises checks and all maintenance records were up to date. Required test and safety certificates were in place. Systems were in place to protect people from abuse and staffing levels ensured people received both shared and one to one care as deemed appropriate. Lessons had been learnt following a recent safeguarding incident. The provider had introduced more robust processes to be followed for the care and treatment of wounds.

Relatives we spoke with considered staff to be caring and compassionate and our observations supported this. Staff were aware of people's needs, promoted independence and took time to make sure people remained safe. Staff recognised the benefits of keeping people stimulated and entertained. Staff had used other skills during the pandemic to limit the contact with others outside the home and help protect people. Staff had helped people maintain important relationships with family and friends throughout the pandemic.

Systems and processes for audit and quality assurance were in place but had not identified the shortfalls we found with the electronic care planning system. The nominated individual was responsible for managing the service in the absence of the registered manager. Daily meetings with leads and heads of units were held to improve oversight of the service. Supervision of staff, especially new staff, was a priority for the provider. Communication with relatives had not always been consistent. Families had appreciated the efforts of the home during the COVID-19 pandemic but felt communication during this time had suffered. The provider was open and transparent with stakeholders. The service was keen to re-establish partnerships with professionals that had lapsed during the COVID-19 pandemic.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

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

Rating at last inspection

The last rating for this service was outstanding. (published 17 February 2020).

Why we inspected
We undertook this focused inspection to follow up on specific concerns which we had received about the service. The inspection was prompted in part due to concerns received about falls and wound care. A decision was made for us to inspect and examine those risks.
We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. 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 changed from outstanding to requires improvement. This is based on the findings at this inspection.

We have found evidence that the provider needs to make improvement. We have identified breaches in relation to safe care and treatment and good governance at this inspection. Please see the safe and well led sections of this full report.

You can see what action we have asked the provider to take at the end of this full report.

The provider has taken action to mitigate the risks found on inspection and continues to work with relevant external professionals to help resolve them.

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

Follow up
We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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.

Details are in our safe findings below.

Is the service caring?

Good

The service was caring.

Details are in our caring findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Marion Lauder House

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.

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
The inspection was carried out by one inspector and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Marion Lauder Nursing Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission, but they were not on site and were no longer responsible for the management and oversight of the home. At the time of this inspection the provider was legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before 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.

The provider was not asked to complete a provider information return prior to this inspection. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. We took this into account in making our judgements in this report. We used all of this information to plan our inspection.

During the inspection
We spoke with two people who used the service and thirteen relatives about their experience of the care provided. We spoke with eight members of staff including the nominated individual, deputy manager, clinical lead, a nurse, administrator, activities staff, maintenance staff and the chef.

The nominated individual, who is the provider, is responsible for supervising the management of the service. They were also responsible for the oversight of the home in the absence of the registered manager. We reviewed a range of records. This included five people's care records and multiple 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
After the inspection we continued to seek clarification from the provider to validate evidence found. We looked at audits, quality assurance records and a recent action plan. We contacted a further three care workers who work at the home and gained their views over the telephone.

Requires Improvement

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 good. At this inspection this key question has now deteriorated to requires improvement.

This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management

- The electronic care planning system did not always accurately reflect the risks posed to people. Staff did not respond to a person's weight loss appropriately. The electronic care planning system in use did not accurately reflect their true weight.
- We identified some delays with specific care plans being input onto the system. These were not prioritised according to the level of risk. One person was considered a high falls risk but did not yet have an electronic care plan in relation to falls or mobility.
- Referrals to other services were not always made in a timely manner. This meant that input and support from appropriate health professionals was on occasions delayed.
- Electronic support plans did not reflect the interventions of the falls risk team. It wasn't clear to staff what action to take to reduce the risk of further falls.

People were at risk of potential harm as systems and processes were not robust enough to demonstrate people's safety was being maintained. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider and nominated individual, managing the home at the time of this inspection, responded following the inspection. Care plan processes were revised, and they were speaking with the electronic care plan company about potential system improvements.

- Actions staff needed to take to reduce some risks were reflected in electronic care plans. Staff could see on hand-held devices any regimes of care in place, such as regular repositioning or specific diets.
- Reviews of care took account of any incidents that had occurred and any changes in need were documented in appropriate care plans.
- Robust checks of the premises were in place. Records to evidence regular maintenance and service of equipment were well organised and up to date. Required test and safety certificates were in place and staff responsible for this area had good oversight.

Using medicines safely

- Safety was effectively managed in this area and the systems in place, for example a comprehensive medicines audit, demonstrated this.
- Competencies of nursing staff administering medicines had been completed at regular intervals.

● When medicine errors were identified actions to prevent a repeat incident had been documented. We identified an action that had not been fully completed and brought this to the provider's attention. Steps were taken to address this.
● Protocols for medicines to be taken 'as and when' (PRN) were in place but not consistently stored with people's medication administration records (MARs). We discussed this with the provider who took action to rectify this.

Preventing and controlling infection
● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was meeting shielding and social distancing rules.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was accessing testing for people using the service and staff.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented.
● We were assured that the provider's infection prevention and control policy was up to date.
● We were assured the provider was facilitating visits for people living in the home in accordance with the current guidance.
● Good measures were in place in relation to the prevention and control of infection. Some environmental changes had been made to the home during the pandemic to assist with this.

Systems and processes to safeguard people from the risk of abuse;
● Systems were in place to protect people from abuse. Staff said they would not hesitate to report any concerns they had and were aware of the ways available to them to do this.
● Safeguarding referrals were sent to the host authority and to the Care Quality Commission.
● Following a referral to safeguarding there was evidence of referrals to other professionals, for example the speech and language team (SaLT), tissue viability nurse or the falls clinic, where appropriate.

Staffing and recruitment
● Staffing levels were appropriate and able to meet the needs of people living in the home. Staff were very visible throughout our inspection.
● Staffing levels were monitored to ensure there were enough staff to provide safe support.
● In the event of people identified as requiring additional support, for example due to physical health conditions, the home had approached commissioners. Some people were receiving one to one support to help keep them safe.
● The provider's recruitment processes minimised the risk of unsuitable staff being employed. Disclosure and Barring Service checks and appropriate references were sought prior to staff working in the home.

Learning lessons when things go wrong
● The provider had introduced a more robust process to be followed in the event of staff identifying any wounds.
● A wound flow chart detailed actions to be taken, specific wound care regimes and the involvement of other health professionals, for example a podiatrist, for a wound on the foot.
● Accidents and incidents were monitored to see if lessons could be learnt to keep people safe.

Good

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as outstanding. At this inspection this key question has now been rated good. This meant people were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; respecting equality and diversity

- People were well supported. Staff had people's best interests at heart and treated people as individuals. There was positive feedback about staff being caring and compassionate. Comments from relatives we spoke with included, "Whenever they talk about mum they do so in a nice compassionate sort of way", "I find that they really are [caring]. Mum seems happy there. She will say something if she is not happy'', and "Mum has told me that they are very good to her.''
- We observed warm and positive relationships between people and staff. Staff spoke with people at eye-level. There was a good use of gentle touch to acknowledge and reassure people.
- Staff recognised the benefits of keeping people stimulated and entertained and facilitated more activities within the home. Staff had used other skills during the pandemic to limit the contact with others outside the home and help protect people.
- Staff were aware of the negative impact restrictions in place because of the pandemic had made to people's lives. They continued to look for ways of lessening the impact on people and had helped them maintain important relationships with family and friends throughout the pandemic.

Supporting people to express their views and be involved in making decisions about their care

- People and relatives told us they had been involved in making decisions about their care and support needs, where appropriate.
- Staff supported and encouraged people to express their views. A recent survey indicated that people were happy with how the service responded to and respected individuality.
- People were monitored and assessed, with additional support being sought when needed.

Respecting and promoting people's privacy, dignity and independence

- People's right to privacy and confidentiality was respected. Staff knocked on people's doors and waited for a response before entering.
- Staff respected people's independence. We observed staff checking people remained safe whilst moving independently around the home, for example making sure they had the right equipment and adjusting footwear.
- Staff had genuine concern for people and were keen to ensure their rights were upheld and people were not discriminated against in any way.

Requires Improvement

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 outstanding. At this inspection this key question has now deteriorated to requires improvement.

This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

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

- Communication within the team had been disjointed and referrals to other health professionals were not always undertaken by nurses in a timely way. Senior staff were not following established processes and this had not been addressed by management.
- Systems and processes for audit and quality assurance were in place but had not identified the shortfalls we found or had not addressed them at the time of this inspection. For example, the issues with the electronic care planning system.
- Pre-admission assessments and discharge referrals were sometimes contradictory and did not always reflect people's current needs. We saw no evidence that these anomalies had been questioned by the registered manager following inappropriate placements in to the home.

Governance systems were not robust enough to demonstrate safety was effectively managed. Limitations of systems had not been identified. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The service had been through a challenging time in relation to the COVID-19 pandemic. The registered manager, who had been in post for twelve months, was no longer responsible for the service.
- The nominated individual, also the provider, was now responsible for managing the service as the registered manager had left the service the week before our inspection. A new deputy manager had started in post the day before this inspection.
- Recently introduced daily management meetings with leads and heads of units were beneficial for the new management team.

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

- Supervision of staff had slipped during the COVID-19 pandemic, although staff we spoke with did feel supported in their role. Supervision of staff, especially new staff, was a priority for the provider.
- Families had appreciated the efforts of the home during the COVID-19 pandemic but felt communication during this time had suffered. Communication with relatives had not always been consistent. One relative told us, "Out of ten, I would give them a six. The reason would be that the communication could have been

better.''
● The home had retained their silver 'Investors in People' award and had a workforce development plan in place.
● People and those close to them were asked about their satisfaction with the service. A survey had recently been completed and was available in easy-read format.
● During the Coronavirus pandemic communication with people's relatives had more often been by telephone or online, and by video calls.

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 was aware of their responsibilities in relation to the duty of candour. They were also clear of the requirement to notify CQC of all significant incidents and concerns and had done so.
● A serious error by a pharmacist occurred during the period of this inspection. This resulted in staff applying a pain patch to a person, medication that was not prescribed to them. The nominated individual reported this through the correct channels and to all relevant stakeholders. A thorough investigation was undertaken.
● Following this inspection, the provider has positively engaged with CQC and other stakeholders. An action plan was in place to clarify roles and responsibilities and address the concerns identified in the service.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Continuous learning and improving care
●The provider was able to demonstrate that lessons had been learned and revised processes were in place to support improvements in the service, for example with wound care. This would help achieve good outcomes for people.
● Staff we spoke with were optimistic. They felt as a team they supported each other and were working well together. This was evident during the inspection.
● The provider took the business decision to suspend new placements at the home for four weeks. This would give management time to stabilise the service and make the required improvements.
● COVID-19 restrictions meant opportunities to work closely with external health professionals, for example the speech and language team (SaLT), dieticians and physiotherapists, had become limited. Most contact had been virtual, and this had negatively impacted on the nursing team. We took this into account at this inspection.

Working in partnership with others
● The home had continued a partnership with the local authority to support people to move from hospital. Information received from health and social care professionals, however, did not always accurately reflect the current needs of people being admitted to the service. The provider was working with professionals to identify any people inappropriately placed in the service.
● A quality officer from the local authority had visited the home the week before our inspection. The provider had taken on board their findings, had devised an action plan and was working to address the concerns at the time of our visit.
● The service had continued the sponsorship of nurses from overseas and the business plan reflected this.
● The provider was open and transparent with stakeholders. The service was keen to re-establish partnerships with professionals that had lapsed during the COVID-19 pandemic.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were at risk of potential harm as systems and processes were not robust enough to demonstrate people's safety was being maintained. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Governance systems were not robust enough to demonstrate safety was effectively managed. Limitations of systems had not been identified. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.