Care Quality Commission

Latimer Grange Limited

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Inspection report

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06 December 2017

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	Inadequate
Is the service effective?	Requires Improvement
Is the service caring?	Requires Improvement
Is the service responsive?	Requires Improvement
Is the service well-led?	Inadequate

Summary of findings

Overall summary

The inspection took place over four visits on 3, 21 and 29 November 2017 and 6 December 2017. Each inspection visit was unannounced. We inspected the service due to concerns received about the provider, registered manager and two members of staff.

The last inspection of the service was on 3 July 2017, we found that the provider was in breach of Regulation 14 (1) (4) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because a person who was at risk of malnutrition had not had nutrition and hydration assessments carried out to ensure their nutritional needs were met.

Following the last inspection, we asked the provider to complete an action plan to show what they would do and by when to make the improvements required. We received an action plan from the provider on 14 September 2017 stating how they would make the necessary improvements. We found at this inspection that whilst action had been taken to make improvements these had not been sustained and as a consequence people's nutritional and hydration needs were not being consistently met.

Latimer Grange is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection.

Latimer Grange is registered to accommodate 27 people in one adapted building. There are 23 bedrooms, 16 of which have ensuite facilities. There is a communal dining room, a communal lounge with three distinct areas and an enclosed landscaped garden with a covered seated smoking area.

The service has had a registered manager since 30 May 2017. A registered manager is a person who has registered with the CQC 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.' The registered manager was absent from the service from 18 October 2017 and the absence was expected to continue to 15 January 2018 and possibly for longer. The provider had not notified CQC in writing of the registered manager's absence.

People we spoke with were unanimous saying they were satisfied with the care and support they received. People's relatives were also satisfied. However, we found serious concerns about the safety of the service.

When people were discovered to have injuries such as bruising, there was no attempt to identify the cause of the injuries. Risk assessments were not carried out to identify how people could be protected from avoidable injuries.

People were not adequately protected from the risk of falls. Risk assessments were not reviewed after people experienced falls. This demonstrated that the provider did not have effective systems for identifying

learning after incidents occurred and making improvements.

People's nutritional health was not adequately monitored. A person's records showed they had suffered a significant weight loss in the space of two months. However, no action had been taken to review their nutritional risk assessment. This demonstrated the person had not had safe care and support.

We found the management of medicines to be inadequate. Two people had repeatedly refused to take their medicines. There was no strategy in place to understand why or what steps could be taken to protect people from the risks associated with not having medicines they required for their well-being. There were concerns when a staff member handled a person's medicines without wearing gloves. Medicines for disposal were not stored securely or returned to the dispensing pharmacist in a timely manner.

An information folder that was intended for fire and rescue emergency services was inaccurate and out of date with regards to which rooms people occupied and who lived at Latimer Grange. This could endanger fire and rescue personnel and staff if there were unable to evacuate people in the event of a fire.

Hot water pipes adjacent to baths were exposed. These posed a risk of scalding to a person if they fell in that area.

Cleaning products which were identified as substances hazardous to health were not stored safely and posed a risk to people. We made a recommendation about this.

We found that assessments of people's mental capacity were too broad and did not include assessments of people's capacity to understand specific aspects of their care and support. People who were under continuous supervision and control and were not free to leave Latimer Grange did not have a capacity assessments or best interest decisions in place to consent to arrangements for care and treatment. Applications to deprive people of their liberty had not been made. The interim manager told us they were not confident about carrying out assessments of people's mental capacity.

The premises were not consistently well maintained. A potential structural defect visible in an office had not been risk assessed. There was accommodation above the office on the first floor of Latimer Grange but there was no risk assessment about the impact of the structural defect.

There was no dedicated storage space for equipment such as hoists and wheelchairs. This meant equipment, some of which was not used, was kept in communal areas which was intrusive of people's home space.

The management arrangements were ineffective because the provider had not ensured an adequate level of support for the interim manager who relied on support from the local authority. After our inspection on 3 July 2017 we reported that the provider was beginning to implement more effective monitoring of the quality of the service people experienced. However, at this inspection we found no evidence this had taken place.

There was a lack of leadership and management that placed people at risk because areas requiring improvement were not being identified and acted upon. A new requirement, the Accessible Information Standard had not been implemented at the service which demonstrated a lack of leadership.

The provider determined what staffing levels should be. These were fixed and were not adjusted to respond to periods when people had increased needs, for example when they returned from hospital or if their

health worsened.

Care was not consistently delivered in line with standard and evidence based guidance. For example, the service did not have food items that were specifically for people living with diabetes

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People's care plans had no information about their preferences or choices about their end of life care.

The provider had a staff training plan that was aimed at ensuring staff kept up to date with their training. However, no action was taken to follow up staff who had not attended training.

Staff followed the instructions of health professionals who visited the service to attend to people's nursing and medical needs. People were supported to access health services when they needed them.

Staff sought and obtained people's consent before they provided care and support.

We saw several examples of staff being kind and caring and people spoke highly of the staff. Staff were busy and were unable to spend as much time as they and people wanted to hold conversations.

People were able to spend time where they wanted, whether that was in communal areas or in the privacy of their room. We saw people being supported to go to different areas of the home.

People told us they felt comfortable about raising any concerns or complaints about their care and support if the need arose.

We found four breaches of regulations. The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. You can see what action we told the provider to take at the back of the full version of the report.
Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

People had unexplained injuries that were not investigated. Risk assessments were not reviewed after incidents of injuries which exposed people to risk of further injuries.

Medicines management arrangements did not ensure that people were supported to have medicines they needed. A large amount of unused medicines were found that should have been returned to the supplying pharmacist.

A potential structural defect to part of the building had not been risk assessed. Fire safety information was not up to date.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Assessments of people's mental capacity were general assessments. The assessments did not focus on people's capacity to understand or decide about specific aspects of their care and support.

People's nutritional needs were not monitored and their food and fluid charts were not completed. People with diabetes were not supported to access sugar free alternative foods. The service did have a hypoglycaemia kit.

Staff were supported through training, but no actions were taken to ensure that staff kept up to date with their training.

Staff worked with health services to arrange healthcare visits to Latimer Grange and supported people to access health services when they needed them.

Is the service caring?

Requires Improvement

The service was not consistently caring.

The service had not ensured that people with sensory

impairment were supported with their communication and information needs.

People told us that staff were kind to them and we observed several examples of that. Staff provided people with information about their care and support and external events that were having an effect on the running of the service.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People did not consistently experience personalised care and support that met their needs.

The service had not implemented the Accessible Information Standard to ensure that people with sensory impairments were supported to access or understand information relevant to their care and support.

People's wishes about their end-of-life care were not recorded in their care plans.

People told us they knew how to raise concerns or make a complaint if the need arose.

Is the service well-led?

Inadequate

The service was not well led.

There were widespread shortfalls in the quality of care and support which left people exposed to the risk of harm and unsafe care. Lessons were not learnt after people had injuries or poor care.

The leadership and management of the service was inadequate. There was no credible plan of the provider's aims and objectives for people and staff. There was no monitoring to check that people's needs were being met or to identify and implement improvements to people's experience of the service.

The interim management arrangements during the registered manager's absence were not supportive of the interim manager.

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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.

The inspection was prompted by a police investigation of alleged neglect and ill treatment of people at Latimer Grange. This inspection did not examine the circumstances of the investigation or allegations. However, the information shared with CQC about the allegations indicated potential concerns about the management of risk relating to falls, unexplained injuries, unsafe medicines management, people's health needs and whether people were being treated with dignity.

Inspection site visit activity started on 3 November 2017 and ended on 6 December 2017. We visited on 3 November 2017, 21 November 2016, 29 November 2017 and 6 December 2017. All of the inspection visits were unannounced.

The membership of the inspection team consisted of two inspectors on 3 November, 21 November and 6 December and an inspection manager and two inspectors on 29 November 2017.

We spoke with seven people and three relatives. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We spoke with the interim manager, six care assistants, a cook, a cleaner and a maintenance person. We spoke with two health professionals who visited Latimer Grange to attend to people's health needs. We looked at eight people's care plans, every person's medicines administration records and staff training records. We looked at the buildings maintenance records and service's accident book.

At our visit on 21/11/2017 we spoke with an officer of the local authority safeguarding adult team who was visiting the service.

Inadequate

Is the service safe?

Our findings

The provider did not have effective arrangements in place to protect people from avoidable harm. People were not adequately protected from the risk of falls. A person who had two falls in September 2017 had their falls risk assessment reviewed in October 2017. They had another two falls in November 2017 but their risk assessment was not reviewed which meant that the person was not adequately protected from a risk of further falls. The policies and procedures in place demonstrated the service was not being operated to protect people from harm.

When we visited Latimer Grange on 3 November 2017 we found that no risk assessment had been made to assess and mitigate the risks of some potential inappropriate behaviour between two people, neither of whom had the mental capacity to make an informed decision about a personal relationship. When we visited the service on 21 November 2017 we found that the interim manager did not have the experience or skills necessary to assess people's mental capacity or carry out associated risk assessments. They required support from the local authority to carry out a mental capacity assessment of the two people and put into place a protection plan.

The provider had policies and procedures for recording and reporting injuries to people. This was covered in safeguarding training staff received. However, seven of the staff, including the interim manager, had not attended refresher training on 3 October 2017 and two had not had any training. Some staff had not had the latest training about how to use the provider's reporting procedures for incidents where people had suffered injuries. This meant that arrangements for reviewing and investigating incidents were not operating. The impact of this was that lessons were not being learned and actions were not taken to minimise the risk of people experiencing harm. When we reported on our inspection of 3 July 2017 we advised the provider that risk assessments must be reviewed after incidents where people suffered an injury. We found at this inspection that this was not happening. This demonstrated that actions were not being taken to improve people's safety or reduce the number of incidents they experienced.

One person had unexplained bruising on 25 November 2017 but this had not been reported to the interim manager which meant the cause of the bruising had not been investigated. Another person had a large unexplained bruise recorded on 16 October 2017 observed during personal care being undertaken. This was reported to the registered manager before their absence from the service but no investigation was evident and no investigation had been carried out by the interim manager. A third person had six recorded incidents of unexplained bruising between 24 July 2017 and 3 November 2017 that had not been investigated to establish a cause of the bruising. Although staff completed 'body map' charts to record people's injuries, those injuries were not always reported using the provider's internal reporting procedures and the injuries were not investigated. There were no records to show that the person's injuries were monitored after the initial record had been made.

The failure to investigate such bruises and identify the cause exposes service users to the risk of further injuries that may occur and they may not be identified or supported appropriately to protect them from on-going harm. This was a breach of Regulation 12(1)(2)(a) of the Health and Social Care Act 2008 (Regulated

Activities) Regulations 2014.

The provider's arrangements for the safe management of medicines were inadequate. Three people's medication administration records (MARs) showed that they regularly refused to take their prescribed medicines during the month of November. One person had refused a medication on 55 out of a possible 59 occasions and refused other medicines regularly. In a period of 20 days they had refused 76 doses of their prescribed medicines. Another person had refused a medicine that made it easier to pass urine on 14 out of 20 occasions. They had also refused an antipsychotic medication on 33 out of 38 occasions. There was information contained in people's care plans that stated that they may refuse medication, but there was no guidance for staff on what action they should take if a service user regularly refused their medication to ensure they received their medication as prescribed. For example, a person's care plan included a note, 'There are times when [person] will refuse to take some of [their] prescribed medication', but there was no guidance for staff on what they should do when that happened. The care plans contained no evidence that the GP's advice had been sought on service user's refusal to take their prescribed medication. Without considering alternative options people were at risk of experiencing avoidable harm and deterioration in their health through not taking their medications on a regular basis as prescribed by their GP. There was no system in place for people to have their health reviewed by a medical professional when prescribed medicines had not been administered in accordance with prescriber's advice.

On 29 November 2017 we found a small box containing 470 tablets in a medicine trolley. These were medicines that people had refused. No record had been kept of medicines that were for disposal, including the name and strength of the medicine, the name of the person to whom the medicine was prescribed. Guidance from the Royal Pharmaceutical Society of Great Britain 'The Handling of Medicines in Social Care' is that surplus or unwanted medicines should not be stored in residential care settings, but returned to the dispensing pharmacist. There had been no auditing of medicines that had been refused which determined that medicines needed to be returned to the pharmacy. The interim manager was unaware that medicines that had been refused had been stored inappropriately.

The provider failed to demonstrate that there was an effective system and process in place to safely dispose of medicines that had not been administered. This was a breach of Regulation 12(1)(2)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During our inspection visits on 3 and 21 November 2017 we noted that an office used by the interim manager had wide crack across the width of an outside wall than had penetrated the wall paper. The crack was also partly visible from outside the building. We were informed by the interim manager that they understood structural engineers had been to inspect the building and carried out work to establish the cause. A possible cause was subsidence. Structural engineers were expected to return. However, there was no documentation made available to confirm this. No risk assessment of the safety of the office or of the premises which included accommodation on the floor above the office had been undertaken. When we returned to the service on 29 November 2017 the wall had been covered by two wooden boards, but the interim manager did not know whether the 'crack' had been repaired or whether the wooden boarding was a cosmetic repair. On 29 November 2017 a hairline crack was still visible from the outside of the building. This presented a potential risk of harm to people at the service. The interim manager was unable to offer us reassurance that this risk had been appropriately assessed. Following the inspection we requested written confirmation from the provider that the building was structurally safe and the plans for repairing the wall. This was provided to us.

The provider failed to ensure the premises were properly maintained. This was a breach of Regulation 15 (1)(e) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

People and staff were not protected from risk associated with hazardous substances. The provider had not ensured that Health and Safety Executive (HSE) guidelines about hazardous substances were being followed. Cleaning products which were identified as substances hazardous to health were not stored safely and posed a risk to people. On 21 November 2017 we observed an unattended cleaner's trolley in a corridor into which people would have to walk to or from their rooms. A bottle of bleach was clearly visible which could have been accessed by a person from one of those rooms. On 29 November 2017 we saw that cleaning fluids, disinfectant and liquid air freshener had been taken out of their original containers which contained the information relating to the hazardous properties and decanted into spray bottles. These spray bottles were left in communal bathrooms where people were able to access them. HSE guidelines are that hazardous substances must be kept and stored in their original containers especially in premises where people live. This placed people and staff at risk of harm.

People were at risk of scalds by unprotected hot water pipes. Throughout the inspection we observed that there were unprotected hot water pipes in people's ensuite bathrooms and in communal bathrooms. There was a risk that if a person was to fall near these pipes and be in physical contact with the pipes that a serious injury would occur or suffer from a scald. Following the inspection the provider sent us confirmation that all exposed hot pipes were appropriately covered.

A fire extinguisher situated on a wall beside a door between the communal lounge and dining room was not safely positioned. The hose from the fire extinguisher was positioned by the edge of the door. This had the potential to be caught or grabbed by any person walking past which would have posed a risk. We brought this to the interim manager's attention so that they could arrange for the fire extinguisher to be refitted.

The provider had not ensured that there was always a safe and clean area for visiting nurses to carry out blood tests. On 29 November 2017, a nurse was taken to a staff room to carry out a blood test. The room was untidy and without washing facilities. This placed the nurses and person's health at risk in the event of an accident in the room. This was contrary to guidance in the Code of Practice on the prevention and control of infections.

In contrast to what we found, people we spoke with told us they felt safe. Comments included, "I feel safe here, I've never seen anything that has bothered me", "I feel safe in the carer's presence", "It's nice and peaceful here, I feel safe" and "I'm safe, the staff are always here when I need them."

Staff we spoke with told us they felt the service was safe. A care assistant told us, "My [Relative] lived here. I'd have never left her here if I thought she wasn't safe."

The interim manager told us that staffing levels were 'fixed' so that four care assistants were on duty during the day and two at night. Staffing levels were not reviewed, for example if a person's needs increased because of illness or because they required more support after a hospital discharge. There was no systematic way of calculating staffing levels. When we reported on our inspection of 3 July 2017 we said that people's dependency assessments we saw in people's care plans could be used to calculate staffing levels, but this had not happened. However, staff told us that four staff were enough. We saw that staff were attentive to people's needs and call bells answered quickly. When staff saw people indicating that they wanted support staff quickly attended to them.

When we cross-checked staff rotas and staff training records we found that sufficient numbers of trained staff were on duty during the day. However, on 29 November 2017 we had to point out to the interim manager that the night time rota for the nights of 1 and 2 December 2017 had staff that were not trained in fire safety. This may have placed people at risk in the event of a fire emergency. The rotas were changed as a

result to ensure at least one staff member was trained in fire safety on each night shift.

No staff had been recruited since our last inspection when we found that recruitment procedures were safe, however, the provider should ensure adequate documentation is available on staff files to demonstrate how they come to a decision regarding someone's employment with the service.
Fire alarms and fire doors were tested monthly and there had been regular fire evacuation drills. The Northamptonshire Fire and Rescue Service had carried out a fire safety audit on 14 April 2016 which reported no concerns. Every person's bedroom had been checked for safety. These checks included checking that radiator covers were secure, that lights worked and that the call alarms people used to summon assistance were in working order.

The premises were clean. The service employed cleaners to clean people's rooms, communal areas and bathrooms. The kitchen was clean and food storage was safe. The service had been inspected by a local authority food hygiene officer in October 2016 and was awarded a five star rating (the highest).

Requires Improvement

Is the service effective?

Our findings

At our previous inspection on 3 July 2017 we found that the provider was in breach of Regulation 14 (1) (4) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. One person was at risk of malnutrition had not had nutrition and hydration assessments carried out to ensure their nutritional needs were met. We received an action plan from the provider on 14 September 2017 stating how they would make the necessary improvements. We found at this inspection that whilst action had been taken to make improvements these had not been sustained and as a consequence people's nutritional needs were not being consistently met.

People's food and fluid intake was not effectively monitored when staff were concerned that people were not eating or drinking enough. The design of the charts staff used were not effective because they were not specific to monitoring of food and fluid intake. There was no information about what a person's recommended food and fluid intake should be. Staff did not record how much food and fluid had been offered and how much had been consumed. We saw entries such as 'breakfast and jug of juice given', 'cup of coffee', 'dinner' and 'lunch'. There was no cross referencing to people's weight or body mass index. The way information was recorded meant that people's food and fluid intake could not be properly monitored which exposed people to risk of malnutrition and dehydration. We saw charts where entries in the food and fluid columns had ceased but there was no evaluative summary of why. The risk of malnutrition and dehydration were not being effectively assessed or managed to maintain people's health and wellbeing.

The provider failed to ensure that the nutritional and hydration needs of service users were being met. This was a breach of Regulation 14 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Moving and handling equipment was inappropriately stored in two areas of people's communal lounge and on a landing outside a person's room. This equipment included a hoist and slings which no person using the service required, a standing frame, a weighing chair, and six wheelchairs. We discussed the absence of storage areas with the registered manager on 29 November 2017. When we visited Latimer Grange on 6 December 2017 the equipment had been moved to an outdoor space. Storing such equipment in communal areas meant there was a potential hazard to people who liked to walk around communal areas independently. That risk had not been assessed.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the

principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

Mental capacity assessments that were contained in the care plans were not decision specific. For example, the mental capacity assessments that were in place were detailed on one form and were for assessing capacity for residential care, personal care and medication administration. The Mental Capacity Act 2005 (MCA) states that care plans for people lacking mental capacity to agree to arrangements for their care or treatment must show evidence of best interest's decision-making in line with the MCA, based on decision-specific capacity assessments. However, this did not happen. For example, a person had a mental capacity assessment on 1 August 2017. The assessment was that they lacked capacity to understand about the need for medicines, but no further action was taken about how they could be supported in their best interests with their medicines. The person continued to refuse the majority of their medication which placed their health and well-being at risk.

The interim manager told us they were not confident about carrying out assessments of people's mental capacity. They had not had training about the MCA since 26 June 2014. There was no one at the service who was capable of carrying out mental capacity assessments.

The provider failed to ensure that they followed the principles of the MCA 2005 when assessing people's capacity to consent to care and treatment. These matters were a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff had received training and showed an awareness of the MCA. They knew they had to seek a person's consent before providing care and support. We saw staff offering people choices about how they wanted to be supported. For example, before staff supported a person from their armchair to a bathroom they did not presume the person wanted to use a wheelchair. Staff showed the person the wheelchair and asked the person how they wanted to go to the bathroom. The person opted to walk and two staff supported them to do so. This showed how staff sought a person's consent and respected their choice.

People's care plans included assessments of people's needs and information for staff about how to support people with those needs. Care plans included 20 sections covering aspects of people's care needs; for example their personal care needs, physical well-being, communication needs, sight and hearing, oral health and others. Not all care plans we saw had been regularly reviewed. Most had been reviewed every month or two months, but we saw sections of care plans that had not been reviewed regularly. For example, two people's oral health plans had not been reviewed since January 2017. We asked the interim manager how often oral health assessments were required to be reviewed and we were told monthly. The provider did not have a system for ensuring that care plans were reviewed on a regular basis or when people's needs changed.

The provider had a staff training plan in place, however, it was not up to date. A third of refresher training sessions had not been attended by staff since February 2017, despite it being monitored by the administrative staff. There was also no active system in place at the time of our inspection to follow up non-attendance. For example, on 29 November 2017 only three out of six care staff had attended refresher training about infection prevention and control and four out of six had attended refresher training in moving and handling. There had been no oversight of the training plan after the registered manager absence began which meant that staff were not attending refresher training to update their knowledge and skills. For example, some of the staff had not received any training in how to report any injuries that occurred with people. Staff had not had any one-to-one supervision meetings to support them during the absence of the registered manager and deputy manager. This meant staff were not supported during a period of stress and

uncertainty which risked undermining their performance. There was potential for staff not being supported to provide care that was consistently safe because they were distracted by recent developments at the service.

There were four people at Latimer Grange who lived with diabetes. We looked at two of their care plans. One person's plan referred to their diabetes in the 'physical well-being' section of their care plan, but the section of the care plan about their diet said, '[Person] eats a full and varied diet.' Another person's care plan included a list of foods a diabetes nurse had advised the person to eat. They were supported to have a low sugar diet and had sweeteners rather than sugar in their hot drinks. However, the provider had not ensured that there were diabetes friendly food in stock as an alternative to sugary foods such as biscuits and tinned fruit which people with diabetes were given. The cook we spoke with understood about the needs of people with diabetes from their training as a cook but they had not had training arranged by the provider about supporting people with diabetes that other staff had. There was a potential risk that people living with diabetes could have foods that adversely raised their blood sugar levels. People may be at risk of complications associated with their diabetes if correct diet and monitoring was not followed. The service did not have a hypoglycaemia kit which could be used in the event a person with diabetes had hypoglycaemia and reduce ambulance call-outs and hospital admissions.

We recommend that the provider seeks advice from a reputable source about supporting people who live with diabetes.

Another health professional who visited Latimer Grange to carry out blood tests told us that the provider had not ensured there was a sufficient supply of blood glucose test strips. They had had used their own supply to ensure that they could carry out the tests. However, there was a risk that tests could not be carried out because the provider had not ensured there were adequate stocks of the test strips. This would place people for whom blood tests were essential at risk if the tests were not carried out because a lack of the necessary equipment.

The premises were clean and odour free. However, the décor was faded. Carpets throughout communal areas and corridors in Latimer Grange had multi-coloured designs and shapes. Flooring patterns are not recommended for accommodation used by people living with dementia. The shapes and different colours can look like something that needs to be stepped over which could pose a risk to people tripping or falling over.

We recommend the provider seeks advice from a reputable source about the environmental needs of people living with dementia.

People told us that they felt staff were well trained and understood their needs. A person told us, "The staff know me well and look after me. They understand about my [condition that affects mobility]." Staff told us they felt well supported through the training they had. A relative [of MB] told us, "I can't find anything about the care that I'd fault, and I'm a nurse."

People spoke favourably about the meals they had. A person told us, "The food is very good. It's very well served, we have choice and I have plenty enough to eat and drink." Another person told us, "The meals are good. If I don't like the main choice the cook will make an alternative. I do not go hungry, definitely not."

People told us that staff supported them with their health needs. A person told us, "When I'm unwell the staff get a doctor out to see me." Staff were attentive to changes in people's health and they called for a doctor or nurse to visit to attend to a person if they were unwell. We saw in people's records that showed

staff had called a GP or nurse to come to Latimer Grange to attend to people who had told staff they felt unwell. On one occasion staff identified that a person's behaviour had been unusual and confused. They reported this to the person's GP who reviewed the person's medicines and withdrew one. The service arranged for regular visits by a diabetes trained nurse to administer insulin and test people's blood sugar levels.
However, no action had been taken to seek medical advice when people regularly refused to have their medicines. The risks to people's health of not them not taking medicines had not been addressed which exposed them to risks of deterioration in health and wellbeing.

People were involved in some decisions about the environment and developments at Latimer Grange. The provider had plans to extend a sun lounge to include a 'coffee shop' and 'market stall' that people could use for activities such as dancing. A person was involved in landscaping the garden. After people and relatives asked about Wi-Fi the provider had it installed. We saw a person using a computer tablet in their room. Their relative told us it had improved their enjoyment of living at Latimer Grange.

Requires Improvement

Is the service caring?

Our findings

People's care records were not securely kept and could be viewed by unauthorised persons. We found a person's daily records outside their room on the seat of a stair lift. Two other peoples' daily records, which contained confidential information, were outside their rooms. In a room that was shared one person's daily records were on the bed of the person they shared their room with. We found a person's weight records in another person's folder. These examples demonstrated a lack of awareness about how to treat confidential information. We discussed this with the interim manager on 29 November 2017 and action was taken to remove people's records from communal areas.

This was a breach of Regulation 17 (1) (2) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Providers are required to identify and meet the information and communication needs of people who use their services. This includes ensuring that people with sight or hearing impairment or other communication challenges are supported to access information about their care. For example requesting health appointment letters by braille or providing information in a way the person has requested. A person living at Latimer Grange was registered with a sight impairment. Their care plan referred to their sensory impairment, but included only a statement, 'talk clearly' and 'Important [person] is kept informed of whatever task staff are undertaking.' We did hear staff explaining their support to the person. However, communication was limited to a verbal reassurance which the person had not accepted. No steps had been taken to support the person to receive information in formats they could access understand; for example, in audio, braille, large print or easy read. No steps had been taken to obtain advice and support from organisations specialising in supporting people with sight impairment. There was a potential risk that the person would not have access to or understand information that was essential to their wellbeing.

People told us that they were treated with kindness. Comments from people included, "The staff are all very pleasant"   A relative told us, "My [Relative] loves it here. She gets everything she wants. She tells me that often." Another person's relative said, "The staff are very welcoming and friendly." We saw staff supporting people with kindness and offering encouragement. For example, when staff supported people to stand from their armchairs and walk they explained how they would support the person and offered them encouragement then praise, for example saying "You have done very well." Staff told us they did this to motivate people and to encourage them to do as much as they could for themselves, for example when they offered a person a choice of a wheelchair or support with walking. Staff were attentive to people's comfort needs. For example, staff provided people with blankets when people told them they felt cold in the communal lounge. People told us that staff sometimes took time to sit and talk with them. However, during busy periods, for example at lunchtime, staff were more task orientated and did not talk with people but focused on the task of bringing meals to people and supporting people to eat if they required that support.

The provider's statement of purpose, policies and staff training promoted care that was kind and compassionate, however, there were no systems in place to check that was happening in practice. At the time of our inspection the police were investigating allegations which included allegations that people had

not been treated with dignity and respect. The provider had not taken steps to ensure that the values they promoted in their Statement of Purpose were reinforced through practical support for staff. Staff told us they would report any instances of unkind care to the interim manager the local authority or CQC.

People were able to express their views and supported to do so through daily conversation with staff. A person told us, "The staff converse with us to see how we are or what we would like." Another person said, "Staff at all levels are always asking if I'm okay." People told us the registered manager often engaged in conversation with them. Every person we spoke with was concerned about the situation that developed at the service when the registered manager's and two other staff's absence began in mid-October 2017. Staff informed people what had happened, but they were unclear about the impact on the service and the delivery of care. One person had an adverse reaction to events and had lost their appetite to the extent a GP was called out to see them. However, the provider had not considered offering people advice about independent advocacy services to help them deal with the anxieties they felt about the present and future situation of the service.

The provider promoted dignity and respect through their Statement of Purpose (SoP). A SoP is a document that a provider must have as part of their registration with CQC. It sets out their aims and commitments to people who use the service, for example ensuring people's rights. However, the provider had no procedures for monitoring whether what they committed to in the SoP was happening.

Staff respected people's privacy and wishes about how they spent their time. For example, a person preferred to sleep in the communal lounge at night rather than in their bedroom. Staff respected their choice. One room was shared by two people, but the interim manager was unable to tell us if the two people had agreed to that, although one of the people told us they had no objection. There was a privacy screen in the room that was used when one of the people was supported with personal care.

Requires Improvement

Is the service responsive?

Our findings

People did not consistently experience care and support that was responsive to their needs. People suffered unexplained injuries. They were not adequately supported with their medicines. People's food and fluid intake was not effectively monitored which placed them at risk of malnutrition. The Accessible Information Standard had not been implemented to ensure that a person with sensory impairment was provided with information in a form that suited their communication requirements.

The Accessible Information Standard had not been implemented to ensure that a person with sensory impairment was provided with information in a form that suited their communication requirements. The service had not considered ways to make sure people had access to the information they needed in a way they could understand it, to comply with the Accessible Information Standard. The Accessible Information Standard is a framework put in place from August 2016 making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given. The provider had not ensured during the registered manager's presence or their absence that people consistently experienced personalise care that met their needs.

People did not have the opportunity to discuss their end of life care plans or advanced decisions. Care plans we looked at had no information to the effect that people's wishes for their end of life care. It was clear in people's care plans that advance wishes and end of life had not been discussed with them or their loved ones. Care plans stated that this 'sensitive subject would be discussed when the appropriate time arises.' People were not given the opportunity in advance to discuss their wishes in relation in end of life care, their choices and preferences. This meant that in the event of people becoming deceased there was no information about their wishes.

People's care plans included information about their lives and interests. The provider's Statement of Purpose referred to activities that would be provided for people. These included gardening, walking and exercise, music, games, access to books and films, religious worship and reminiscence. After our inspection in July 2017, we reported that an activities coordinator was looking into ways of providing people with a wider range of activities, especially for people with dementia.

People told us they had enjoyed a Halloween party and a cheese and wine party a few days later. People told us that they very much enjoyed weekly games of bingo because the person who did the calling made it a lot of fun. We saw a game of bingo in progress on 3 November 2017 which most people participated in and it was evident that people enjoyed it. However, at each of our visits in November 2017 we witnessed very few other activities in communal areas apart from one person reading newspapers and doing crosswords that staff provided. They told us, "I have things to do, plenty of things." Another person told us, "They [staff] chat if they have time, but they are very busy." With saw that happen several times when staff talked with people. We heard a conversation staff had with a person about their interests. People who stayed in their rooms watched television, read newspapers and used an I-pad. We saw no activities led by staff to stimulate people. During SOFI observations of eight people on 3 November 2017, eight people on 21 November 2017 and five people on 29 November 2017 we saw no stimulating interventions by staff. With one exception,

people were seated in the same chairs throughout the day apart from when they went to the dining room or to a bathroom. One reason for that was that the activities coordinator was acting as interim manager from 30 October 2017, but the provider had not made suitable arrangements to ensure that activities continued during their absence. This meant that people were not supported to follow interests and hobbies that were important to them and which enhanced their experience of living at Latimer Grange.

People were supported to maintain relationships with people that mattered to them. People's relatives were allowed to visit them without undue restriction. A person told us, "I don't feel isolated."

People told us that they knew how to raise a complaint or a concern if they had one. They added they had not had a reason to make a complaint or raise a concern, but they were confident that if they did they would be listened to. People we spoke with were aware of adverse media publicity about Latimer Grange. They were aware of frequent visits to Latimer Grange by CQC, officials from the local authority and police officers. They were concerned about these and at least one person was anxious about what these visits meant for the future of the service. The provider wrote to relatives and invited them to a meeting on 6 December 2017 to explain as much as they were able about the situation.

Inadequate

Is the service well-led?

Our findings

The provider was also the registered manager; however since 18 October 2017 they had been restricted from entering Latimer Grange due to an on-going police investigation affecting the provider, registered manager and two members of staff. However, the information shared with CQC about the allegations indicated potential concerns about the management of risk relating to falls, unexplained injuries, unsafe medicines management, people's health needs and whether people were being treated with dignity. The provider had made arrangements for an interim manager, however, it was evident in a short space of time that the arrangements were ineffective and the staff member did not have the skills, knowledge and access to information to be an effective manager. It was evident that the absence of the registered manager had resulted in a break down in the operational and managerial infrastructure and oversight of the service.

The interim manager lacked the leadership skills and operational knowledge to ensure the safety and quality of the service was assessed and monitored. At our last inspection in July 2017 the concerns that were raised had not been addressed and the provider had not given appropriate support, direction and resources to enable these concerns to be addressed.

The provider had not supported the interim manager with information about how to carry out quality assurance, for example audits, to ensure the safe delivery of care and support. There was no monitoring of activity since 3 July 2017 when we last inspected the service. The deputy manager told us then that they had not begun any quality assurance but were about to begin doing so. However, there had been no quality monitoring of the service between July and November. New quality assurance and audit forms had been developed by the deputy manager at that time but not used.

During the period of the registered manager's and deputy manager's absence the interim manager had no access to information about which audits to carry out and when. There was no guidance being provided to support the manager. The provider's quality assurance policy was of no assistance because it had only guidance about the principles of quality assurance and nothing about how quality assurance was to be carried out in practice.

The provider's Statement of Purpose (SoP) set out their aims and objectives for the service. These included meeting people's cultural, religious and sexual needs'; ensuring a right to choice and providing a range of activities. However, there were no systems being used to monitor whether all of those aims were being met.

The absence of effective monitoring and quality assurance meant that the provider had not identified any of the concerns we identified. There were no systems in place to drive improvements to the quality of care and support that people experienced. This meant that some people had experienced unsafe care since 30 October 2017 others people were exposed to a risk of experiencing care that was unsafe.

That provider had not ensured that the interim manager was provided with the training and knowledge they needed to carry out risk and mental capacity assessments to protect people from harm. Risk assessments were not reviewed after events where people suffered injuries, for example from falls which exposed people

to the risk of future injury. The interim management arrangements had not ensured safe management of medicines about which we found serious concerns.

Concerns were raised about the financial viability of the service due to invoices not being paid. For example the visiting chiropodist had not been paid for two previous visits they made. This was a risk to people who required trained health professionals to complete this role because of other health complications, for example diabetes.

A health professional who visited the service told us that the provider had not ensured there was a sufficient supply of blood glucose test strips and had left some of their own supply on 22 November 2017. Without those strips people's blood glucose levels cannot be tested. The provider had not ensured that people's blood tests were carried out in a safe environment. On 29 November 2017, a nurse was directed to a staff room without any washing facilities to carry out a blood glucose test. The provider had not ensured that the service had a hypoglycaemia kit. These were examples of a lack of leadership and effective management of the service which placed people at risk of harm.

There was a lack of good governance procedures in place at the service. The provider had not ensured there were systems and processes in place to assess, monitor and improve the quality of service provided to people. The provider carried out a review of policies in April and May 2017 but this had not identified that polices were out of date. For example, policies about standards of care referred to the essential standards of care that were replaced from 1 October 2014 with the fundamental standards of care.

The governance of the service had not ensured that the provider's regulatory responsibilities had been understood. For example, the manager's job description referred to the Commission for Social Care Inspection's (CSCI) standards and the Care Standards Act 2000. CSCI ceased to exist in 2010 and the Care Standards Act 2000 was replaced with the Health and Social Care Act 2008. The job description referred to preventing 'untoward neglect of furnishings and fitments' but included no equivalent requirement to protect people from abuse and avoidable harm.

The provider had not ensured that the interim manager was supported to understand the requirements of current legislation and responsibilities of a registered manager. The impact on people of inadequate leadership, management and governance was that people were not adequately protected from risk of harm, did not consistently experience positive outcomes and were deprived of improvements to their experience of the service.

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

The provider had not notified CQC in writing of their absence when it was known the absence would exceed 28 days. This was a breach of regulation 14 of the CQC (Registration) Regulations 2009.

We found serious concerns at this inspection that we had reported on before. After our inspection of 26/08/2013 we reported that management of medicines was not safe; and after our inspection on 10/04/2014 we reported that the provider's monitoring and assessing of the service was not effective. After our inspection of 2 July 2017 we reported that people's nutritional needs were not being met. This shows that the provider has a history of not sustaining improvement.

People's views about the service were sought by the registered manager and deputy manager when they were at service until mid-October 2017. However, this was informally and people's views were not recorded.

The registered manager intended to seek relatives views about the service but this had not happened.

Until 16 November 2017 circumstances beyond the provider's control prevented them from contacting people using the service, their relatives and staff to explain the situation at the service. However, the provider had contacted relatives and invited them to a meeting to discuss the situation at Latimer Grange. Due to the police investigation they were only able to provide limited information about the future of the home. The police investigation is still on-going.

The staff received little support during this time. Staff told us it was a stressful time for them and people using the service. They appreciated the efforts the interim manager was making. One told us, "We all work as a team and work really well together" and another said, "We are all trying our best to keep the place going because. We try to be nice and happy for the residents." Staff felt they had not, apart from the interim manager's efforts, been supported. Other comments from staff included, "We are kept in the dark" and "We've got no idea what is going on." Whilst staff were motivated by the interim manager to try and provide the best care and support possible, they had no support from the provider about the situation that had developed at the service since 18 October 2017.

On 6 December 2017, the provider agreed to a local authority request that a management consultant offer guidance and information to the interim manager. The provider has also put in place a consultant of their own choice to manage the service and agreed to work with the local authority, the Commission and the local authority's consultant to make the improvements needed. The local authority was also continuing to monitor the management and leadership of the service to ensure people remained safe.