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Lymehurst

Inspection report

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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

This inspection took place 23 January 2019 and was unannounced. This inspection was completed due to a safeguarding incident.

We had previously carried out an unannounced comprehensive inspection of this service on 23 August 2018, where one breach of legal requirement was found. After the inspection, the provider wrote to us, with an action plan, to say what they would do to meet the legal requirement in relation to their governance practices.

At this inspection, we checked whether the provider had followed their action plan to determine whether they now met legal requirements. Although some action had been taken, we found the provider was still not meeting the legal requirements for governance. We also found two further breaches of legislation relating to safeguarding and the management of risk.

Lymehurst is registered to provide accommodation and personal care to up to 35 people. At the time of the inspection 29 people were using the service.

Lymehurst 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.

There was a registered manager in post but they were not present for our inspection. 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.

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 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 registered manager had failed to escalate safeguarding concerns in line with local safeguarding protocols. When the provider was made aware, they acted quickly to ensure everyone living at Lymehurst was kept safe from the risk of abuse.

When people had accidents, their care was not reviewed to show it continued to meet their needs. Incidents were not investigated or followed up. There were no records of people being referred to specialist teams when they had a high incidence of accidents.

The registered manager had not fully implemented new quality systems, despite the provider introducing these. The provider had not ensured sufficient management oversight in the running of the home.

Measures to reduce known risks to people were in place but not always recorded. Staff knew about equipment in place to help keep people safe, but this was not reflected in their care records.

There were enough staff working at the home to meet people's needs safely and people received their medicines when they needed them.

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 consistently safe.

People had not been protected against the risk of abuse and improper treatment. Risk management records were not fully in place. Accidents and incidents were not monitored.

People were supported by enough staff and received their medicine when they needed it. The provider took positive action when they were made aware of safeguarding concerns at the home.

Is the service well-led?

Inadequate

The service was not well-led.

Governance arrangements did not ensure people's care needs and risks were well managed. There was a lack of management oversight at the home. Not all improvements required since our previous inspection had been implemented.

Lymehurst

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 was planned to check 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 focused inspection of Lymehurst on 23 January 2018.

This inspection was prompted by a safeguarding concern. This incident is subject to a police investigation and as a result this inspection did not examine the circumstances of the incident. However, the information shared with CQC about the incident indicated potential concerns around the management of risk of abuse. This inspection examined those risks to ensure there were no on-going risks.

We also checked the provider had followed their action plan to confirm whether they now met legal requirements following our previous comprehensive inspection on 23 August 2018.

The team inspected the service against two of the five questions we ask about services: is the service safe and well-led? No risks or concerns were identified in the remaining Key Questions through our ongoing monitoring or during our inspection activity, so we did not inspect them. The ratings from the previous comprehensive inspection for these Key Questions were included in calculating the overall rating in this inspection.

The inspection team consisted of two inspectors. During our inspection we spoke with three people who used the service. We spoke with 10 staff, which included care staff, kitchen staff, cleaning staff and the registered provider. We looked at eight people's care records along with daily records, medicine records, four staff files and records relating to the management of the home.

Inadequate

Is the service safe?

Our findings

At our previous inspection, we found the service was not consistently safe and had rated the safety of the service as requires improvement. At this inspection we found safeguarding concerns had not been reported and risk assessments did not always contain plans for managing risk.

Our inspection was prompted by a safeguarding incident at the home. Although the provider had a safeguarding policy in place this had not always been followed by the registered manager. When some staff had raised concerns, the registered manager had failed to escalate an allegation of abuse and improper treatment to the local safeguarding team, police or to us. We were also aware of at least one other incident where the registered manager had not notified us of an allegation of abuse and two which the local safeguarding team were not aware of. The registered manager had failed to safeguard people against abuse and improper treatment.

These issues constitute a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We inspected the home to ensure there was no on-going risk to people following the safeguarding incident. When the provider was made aware of the safeguarding incident they immediately acted to ensure people were protected from any on-going abuse. Since our previous inspection staff had received training in how to keep people safe from abuse and understood their responsibility to report any concerns.

Risks associated with people's safety were assessed. However, people's risk assessments did not always give clear or up to date information on how the risk was being reduced. Staff told us about the equipment in place to reduce injury to one person who was at risk of falling out of bed. What they told us was not written into the person's care plan. Staff told us although risk assessments were in place, the care plans did not give sufficient information on how to support people. One staff member said, "Staff have a lot of knowledge. We would not rely solely on the records for information." Other records we looked at confirmed this. This placed people at risk of unsafe and inconsistent care.

One person had a sensor alarm mat outside their door. The wire from this mat trailed across the corridor, under a bathroom door where it was plugged into the home's call monitoring system. Staff told us the registered manager had put this in place and staff knew why it was needed to keep the person safe. However, there was no record to say why this sensor mat had been assessed as needed, or what the risk was. No consideration had been given to the environmental hazard this caused, despite one person needing to cross it to reach their room. This put people at risk as staff may not always have the most current information on how to care for people

At our previous inspection the provider had no system for reviewing accidents and incidents. Although a new monitoring form had been introduced, there was no clear arrangement seen for reviewing and investigating any incidents. Staff understood their responsibility for responding to and reporting incidents and completed accident forms, as they were required to do. However, there was no evidence to show

managers had investigated, followed up or reviewed these. Where people experienced falls, there was no re-assessment of their care needs or risks. One person had experienced a high number of falls for at least the past five months. Two staff members told us they thought a referral had been made to the local falls clinic by the registered manager, but no information was found to support this. Although a falls risk assessment was in place for the person, there was no recent assessment to confirm whether any alternatives had been looked at to keep the person safe. This put people at risk because trends may not be identified or lessons learnt if things go wrong.

We had been made aware of one incident where the registered manager had given one person another person's prescribed nutritional supplement. The registered manager failed to consult with or obtain a health professional's advice prior to giving this supplement. This placed the person at risk of receiving unsafe care and treatment.

At our previous inspection, kitchen staff did not test the heat of people's food before serving it and it was not clear what training they had received. Since our previous inspection, kitchen staff had received food safety training and told us they now checked food temperatures. However, they were not recording this. Staff told us they were not aware they had to record this information despite the provider telling us they had been informed. It therefore could not be evidenced that food had reached the correct temperature before being served. This placed people at risk of food poisoning.

These issues constitute a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were supported by sufficient staff to meet their needs. The provider and staff had worked together to ensure there were enough staff on shift following the recent incident. The provider said, "The staff have pulled together to make sure the residents are looked after." At our previous inspection, people were sometimes left for periods of time with no staff support in the communal areas of the home. The registered manager had told us they would ensure a staff member was present in the communal areas. At this inspection, we found this had been done and people were not left unsupported for any length of time. When people needed assistance, they were not kept waiting and call bells were responded to in a timely way.

Prior to staff being employed, the provider carried out checks on their backgrounds. Checks included employment references, identity and criminal checks. The provider ensured Disclosure and Barring Service (DBS) checks were completed. The DBS carry out a criminal record and
barring check on individuals who intend to work with children or adults. Where required, the provider completed assessments on staff to ensure there was no risk to people using the service.

People were supported and cared for in a clean environment which helped to minimise the risk of infection. Care staff kept people protected from the risk of infection by following safe infection control procedures when carrying out their care related tasks. Gloves and hand sanitiser were available throughout the home, along with hand washing areas and we saw staff use these.

People were supported by staff to take their medicines when they needed and wanted them. Staff gave people their medicines with patience and explanations of what they were doing. Staff recognised when one person was in discomfort and offered them one of their medicines they took only when they needed it. Staff had received training in the safe administration of medicines and medicines were stored safely at the home. At our previous inspection care staff did not record when they had applied people's topical medicines. At this inspection we found this was now being done. Medical administration records we looked at showed that people received their medicine as prescribed.

Inadequate

Is the service well-led?

Our findings

At our previous inspection we had found the provider in breach of one regulation relating to the governance of the home and had rated this key question as requires improvement. At this inspection, although some improvement had been made, we found there were shortfalls with the governance of the home and areas where improvement was still needed. We also found there was a continued lack of oversight from the provider in how the home was being run.

Systems and processes to monitor the quality and safety of the service continued to be ineffective in ensuring the service was well managed. Since our previous inspection, the provider had introduced an auditing system. Both the registered manager and provider now had responsibility for competing audits. Despite audits being completed on medicines, care records and incidents, they had not identified the issues we found during our inspection. They were not used to monitor people's care to ensure care plans were effectively minimising the likelihood of risk. The provider's audits also failed to check the registered manager had completed their audits effectively.

The provider had not ensured people's care plans always contained an accurate or up to date record of their needs. During this inspection we again found people's care records were not always up to date or accurate. One staff member told us they had started to prepare for a person's birthday, only to find their incorrect date of birth was recorded in their care record. Measures to control and reduce risks to people were in place, but were not always detailed in people's care plans. It was also not clear what actions had been taken in referring people to other health professionals where on-going risk was identified. This placed people at risk inconsistent care because staff may not have the most up to date information available.

The provider had not ensured accidents and incidents were investigated and outcomes recorded. People's identified risk, as a result of reduced mobility, was not escalated within the home and to external authorities. At our previous inspection the provider had no system of monitoring and analysing accidents and incidents. The provider had told us, in their action plan, the registered manager would complete a weekly falls report. The provider confirmed only a falls monitoring form had been introduced, which was completed monthly. The registered manager had not completed monitoring of any other incidents. This form had not been used to monitor people's falls for any trends, just to record the actions taken at the time of the incident. Only one form was found, which was from November 2018. There was also no evidence to show any outcomes had been discussed with people, families or staff. This placed people at risk because audits had not been analysed to ensure appropriate actions had been taken to keep people safe.

The provider told us they supported the registered manager through regular meetings. However, the provider made no formal records of these meetings. There were no action plans created of the agreed responsibilities between the provider and registered manager. There also was no evidence of the registered manager's competence in their role or identified areas of improvement, such as training. The registered manager had failed to appropriately identify safeguarding incidents and report these to the local safeguarding team or notify us of these incidents. We found, although the provider was present at the home regularly, there was an expectation on the registered manager to successfully complete delegated

responsibilities, without the provider fully monitoring this. This placed people at risk of a poor-quality service.

These issues constitute a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Since our previous inspection, the provider had started to ensure all staff's training was up to date. The provider had reviewed all staff's training needs and had prioritised training such as safeguarding and food safety. Although records were not fully up to date, the provider gave us assurance staff had received the training. The provider was now arranging further training for all staff to ensure they were up to date.

It is a legal requirement that a provider's latest CQC inspection rating is displayed at the service. This is so that people, visitors and those seeking information about the service can be informed of our judgments. We found the provider had conspicuously displayed this in the home.

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 fully assessed the risks to the health and safety of service users of receiving their care or how any identified risks were to be mitigated.

The enforcement action we took:

We have imposed a condition on the provider's registration for this location.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Safeguarding systems had not been operated effectively to protect people from abuse and improper treatment.

The enforcement action we took:

We have cancelled the registered manager's registration.
We have imposed a condition on the provider's registration for this location.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Governance systems were not being effectively implemented and monitored to ensure a continuous improvement in the quality of care for service users.

The enforcement action we took:

We have imposed a condition on the provider's registration for this location.