Burlington Care Limited

The Lawns Care Home

Inspection report

Ridsdale Street
Darlington
County Durham
DL1 4EG

Tel: 01325357161

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17 February 2022

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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

About the service
The Lawns Care Home is a residential care home providing accommodation and personal care to up to 62 people. The service provides support to older people and people living with a dementia, in one adapted building across two floors. At the time of our inspection there were 45 people using the service.

People's experience of using this service and what we found
People's medicines were not managed safely, and people did not receive their medicines as prescribed. Risks to people were not always appropriately assessed, monitored and managed. People's nutrition and hydration needs were not adequately recorded or known by staff. No action was taken if people at risk did not have enough to drink. Staff were not always deployed throughout the service appropriately, and staff consistently told us there were not enough care workers. Pre-employment recruitment checks for agency staff were not always fully in place. The service was not clean. Lessons were not always learnt when things went wrong.

Leadership, governance and culture within the service did not ensure high quality care was delivered. Care records were not always person-centred and up to date. We received mixed feedback about the atmosphere within the home. Quality assurance was ineffective, and the service had deteriorated since our previous inspection. The provider did not have appropriate or effective oversight of the service. People were not always referred to healthcare professionals in a timely manner.

People told us they felt safe and they liked the staff. Immediately after our inspection the provider implemented an action plan to address the concerns identified around medicines, the environment, risk assessments and people's nutrition and hydration needs. Visitors to the service were appropriately screened for COVID-19 and visiting arrangements were in line with government guidance. The service had enough PPE and staff took part in a regular COVID-19 testing programme.

Following our feedback, the provider ensured that appropriate support was provided to the service. The provider understood their regulatory requirements and their duty to be open and honest when things go wrong. Relatives generally told us they were kept up to date. The provider and acting manager were receptive and responsive to feedback and worked with CQC to implement action plans to resolve the issues identified.

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 good (published 26 February 2020).

A targeted inspection took place in November 2020 (published 25 November 2020). The service was inspected but not rated and therefore this did not change the last rating for the service.

At our last comprehensive inspection, we recommended that the provider consider current guidance on medicines management and take action to update their practice. At this inspection we found the provider had not acted upon this recommendation and had not made the necessary improvements.

Why we inspected
The inspection was prompted in part due to concerns received about management of medicines, cleanliness of the service, and safeguarding concerns. A decision was made for us to inspect and examine those risks. We undertook a focused inspection to review the key questions of safe and well-led only.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

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. This included checking the provider was meeting COVID-19 vaccination requirements.

The overall rating for the service has changed from good to inadequate based on the findings of this inspection.

We have found evidence that the provider needs to make improvements. 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.

During the inspection we fed back our concerns to the provider. We also liaised with the local authority and relevant stakeholders.

The provider and the acting manager were very responsive to our feedback. The provider immediately prepared and implemented a robust action plan. The provider and the acting manager prioritised the concerns which posed the highest level of risk to people. Steps were taken to address our concerns, minimise risk, and ensure the safety of people using the service. The provider arranged for the acting manager to have ongoing support from the senior management team, who visited the service regularly to support with improving the quality of the service. We have had positive feedback from professionals following the implementation of the provider's action plan.

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

Enforcement and Recommendations
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and will take further action if needed.

We have identified breaches in relation to safe care and treatment, nutrition and hydration, staffing and good governance at this inspection.

Full information about CQC's regulatory response to the more serious concerns found during inspections is

added to reports after any representations and appeals have been concluded.

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe, and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions of the registration.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

The Lawns Care Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

As part of this inspection we looked at the infection control and prevention measures in place. This included checking the provider was meeting COVID-19 vaccination requirements. 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 two inspectors, one pharmacist specialist, 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
The Lawns Care Home is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. The Lawns Care Home is a care home without nursing care. 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. However, the registered manager was on long term sick leave at the time of the inspection, and had recently handed their notice in. The service had an acting manager in post.

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

During the inspection
We spoke with six people who used the service and 12 relatives about their experience of the care provided. We spoke with 16 members of staff including the acting manager, the activities co-ordinator, senior care workers, care workers, kitchen staff and domestic assistants. We also spoke with the regional manager and nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We reviewed a range of records. This included six people's care records and multiple medication records. A variety of documents relating to the management of the service, including policies and procedures and maintenance records were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We reviewed further documents including quality assurance audits and staff recruitment records. We sought feedback from one professional who regularly visited the service.

Inadequate

Is the service safe?

Our findings

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

At our last comprehensive inspection, we rated this key question requires improvement. At this inspection the rating has changed to inadequate. This meant people were not safe and were at risk of avoidable harm.

Using medicines safely

At our last comprehensive inspection, we recommended that the provider consider current guidance on medicines management and take action to update their practice. At this inspection we found the provider had not acted upon this recommendation and had not made the necessary improvements.

- Medicines were not managed safely. We found loose individual tablets on the floor outside one of the clinic rooms, on the floor in the clinic rooms, on the medicine trolleys and on the floor in a person's bedroom.
- Medicines were not stored appropriately. Medicine trolleys were disorganised, cluttered and dirty. Fridge temperatures were not always monitored. One fridge contained temperature critical medicines and the temperature of the fridge exceeded the recommended range.
- Medicines were not administered as prescribed. Stock counts did not always match the administration records. This meant staff had signed to say a medicine had been administered, but the 'administered' tablet was still in stock.
- Medicines which were prescribed for people were not always available in the service. For example, one person was prescribed two different inhalers. Neither inhaler was present in the service.
- Person-centred protocols and guidance were not in place for medicines prescribed on a 'when required' basis. It was not always recorded why these medicines had been administered and whether they had been effective.
- Body maps were not in place for creams and lotions. This meant it was not always clear where they should be administered.

Medicines were not safely managed and were not administered as prescribed. This placed people at risk of harm. This was a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Immediately after the inspection the provider implemented an action plan to address the concerns identified around medicines. Professionals with medicines expertise visited the service on 1 March 2022 and confirmed that, whilst there were still some outstanding actions, improvements had been made.

Assessing risk, safety monitoring and management

- Risks to people were not always appropriately assessed, monitored and managed. There were no diabetes care plans or risk assessments in place for people who were diagnosed with this condition. There was no information for staff about these conditions, what the risks were, and what staff should look out for if a

person were becoming unwell.
● Incidents of behaviours which could challenge others, were not fully or robustly recorded. There was no analysis of potential triggers or themes, and no consideration of potential impact on others who used the service.
● Fire drills which included mock evacuations were not completed in line with the provider's policy. This placed people at risk of harm as staff were not rehearsed sufficiently in evacuation procedures in the event of a fire.

Risk was not safely managed. This placed people at risk of harm. This was a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Risks around people's nutrition and hydration were not adequately assessed, recorded, managed and relayed to staff.
● The kitchen staff, care workers, and senior care workers, did not have accurate and up to date knowledge of people's nutrition and dietary needs. There was a whiteboard in the kitchen, the purpose of which was to list any dietary requirements for people. The whiteboard was inaccurate and out of date.
● People who required a low sugar diet did not always receive this. The kitchen had run out of several low sugar items on the day of our inspection, and kitchen staff were not aware of this. We reviewed meal charts for one person who required a low sugar diet. This person was regularly eating biscuits, jam and desserts. On one occasion, this person's meal had been fortified with cream and sugar.
● Risks were not appropriately managed for people who required modified diets. One person required a level 5 'mince and moist' diet and was prescribed thickener in their drinks. There was limited guidance for staff around what this person could eat. This placed this person at risk of harm.
● Risks were not managed appropriately for people who were at risk of dehydration. Fluid intake was not always monitored for people at risk. Where fluid intake records were in place, they did not always have a target fluid intake for people. When there was a target fluid intake, there was no evidence that any action was taken if people didn't reach their target.

Nutrition and hydration were not safely managed. This placed people at risk of harm. This was a breach of regulation 14(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Immediately after we fed back our concerns to the service, the provider implemented an action plan to resolve the issues. We have been informed that diabetes care plans and risk assessments are now in place, staff have been given appropriate guidance, and additional training has been sourced. We have been informed that people's dietary and hydration needs have been reviewed and accurately relayed to staff, to ensure people receive appropriate nutrition for their needs.

Staffing and recruitment
● Staff were not always deployed appropriately. During our inspection, we noted at least three occasions when no staff were present on one of the home's smaller units. The acting manager confirmed a member of staff should always be present on this unit to ensure the safety of people.
● Although the acting manager told us the service maintained safe staffing levels, feedback we received from people, staff and relatives was that there were not enough staff on duty. Relative comments included, "No I don't think there are enough staff", "They are rushed off their feet" and "They are horribly busy and I feel for them. I think some are under a lot of stress." Comments from staff included, "We don't have enough staff", "There are absolutely not enough staff" and "Care workers rush around and don't have time to speak to residents."

Staffing was not always suitable to support people's needs. This placed people at risk of harm. This was a breach of regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The service regularly used agency staff. Appropriate records for agency staff were not always in place. Records for several agency staff showed they had not completed mandatory training. Disclosure and Barring Service (DBS) checks for agency staff were not robustly recorded. The service could therefore not be assured these staff were safe and appropriate to work with vulnerable adults.

Appropriate recruitment records were not always in place. This was a breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection
● The service was not clean. There were areas of the home which required a deep clean, including the bathrooms, the carpets, the clinic rooms, several bedrooms and the outside patio area. Carpets were stained and there were chips and holes in the flooring.
● There were insufficient numbers of cleaning staff to maintain a hygienic service. There were significant gaps in the cleaning schedules, with some tasks not being completed at all.

The premises were not always clean, hygienic or well maintained. This placed people at risk of harm. This was a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Following our feedback on the first day of inspection about the cleanliness of the service, the acting manager arranged for additional staff to assist with cleaning the service. When we returned for the second day of the inspection, the service was visibly cleaner. Maintenance was being carried out on our second visit and the provider had purchased new flooring.
● Visitors to the service were appropriately screened for COVID-19. Visitors were required to have a negative lateral flow test and to wear appropriate PPE.
● Staff and people using the service took part in a regular COVID-19 testing programme.
● Visiting arrangements were in line with national government guidance.

From 11 November 2021 registered persons must make sure all care home workers and other professionals visiting the service are fully vaccinated against COVID-19, unless they have an exemption or there is an emergency. We checked to make sure the service was meeting this requirement.

The Government has announced its intention to change the legal requirement for vaccination in care homes, but the service was meeting the current requirement to ensure non-exempt staff and visiting professionals were vaccinated against COVID-19.

Learning lessons when things go wrong
● Lessons were not always effectively learnt. A 'lessons learnt' exercise was completed with senior care workers in December 2021 around medicine issues. Senior care workers were required to sign to confirm their understanding. However, issues identified in the lessons learnt were mirrored in the findings of this inspection in February 2022.
● A supervision between the acting manager and regional manager in January 2022 confirmed that agency staff were not to work at the service without DBS checks, or if there were any gaps in their records. However, we found these same issues on inspection, which had not been explored or resolved.

Lessons were not always effectively learnt when things went wrong. This was a breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The acting manager and the provider took steps immediately after our feedback to learn, implement actions, and resolve issues.

Systems and processes to safeguard people from the risk of abuse
● People were not always protected from the risk of harm. The issues we found on inspection around medicine management, cleanliness, care planning and risk assessments, nutrition and hydration, and staffing, placed people at significant risk of harm.

This failure to protect people from the risk of harm was a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People told us they felt safe. Comments from people included, "I like the staff. They are kind and caring" and "They do a very good job at trying to meet everyone's needs."
● Relatives told us their loved ones were safe and well cared for. Feedback from relatives included, "My relative is absolutely safe, they are looked after well" and "I am happy with the home; carers are friendly and kind and go about their business of looking after people."
● Staff had received safeguarding training and knew what to do if they had any concerns. Staff told us they would raise concerns with the acting manager or the local authority safeguarding team.

Inadequate

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At our last inspection we rated this key question good. At this inspection the rating has changed to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- Leadership, governance and culture within the service did not ensure high quality care was delivered.
- Care records were not always person-centred, up to date or accurate. We found people were sometimes referred to by the wrong gender or the wrong name in their care plans. Some care plans contained inconsistent or conflicting information about people's needs.
- Daily notes for people were not always completed. For example, the provider's policy stated that bed rail checks should be completed daily. For one person, we found these checks had been recorded just once in a 28-day period.
- We received mixed feedback from staff about the atmosphere and morale within the home. One staff member told us, "It's a nice home. We're like family and when we have problems, we help each other." However, positive feedback was outweighed by negative feedback. Further staff comments included, "We don't know whether we're coming or going – staff morale is rock bottom. People don't want to be here" and "There is a lot of back biting among staff."

There was a failure to create a positive and person-centred culture. This was a breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; continuous learning and improving care

- Quality performance checks were not effective. The quality of the service had deteriorated since our previous inspection.
- Audits failed to identify several of the issues we found on inspection. For example, the manager's weekly medication audit dated 17 January 2022 stated that the clinic room was clean and organised. The clinic room was dirty and disorganised at inspection on 16 February 2022.
- Where audits had identified issues, actions were not always taken to ensure the issues were resolved. For example, the domestic and laundry audit dated 24 January 2022 highlighted gaps in the cleaning schedules, but no actions were recorded. The gaps continued in the weekly schedules and were present during inspection on 16 February 2022.
- Audits did not look for patterns and trends, so that themes could be identified, and improvements made accordingly. For example, there was no monthly analysis of accidents and incidents to look for common occurrences.
- The provider did not have appropriate or effective oversight of the service. The provider had failed to

adequately support the acting manager since they came into post in October 2021. The regional manager completed a monthly audit. However, this audit had not been fully completed since the acting manager was in post. We were told this was due to COVID-19 restraints.

There was a failure to effectively monitor the quality of the service. This was a breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Following our feedback, the provider ensured that appropriate support was provided to the service.
● The acting manager and provider understood their regulatory requirements. Services that provide health and social care are required to inform CQC of important events which happen in the service by submitting a 'notification'. Notifications were submitted appropriately and in a timely manner.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; working in partnership with others
● Referrals to healthcare professionals were not always made in a timely manner. For example, one person had suffered multiple falls in the service and there was a delay in identifying and seeking appropriate support for this person.
● The service did not always robustly liaise with professionals when readmitting people back into the service after a hospital stay.

There was a failure to always engage robustly with healthcare professionals and in a timely manner. This was a breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Relatives generally told us they were kept up to date. One relative told us, "I get emails and texts and I am told what is going on."
● The provider was in the process of sending out questionnaires to gather formal feedback.
● The service worked well with CQC during and after the inspection.

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 understood and acted upon the duty of candour. Serious concerns were investigated by an independent party, and investigation reports were sent to appropriate relatives and the person involved.
● The provider and the acting manager were open and honest throughout the inspection process. The provider and acting manager worked with CQC and other professionals to investigate issues and implement action plans.
● The provider and acting manager were receptive and responsive to feedback and were transparent with their investigations and findings when things had gone wrong.