Care Quality Commission

Loven Larchwood Limited

Larchwood Nursing and Residential Home

Inspection report

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Ratings

Overall rating for this service	Requires improvement
Is the service safe?	Requires improvement
Is the service effective?	Requires improvement
Is the service caring?	Requires improvement
Is the service responsive?	Requires improvement
Is the service well-led?	Requires improvement

Overall summary

This inspection took place on 29 and 30 June 2015 and was unannounced. Larchwood Nursing and Residential Home is a nursing home providing care and support for up to 46 older people, some of whom may live with dementia. There were 39 people living at the home at the time of our inspection.

The home had a registered manager who had been in post since November 2013. 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.

Summary of findings

People told us they felt safe living at the home. Staff were aware of safeguarding people from abuse and they knew how to report concerns to the relevant agencies. Individual risks to people were assessed by staff and reduced or removed. There was adequate servicing and maintenance checks to equipment and systems in the home to ensure people's safety.

There were occasions when there were not always enough staff available to meet people's needs and this left people waiting for help.

Medicines were safely stored and administered, and staff members who administered medicines had been trained to do so. Staff members also received other training, which provided them with the skills and knowledge to carry out their roles.

The CQC is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) Deprivation of Liberty Safeguards (DoLS) and to report on what we find. The service was meeting the requirements of DoLS. The manager had acted on the requirements of the safeguards to ensure that people were protected.

Staff members understood the MCA and presumed people had the capacity to make decisions first. Where someone lacked capacity, best interests decisions to guide staff about how to support the person to be able to make the decision were available. However, people's consent was not always obtained before care was provided.

People were not all given a choice about what they ate and nutritional supplements were not always available quickly. Staff members worked together with health professionals in the community to ensure suitable health provision was in place for people, although advice was not always put into place immediately.

Most staff were caring, kind, respectful and courteous, although there were times when people were ignored. Staff members knew people well, what they liked and how they wanted to be treated. People's needs were responded to most of the time quickly, although there were times when they had to wait. Care plans contained enough information to support individual people with their needs and records that supported the care given were completed properly.

A complaints procedure was available but not all of the people using the service were confident that these would be responded to. Occasionally these issues reoccurred. The manager was supportive and approachable, and people or their relatives could speak with her at any time.

The home monitored care and other records to assess the risks to people and ensure that these were reduced as much as possible. Action plans to show improvement and analysis of these records were not available. Analysis of complaints had also not been carried out to identify themes and trends.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was not always safe.

People were not supported by enough staff to meet their needs quickly.

Risks had been assessed and acted on to protect people from harm, people felt safe and staff knew what actions to take if they had concerns.

Medicines were safely stored and administered to people.

Requires improvement

Is the service effective?
The service was not always effective.

Staff members received enough training to do the job required.

The manager had acted on guidance about the Deprivation of Liberty Safeguards. Staff had access to mental capacity assessments or best interest decisions for people who could not make decisions for themselves.

The home worked with health care professionals to ensure people's health care needs were met but did not always put their advice into place quickly enough.

People were not all given a choice about what they ate and drink records were always completed to prevent people becoming dehydrated.

Requires improvement

Is the service caring?
The service was not always caring.

Most staff members developed good relationships with people living at the home, they were kind and courteous, although this did not stop some people from being ignored at times.

People were not always treated with dignity and respect.

People's friends and family were welcomed at the home and staff supported and encouraged these relationships.

Requires improvement

Is the service responsive?
The service was not always responsive.

People had their individual care needs properly planned for and staff responded quickly when people's needs changed.

Information was available if people wished to complain, although not everyone had confidence that these would be responded to.

Requires improvement

Is the service well-led?
The service was not always well led.

Requires improvement

Summary of findings

Audits to monitor the quality of the service provided were completed and identified the areas that required improvement. Action plans were not always available to show whether this had been completed, nor was analysis of complaints easily available.

Staff members and the manager worked with each other to ensure there was a good morale within the home.

Larchwood Nursing and Residential Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection 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.

This inspection took place on 29 and 30 June 2015 and was unannounced.

The inspection was carried out by two inspectors.

Before the inspection, we checked the information that we held about the service and the service provider. For example, notifications, which the provider is legally required to tell us about, advised us of any deaths, significant incidents and changes or events which had taken place within the service provided.

During our inspection we spoke with 10 people who used the service and three visitors. We also spoke with seven staff members, including trained nurses, care and kitchen staff, and the manager. 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 completed general observations and reviewed records. These included seven people's care records, staff training records, nine medication records and records relating to audit and quality monitoring processes.

Requires improvement

Is the service safe?

Our findings

The majority of people that we spoke with told us that they thought there were not enough staff working at the home. Some people told us about the impact this had on them, other people told us about the impact this had on other people. One person said, "The staffing is not good. I often have to wait for help to go to the toilet or cannot get up when I want to" and another person told us, "There are not enough staff here. It doesn't really affect me as I can look after myself but I often hear people crying out for help but no help given". Other people told us that they often had to wait for drinks and for staff in the communal areas of the home.

Staff members told us that they thought there were usually enough staff available and that staffing levels allowed them to spend time with people. They said that this became difficult if there was staff sick leave at short notice, which made obtaining additional staff at short notice difficult. During our inspection we observed that one person had to wait for 20 minutes to leave the toilet and other people were left for long periods in communal areas without any assistance from staff members. People had to wait for up to 45 minutes for their lunchtime meal while staff members brought everyone to the dining room. One person told that they had asked a staff member for a drink 20 minutes prior, although it had not been provided. We observed one person who had been sitting in a hot conservatory for 20 minutes but could not attracted attention from a staff member so that they could move until we intervened and made the request for them.

The manager told us that staffing levels were set at a desired level of six care staff plus trained nursing staff, housekeeping and kitchen staff during the day. The number of care staff could reduce depending on the number of people living at the home. Staffing levels had been reduced to five care staff in the two weeks preceding our inspection and this was confirmed by the staff rota, although the manager planned to review these numbers against people's care needs. There were occasions when there were not enough staff available to ensure that people received care and attention quickly enough.

The recruitment records of staff working at the service showed that the correct checks had been made by the provider to make sure that the staff they employed were of good character. However, we found that gaps in staff member's employment history had not always been checked. This meant that not all of the required information had been obtained prior to the staff member starting work.

All of the people we spoke with told us that they felt safe living at the home and would know who to contact if they had concerns. Visitors said that they were reassured about the care their relatives received and they felt that people were safe. Staff members we spoke with understood what abuse was and how they should report any concerns that they had. There was a clear reporting structure with the registered manager and deputy manager responsible for safeguarding referrals, which staff members were all aware of. Staff members had received training in safeguarding people and records we examined confirmed this.

Information we hold about the provider showed that they had reported safeguarding incidents to the relevant authorities including us, the Care Quality Commission, as is required. This meant we could be confident that the service would be able to recognise and report safeguarding concerns correctly.

Risks to people's safety had been assessed and records of these assessments had been made. These were individual to each person and covered areas such as; malnutrition, behaviour, medicine management, moving and handling, and evacuation from the building in the event of an emergency. Most assessments had guidance for staff to follow to ensure that people remained safe. Our conversations with staff demonstrated that they were aware of these assessments and that the guidance had been followed. However, we found that risk assessments had not been updated following a change in one person's health. Staff members were able to explain to us how the person's health had changed and additional actions they had taken to reduce the risks to this person.

Information about each person's needs in the event of an emergency were available, which ensured staff would be able to take the appropriate action if required.

Servicing and maintenance checks for equipment and systems around the home were carried out. We saw that fire safety equipment had been checked and serviced within the last 12 months and that staff members had received training in fire safety as well as practising fire evacuation and drills.

Requires improvement

Is the service safe?

People were happy with the support they received with their medicines, one person told us that their medicines were always given to them at the times they expected and another person said, “Yes, I always receive my tablets”. We found that the arrangements for the management of medicines were safe. They were stored safely and securely in locked trolleys and storage cupboards, in a locked room. The fridge and room temperature that medicines were stored at was recorded each day to make sure that it was at an acceptable level to keep the medicines fit for use. However, this was not completed for medicines stored in people’s own rooms.

Arrangements were in place to record when medicines were received, given to people and disposed of. The records kept regarding the administration of medicines were in good order. They provided an account of medicines used and demonstrated that people were given their medicines as intended by the person who had prescribed them. There were clear records in regard to the administration of insulin and medicine given through patches. However, we found there was no guidance for staff on the circumstances that ‘as required’ medicines were to be used.

We observed staff giving out medicines, which was carried out correctly and in line with current guidance in place to make sure that people are given their medicines safely. We could therefore be assured that people would be given medicines in a safe way to meet their needs.

Requires improvement

Is the service effective?

Our findings

People told us that they got enough to eat but that there was a lack of choice. Comments from people included, "There is not much choice of food and I never know what is coming but I get plenty to eat and drink and we have a choice of drink – tea is my favourite" and, “The food is ok but I never know what we are having until the mealtime”. One person told us that there was always something that they liked to eat, while another commented that they chose to eat in their own room due to the length of time they had to wait in the dining room.

We observed that people enjoyed the food that they ate but that they spent so long in the dining room that it was not a sociable affair. Some people waited for over 45 minutes before being served their meals. This was due to the disorganised nature of getting people into the dining room while staff accommodated individual moving and handling needs. Some people did not finish their meal until 2pm and also had to wait for help to leave the dining area, only to return at 4pm for tea.

We also saw that staff members provided different support in different areas of the home. In one area some people were offered a choice of meal, while others were not. There were no alternative formats, such as meals already plated up or pictures, for people who did not understand verbal prompts. We overheard one staff member making suggestions about what a person should eat, but without consulting the person about this. In another area, staff members helping people were attentive, spoke with people appropriately and allowed people to eat at their own pace. They provided people with a choice, although one staff member stated that the chef had already visited people to ask their preferences. For those people who were less able to recognise their meal, staff explained what meal had been provided or what food had been placed on the cutlery. In this part of the home pictures of the meal choices for the day were available outside the dining room.

Where there were concerns about how much people drank, this was not always recorded on fluid intake charts. We found clear and detailed records for one person and these showed that the person usually drank the amount of fluid required, or close to that amount. For another person, whose care plan advised staff that this was required, there was no chart to record how much they had drunk. We spoke with the manager about this and they agreed that it was required. There were not always ideal fluid intake amount available for each person. For two people we saw that they had received just over half a litre to drink in more than one 24 hour period in the week prior to our inspection. This meant that people were not always receiving enough drinks to maintain adequate hydration.

During this inspection we saw that people could see their doctor when they needed to and that they could visit the GP surgery or receive treatment from the doctor or district nurses in the home. There was information within people’s care records about their individual health needs and what staff needed to do to support people to maintain good health. We saw that referrals to health care professionals, such as diabetic specialist nurses and tissue viability nurses, were made quickly so that people received the advice and treatment they required. However, we also saw that staff members had not always acted on advice they were given quickly enough.

Records showed that where the service had been concerned about people who had lost weight, they had been referred for specialist advice. However, again there was a difference in the two areas of the home in regard to how well advice from health care professionals had been carried out. Advice for one person stated that their soft diet should be mashed by fork, although we observed that this did not happen on either day of our visit. Another person had received advice and a treatment plan from a health care professional regarding their low weight six days before the start of our inspection. None of the advice or treatment, such as the provision of finger foods or small additional snacks between meals or nutritional supplements, had been started at the time of our inspection.

This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

All of the staff we spoke with told us that they had received enough training to meet the needs of the people who lived at the service. Staff members said that they had the opportunity to undertake additional training that was appropriate to their role. One staff member told us about training they had received in dementia care. They told us how this had enabled them to become the dementia ‘champion’ for the home. They also told us that they were supported by the provider to undertake national qualifications in care.

Requires improvement

Is the service effective?

We checked their training records and saw that they had received training in a variety of different subjects including; infection control, manual handling, safeguarding adults, first aid, and dementia care. We observed staff members in their work and found that they were usually tactful, patient and effective in reducing people's anxiety or in delivering care. However, we observed that not all staff members carried out care tasks appropriately. On one occasion a staff member helped a person to transfer from their wheelchair by lifting them under the arms. On another occasion the staff member wheeled a person in a wheelchair without the use of the footplates. Although this staff member had received training in moving and handling, there were no additional checks to ensure staff whose first language was not English had fully understood all of the information given to them.

Staff told us that they had supervision meetings with their line manager in which they could raise any issues they had and where their performance was discussed. They said that these were helpful and supportive, and provided adequate support for them to carry out their roles.

The Care Quality Commission (CQC) is required by law to monitor the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS) and to report on what we find. The MCA aims to protect the human rights of people who may lack the mental capacity to make some decisions for themselves. The DoLS are part of the MCA and aim to protect people who may need to be deprived of their liberty, in their best interests, to deliver essential care and treatment, when there is no less restrictive way of doing so. Any deprivation of liberty must be authorised by the local authority for it to be lawful.

The registered manager provided us with an explanation of the MCA and their role in ensuring people were able to continue making their own decisions for as long as possible. Staff members we spoke with told us that they had received training in this area. Staff members were clear that people were able to make their own decisions unless they had been assessed to not have the capacity to do this. However, staff members understanding that people were able to make even unwise decisions if they had the capacity to do so, was variable.

The provider was meeting the requirements of the Deprivation of Liberty Safeguards (DoLS). The staff and registered manager were aware of DoLS and what authorisation they needed to apply for if they needed to deprive someone of their liberty in order to provided necessary care and treatment. The registered manager was aware of changes following the 2014 Supreme Court judgement which clarified the circumstances under which a person may be deprived of their liberty. Following this, an assessment had been undertaken for those people living in the home who may have been deprived of their liberty and advice had been sought from the local authority regarding action required.

Requires improvement

Is the service caring?

Our findings

People we spoke with said that they were happy with the staff members and that the staff were kind, caring and compassionate. Comments included, "The staff are very kind", "The staff are good, they always have a laugh with you", "I would recommend this place, the staff are lovely" and "The staff are nice but there is not enough of them". Two people also told us that although most staff were good, this was not the case for all staff and some were, "Bossy".

We spent time in two areas in particular observing how staff members interacted with people. We saw that most staff were kind to people and attended to their requests promptly. They spoke with people appropriately, addressed them in the way that they preferred and listened to their requests. Staff made eye contact with people and crouched down to speak to them at their level so not to intimidate them. They understood the requests of people who found it difficult to verbally communicate. We observed one staff member speaking with a person in their first language, although the person was also able to speak in fluent English. The staff member explained that they liked to provide the person with the opportunity to discuss things in a way that protected their person's privacy as there were few other people who spoke the same language.

When asked, staff members demonstrated a good knowledge about how people communicated different feelings such as being unhappy or in pain so that they were able to respond to these. We saw that in one area of the home in particular staff members had developed close relationships with people that resulted in 'banter' back and forth and laughter throughout the day.

However, we also saw a few instances where people's requests for attention were ignored by staff walking by them or they were taken to another area of the home without the staff member letting them know this was going to happen. On one occasion we drew the attention of a staff member to the request of a person wanting to return to their room. The staff member was reluctant to assist the person, who was distressed, as their room was in another part of the home.

There was a variable response from people when we asked if they were able to make decisions about their care. Most people told us, and significantly everyone in one area of the home, that they were able to decide what they wanted to do, when they wanted to do it and how they wanted it to be carried out. One person told us that they were able to choose whether they had a male or female carer to help them and that staff members respected this decision.

We spoke with three other people, however, who said that they were not able to make any decisions about their care. One person commented, "I'm not asked how I feel about my care – when you come in here your dignity is taken away". One person's visitor told us that they were involved in their relative's care when their relative was not able to do this.

There was information in relation to the people's individual life history, their likes, dislikes and preferences. Staff members told us that they involved people in their care by asking them how they wanted this provided. Our observations showed that although most staff members did involve people in their care, this did not happen on every occasion. There were occasions when staff members did not always speak with people or let them know when they were going to do something that affected the person. This meant that there was a risk that changes to the way a person wanted their care to be given may not be consistently made by all staff.

In most areas staff were seen quietly asking people whether they were comfortable, needed a drink or required personal care. They also ensured that curtains were pulled and doors were closed when providing personal care and knocked on people's doors before entering their rooms. However, we saw that on one occasion a staff member spoke to two people in a way that treated them in a belittling way.

Although we observed that most staff were kind, compassionate and caring, there were a very few staff that did not always treat people with dignity and respect.

Requires improvement

Is the service responsive?

Our findings

There were mixed views from people living in the home about whether there was enough to do each day. People were able to attend events and entertainment in and out of the home and they were able to keep in touch with relatives and friends. Comments included, "The activities are okay and I can go outside when I want", "I get taken outside a lot which I like", "Someone came in to play the piano last week which was nice but there is not really much to do" and, "The activities are a bit up and down, it depends if anything interesting to do".

People were able to receive visitors throughout the day and we saw that there were visitors to the home at all times during our inspection. They told us that they could go out (with or without their visitors) around the home or to the local town centre.

The home employed a staff member specifically for the purpose of arranging activities, outings and entertainment. People had access to a number of activities and interests organised by this staff member. This included events and entertainment, such as exercise and games, or time with people on an individual basis. People told us that when this staff member was not available staff members were less able to provide them with activities. During our inspection we saw that staff members sat with people in some areas but not others. Where this interaction was available, there was a strong communal participation and all of the people in the room were able to take part in the flow of conversation.

The care and support plans that we checked showed that the service had conducted a full assessment of people's individual needs to determine whether or not they could provide them with the support that they required. Care plans were in place to give staff guidance on how to support people with their identified needs such as personal care, medicines management, communication, nutrition and with mobility needs. The information provided showed what was important to that person and their daily routine and sometimes what activities they enjoyed. Staff were able to describe people's care needs, preferences and usual routines. These matched the information recorded in people's records.

Charts showed that people who were not able to move easily and were at risk of developing pressure ulcers were repositioned every two to four hours. The information in care records to guide staff members in improving or reducing the risk of people developing pressure ulcers was variable. Where plans were available, these were clear and gave clear guidance. However, we found that there were no plans available for one person who was at high risk of developing an ulcer and one person who had developed a pressure ulcer. Despite this, we found that appropriate action had been taken to treat the pressure ulcer.

We observed that although staff were usually responsive to people's needs, there were occasions when this was not the case. For example, we saw that staff made sure that people sitting outside were in the shade and wore sun cream if this was their wish. However, fans had not been provided for two people sitting inside who had requested them as they were hot.

People told us that they knew what to do if they wanted to complain, although everyone was confident that action would be taken to improve things. One person told us that, "I've not had to complain" and another person said, "I haven't raised any concerns as I am not confident that they would be sorted. If I am unhappy I ask my son to tell them for me". Yet another person told us how they had complained about the time staff members got them up in the morning and although this had improved, not all staff members accepted this change. The person told us on our first day of inspection, "They used to get me up at 4am or 5am but it is better now since I told them I don't like it". The person added the next day, "I was up at 6am this morning, which was not my choice".

Staff members were familiar with the complaint procedure and told us that where possible they would try to resolve issues immediately. A copy of the home's complaint procedure was available in the main reception area and in each person's room. It provided appropriate guidance for people if they wanted to make a complaint. We examined the complaints records and found that there had been six complaints made to the home in the preceding 12 months. These had been investigated and information was available to show the action taken or whether the complaint had been responded to. We were satisfied that formal complaints were dealt with appropriately, although informal concerns and complaints were not all responded to by all staff members.

Requires improvement

Is the service well-led?

Our findings

Although the home had a system to assess and monitor the quality of the service provided, areas that considered how the home could be improved when issues had been identified had not been developed. Complaints analysis and recording of the actions taken had not been completed, which meant that an overall view of possible trends and themes could not be easily seen or responded to by the service.

The most recent satisfaction survey to enable people and their relatives to give their views on the running of the home was completed in February 2015. This information had been collated and showed approximately three quarters of the people responding to the survey had a positive feeling about the home and the care that they received. The results also showed that a quarter of people were less happy about how safe they felt at the home and the privacy and respect they received. Other areas where some people were less happy were similar to areas identified during this inspection. The manager was not able to tell us what action had been taken in response to these findings.

The staff survey, also carried out in February 2015 identified that three quarters of staff members felt the manager was approachable. However, a third of staff did not feel that the quality of care provided was good and just over a half of the staff responding to the survey felt their working environment was good. Action plans had not been developed for any of the satisfaction surveys carried out to show how issues identified in these surveys had been addressed.

We found that assessment and monitoring processes had identified similar issues to those found during this inspection. However, they had failed to take adequate action to address the issues that were still present some four months later. This was a breach of Regulation 17 of the Health and Social Care Regulations 2008 (Regulated Activities) Regulations 2014.

During our observations, it was clear that the people who lived at the service knew who the registered manager was and all of the staff who were supporting them. Staff said that they were kept informed about matters that affected the service through supervisions, team meetings and talking to the registered manager regularly. They told us about staff meetings they attended and that information was fed back to staff who did not attend the meetings during daily handover periods. This ensured that staff knew what was expected of them and felt supported.

Staff told us that they worked well as a team in their respective areas and supported each other. We found that staff spoke with each other politely and were accommodating when there were requests for assistance. The registered manager told us that staff morale was variable but usually quite good, she confirmed that staff members would speak with her if there were ongoing issues that they were not able to resolve amongst themselves.

There were regular meetings for people and their relatives where information about the running of the home had been discussed. These meetings kept people up to date with proposed changes, although the minutes did not show that people's views of the service or changes was encouraged or noted.

Staff told us the registered manager was very approachable and that they could rely on any of the staff team for support or advice. They told us that the registered manager had an open door policy, was visible around the home and very approachable. We observed this during our inspection when the registered manager visited each area in the home during our inspection. People knew who she was and why she was there.

The home has had a registered manager in post since November 2013.

We found that the home had a quality monitoring system in place and that actions and analysis of information was available. We found that people's care records were regularly audited to ensure they had been completed correctly by staff and contained accurate and up to date information about people's needs. Medication audits identified issues, such as storage temperature checks that had been missed or where there were gaps in medicine administration records. The regional manager monitored actions identified through this system and how well they were implemented on a monthly basis. We found that the overall initial audit completed by the regional manager had improved from an amber (89%) rating to a green rating (90-94%) after actions had been taken.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs People who use services were not protected against the risks associated with a lack of suitable and nutritious food, and dietary supplements prescribed by a health care professional. Regulation 14 (3) (a), (c).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance People who use services were not protected against the risks associated with inadequate monitoring and improvement of the quality of the service provided. Regulation 17 (2) (a), (e).