Nellsar Limited

Lukestone Dementia Nursing Home

Inspection report

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Date of inspection visit:
02 September 2021
03 September 2021

Date of publication:
02 December 2021

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Lukestone Dementia Nursing Home is a residential home providing personal and nursing care for up to 43 people living with dementia. At the time of the inspection, there were 43 people living at the home. Lukestone Dementia Nursing Home is a large secure building, adapted over three floors, in a residential area of Maidstone.

People's experience of using this service and what we found
There were not always risk assessments in place to give staff the guidance they need to keep people safe. Medicines were not always managed safely as there was a failure to ensure one person received their prescribed medicine for two weeks. Incidents were not always effectively reviewed to prevent a reoccurrence.

Staff told us there was not always enough staff to observe people and ensure their safety and meet their needs. Staff told us they did not have the training they needed to meet people's needs around emotional distress and dementia.

Management checks and quality assurance systems had failed to identify the concerns we found at inspection and therefore necessary improvements had not been made. People and staff were not always engaged well with the service. Staff concerns were not known by the registered manager. People and their loved ones were not involved with their care planning.

People told us they felt safe and staff knew how to report incidents of avoidable harm. The prevention and control of infection was managed.

People living at Lukestone Dementia Nursing Home told us "it is a nice environment," "staff are honest and open" and "they are good staff, nice people. I can always have a laugh." Relative's commented, "This place seems like a home," "The staff are absolutely brilliant," and "I am very happy with this care home."

It was clear that most staff knew people well. Interactions were kind and supportive and people living at the service and their loved ones praised the care they received.

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 20th June 2018).

Why we inspected
We undertook this focused inspection to follow up on specific concerns which we had received about the service. The inspection was prompted in part due to concerns received about the management of risk. A

decision was made for us to inspect and examine those risks.

We have found evidence that the provider needs to make improvements. Please see the safe and well-led section of this full report.

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 discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

At this inspection, we have identified breaches in safe in relation to management of risks and learning lessons from incidents and the safe management of medicines. We have identified breaches in well-led in the lack of effective management systems to ensure safe and quality of care and a lack of good record keeping.

Please see the action we have told the provider to take at the end of this report.

We will continue to monitor information we receive about the service until we return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-Led findings below.

Lukestone Dementia Nursing 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 Care Act 2014.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

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

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

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before the inspection

We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection
We spoke with five people who used the service and one relative about their experience of the care provided. We spoke with five members of staff including the registered manager, operations manager, deputy manager, nurses, care workers and a volunteer.

We reviewed a range of records. This included five people's care records and associated documentation such as daily notes. We also looked at six staff files (three permanent staff and three agency staff) in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies, procedures, and incident and accidents logs were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data, quality assurance records, staff meetings, surveys and further care records. We also spoke with five staff, four more relatives and the local authority.

Requires Improvement

Is the service safe?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement.

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

Assessing risk, safety monitoring and management

● People were not always protected from harm. Risks to people were not always mitigated as the service did not always provide detailed risk assessments and guidance for staff on how to support people with specialist medical needs. For example, people at high risk of falls or at risk of choking. In addition, people with such needs were admitted to the service even though staff did not have the knowledge or information to safely manage them.

● Documentation in regard to falls and wound management were not always completed and although some steps had been taken to reduce the likelihood of falls such as pressure mats and bed rails, falls continued. Risk assessments were not always updated, and referrals were not always made. After the inspection, a person's risk assessment was updated, and a referral made to the fall's clinic.

● People who needed constant supervision and care had left the service on their own on three occasions.

The failure to ensure risks to people were mitigated and failure to provide sufficient guidance for staff is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● During the inspection, the registered manager updated people's risk assessments. However, some still required further information for staff.

Using medicines safely

● Medicines were not always supplied and administered safely. Staff told us that they were worried about making mistakes as they were often disturbed during medication rounds through the night.

● One person had missed their medication to help manage behaviours that challenge for 14 days. The delay in receiving the persons prescription was a result of the person switching doctor's surgery upon admission to the service. However another route should have been taken by the service to obtain a prescription.

The failure to ensure medicines were managed safely is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Other medicines such as time specific medicines and 'as required medicines' were administered safely as prescribed. Systems and checks were in place to support the safe management of medicines. For example, checking safe storage temperatures of medicines.

Learning lessons when things go wrong

● Incidents were investigated when things went wrong and the provider was trying to improve the way the service records, manages and analyses accidents and incidents. However, lessons were not always learnt. For example, one person absconded from the service twice in as many months. Staff did find out how the person had absconded the second time and put measures in place to reduce the risk of reoccurrence.

● Behaviours that challenged were not always recorded, so patterns could not be identified. For example, in July only one behaviour chart (ABC) had been completed. On our inspection we witnessed a resident shout and swear at another resident on two occasions. One member of staff said, "I have told [staff] to complete ABC charts, but we are not really documenting enough when it comes to behaviours, it is time consuming, but I do worry for the residents who have to deal with it."

The failure to ensure risks to people were mitigated and incidents reviewed to prevent further occurrences is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

● The registered manager used a dependency tool to identify the required staffing levels in the service. Staff felt that there were not enough staff to support people properly and safely. Staff described how the lounge was often left unattended and there were lots of falls and people with distressed behaviours. Staff said, "There is not enough staff to observe people, and that is so important, especially when they are aggressive towards other residents - it is a big risk."; and, "I do think the level of observation is not good, you need whereabouts charts and more monitoring." The registered manager told us they usually manage to cover the required staffing levels ok, but it can be difficult to cover last minute sickness sometimes. The registered manager told us that they were actively recruiting but were finding it difficult to find suitable staff. This is an area for improvement.

● Appropriate safe recruitment of staff checks were carried out.

● The provider had not ensured staff and agency staff had all the qualifications, skills and experience to care for people safely. Staff and agency staff (who were often used) had not received all the training required to support people with their complex medical needs, for example tracheostomy care. This meant there were times when no staff on shift had the appropriate training and people were at risk of receiving poor care or neglect of care. Staff told us that they did not always have the training or knowledge to deal with behaviours that challenged. This is an area for improvement.

Systems and processes to safeguard people from the risk of abuse

● Systems and processes safeguarded people from the risk of abuse. Staff we spoke with understood their role in safeguarding people from abuse and avoidable harm. Staff told us they were confident in raising concerns with their seniors.

● On the day of inspection we saw staff diffuse developing situations between people and both residents and relatives felt their loved ones were safe in Lukestone. One person told us "I am certainly safe. I am being looked after very well. I have nothing to complain about. They come quickly if I ring my bell. They definitely look after me well." A relative commented, "I am confident that [my loved one] is safe. [Staff] keep me updated if there are any problems. They do understand her needs. Staff are empathetic when she displays challenging behaviour."

Preventing and controlling infection

● The service was clean, well maintained and there was a robust cleaning regime in place. A relative told us, "This place seems like a house. It is clean. My mum's room is spotless"

● Staff were aware of how to prevent and control the spread of infection. Management kept up to date with government guidance and filtered the information to staff. We saw staff wearing appropriate personal

protective equipment, such as gloves and aprons (PPE) and they had robust procedures in place to minimise the risk of and spread of infection.

- We were assured that the provider was preventing visitors from catching and spreading infections.
- We were assured that the provider was meeting shielding and social distancing rules as far as possible.
- We were assured that the provider was admitting people safely to the service.
- We were assured that the provider was using PPE effectively and safely.
- We were assured that the provider was accessing testing for people using the service and staff.
- We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
- We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
- We were assured that the provider's infection prevention and control policy was up to date.
- We were assured the provider was facilitating visits for people living in the home in accordance with the current guidance.

Requires Improvement

Is the service well-led?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement.

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

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

- The provider did not always put measures in place to ensure known risks to people were safely mitigated.
- Audits failed to identify issues found on inspection, such as lack of consistent documentation for risks, falls, wound management and behaviours. This meant the provider had failed to make the improvements needed.
- Care records such as care plans and risk assessments were not always accurate, complete and up to date. Records around incidents of behaviour were not consistently completed.
- Staff meetings were held and these discussed areas for improvement, such as behaviour charts not being completed. However, staff told us that this still was not happening as they did not have the time to complete them.
- Staff had not raised concerns they shared with us within staff surveys. This was a missed learning opportunity and indicates surveys may have become a 'tick box enterprise' for staff.

Systems were not robust enough to demonstrate risks to people was effectively managed. Records relating to the care and treatment of people were not always fit for purpose. This placed people at risk of harm. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The registered manager understood their statutory requirement to notify the CQC of important events in the service.

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

- The environment at Lukestone was pleasant, with each resident having a different coloured door as a memory aid and there were photos of activities and aide memoirs on the walls. However, on both days of the inspection people were sitting in the lounge silently and did not engage with anyone. Staff were focused on the tasks they were doing rather than the people in the room. A relative told us that "the lounge is really depressing."
- One person who had previously displayed behaviour that challenged in other homes, was calm and settled at Lukestone. Even though the person had not been at the service long, a member of staff told us

about them, and we saw activities staff engaging with and encouraging the person. A relative told us "[an external professional] told me recently that my dad was calm and was very happy [living at Lukestone]. I am amazed because in his previous home he was having anger outbreaks every day."

● It was clear that most staff knew people well. Interactions were kind and supportive and people living at the service and their loved ones praised the care they received. People told us "it is a nice environment," "staff are honest and open." A relative commented, "This place seems like a home."

● There was guidance around the home about how to report any worries people had. One person told us, "If I had concerns, I would talk to the boss."

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 registered manager and provider had undergone a lot of work and training around duty of candour. Investigations were carried out and families were kept informed of incidents.

● Relatives felt that staff were open and honest when things went wrong, one relative told us, "If they have any concerns, they always phone. If she slips, they always phone. Mum's skin is quite thin, so she will get skin tears, but if it happens, they always tell me." Another relative told us; "[loved one] has had a few minor falls, but I do not worry: they always tell me – there is no covering up. I think they do understand [my loved one]."

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

● The provider carried out surveys for relatives and staff, these were then collated, and comments were listed. These mostly consisted of compliments from relatives.

● Staff shared their concerns with us about the lack of dementia and behaviour that challenges training, however these concerns were not raised in surveys or known to the registered manager. This indicates a hesitance to raise or escalate concerns.

● Relatives told us that they had good relationships with the service, however people and their relatives were not involved in care planning or risk assessments. Relatives were not offered access to care records when they had questions about changes to their loved ones medication.

Working in partnership with others

● The staff and registered manager had good relationships with healthcare professionals, including the local speech and language team, dietician, doctor and hospice with whom they sought advice from regularly.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks to people were not always mitigated as the service did not always provide detailed risk assessments and guidance for staff on how to support people with specialist medical needs. Medicines were not always managed safely. There was a failure to effectively review incidents to prevent further occurrences.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems were not robust enough to demonstrate risks to people were effectively managed. Audits failed to identify issues found on inspection. Records relating to the care and treatment of people were not fit for purpose.