Loven Larchwood Limited

Larchwood Nursing and Residential Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This unannounced inspection took place on 6 November 2018. Larchwood Nursing and Residential Home provides nursing and accommodation for up to 48 people. At the time of our inspection, 44 people were living in the home.

Larchwood Nursing and Residential Home is a 'nursing and residential home'. People receive accommodation and personal care as a single package, and some people receive nursing care as a separate package. CQC regulates both the premises and the care provided, and these were looked at during this inspection.

Larchwood Nursing and Residential Home accommodates people in individual rooms, each with an en suite toilet and basin facility. Each floor has some communal bathrooms and toilets in addition, as well as a dining area and lounge.

The service had a recent history of non-compliance. Our inspection in September 2017 found the home to be inadequate in four areas with eight breaches of Regulations of the Health and Social Care Act 2010 (Regulated Activities) Regulations 2014 and one breach of CQC Registration Regulations 2009. We placed additional conditions on the provider's registration requiring them to submit monthly reports to us setting out how they would assess, monitor and, where required, take action to improve the quality and safety of the care and support provided to people living at Larchwood.

At our last inspection on 12 March 2018, we found that improvements had been made in some areas, following the inspection on 19 September 2017, where there were serious concerns about this service. Following that inspection, we took action against the provider and met with them to confirm what action they would take to improve the service. We served a Notice of Decision to impose positive conditions on their registration, which they have complied with.

At our last inspection on 12 March 2018, some improvements had been made but the provider remained in breach of four Regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because there was inconsistent management and oversight of the service, and there were concerns around infection control and the management of risks to people. Further improvements were also required to ensure people received person-centred care, and to ensure there were enough staff deployed effectively to care for people.

At this inspection on 6 November 2018 we found four repeated breaches of Regulations and one further breach of Regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was a registered manager in post. 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.

There was poor leadership in place, with concerns not being identified. The registered manager was not often visible throughout the home and was not aware of all areas requiring improvement. Staff working in the home were not always well supported.

Staff working in the home were not always deployed so that a mix of competency and experience worked together. New staff and agency staff were not always supported to gather enough knowledge of people before working as part of the staff team. This resulted in there not always being competent staff available to people when they required care.

Risks to people because of their health conditions had not all been identified and mitigated, and there was no guidance around some of these in people's care plans. Risks to people due to their environment, such as unsafe equipment, had not always been identified. There remained poor infection control practices and unclean areas and equipment.

People were not supported to eat and drink enough, and drinks and meals were consistently left out of reach for people. People were not always given choices of what they were going to eat, or communicated with about what their meal was. There was poor recording around eating and drinking when people were at risk of malnutrition or dehydration. Where further action was needed, such as weekly weights, this was not always completed.

Staff had not always considered people's mental capacity to make important decisions to ensure their rights were upheld. There was contradictory information about people's mental capacity in some people's care plans. The service was therefore not adhering to the Mental Capacity Act 2005 (MCA).

People were supported to see a doctor if they required, however people were not always referred to specialists such as a dietician in a timely way when required.

Care plans were not always person-centred and did not contain sufficient guidance for staff around people's conditions. People were not always able to choose how to spend their time and staff did not always listen to people. As a result, people did not consistently receive support as they preferred.

Relatives and people knew who to complain to if they required. However, not all people, relatives or staff felt as though they could raise any concerns.

The systems in place for checking, monitoring and improving the service were not robust and had not led to a sustained, suitable level of improvement. Many concerns found on the inspection were not identified by the provider, and previous improvements made to the service had not been sustained.

There were activities on offer for people, both within the home with the activities coordinator, and external outings. The activities coordinator completed one to one activities with some people in their rooms, and group activities such as bingo and flower arranging.

The overall rating for this service is 'Inadequate' and the service therefore remains in 'special measures'. In two key questions the service is still rated 'Inadequate', and for the remaining three key questions, the ratings are 'Requires Improvement.'

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.

Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

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.

Medicines were not managed and recorded safely.

Risk assessments were not always carried out according to people's health needs and their environment, and therefore risks were not identified and mitigated appropriately.

There were not enough competent staff deployed throughout the home to ensure people were kept safe.

Is the service effective?

Requires Improvement

The service was not always effective.

People's mental capacity was not always fully assessed appropriately for specific decisions.

People did not always have a drink available to them as these were left out of reach, and people were not properly supported to eat enough. There was not always a choice of food.

People had access to healthcare services, but were not always referred to specialists when needed.

Is the service caring?

Requires Improvement

The service was not always caring.

There was mixed feedback from people around whether staff were caring or not.

People were not always given choice and were not involved in their care.

People's privacy was upheld when having personal care completed.

People had visitors when they wanted.

Is the service responsive?

Requires Improvement

The service was not always responsive.

There was no guidance in place to ensure staff knew people's individual needs and preferences. Staff did not always deliver care in the way people wanted.

There were not sufficient end of life care plans in place and people's wishes had not been explored.

There were activities on offer within the home and trips out.

People knew who to talk to if they had any complaints.

Is the service well-led?

Inadequate

The service was not well-led.

The registered manager had not ensured the improvements previously made had been continued and sustained.

Systems in place for monitoring and improving the service were not effective and had not resulted in issues being identified and acted on prior to our inspection.

The registered manager had engaged with external agencies and shared information appropriately.

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 6 and 7 November 2018 and was unannounced. The inspection team consisted of two inspectors, a medicines inspector, a specialist nurse advisor 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.

As part of the inspection, we reviewed the information available to us about the home, such as the notifications and the action plans that they had sent us. A notification is information about important events which the provider is required to send us by law. We also obtained feedback from interested parties, such as the clinical commissioning group. We requested a Provider Information Return prior to the inspection. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We reviewed this information before the inspection.

As part of our inspection we spoke with a nurse, the registered manager, three care staff, kitchen staff and activities staff, as well as a visiting healthcare professional. We spoke with five people living in the home and four relatives, and observed the support provided to people in communal areas of the home, and activities taking place.

We looked at four people's care records in detail, and samples of others, as well as the Medicines Administration Records (MARs), and records relating to the overall running of the home.

Inadequate

Is the service safe?

Our findings

At our last inspection on 12 March 2018, we found the service was not always safe and was rated 'Requires Improvement' in this area. During this inspection, we found that people were not safe. There was a deterioration in some areas and improvements had not been sustained. We have therefore rated this key question as 'Inadequate'.

At our inspection on 19 September 2017, we had concerns about the assessment and management of risks around infection control. We also had concerns around medicines management and the management of risks to people's health and safety. The service was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At our inspection on 12 March 2018, we found that improvements had been made, however the provider remained in breach. At this inspection, we continued to find concerns and again, the provider remained in breach of this Regulation.

Risks to the health, safety and wellbeing of people who used the service were still not always identified, assessed and planned for. We continued to see prescribed items left out unsecured, such as thickener for drinks. This presented a risk of misuse by people living in the home, some of whom were living with dementia.

We saw that one person was eating their lunch in an unsafe position and asked staff to support them to reposition. A staff member said this was difficult as the person often slid down the bed again. However, the person remained at risk if eating in that position, and staff returned to them to support them to change position to eat. We asked if there was any equipment in place to support the person to maintain a good seated position when having their meals in bed, and staff said there was not. However, a staff member agreed to go and support them to sit up as much as possible.

Risks to people due to their conditions were not identified and managed. For example, for one person who was diabetic, there was no care plan in place. This meant there was a risk that staff would not know what the person's expected blood sugars should be, and there was no additional information, for example, about potential symptoms associated with their condition such as checking the persons' feet or how often they should have their eyes tests. We saw from their records that their blood sugars were erratic, and there was a high risk of hypo- and hyperglycaemia. We raised this with the management team, and the deputy manager wrote a basic care plan for this which stated, '[Person] needs staff to act according to guidelines from diabetic nurse'. We asked when they were last seen by the diabetic nurse, and the deputy manager was unable to find evidence of this. For another person, they were identified as being at high risk of falls. However, there was no falls risk assessment or care plan in place which guided staff on how to manage these risks. Their continence care plan had no information in place, although we saw the person had a catheter. This meant staff lacked guidance on how to provide care around the risks associated with this.

We saw one person who was nil by mouth, and saw that their mouth appeared very dry and unclean. Their care plan stated they should be supported with oral hygiene twice daily, however, between 10 and 23 October 2018, staff had only recorded this as being done five times. This presented a risk of severe

discomfort, lack of hygiene and that any oral health problems would not be picked up.

Risks associated with not eating and drinking enough were not always identified and managed. Where people had lost weight, they were not always appropriately supported. One person's moving and handling risk assessment dated 1 November 2018 stated that the current weight was 52.4kg, however their current weight was recorded as 47.3kg in another part of the care plan. The person had a very low BMI and was not referred to a dietician. The care plan stated that the person needed to be weighed weekly, however they were being weighed monthly. The care plan for nutrition stated the person had a normal diet, however the pre-assessment initial care plan stated fortified high protein high calorie diet. The care plan also stated to offer snacks in between meals, however there was no evidence of this on the food charts. Two people told us they still felt hungry after their lunch, and one person did not receive a choice of dessert, and said they would like a banana, which we then requested for them.

Staff did not always record food intake consistently, so it was difficult to monitor whether people were eating enough. For example, a nutritional assessment for the latter person stated to record dietary intake daily. This was not being completed. On 5 November 2018 the notes indicated that the person had seven teaspoons of porridge at 09.46am. At 01.57pm lunch was offered and declined. There was no more dietary intake recorded on the chart for that day. On 29 October 2018 a meal was recorded as being offered at at 17.33pm, but according to the notes, no further food was offered until the next day.

Equipment was not always fit for use. For example, in one person's en-suite toilet, we saw a raised toilet seat that was not fitted to the toilet, and was precariously sitting on the top of the toilet seat and wobbling. This presented a serious risk of the person falling from the toilet. We saw in another person's room that they had four different pressure cushions, one with an old label belonging to someone else. This meant it was not clear what equipment the person was supposed to use, and their care plan only stated that they should use a pressure cushion, not which one. The registered manager ensured these two examples were rectified the day after the inspection, however we remained concerned that these risks had not been identified until the inspection team saw them.

We continued to have concerns around infection control, as we saw dirty equipment such as people's chairs, medicines administration equipment and a full dirty drinking water jug in one person's room. There continued to be strong malodours in various places throughout the home, including in the communal dining room. There remained some poor practice regarding infection control. One person told us, "The [domestic staff] come in and sometimes they are eating food or blowing their nose. I don't like that. They eat our sandwiches and they have them in their hand when they come in." During the lunchtime, we saw staff picking up cutlery by the eating end rather than the handle, which did not promote best hygiene practices.

Staff did not always follow best practice when administering medicines. One person said, "The staff give me my medication. Sometimes they wait while you take it and sometimes they don't, it depends how busy they are. Sometimes it comes late." This was closely reflected by a further two people we spoke with. One relative told us that their family member was not always given their supplements, as staff often left them on the side in their bedroom. We observed that this was the case for another person living in the home, and that the supplement had been signed for as given by staff. However, there was more than half the bottle left much later in the day, which we returned to the registered manager. Therefore, the records did not show what supplements people actually had, and whether they were receiving these as prescribed.

There was unsafe medicines administration and storage. Arrangements were in place for the storage of medicines in a dedicated medicine storage room. However, on arrival we found that the door was unlocked and medicines stored within including medicines awaiting disposal and refrigerated medicines were

accessible to unauthorised persons and people living at the service who could have accessed them placing themselves at risk of harm.

We looked at people's medicines administration records (MARs) and found there were gaps for both oral medicines and medicines prescribed for external use such as creams and ointments. This meant records did not confirm people received their medicines as prescribed. We found that some medicines prescribed to be given, for example, as a once weekly dose, were given later than the day they were scheduled to be given.

Some medicines had not been available for use and had not been obtained in time to ensure people received their treatments continuously. The registered manager told us that this had been an ongoing concern and arrangements with the supplying pharmacy were now under review.

Supporting information was available for staff to refer to when handling and giving people their medicines. There was personal identification to help staff give people their medicines safely. There were additional records in place for high risk medicines to ensure safety. For people prescribed skin patches, there were additional charts showing they were applied to people's bodies in varying positions to reduce skin irritation, and confirming they were later removed before the next patch was applied. However, these records were not always completed by staff. For one person, who was in a great deal of pain according to their records, their recent pain patch had been missed so they did not receive this as prescribed.

For people with diabetes, additional charts for prescribed insulin showing the body sites of injection to enable them to be varied were not always completed by staff. This meant that it was not clear whether the administration of insulin was appropriate and safe.

For medicines prescribed for external use, there was a lack of written information or body charts in use to show staff where on the person's body and how frequently they should be applied.

Information about people's known allergies and medicine sensitivities in notes and on medicine charts was sometimes inconsistent which could have led to error, particularly when new medicines were prescribed. When people were prescribed medicines on a when-required (PRN) basis, such as those to assist with people's psychological agitation, there was written information to show staff how and when to give them to people to ensure they were given appropriately. However, this was not in place for all PRN medicines. For a person who had recently been in hospital and whose medicines had changed, their medicine administration record charts had omitted one of their pain-relief medicines. Records could not confirm that this person's pain-relief had been checked by staff with their GP in a timely manner. Because of this, the person may not have had appropriate pain-relief. There was also a lack of written information about the strategy for this person's pain relief or means of assessing their pain. Furthermore, there was a lack of written information about the strategy for the person's pain relief or means of assessing their pain.

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

We had mixed feedback about whether there were enough staff to consistently meet people's needs. One person said, "Some [staff] can be a bit rough because they rush you." Two relatives we spoke with said there were not enough staff to meet people's needs. As a result, people did not always receive care in a timely way. One said this was particularly at weekends, when people were left in communal areas for long periods of time.

All the staff we spoke with said they were often short of staff or not always able to work efficiently. One staff

member said, "The carers [staff] are rushed off their feet." Another said that sometimes when staff did not leave drinks within reach, "I work with same staff members, we always make sure people have their fluids, but I think sometimes if they're short staffed they forget to put their tables back." They added, "My last two shifts have been short, only me and one other carer upstairs." They went on to say this was very hard because most people needed two staff for their care. A further staff member said, "I don't think we have full staff, some call in sick, the [people] are complex and we are full." At times there were unfamiliar agency staff on shift, or new staff who were counted in the staff numbers, but still required full guidance from more experienced staff.

The rota showed how many staff were on duty, and the organisation used a dependency tool to assess how many care hours were needed. On most days, these hours were met, but often covered with agency staff. On some days, these were not met. Overall, we found that there were not enough competent staff deployed throughout the home to ensure people's needs were met in a timely manner.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found that improvements had been made with regards to the cleanliness of the kitchen and in food hygiene, and the home was awarded five stars by the Local Authority's environmental health officer.

There had been improvements in the management of people's wounds. A healthcare professional told us that the home was managing people's wounds so that they were healing well, for example people with serious pressure ulcers. We saw that where people were being supported to change position for pressure relief, staff were completing this regularly. We saw records of regular dressing changes for people when they required this.

There were systems in place to keep the home safe for people such as checks in place for lifting equipment and electrics, as well as for the water system.

People told us they felt safe. One person said, "I feel totally safe here." Staff had received safeguarding training and told us they would report any concerns they had.

We saw that where an incident or accident occurred, the registered manager had reported these to other authorities if needed, such as the local authority safeguarding team. Where they concerned staff, supervisions were used to discuss staff making improvements if needed. However, these were not always followed up with further competency checks.

Requires Improvement

Is the service effective?

Our findings

At our last inspection on 12 March 2018, we found the service was not always effective and was rated 'Requires Improvement' in this area. During this inspection, we found that although some improvements had been made, there was a deterioration in some areas and improvements had not been sustained.

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

Where one person had variable capacity, according to the registered manager, they had not had a mental capacity assessment to inform whether they were able to make important decisions about their medical treatment.

There was contradictory information about people's capacity in their care plans. For example, one person's care plan said they were, 'unable to maintain own end of life wishes'. This was contradictory as the mental capacity care plan stated the person, 'has been assessed as having capacity'. For another person who lacked capacity, there were no decision-specific assessments in place. We were not assured that people's rights were being upheld as much as possible.

The above concerns constitute a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). The registered manager had applied for DoLS for some people living in the home, and some people were under constant supervision for their own safety.

At our last inspection in March 2018, we found that improvements had been made in terms of staff competency. However, at this inspection we found that these improvements had not been sustained. Staff working in the home were not always deployed so that a mix of competency and experience could work together. One staff member said they felt the management team did not always deploy agency or new staff with experienced staff in an effective way. This resulted in there not always being competent staff available to people when they required care.

Not all staff were competent to meet people's needs because their English language skills were not always good enough to communicate with people about their needs. One person said, "[Staff member] said to me that they can just about understand everything I say but doesn't speak much English so can't answer me." A further person told us they found there was a language barrier with some staff, "You get [some staff] putting you to bed and I can't understand them. I hate it."

Staff employed by the organisation were provided with training in areas such as manual handling, infection control and the mental capacity act (MCA). However, staff including agency and new staff members did not always have enough knowledge to meet people's needs when they were on shift. One staff member told us, "I don't think [staff] are getting as much training as they are getting one shadow shift and then they're on the floor as they need staff to work on the floor." We had concerns around the way in which an agency care worker performed around the mealtime, and some staff we spoke with confirmed that agency staff were not always competent. We asked the registered manager for the profile for the agency care worker we observed at lunchtime, and this was not available. In addition, we asked for the induction checklist for this staff member as it was their first day, and we were told this had not been done. This demonstrated to us that there was no way for the provider to assure themselves that staff working with people were competent to do so.

The above concerns constitute a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection in March 2018, we found that improvements had been made to ensuring people received adequate nutrition and hydration, and that further improvements and care planning for diet and nutrition were still needed. At this inspection, we found that improvements had not been sustained and there was a deterioration in this area.

People were not adequately supported to eat and drink because they did not always have access to their meals and drinks. Staff did not always support people to eat and drink when they required this. The people we spoke with were not complimentary about the food they received. One person said, "The food is passable. I like breakfast but I wouldn't bother about any of the other meals." Another said, "I don't go to the dining room to eat. I went when I first got here and it upset me to see people having food shoved in their face." Another person said, "Some meals are not too good. I don't understand the fancy names. I like good old-fashioned English food. They gave me pasta the other day and it was all dried up. The meal I had yesterday was all dry, they didn't give you any gravy." The registered manager was aware that the food quality required improvement, and was taking some actions to rectify this, such as providing additional training for kitchen staff.

One person told us, "[Staff] will get the doctor if you need them and the optician came here to test my eyes." A visiting healthcare professional told us that the staff knew information about people and followed recommendations from them. We found that whilst people were supported to see healthcare professionals in some cases, such as mental health professionals when needed, they were not always referred on to further services, such as a dietician, in a timely way.

The environment was not always suitable because the heating could not be altered as it then meant there was no hot water. The registered manager told us the company who had carried out recent work on the boiler were called to return to rectify this, but this would not be able to be done until the Spring. This meant that in some people's room and communal areas, the home was uncomfortably warm. In some areas, there had been improvements to the environment. For example, the dining room was now in a light, airy and more spacious area of the home.

Requires Improvement

Is the service caring?

Our findings

At our last inspection on 12 March 2018, we found the service was not always responsive and was rated 'Requires Improvement' in this area. During this inspection, we found that this area remained requiring improvement.

We received mixed feedback about whether staff were caring or not. One person said, "I eat my meals in my room and sometimes it is just thrown at you, there is not a bit of kindness in some of [the staff]." A further person said, "[Staff] don't listen to you." Two relatives we spoke with said that staff were kind and caring, however one reflected that there were not enough of them, which meant people could not always receive the care they required.

One relative told us that staff adapted their communication to support their family member. They said, "The staff always tell [family member] what they are doing and say, 'excuse me'. When [family member] first came in here [staff] struggled to understand what [family member] actually meant but after talking to me and getting to know better they now understand." We saw that over the lunch period, communication was mixed, with some staff interacting with people more than others when supporting them to eat.

People and their relatives were not invited to be involved in the care plan. One close relative we spoke with did not know about any care plan. Some people and their relatives felt it was too much trouble to ask staff for support. Examples of this included one person who told us they had not pressed their bell for support to have a drink because they didn't want to be any trouble. One relative said they did not feel comfortable to ask if their family member could have a shower, as they said it seemed like too much trouble for the staff.

People were supported with personal care behind closed doors, and we saw that staff knocked on people's doors before entering, respecting their privacy. People were able to have visitors when they wished.

Requires Improvement

Is the service responsive?

Our findings

At our last inspection on 12 March 2018, we found the service was not always responsive and was rated 'Requires Improvement' in this area. During this inspection, we found that although some improvements had been made, there was a deterioration in some areas and improvements had not been sustained.

Food and drinks were consistently left out of reach and did not meet people's preferences. For another person, they said, "One thing does annoy me. [Staff] keep bringing me tea with sugar in it. I have told them I don't have sugar but they don't listen. That is why there are several half-drunk cups on my table here." Two relatives said staff often left cups of tea on the side to get cold as they were out of reach. For another person, we saw that they had drinks including a full, cold cup of tea and their lunch, on the table by their bed. They said they had wanted to drink it earlier in the morning when it arrived, but they hadn't been able to reach it. They then said they were not able to reach their lunch, which had been put out of reach and left. We then went to ask staff to support them with their food and drink. This person's records showed they were not drinking a safe amount, averaging 422mls a day over the last week, and they also had a urinary tract infection. There was a clear risk that this was a result of staff not supporting them effectively to eat and drink enough. We also saw that an agency staff member had been asked to support someone with their meal, and we found the meal untouched ten minutes later in the person's bedroom on the side getting cold, and the person was asleep.

We observed the mealtime experience in both the dining rooms, and found this required improvement. People were not always empowered to choose what they wanted to eat. We observed two incidences throughout lunch when people asked care staff what was for lunch and they did not know. The midday meal on the picture menu of the day was fish. However, the meal served was a choice of sausages or chicken. One person was given a plate of food by a staff member, with no explanation of what the food was, and no offer of assistance or any condiments. Desserts were put in front of people without asking them what they would like. On another occasion, we saw that a member of staff brought in a cup of tea to one person in their bedroom, and put a piece of sausage roll on a plate on the table without asking if the person wanted it, and no alternative was offered. We asked the person if they wanted the sausage roll and they said no.

Care plans were not person-centred. For example, care plans for one person had another's name in place. There were no care plans in place for people's specific health conditions. For example, we found that one person did not have a care plan for their diabetes. The registered manager put in place a simple plan for this by the end of the day of our inspection visit. However, people diagnosed with conditions such as depression, Parkinson's and epilepsy, had no care plans in place. For a person with severe pain, there was no care plan for this. These gaps in care plans presented a risk that people's symptoms could go unnoticed and untreated because there was no guidance for staff in people's individual needs in some areas.

Staff did not always know people well and there was a lack of guidance for staff on meeting people's needs. As a result, their preferences were not consistently met. We had mixed feedback about whether people had support when they wanted. One person said, "You can have a bath or a shower if you want. I don't have either, I just have a wash in my room." Another said, "I get a shower once a week which is okay." On the day

of our inspection visit, one relative we spoke with was concerned because their family member was still waiting for a morning wash at 11:44am. Another said there was not always hot water available and this meant their family member was not always able to wash when they wanted. We saw that people were not always regularly supported to have a bath or shower. People could not recall discussing how the staff could help them or discussing their health needs. They could not recall discussing choices about their care. None of the people we spoke with could recall being asked for their opinion on the service. Three people told us they had not been offered a choice of male or female care staff to support them with personal care.

We found that end of life care plans were not person-centred with details of people's preferences or last wishes. For one person, who had complex healthcare needs, and was in pain, the registered manager told us they were nearing the end of their life. Their care plan had no information about any discussions that had taken place around the person's needs, preferences or last wishes towards the end of their life. Another person's care plan simply said they did not want to be hospitalised, but there was no further information. They were on end of life care according to their care plan.

These concerns constituted a continued breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We received mixed feedback about the activities on offer. One person said, "I am not interested in the activities, they are not my cup of tea so I stay in my room." However, another said, "They [staff] always tell you what is happening. I go to the activities and they seem okay." On the day of our inspection visit the activities coordinator was doing flower arranging with people, and we saw that some people were engaging with this activity. The activities coordinator demonstrated that they knew about some people's preferences, and explained what activities they did with people who preferred to stay in their rooms, such as reading or hand massage. They had taken people on outings in the summer, such as a boat ride on the Norfolk Broads. There were also visiting activities such as animals and musicians, and in-house activities such as board games and bingo. People were supported with their spiritual needs. One person told us, "There is a vicar that comes to do a service which is really nice. I also go to the Church on a Sunday." People also had access to personal care professionals such as chiropodists and hairdressers when they wished.

There was a complaints policy in place and people and relatives said they knew who the registered manager was. One person told us, "I would speak to the [registered manager] if I need to talk about anything. She seems approachable." There had been no recent formal complaints made to the home. There were meetings for people who lived in the home and relatives, but most people said they did not attend these. One family member told us they discussed the food and what improvements could be made at a recent meeting. The registered manager had made us aware that they were making improvements in this area.

Inadequate

Is the service well-led?

Our findings

At our last inspection on 12 March 2018, we found the service was not well-led and was rated 'Inadequate' in this area. During this inspection, we found that although some improvements had been made, there was a deterioration in some areas and other improvements had not been sustained. It therefore continued to be rated, 'Inadequate', in this area.

There was a registered manager in post, who had joined the organisation in January 2018. 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. There was also a deputy manager in post.

The service had a recent history of non-compliance. Our inspection in September 2017 found the home to be inadequate in four areas with eight breaches of Regulations of the Health and Social Care Act 2010 (Regulated Activities) Regulations 2014 and one breach of CQC Registration Regulations 2009. Following the inspection in September 2017, we had serious concerns and we informed the provider in writing of these. We placed additional conditions on their registration requiring them to submit monthly reports to us setting out how they would assess, monitor and, where required, take action to improve the quality and safety of the care and support provided to people living at Larchwood. The registered manager had supplied these reports as requested.

The last inspection on 12 March 2018 found the provider had made improvements to the home. The service had met the required standards to meet four breaches, and remained in breach of four Regulations of the Health and Social Care Act 2010 (Regulated Activities) Regulations 2014. They had also met the breach of the CQC Registration Regulations 2009. There were no new breaches found at the inspection on 12 March 2018.

At this inspection we found that the improvements made in the home in March 2018, had not all been continued or sustained. We found that there were again breaches and the home was not providing good care in any areas. The home continued to be in breach of Regulations 9, 18, 12 and 17 of the Health and Social Care Act 2010 (Regulated Activities) Regulations 2014. In addition, there was a further breach of Regulation 11 at this inspection, indicating that the service had deteriorated.

Not all staff felt they could raise concerns, and there was not always a positive culture of teamwork within the home. Some staff were under undue pressure due to working short-staffed or with unfamiliar agency staff who required a lot more guidance. We saw from supervision records that there were many staff who felt there was discord between staff in the home. We spoke with a number of staff who had special requirements at work due to physical conditions, and they did not always feel properly supported by the organisation. At times, where staff had specific health requirements, this put them at risk as they were not always able to take their breaks and were overworked at times. This had an impact on the safe delivery of the service, as we found that people did not always receive care as planned and needed.

We found ongoing concerns in areas which had deteriorated since our last inspection, such as nutrition and hydration, which had not been identified. Areas where need for improvement had been identified, such as medicines, presented risks which had not been reasonably mitigated by the organisation. People's care plans were still not person-centred and their preferences not always reasonably met. We found unsafe and unclean equipment in use during the inspection which had not previously been identified. The quality assurance systems in place were not robust enough to identify areas which were in need of improvement or to ensure action was taken and that previous improvements were sustained.

Audits were in place to enable staff to monitor medicine administration and associated records. However, we found this was ineffective at promptly identifying and resolving issues. In addition, there was a lack of an effective system for reporting medicine errors and incidents to enable staff to take action to resolve them and help prevent them from happening again.

The quality of food provided had been identified as needing improvement by the registered manager, and they were providing additional training for the chef. However, they had not identified that not everybody was receiving a suitable choice of food and drink, and being supported accordingly. There was not sufficient checking of people's intake, either by physically checking with people in their rooms, or by checking the daily records to see what people were offered and consuming.

Where there were audits in place, action was not always taken following findings – a nutrition audit on 5 October 2018 showed that one person had a very low BMI, and they were not on a special diet. This had not been followed up by providing a fortified diet or referring to the dietician, or reviewing their needs. Furthermore, it had not led to checking that the person was receiving the weekly weights specified in their care plan.

Staffing levels had not been fully and accurately assessed using the dependency tool. One staff member said, "[Registered manager and deputy manager] don't realise how hard we work when there's not enough staff. [Registered manager] doesn't help out [doing care]. [Management team] would never come and help." The use of agency staff alongside permanent staff to ensure people's needs were consistently met by enough staff had not been resolved.

We had mixed feedback about the registered manager, as people did not always know who they were as they were not regularly visible throughout the home. One person said, "I would speak to the [registered manager] if I need to talk about anything. She seems approachable." However, all the people and staff we spoke with told us the registered manager was not often seen throughout the home. One member of staff told us they felt the registered manager and the deputy manager did not know what went on in the home and what the issues were.

There was not consistently good leadership in place. We asked people what the service did well. One person said, "I don't think there is anything that they do really well, it is all passable," and another said, "I can't think of anything they do really well." A staff member told us there was not always good teamwork, and this was also reflected in the supervisions records we looked at. Three out of the four supervision records we looked at showed staff were raising concerns about other staff. The registered manager had taken some action, such as providing a team building exercise for staff at a recent staff meeting. However, the teamwork and culture between the staff still required improvement to ensure a good service was delivered.

There were quarterly provider visit audits taking place, however these had not picked up all ongoing areas of concern and had not been effectual in driving and sustaining improvements.

We found that the action plans sent to CQC as a result of the conditions placed on the provider's registration had not identified all of the areas still requiring improvement. Where ongoing issues were identified, for example around infection control and medicines administration, this had still not been rectified to a suitable standard. The last action plan sent to us in October 2018 stated how the service was overseeing people at risk of malnutrition and dehydration, however we continued to find significant concerns in these areas.

The ongoing actions taken according to the monthly action plans sent in to CQC according to the conditions we imposed, were not reflected in what we found on our inspection. The service had deteriorated in quality since our last inspection in March 2018.

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

The registered manager had engaged with the local authority quality assurance and safeguarding teams, and the CQC to ensure they received any information and notifications required. Where they engaged with other health and social care professionals, such as social workers, they shared information with them as required.