Careconcepts Limited

Marion Lauder House

Inspection report

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Ratings

Overall rating for this service	**Requires Improvement**
Is the service safe?	**Requires Improvement**
Is the service effective?	**Inadequate**
Is the service caring?	**Good**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Overall summary

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 was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, and to provide a rating for the service under the Care Act 2014.

The inspection was unannounced and took place on 12 August 2014. The inspection was carried out by two inspectors, pharmacist inspector, an expert by experience and a specialist advisor. Experts by experience are people who have personal experience of using or caring for someone who use this type of care service. Specialist advisors have up-to-date knowledge and experience in their specialist area. The expert by experience had personal experience relating to care homes and dementia care and the specialist advisor was a nurse specialising in cognitive behaviour and mental health.

Summary of findings

We carried out an inspection on 13 May 2013 where no regulatory breaches were identified. A responsive inspection was carried out on 5 August 2013 following on from information of concern we had received. Again no regulatory breaches were identified at that time.

Marion Lauder House provides accommodation for up to 76 people who require nursing and personal care. The home includes a dementia nursing unit which is located over two floors, a residential unit and a respite unit which are located on the ground floor.

We had received information of concern about the respite unit and the downstairs nursing unit. We found there were breaches of Regulations 9, 11, 12 and 14. You can see what action we have asked the provider to take at the back of the full version of the report.

At the time of our inspection 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 and has the legal responsibility for meeting the requirements of the law; as does the provider.

The registered manager told us they were aware of their responsibilities under the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. The Deprivation of Liberty Safeguards aim to make sure people in care homes are looked after in a way that does not inappropriately restrict their freedom. We found improvement was needed to ensure the correct process was followed where an application had been made to DoLS and to ensure the process was supported by appropriate records.

We were able to access all areas of the home and noted there was a strong stale odour throughout the downstairs nursing unit and on the stairway. We found carpets on the stairs to be badly stained and the dining area on the ground floor nursing unit was dirty. Some of the toilets were in need of cleaning. We found there was a breach of Regulation 12. The provider made us aware of their refurbishment plan and we could see some areas had been redecorated. We saw the residential unit, the respite and the upstairs nursing unit were clean and tidy. We looked at three bedrooms and found them to be well presented and clean.

The registered manager told us they had introduced a fixed staff team on the upstairs nursing unit in order to provide more continuity of care for the people who used the service. We received lots of positive feedback about this part of the service.

We found that medicines, including controlled drugs, were stored safely. However we found the homes medicines policies were not consistently applied across the home and that there was a lack of supporting personalised information about people's individual medicines needs.

Support plans showed that people had access to their GP and other health and social care professionals such as; psychiatrists, dietician, district nurses and social workers. We found some information contained in the care files we looked at was out of date and did not always reflect the person's needs. We spent time observing how staff interacted with people who lived at the home. It was apparent from our observations of the care staff throughout the day that the team were caring. We spoke with six members of staff who told us they enjoyed their job and were proud of what they did.

We had not always been informed by the registered manager of incidents and accidents which had occurred at the home through statutory notifications so we were unable to check whether appropriate action had been taken. A statutory notification is something all providers must send to us to tell us of incidents, accidents or deaths which have occurred within the home.

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?

Requires Improvement

The service was not always safe.

We found improvement was needed to ensure the correct process was followed where an application had been made to DoLS and to ensure the process was supported by appropriate records.

We found the home to have a strong odour throughout the downstairs nursing unit and on the stairway. There was a refurbishment plan underway but we found the home was dirty in some communal areas. The décor downstairs was 'tired' and the flooring to some toilets was in need of repair and sealing.

We found there was a lack of supporting personalised information about people's individual medicines needs with their care plans to support the administration of medicines in the safest and best way. We did however see new care plans were being introduced which would be more person centred.

Is the service effective?

Inadequate

We found the service was not always effective.

We spoke with staff who told us they had attended various training courses including mandatory health and safety training, infection prevention and control, food hygiene, DoLS and safeguarding. However some staff were not able to elaborate on the content of these courses or how they would implement their learning.

People who used the service were not always supported to eat and drink sufficient amounts for their needs.

The upstairs nursing unit was small and friendly with a consistent staff team and people seemed to be settled and content within the environment. However, the communal areas in the downstairs nursing unit were large, noisy and not conducive to providing specialist support to people who were living with dementia.

Is the service caring?

Good

The service was caring.

We found overall staff seemed to genuinely care about the people they supported. Throughout the home staff were kept busy trying to support people with their needs and where consideration had been given to ensuring there was a regular team supporting a smaller group of people, we found the care was of a good standard.

Summary of findings

Although staff were task focussed we did observe some staff had a good rapport with people who used the service and we received positive comments from the people living on, staff working in and relatives visiting the first floor nursing unit.

Our observations told us staff were well intentioned and cared about what they did and about the care and welfare of the people they supported. We found overall people were well cared for in terms of their appearance being smart, their clothes being presentable and they looked clean and tidy.

Is the service responsive?

Requires Improvement

We observed parts of the service was not always responsive because the staff did not have the necessary skills, and systems were not in place, to ensure the service provided specialist dementia support.

The care planning format was institutionalised and did not provide a person centred plan about the person's individual needs and priorities to be addressed.

We found people being admitted into the home from hospital were not always supported appropriately, because staff had not been informed of their needs, which resulted in them and their families experiencing some distress.

Staff on the upstairs nursing unit knew people well and were able to tell us about individual's care needs. This was because the unit was smaller and the care more person centred.

Is the service well-led?

Requires Improvement

The service was not well led.

We found the provider had good systems in place to try and promote a positive open and inclusive service.

We found there was not a strong emphasis on person centred care or specialist care for people living with dementia. We found on the downstairs nursing unit staff were not properly co-ordinated to meet people's needs effectively, and where good practice was undertaken there was little or no recognition from the registered manager to ensure this practice was carried out across the service.

We saw some audits had been carried out by the deputy manager but were not always up to date. We did not see any audits on the day of our visit which had been carried out by the registered manager. This meant the quality of the service was not being monitored by the person in charge.

Marion Lauder House

Detailed findings

Background to this inspection

The inspection was unannounced. The inspection team consisted of two inspectors, a pharmacist inspector, an expert by experience in dementia care and a specialist advisor. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert by experience had personal experience relating to care homes and dementia care and the specialist advisor was a nurse specialising in cognitive behaviour and mental health.

We spent time speaking to people who lived at the home, and 12 support staff. We looked around the environment, looked at six people's support plans and reviewed staff records.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

Before our inspection we reviewed all the information we held about the service. We considered information that had been shared with us by the local authority and looked at safeguarding alerts that had been made. We had received information of concern about the respite unit and the downstairs nursing and dementia unit.

We had asked the provider to complete a Provider Information Return (PIR), which told us what was currently happening at this service. We used this to inform our planning. Before the inspection we emailed the nursing home team, and reviewed information we held from commissioners to gain their views of the service. We followed this up after the inspection and spoke directly with the nursing home team to help clarify some of the things we had found.

Requires Improvement

Is the service safe?

Our findings

We had received concerns about the standards of hygiene and the suitability of the environment for people living with dementia at Marion Lauder House. We looked at all areas of the home and found the home to have a strong odour throughout. This was particularly evident in the dining room of the respite unit and in the corridors and stairways of the main building. We saw stains on the stairs, which indicated they had not been cleaned for some time. We inspected the environment and found it to be dirty in some communal areas. The décor was 'tired' and the flooring to some toilets was in need of repair and sealing.

We saw what looked like faecal matter on the wall at the side of one of the toilets and the bowl of the toilet was dirty and stained. It was noted that the sluice room on the first floor was unlocked. There was faeces evident in the sink and also an accessible bottle of bleaching agent. This was a risk to people who used the service as they were able to independently access this. We asked staff to ensure that this area was locked when not in use.

In the dining room on the ground floor unit we saw there were stains up the walls which looked like they had been there for some time and the floor and tables were sticky to touch despite having been wiped over. The dining room was generally dirty, disorganised and we saw wheelchairs were being stored at one end of the room.

We observed one person in the downstairs lounge area becoming upset which resulted in them spilling their drink onto the floor. Staff responded by leaving the person they were supporting in order to clean up the spillage. We spoke with the person who had been left. They told us they didn't know where the staff member had gone and they wanted to go outside for a cigarette. We observed the person was left for 15 minutes before we intervened and asked a member of staff to offer them the support they wanted. We spoke with staff who told us it was difficult to support people properly when they were called away to clean up spillages, which happened often.

We observed there were care support staff, registered nurses, maintenance people, kitchen staff team leaders and senior staff on duty but did not see any domestic staff on the day of our visit. The registered manager told us they did employ domestic staff, who worked in the mornings and sometimes care staff would be expected to clean up spillages as it was part of their job. We asked to see a cleaning rota but none was made available to us at the time of our visit. We were supplied with a rota after the visit which identified there were six domestic staff employed and one house keeper. The rota showed three domestic staff were available between 8.00am and 4.00pm and one available from 4.30 pm until 1.30 am. It was not clear what tasks the domestic staff were responsible for. It was therefore not clear who would be responsible to clean throughout the day.

People were supported on the respite unit by three care staff during the day and one at night. This was the same on the residential unit. The nursing units were located on the ground and first floors. The ground floor nursing unit was supported by six care staff, two or three nurses during the day and one nurse at night. The first floor nursing unit was supported by five staff and one nurse from the ground floor unit would support when needed during the day and night. There was also a deputy manager and the registered manager. We found there were enough staff to support the needs of people using the service although people did not always experience a good service because staff were not co-ordinated effectively. For example, on the downstairs nursing unit we saw people who needed support to eat their lunch did not always receive the level of support they needed.

We saw the provider had taken action to raise staff awareness of safeguarding issues by providing training. We spoke with three support staff who were able to describe the various types of abuse and the action they would take if they suspected a person was being abused. However some other staff we spoke with were not able to elaborate on their learning. There had been referrals made to safeguarding following on from incidents at the home and one investigation was on going. This meant staff had appropriate knowledge to keep people safe but not all staff knew how to apply their knowledge to safeguard people if needed.

We had received information of concern about unsafe storage and administration of medicine.

On the day of our visit we found all medicines were administered by qualified nurses or suitably trained care workers. However, on the residential unit some night shifts

Requires Improvement

Is the service safe?

were covered by care workers who had not completed medicines training. Day staff stayed on to administer night medicines but this reduced the flexibility and choice in the timing of night-time medication.

The medicines administration records were clearly presented to show the treatment people had received but clear records supporting and evidencing the application of prescribed creams were not made on the nursing unit. Written information was in place about the use of 'when required' medicines but this was brief and did not link to people's individualised plan of care. People's medicines were checked and confirmed on admission to the home but telephone consultations with healthcare professionals were not always clearly recorded. This meant it was not always clear why people's medicines had changed, or on whose authority.

Where the covert (hidden) administration of medication was used there was evidence of care staff, health professional and family involvement in the decision making. However there was no clearly documented management plan for covert administration to ensure these medicines were safely administered and that covert administration was kept under regular review. Information kept with one person's medicines administration record indicated that covert administration was used but both nurses on duty said this was no longer necessary. This meant people were at risk of unsafe care and treatment because records were not kept up- to- date.

The issues we identified breached Regulation 13 (Management of medicines) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This is because the registered manager did not protect service users against the risks associated with the unsafe use and management of medicines.

The Care Quality Commission is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS), which applies to care homes. These safeguards protect the rights of adults using services by making sure any restrictions on their freedom and liberty are assessed by appropriately trained professionals. The registered manager told us none of the people who lived in the home were being deprived of their liberty although some people were on 1:1 support at all times.

We were informed that one person needing 1:1 support was under constant supervision throughout the day and night and was not free to leave the building unless accompanied by staff. Staff told us this person was constantly supervised at night and staff would stay with them in their bedroom. We spoke to the registered manager about this and asked whether other less intrusive and restrictive options had been considered. For example there was a sensor mat by the side of the bed which would alert staff if the person got up. We spoke with the manager about the possibility of staff being located outside the bedroom to promote the privacy and dignity of the individual concerned. The manager said this was something they could consider. We considered the home to be using excessive measures to control the movements of this individual.

After the inspection we received further information from the provider which demonstrated the home had followed the correct procedures to keep people safe. We saw capacity assessments had been done and a best interest meeting had taken place for the person requiring 1:1 support. We also spoke with the provider about the importance of ensuring people have up to date information recorded in their care plan. The provider assured us this would be done as a priority.

Inadequate

Is the service effective?

Our findings

There was a programme of training, supervision and appraisal. The manager told us a rolling programme of training was in place for all staff. Staff confirmed they received supervision and had "access to lots of training". They told us they had undertaken safeguarding and dementia training but not all staff were unable to expand on what they had learnt from courses.

There was evidence in the staff records we looked at that some staff received supervision on a regular basis. Supervision is a formal discussion between staff and their line manager. It is an effective way of sharing information and identifying training and support needs. We also saw some staff had received an annual appraisal. The registered manager told us improvements had been made in this area and the programme would ensure all staff received regular supervision, training and appraisal over the next twelve months.

We spoke with staff about the support they received from the registered manager. Comments included: "There have been some positive changes recently." "Things are getting better," One registered nurse told us they had transferred over from another service and had been "very well supported and made to feel very welcome".

We conducted two SOFI observations over lunch time to see how people were supported at mealtimes and to see what experience people had. The observations took place on the ground floor nursing unit and the first floor nursing unit. The expert by experience had lunch with people in the residential unit and the specialist advisor spent time with people over lunchtime in the respite unit.

We found the tables had not been laid ready for lunch and there were no placemats, condiments, napkins or serviettes on the table or provided. We saw people were offered a choice of food and pictorial menus were up on display in communal areas in some parts of the home. This meant some of the units were promoting and respecting people by offering them choices in a way which was easy for them to understand.

In the downstairs nursing unit the lunch time service was disorganised. There were seven tables each seating three or four people. Some people remained in the lounge to eat their meals as staff told us this is what they preferred to do. We noted staff were kept busy for the whole of the lunchtime period and were unable to give time to some people needing assistance. There were seven staff in the downstairs dining area which meant there were enough staff available over lunchtime to meet the needs of each person we observed as needing support. There was no effective co-ordination of these staff which meant people were not supported appropriately.

For example we saw two people offering their food to other people sat at the table with them, which they subsequently ate. If there had been a staff member present at the table this could have been avoided. Staff then cleared the plates away assuming the person, whose plate it was, had eaten the meal. We asked staff how they monitored people's food and fluid intake and were told "We just know and record it on a sheet in the kitchen". We asked about the food and fluid charts for one person and were told the notes were in their care file. We checked the file and were unable to find any information pertaining to food or fluid intake. This meant the provider could not be certain people were receiving sufficient nutrition to meet their needs.

In the upstairs nursing unit and the residential unit we observed the lunchtime service to be more relaxed. This was because there were a smaller number of people being supported on each of these units which meant staff were able to offer the appropriate level of support. Staff were aware of people's dietary needs and offered encouragement where it was needed.

A person having lunch in the residential unit told us "The food is alright but you don't get enough of it". We saw fruit was available on the residential unit and the first floor nursing unit for people to access if they felt hungry.

A family member visiting the first floor nursing unit told us "The food is very good, there is plenty of choice, sometimes too much"

We looked at the care plans of people using the service to check their nutritional assessments and fluid intake. We found information contained in their care plans to be out of date or incomplete. For example we saw a nutritional assessment plan in place which was dated 11 March 2013 with only one entry on 26 June 2014 in relation to a referral to the speech and language team (SALT). This would suggest there had been a change in need of this individual but there was no clear record as to what it was.

The issues we identified breached Regulation 20 (records) of the Health and Social Care Act 2008 (Regulated

Inadequate

Is the service effective?

Activities) Regulations 2010. This is because the registered person did not ensure that service users were protected against the risks of unsafe or inappropriate care and treatment arising from a lack of proper information about them.

We also found a breach of Regulation 14 (Meeting nutritional needs) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 because the registered person did not ensure that service users were protected from the risks of inadequate nutrition and dehydration, by means of the provision of support, where necessary, for the purposes of enabling service users to eat and drink sufficient amounts for their needs.

We had recently received information of concern that people were not accessing emergency services or being referred to appropriate healthcare bodies as the need arose. To check whether people were being referred to appropriate healthcare bodies when their needs changed we looked in depth at two people's support plans. We found information was limited and referrals were often made by other healthcare professionals and not the nurse or the registered manager. For example in one person's support plan we saw there was a visit from a speech and language therapist (SALT) following a referral from a community psychiatric nurse (CPN). This referral was made because the person was noted to be holding their tablets in their mouth. The SALT noted medication should be provided in liquid form. This recommendation was made on the 23 July 2014 and had not been actioned. This meant people were at risk of receiving inappropriate care or treatment which did not meet their needs at the time it was needed.

We were told a multi-disciplinary team (MDT) meeting had taken place to recommend that one person should move to full time nursing support in the main building. The team leader attended this meeting and recommended this move but no written record of the meeting was included in the notes and no minutes were available. When questioned, the team leader stated that the social workers do not always forward minutes to them. It was discussed that it is good practice for the clinician to write their own notes in the care record to ensure that the care team are immediately aware of the discussions that have taken place and to also compare with the final minutes of the meeting when received. After the inspection the provider sent us the information we had requested on the day of our visit. We felt improvements could be made to ensure information relating to people's current care needs were immediately accessible.

We saw one example where paramedic support was called for a person who was found to be unresponsive. This was due to low blood sugar and although the care staff could describe clearly how this was managed it was not supported with a written record. We checked the report logs and found the night report prior to the incident appeared to be missing and there was no information included in the care plan to support the individual with their diabetes. There was no system in place to highlight this incident as it was not seen to be an accident therefore not entered into the accident book. This was a concern to us as it meant there were gaps in the recording of incidents.

We looked at the accident book which we saw included a number of occasions where people had fallen and where they had not been supported to gain prompt medical attention. The nurse on duty explained they would do this if the person had fallen and banged their head or if they were in pain. They were questioned how they would always know if this was the case. What they told us did not explain why medical help had not been sought or how they would know if someone was in pain who did not have the capacity to tell them. We found the system for reporting and recording of incidents required improvement to ensure people were not placed at risk.

We spoke with the nursing home team who told us they had recently addressed this issue with the home and requested that they were kept informed each time an incident occurred. This assured us people were not at risk and we saw evidence of the involvement from the nursing home team. We found improvements were needed to guide staff in the correct action to take in the event of an accident or incident occurring within the home.

The issues we identified breached Regulation 9(Care and Welfare) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This is because the registered person did not make suitable arrangements to protect the health, welfare and safety of service users when their needs changed.

Good

Is the service caring?

Our findings

We spent time observing staff interactions with people who lived at the home in all parts of the service. We saw staff were respectful and understanding. One person on the upstairs nursing unit told us "They are very good, the staff, I am happy here". Staff supported people to take part in activities which were taking place on the day of our visit. We spoke with staff who had a good understanding of people's support needs and preferences. We observed staff speaking to people in a respectful manner and offering people choices.

There was a good rapport between the people who lived at the home and the staff who supported them. We observed staff knocking on bedroom doors before entering which demonstrated they were respecting the dignity and privacy of people residing at the home.

The registered manager told us they had recently introduced a fixed staff team on the first floor nursing unit. They told us this was to promote continuity of care which was important when supporting people with complex health needs and/or those living with dementia.

We spoke with the three staff on the first floor nursing unit and with two visiting relatives. All had positive comments about the unit. One family member told us, "The staff are very caring and helpful and they have a bit of fun". Staff told us, "There is more consistency now as the staff team is established upstairs. We were previously moved around so were not able to provide consistency. We have a good understanding of people's needs".

We observed some activities taking place in different parts of the home. In the respite unit this included dancing to music and watching a film.

We spoke with the manager who told us the activities co-ordinator was looking to introduce some more personalised activities across the service. For example on the downstairs nursing unit we were shown a "fiddle board" which had been specially designed for one person who liked to try door handles and open and close locks. Whilst we saw this was suitable for the person it was designed for we still felt more could be done to engage with the people on the unit who were living with dementia.

Staff told us about recent training they had done regarding how to support people at the end of their life. We were shown the award which had been given to Marion Lauder House to demonstrate their commitment to end of life care. On the day of our visit we observed a handover between staff and were made aware that one person was very poorly and at the very end of their life. The handover clearly explained the care provided, how family had been informed, analgesia provided and the need for someone to sit with the person during their last few hours. The registered nurse taking charge of the persons care did not act on this information until we intervened to insist a member of staff sat with the person so they were not alone at this time. How they responded to us suggested they did not understand the importance of having someone sit with the person. We were told after the inspection that the nurse was an agency nurse who had been called in at short notice to cover absence.

Speaking with staff, the registered manager, people who used services and families it was clear people felt the staff cared for the people they supported and we considered this to be an isolated incident. Comments from the upstairs nursing unit and the residential unit included, "Staff are respectful and I am kept fully informed when necessary. (My relative) is always clean and tidy and staff have a good understanding of her needs".

We were told by the nursing home team they felt staff were caring within their role but were not always kept informed about new referrals by the registered manager. We found people were well cared for, their appearance was smart, their clothes were presentable and they looked clean and tidy. The atmosphere, apart from mealtimes on the downstairs nursing unit, was calm and relaxed and we saw staff intervening with the people they knew when they became upset or agitated. Our observations told us staff were well intentioned and cared about what they did and about the care and welfare of the people they supported.

Requires Improvement

Is the service responsive?

Our findings

Within the downstairs nursing unit and the respite unit we found the care provided was not responsive. The staff did not have the necessary skills and individualised care and behaviour management strategies were not in place to help them understand what was needed to ensure that the service provided specialist dementia support.

The care planning format and process was institutionalised in its approach, focussing on a person's diagnosis rather than them as an individual. It did not provide a process for the person's individual needs and priorities to be addressed.

We found care plans were based on perceived problems and issues and not on meaningful outcomes or how they would be achieved. Without this being in place it would be very difficult for a service to be responsive to people with such complex needs.

For example, one care plan we looked at stated that the individual was "prone to wandering" and could also be "physically and verbally aggressive" but it did not state the way this should be managed or how the person should be supported.

In another care plan we saw the person had been diagnosed as "insulin dependent, with vascular dementia and hypertension." The care plan contained reference to diabetes and dementia but no further information was included regarding hypertension. We spoke with the team leader regarding this. They told us this was probably a mistake and the person completing the plan probably meant to write 'hyperglycaemic'. This meant the staff were not being kept up to date with information about people's health needs which put them at risk of receiving inappropriate care and/or treatment.

We looked at the care record of one person who was receiving treatment for a water infection. There was a lot of documentation of the person 'urinating around the lounge' but no mention of this within their care plan and no identified possible link between the person's disorientation and a urinary tract infection (UTI). There was no record of this person being supported to the toilet since admission to the home, apart from when 'accidents' occurred.

We had received information of concern that the respite unit was not able to meet the needs of all the people currently using the service. We spent time in this unit carrying out observations as well as speaking with people using the service and with staff.

The respite unit had three people who were described as "long term residents" and nine additional beds which could either be used for respite or assessment purposes. From information we had received before our visit we knew 158 people had used the respite service in the previous 12 months.

We found the multi-function of this unit providing long term support, assessment and respite was conflicting. We spoke with staff about whether consideration had been given to the appropriateness of people staying permanently on the respite unit and how the disruption of people moving regularly in and out of this service may adversely affect someone's behaviour. One staff told us it was "sometimes difficult to ensure people got on but generally things were ok".

The team leader described how prior to admission they personally visited the person's families to find out as much information as possible about their family member which then influenced the development of the care plan. We saw for one person a large amount of information was provided by social workers prior to admission, which included a detailed initial assessment and also completed DoLS documentation.

After the inspection we were shown the best interest meeting decision for one person who used the service and was now living permanently on the respite unit. We saw the correct process had been followed to arrive at the decision but felt improvement was needed to ensure the care plan and the relevant assessments were reviewed by staff at Marion Lauder House to help them understand the needs of the people coming into the unit.

We saw some people who used the service had input from the nursing home team (NHT). The registered nurse told us any change in clinical need or any concerns they had would be referred to the NHT. We found there was an over reliance on information and assessment from external agencies such as NHT and social workers and not much formal assessment being done within the home.

We spoke with the nursing home team who told us the staff had not always informed them of changes to nursing needs

Requires Improvement

Is the service responsive?

in a timely manner. They told us there had been particular concerns about people being referred due to weight loss and that staff had not always identified this during the first steps. They told us staff had improved in the reporting of health care needs but felt there was still room for improvement to ensure changes to people's health needs were properly monitored and reported by the registered manager.

The issues we identified breached Regulation 9(Care and Welfare) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This is because the registered person did not make suitable arrangements to protect the health, welfare and safety of service users when their needs changed. You can see what action we have told the provider to take at the back of the full version of the report.

Requires Improvement

Is the service well-led?

Our findings

We found strong leadership was not visible or effective at all levels and staff did not have clear lines of accountability for their role and responsibilities.

The registered manager had been in post since 26 January 2011. There was also a deputy manager, team leaders and senior staff to support the registered manager and we were informed the provider of the service was accessible and approachable if people needed to speak with them.

It was apparent from the senior care staff and registered nurses that they had positive relationships with care staff. We spoke with the registered manager who told us they were aware of some of the things they felt they needed to do to improve the leadership within the home. There were systems in place to audit medication administration records (MAR), medication, care plans, health and safety, Infection control, catering, incidents and accidents and falls. We found care plan audits were carried out monthly and the health and safety and incident and accident audits were up to date.

We found there was not a strong management presence throughout the home and when accidents or incidents occurred the registered manager was not always aware. The audits we saw were completed by external healthcare professionals or the deputy manager. We did not see evidence of any over- arching quality assurance measures the registered manager did to ensure they were kept informed of things they needed to know about.

We saw certificates on the wall in the reception area which told us the staff at Marion Lauder House had successfully completed the 'Six Steps to Success North West End of Life Care Programme' in April 2014. Eleven staff members were given the End of Life Champion Award. We saw recognition the service had taken the dementia pledge and joined the dementia action alliance to demonstrate their commitment to dementia care. They had achieved Investors in People award to demonstrate their commitment to their staff team and were a member of the National Association for Providers of Activities for Older People. We did not see evidence in the downstairs nursing unit or the respite unit that this learning or commitment was consistently being delivered effectively on the day of our visit.

We found there was not a strong emphasis on person centred care or specialist care for people living with dementia. We found care was not properly coordinated to meet people's needs effectively in the downstairs nursing unit and the respite unit. For example we carried out observations over lunchtime and found the experience for people on the downstairs unit to be chaotic unlike the upstairs unit which was calm and relaxed.

We shared our experience with the registered manager and asked for them to observe tea time with us in the downstairs unit. What they told us during the observation meant they did not always understand the needs of people living with dementia although they appeared receptive to what we said.

The provider sent us information following on from our visit which was not made available to us by the registered manager at the time of our inspection. This information was in relation to quality audits which were carried out by the home and also included a schedule of works to improve the environment within the home.

The information was clear and concise and up to date and outlined plans for improving aspects of the service such as care planning, staff training and communication.

The home had a newsletter which the provider wrote to people using the service and staff. It contained updates on changes to the home and included dates for events and day trips. We found this was an effective way of keeping people informed about what was happening within Marion Lauder House.

We found overall there were systems in place to effectively manage the service although the issues we identified breached Regulation 10(Assessing and monitoring the quality of service provision) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This is because the registered person did not regularly assess and monitor the quality of the services provided and you can see what action we have told the provider to take at the back of the full version of the report.

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 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	Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control **The provider did not ensure appropriate standards of cleanliness and hygiene were maintained across the home.**

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines **The registered manager did not protect service users against the risks associated with the unsafe use and management of medicines.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records **The registered person did not ensure that service users were protected against the risks of unsafe or inappropriate care and treatment arising from a lack of proper information about them.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services **The registered person did not make suitable arrangements to protect the health, welfare and safety of service users by the carrying out of an assessment of the needs of the service user and the planning and delivery of care and treatment in such a way as to meet the service users individual needs**

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010 Meeting nutritional needs The registered person did not ensure that service users were protected from the risks of inadequate nutrition and dehydration, by means of the provision of support, where necessary, for the purposes of enabling service users to eat and drink sufficient amounts for their needs.