Care UK Community Partnerships Ltd

Lennox House

Inspection report

75 Durham Road
London
N7 7DS

Tel: 02072726562
Website: www.lennoxhouseislington.co.uk

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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

Lennox House is part of the Care UK Community Partnership Company. It provides residential care and nursing care for up to 87 older men and women at purpose built accommodation in a residential area of North London. The home is divided over four floors. On the ground floor intermediate care (this is short term care for people who usually live in their own home) is provided for a maximum of twelve people. Residential care for people using the service who do not require nursing care is provided on the first floor. Nursing care is provided on the other two floors.

This inspection took place on 16, 18 and 22 January 2017. At our previous comprehensive inspection on 28 July and 10 August 2015 the service was meeting all but one the regulations we looked at, in relation to staff not all having had appraisals. This breach had been met by the time of the unannounced focused inspection on 30 June 2016 that we undertook to look specifically at that previous breach of regulation. Subsequent to the June 2016 focused inspection we were informed of serious concerns about a safeguarding incident, that CQC had not been informed of, which had occurred in March 2016. We carried out a further focused unannounced inspection on 5 and 9 August 2016. As a result of that inspection we identified three breaches of regulations Regulation 12 Safe care and treatment, Regulation 13 Safeguarding service users from abuse and Regulation 18 of the registration regulations 2009 in respect of notification of incidents. Please refer to the remainder of this report in respect of our findings in relation to those breaches.

There was no registered manager in place. 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.

Medicines were not managed safely for everyone using the service. We found significant errors and people had missed their medicines due to a lack of supply or other administration and recording errors. Medicines audits carried out in November and December 2016 had identified similar issues, but no action had been taken to address these serious concerns since as the issue of medicines not being ordered in time had been identified again at a recent staff meeting on 11 January 2017. We also found errors in administration and recording of medicines during this inspection.

Apart from medicines audits in November and December 2016, an infection control audit carried out by the housekeeper in January 2017 and a current review of accident and incident trends, no other audits were provided, despite several requests. Audits were not therefore being used to effectively assess and improve the service. The provider informed us that they were undertaking a full review of the service in light of management and oversight failures that had been identified. This review was on-going and not been completed at the time of the inspection. CQC asked for a copy of the plan for reviewing the service, but this was not provided.

There had been significant management change. Since the previous registered manager's departure in

August 2016, the service had been managed by two of the provider's operational support managers, one until late November 2016 who was then replaced by another from late November and was in place at the time of this inspection. There was no registered manager in post, although the provider was attempting to recruit to the post at the time of the inspection.

The staff of the service had access to the organisational policy and procedure for protection of people from abuse. They also had the contact details for the safeguarding team at the local authority in which the service is located. The members of staff we spoke with said that they had training about protecting people from abuse, which we verified on training records and staff were able to describe the action they would take if a concern arose. However, we found that although improvements had been made to reporting concerns there had been two instances where these responses had not been timely enough.

We saw that risks assessments concerning falls, healthcare conditions and risks associated with skin care and the prevention of pressure sores were detailed, and were regularly reviewed for most people. However, we found a small number of instances where these reviews and actions required did not receive a timely response or follow up to care already known to be required. Staff were not always ensuring specific individual support was provided consistently.

The service had experienced staff changes among the activities co-ordinator team. There was insufficient effort being made to engage and stimulate people with activities, including people who remained in their rooms.

There were policies, procedures and information available in relation to the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) to ensure that people who could not make decisions for themselves were protected. The service was applying MCA and DoLS safeguards appropriately and making the necessary applications for assessments when these were required.

People were usually supported to maintain good health. Nurses were on duty at the service 24 hours and a local GP visited the home each week, but would also attend if needed outside of these times. Staff told us they felt that healthcare needs were met effectively and we saw that staff supported people to make and attend medical appointments, for example at hospital. However, there were a small number of occasions when healthcare needs were unclear and where follow-ups had not taken place as quickly as they should be.

Almost everyone we spoke with who used the service, relatives and friends, praised staff for their caring attitudes. We saw that most staff were approachable and friendly towards people and based their interactions on each person as an individual. However, there were exceptions where staff were not engaging with people or were uncertain about how to respond to people living with dementia.

Staff we spoke with felt more positive about the way the service operated and that their views were being sought and listened to more than they had previously experienced.

As a result of this inspection we found that the provider was in breach of Regulations 12, 13 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'.

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 always safe.

Medicines were not managed safely for everyone in the service.

Although most safeguarding concerns were identified there were still improvements required as two recent concerns had not been responded to in a timely way. People's personal safety and any risks associated with their care and treatment were identified and reviewed in most cases but not in all.

The service had effective systems in place to ensure that recruitment of staff was safe.

Is the service effective?

Requires Improvement

The service was not always effective.

Healthcare needs were usually responded to properly and quickly but with some errors in attending to this for everybody in a timely manner.

People were provided with a healthy and balanced diet, although were not always supported effectively.

There was knowledge about how to assess and monitor people's capacity to make decisions about their own care and support.

Staff received regular training and supervision and staff appraisals took place.

Is the service caring?

Requires Improvement

The service was not always caring. The feedback we received from people using the service, relatives and a visitor showed that there was usually a view that staff cared. However, we observed some instances where this was not the case and some staff needed to improve their responses to people.

Some staff needed to improve their interaction and understanding of supporting people with dementia.

Is the service responsive?

Requires Improvement

The service was not always responsive. People were not always engaged in activities or consulted about their view of the service.

Complaints and concerns were listened to and acted upon. The views that were shared with us by people using the service and relatives demonstrated that they had more confidence in approaching the manager and other staff whenever they needed to. This change to approach was not as yet embedded and some people continued to lack confidence in how concerns would be responded to.

Is the service well-led?

Inadequate

The service was not well-led. Issues identified in medicines audits in November and December 2016 had not been addressed. Audits were not being used to effectively assess and improve the service. A review of the systems and effectiveness for monitoring the quality of care was underway at the time of this inspection, although details of the nature and extent of the review were not provided to CQC when requested.

There had been significant management change since the last inspection and the home did not have a registered manager.

Lennox House

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 was unannounced which meant the provider and staff did not know we were coming. The inspection took place on 16, 18 and 22 January 2017. The inspection team comprised of three inspectors and a specialist professional advisor (Pharmacist).

Before the inspection we looked at notifications that we had received and communications with people, their relatives and other professionals, such as the local authority safeguarding and commissioning teams as well as the local specialist NHS trust nursing team.

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. During our inspection we also spoke with three people using the service, three relatives, and two visiting friends of someone using the service, five members of staff, three provider senior managers, the operations support manager, deputy manager and regional director.

As part of this inspection we reviewed twelve people's care plans. We looked at the medicines management for thirty five people, staff induction, training and appraisal and supervision records for eleven staff members. We reviewed other records such as complaints information, feedback to the service from visitors via comments made, maintenance, safety and fire records as well as the changes being made to oversight and governance of the service.

Inadequate

Is the service safe?

Our findings

A person using the service told us, "I have never seen them abusing anyone and they haven't abused me. I can be a bit cheeky but they never shout or raise their voices to me."

A relative told us about an incident that had happened a few weeks ago, which they had formally complained about. This person told us that since that incident the home is improving and the operations support manager was trying.

Another relative told us, "Carers are not always in the room with residents." They explained that often when they are in the communal lounge with their (relative) and several other people there are no care staff present. This often resulted in them having to intervene to stop some people from hitting others. One relative told us, "I stop so many fights." In the four months between the focused inspection and this inspection two notifications had been received regarding physical altercations between people. These were separate occupancies and no-one had come to notable harm. The service had responded appropriately in each case. There was no indication from this inspection that people were having "fights". We spoke with the operations support manager about this and were told that there was no issue about people having physical confrontations other than the two incidents that had been reported to CQC previously. We were told people had the occasional verbal disagreements but rarely anything more serious. However, some staff were not always available in communal areas of the home although staff were seen regularly walking around the corridors. We were also told that staff should be regularly checking on what was happening with people in different parts of the home and again we saw occasions when this was happening and staff were present. However, there was no clear awareness between the care team about who should take on the role of checking on people on each floor and how frequently or to be present with people in communal areas when not attending to people individually.

We looked at the medicines administration records (MAR) for thirty five people across the service. The clinical lead could evidence that medicines reviews were in place and multi-disciplinary team (MDT) notes and actions were printed and stored with the MAR. These reviews were largely due to changes of need or changes noted during a GP visit. The home manager provided copies of medicines audits completed in November 2016. The audit score was low and many of the issues found at this inspection had been identified on the audit. These issues had not been addressed since November 2016.

When we visited the medical room on each floor we found the rooms were securely locked when not in use. The clinical lead nurse provided evidence of a returns book documenting medicines no longer required that had been returned to be destroyed appropriately. The provider also had a current waste contract with a licensed waste contractor. Pharmaceutical waste was separated from clinical waste.

Controlled drugs that were in stock were checked against those recorded in the controlled drugs register (CDR) and the service was found to be compliant. The balances had been transferred to a new CDR register a few days before this inspection but the old balances had not be signed out of the old register which could lead to confusion. The clinical lead agreed to rectify this immediately.

On one floor there was one person who had been having medicines administered covertly since April 2015 and this was had been agreed with the GP. All medicines had been crossed out and annotated. There was a covert medicines GP review form completed on In October 2016 referring to the use of covert medication to control a condition the person had. However, all these medicines had been stopped (after October 2016) with the MAR stated stop the medicine and consider an alternative. The nurse in charge confirmed the person was currently given the alternative medicine covertly as agreed by the GP but the written agreement had not been added to.

On one floor a pill crusher was in use for all people and, although it had been washed up, it was found to be on the side drying with white powder residue still in the bottom. This was shown to the clinical lead by the specialist professional advisor who was a pharmacist. The clinical lead agreed that it had not been washed properly and action was taken immediately to address this with the appropriate staff.

Medicine stock levels checked according to the MAR mostly matched those recorded as given. However, because carried forward received amounts were not always reconciled this was not always the case. There were eight people having either missed between one and seven doses of particular medicines in the last three weeks due to lack of stock. Although these medicines were in stock at the time of the inspection, there were issues with re-ordering medicines.

On another floor MAR charts were found to be tidy and well ordered, PRN (as required medicines) protocols were in place, hand transcribed MAR sheets were clear. There was evidence of multi-disciplinary reviews and support from the mental health team undertaking client's medicines and treatment reviews.

There was a floor where daily medicines stock audit checks were not being completed. We also found that one person had been prescribed cream to be applied twice daily over a red pressure area but between 28 December 2016 to the 16 January 2017 this was only signed for as being applied at night. For another person, the covert medicines agreement in place did not cover three medicines that they were taking. The nurse we spoke with on this floor confirmed these medicines were added to the person's food and that to ensure the person had taken the medicines they would then go back to check the person to ensure that they had eaten the food. Another person had a three monthly injection which should have been given the week before this inspection but had not been.

On another floor, the medicines fridge was found to have recorded temperatures outside acceptable limits (2°C to 8°C). Records were greater than 8°C for five days and on the 7 and 8 January 2017 it was recorded as 13.1°C. The provider's own temperature record form stated that actions must be taken when there is a temperature breach to reduce any risk of medicines if requiring refrigeration not being stored correctly. We were told that medicines were stored in the fridge at the time. The clinical lead confirmed nothing had been reported and no action had been taken. We found a large quantity of soluble paracetomol sachets stored in a draw. In some cases the people's name had been removed from the boxes. These medicines were identified to be from previous medicines cycles and should have been returned to the pharmacy. We alerted the operations support manager about this for immediate action.

Three other people had missed medicines for between one and three doses in the first week of January 2017. Three other people had not been given some of their doses of medicine in the second week of January 2017. Another person had missed medicines for six days prior to this inspection as the medicines had changed to a tablet form but had not been delivered. We raised this immediately and the deputy manager confirmed with the GP that the liquid form of this medicine could continue until the tablets were delivered. The clinical lead nurse told us that these cases had been due to medicines not being ordered for delivery in time. On two other people's medicines charts two medicines doses on two consecutive days in early

January 2017 had not being signed for. The missed medicines were due to them being unavailable although they were fortunately were not medicines that posed an immediate risk to health.

During this inspection the operations support manager provided training records and competency assessments for staff undertaken in the last 12 months. However, our inspection highlighted issues with inconsistent medicines management from ordering through to the point of administration and disposal. The operations support manager stated that there had been no medicines errors. This was not consistent with the issues we identified and which were also identified in the home's medicines audit in November 2016. Medicines were not being safely managed for some people living at the service.

This is in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service had access to the provider organisation's policy and procedure for protection of people from abuse. They also had the contact details of the London Borough of Islington, the authority in which the service is located and which mostly placed people at the service. The provider organisation's procedure for responding to concerns of abuse set out the policy in line with common national and locally agreed procedures. The policy stated that any concerns of abuse should be reported without delay to the relevant authorities, including the CQC. Care and nursing staff we spoke with were clear about reporting any concerns to the senior member of staff on duty. However, we were informed that there had been a failure of a staff member to report an incident to the home manager for a week and an incident in December 2016 where someone had gone missing but this had not quickly been reported to the police. In each of these incidents the people involved had fortunately not come to any harm. However, the failure to report could have meant that they may have done and been left at unnecessary risk.

When we spoke with staff about what they were required to do if they had concerns or were aware of incidents, they were able to tell us about what constituted the type of incident which they should report. The provider's policy states that all accidents or incidents must be reported to the senior member of staff on duty and a record of the accident or incident must be made. We acknowledged that since our August 2016 focused inspection the provider had reviewed and made improvements to the identification and response to safeguarding concerns. Although there continued to be shortcomings. There remained a lack of understanding of at least some senior staff within the home about making sure concerns were taken forward and raised in a timely way in relevant situations, as was evident from an alert that was not raised until a week after an incident occurred.

At our focused inspection in August 2016 we found that people who were at direct risk of abuse from a person's behaviours, and the person exhibiting the behaviours at that time each had care plans and risk assessments in place. However, it was evident that the risk assessments had not been fully reviewed or amended to update risk reduction measures. We noted this as a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 at that time.

For a person who had posed a more recent potential risk to others at the home, we noted that that staff were keeping a record every 30 minutes of their one to one observations. An incident was recorded three days before our visit but staff had intervened. On the first day, when we visited the floor on which this person lived, the client was sitting with other people in the lounge. The care worker who was supposed to be with them providing the one to one support was sitting in the office opposite writing up care notes. The care worker asked an inspector if they were staying in the room as they had to go and do something. The inspector reminded the care worker three times that they were not a member of staff but a CQC inspector. Despite this, the care worker left the room. We immediately raised this with the operations support manager

who spoke with the care worker to emphasise that they should always be with the person and seek cover from another care worker if they had to leave the room. On our subsequent two visits, which were both unannounced, we found that a member of care staff was with the person at all times. This suggested that although the care home were using one to one care to minimise perceived risk, it could still not be guaranteed that one to one care was being fully implemented as expected by all staff in order to mitigate the risk.

A different incident had occurred where a person had gone missing, but was later found safe and well. This had not been reported in a timely way by a senior member of staff on duty. The person had seemingly left the home following visitors who were leaving the building in the evening. The service had reminders in place in the lift asking visitors to be mindful that this may happen. Since that occurrence, the home had taken further steps to ensure that the front door exit from the home required a key pad number to be entered before the door could be opened. However, although this type of incident was uncommon, this was an example of a lack of consistency around taking action to keeping people safe as soon as possible when an incident comes to light.

Some people living at the home were at risk of unsafe care due to some staff not making the necessary immediate reports or taking action if a concern arose.

This is in breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During the inspection period, two senior managers from the provider undertook an unannounced night visit. It was reported to us by one of these managers who had visited that they had not found anything of concern and had also checked on staff awareness of where clients were, whether in their rooms or in communal areas of the home at the time of their visit.

It was the policy of the service provider to ensure that staff received initial safeguarding induction training when they started to work at the service, which was then followed up with periodic refresher training. Staff training records showed this was happening and we were shown a programme of staff training, already underway, to update staff awareness. Staff we spoke with did have appropriate knowledge. However, as referred to above, the procedures for reporting incidents were still not as effective as they needed to be in all cases.

People were usually supported to maintain good health. However, we found an instance where care records did not show a clear follow up or monitoring of healthcare needs that had been identified. A person with a Percutaneous Endoscopic Gastrostomy (PEG) tube feed needed this flushed daily. However, no record had been made for the week prior to our inspection.

This is in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

With regard to other risks, the service was updating and reviewing these for people each month. The risks reviews included situations where people were identified as at risk of pressure sores. We saw that detailed and clear information was provided to staff to minimise this risk. People could be at risk of developing pressure ulcers if preventative care was not correctly managed. This showed that staff had instructions about how to minimise the risk of pressure ulcers and carried out the routine checks required, including body maps twice a day. A body map is a record that staff complete when providing physical care to record any marks or skin blemishes they see.

Other risk assessments, including falls and risks associated with nutrition and healthcare needs, for example diabetes, were recorded. The instructions for staff about the action required to minimise risks were clear. However, we raised one instance where a risk assessment of a person had shown a weight loss. Although a referral to a dietician had been made, the service had been slow to follow this up. We raised this immediately with the senior management of the home and we were informed that a follow up would be actioned urgently.

The service had safe and effective systems in place to manage staff recruitment. Staff files contained the necessary documentation including references, proof of identity, criminal records checks and confirmation that the staff member was eligible to work in the UK. Any gaps in employment that were identified as part of the recruitment process was discussed with the staff member at the interview stage of the process and the discussion was recorded. It was the policy of the provider to undertake Disclosure and Barring Service (DBS) checks renewals every three years for each member of staff.

The service had records confirming nurses NMC (Nursing and Midwifery Council) registration with an overview of when the registration had last been renewed and when they were due to expire and be renewed again.

We looked at rotas for November and December 2016 as well as rotas for the weeks commencing 2, 9 and 16 January 2017 leading up to our inspection. Stated staffing allocations were in line with what we had been told by the operations support manager and matched the staff that were on duty on each visit we carried out. The staffing rota also highlighted the members of staff allocated to the one to one support for a client who needed this. Staffing levels had not been of concern at the service although there were a number of changes to staffing underway which included staff from another provider service which had closed being transferred to the home and some other staff having recently left. The operations support manager stated that large scale use of agency staff was not regular and our examination of staff rotas confirmed that the majority of staff were permanent on the days that we visited.

During our visits we checked the communal areas of the service which were all clean and well maintained. Domestic staff were employed and covered a rota for the entire week. There were detailed infection control procedures. The most recent infection control audit in January 2017 carried out by the housekeeper, highlighted two areas to update and improve. We were shown the outcome of action taken in response to these areas. We were informed by the operations support manager that the recently appointed clinical lead nurses would be taking over the role and responsibility for ensuring that infection control guidance and training for staff was kept current and up to date.

We spoke with the regional managers for facilities and health and safety from the provider organisation. The service employed two full time maintenance workers who covered a rota for the whole week, including weekends. We were shown records of health and safety checks of the building. Appropriate certificates and records were in place for gas, electrical and fire safety systems. We saw that hoists and slings used to support people with transfers were regularly checked and these checks were up to date to support people's safety. The provider had emergency contingency plans for the service to implement should the need arise.

Requires Improvement

Is the service effective?

Our findings

We observed the breakfast and lunchtime meals service on two of the days we visited. Breakfast was unhurried and people were able to choose to eat in their room or go to the dining room if they preferred. The same choice of where to eat was also the case at lunchtimes.

On one floor we saw a person who was sat by the window in the dining room since we began our observation from 12.30pm and was waiting to be assisted with their meal until 1pm. It was explained to us that sometimes people had to wait to be assisted but staff tried their hardest to keep this to a minimum. The home operated a protected meal-time policy which required all staff to focus on service and assisting people who required it to eat their meal. This had not happened for the person we observed. A member of staff told us that they had seen times when people had not been encouraged to eat and their food had been taken away. Although we saw that most people had been served and supported with having their meals we raised these issues immediately with the operations support manager to look into.

One person did not like the food that was offered to them at lunchtime. They had taken a spoonful and declined to eat the rest. An alternative was suggested which the person happily accepted. We saw people being offered a visual choice of the meal. Two plates had been prepared and each person, when they were unable to recall what they had chosen, so they were better able to choose which they wanted. A person was observed to only eat the mash potato on their plate and had left all the other vegetables. The person was offered an alternative of the meat pie with some more mash potato which they ate. All people who were in their rooms had been served their meal in a timely manner. Food that was taken to people's rooms was taken on a tray and was covered.

Menus were displayed in the dining area and were reflective of the food that was served. Allergen information was also displayed on the wall in the dining room. Food looked appetising and was served hot. People were seen to be enjoying their food.

We spoke with the regional hospitality manager who was at the home to carry out a review of the meals service. This person had inducted two agency chefs due to concerns having been identified about the meal service in general. During this inspection we saw that updated advice was being given to senior staff and a review had been ordered in order to have the most current update of people's nutritional needs and dietary preferences.

At our previous comprehensive inspection in August 2015 staff appraisals were not consistently occurring and we noted this as a breach of Regulation 18 (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At our focused follow up inspection in June 2016 this previous breach had been complied with.

We spoke with four care staff and a unit manager who confirmed that they received regular supervision, although one was uncertain if it was called supervision. Records confirmed that staff members received regular supervision as well as their annual appraisal. Supervisions were also classified as coaching and

supervision which were carried out an ad-hoc basis in addition to formal supervisions. Supervision took place approximately three months and topics covered included reflection and feedback, progress against objectives, previous behaviours competency and agreement for areas to priorities. Almost all staff had this level of supervision and in most cases more frequently.

Staff had undertaken induction training prior to commencing work with the provider. Certificates confirmed that staff had attended training in areas such as wound care management, pressure ulcer prevention, MCA/DoLS, safeguarding, care planning, diabetes, food awareness, moving and handling, medicines management and emergency first aid. The provider had systems in place to ensure that staff training was kept current and up to date. Where staff were about to, or had exceeded, the necessary timescale for refresher training this was flagged up on the provider's training database and action was taken to address this.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf for 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 lacked mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedure is for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

Evidence of the home obtaining people's signed consent to their care and treatment was available, and this was obtained from their next of kin if this was the most appropriate way to obtain consent. We looked at the DoLs and the Mental Capacity Assessments and found that these were being completed with applications for DoLS approvals being made when required.

Staff we spoke with had a good basic understanding of their responsibilities under the Mental Capacity Act 2005. Each member of staff emphasised the right of people to be asked for their agreement each time care was provided and they that had the right to choose.

A relative told us when we asked about support for healthcare needs that "They have been absolutely brilliant with (relative) who went recently went to A&E they made sure that a care worker went with (relative)."

Registered Nurses were on duty at the service 24 hours a day each day of the week. A local GP visited the home twice each week, but would also attend if needed outside of these times. Staff told us they felt that healthcare needs were met and there evidence of medical advice being sought outside of the days of the week when a GP visited. People were supported to make and attend medical appointments, for example at hospital.

Requires Improvement

Is the service caring?

Our findings

A relative told us, "Carers don't seem to care" and that their relative was not able to attend church and they did not know if any church services took place at the home. We raised this and were told that there is a visiting Christian minister every two weeks. We spoke with the operations support manager and provider quality development manager who both told us that a programme of staff development was to be implemented to ensure that diversity awareness was improved upon and addressed.

In a dining room on the second floor at lunchtime one person was sat by a window singing to themselves. There was no conversation of interaction between staff and people in the dining room apart from when they were served their meal or given a drink. Interactions we observed were variable, from staff being very engaged with people to other instances where no interaction was attempted. On other floors there was more interaction of a positive nature and staff were engaging with people not only in the dining rooms, but as they were supporting people having lunch in their own room.

Most interactions were patient and caring. However, in one instance it was evident that a member of staff did not know how to respond to someone who was walking along a corridor uncertain where they wanted to go. After some prompting by an inspector the person was then escorted to the lounge to have afternoon tea. We raised the issue of whether staff were suitably aware about how to interact with people and not least those living with dementia. The provider quality development manager stated that the home did not have a dementia champion. The home was in the process of appointing a second clinical lead nurse who it would be a dementia champion for the home. We were shown a programme of weekly dementia awareness training sessions, which had just commenced that all staff were being required to sign up for and attend. Attendance at these sessions was being monitored by the provider.

We were informed of an incident that had taken place where three members of staff had an argument in the corridor by a lounge during an evening. This was an evening during the course of our inspection which we were told about on our next visit after it had occurred. This had been observed by a visiting professional and was raised as it occurred. The operations support manager took immediate action to address this. However, it raised questions about the attitude of those involved.

An area of good practice we did observe was how the service positively supported a couple who were both living at the home to maintain their relationship.

A relative told us, "The staff are fabulous and so caring." This person went on to say that they were aware that the service had been experiencing difficulties but they had not had any direct concerns about how their relative was cared for. A person using the service told us, "They care about me, they are lovely."

Friends of another person told us that although there were been some small areas they thought the service could improve, they felt that, "staff are always kind and polite. The staff do such a great job, its difficult work and they always seem patient with people."

We also observed some examples of good and caring interactions between staff and people using the service. For example, on a morning staff handover we attended, staff went to each person's bedroom, said good morning and talked about how they had been the previous night. One person was coming out of their bedroom as staff approached their room and said, "Oh it's lovely to see you all" and then had a brief chat with the staff. A staff member stayed with this person and gently reminded them to use their walking frame to which the person replied, "Oh yes I must do that or I might fall." The member of staff then walked with them along the corridor to the lounge.

Staff we spoke with talked about people respectfully and in our view did show empathy and a keen interest in people's wellbeing. When we asked care staff about how they sought the views and wishes of people who used the service, they described how they made sure that they asked people about their preferences and gave us examples of when they did this.

Requires Improvement

Is the service responsive?

Our findings

A relative we spoke with told us of a complaint they had made about the care of their relative which they were confident was being addressed. We did not hear of any complaints from other people we spoke with although some people were aware that there had been difficulties at the service.

We looked at comments and cards that had been received by the service and had been left in the comments book in the reception area of the service for people to add their comments. Since our unannounced focused inspection in August 2016, there had been a total of two thank you cards, one email and four written comments. One comment noted that the reception area was unattended and a parking permit was unavailable when they arrived. However, all of the others were complimentary. Comments included "Staff were so kindly during our relative's final days*, Staff are always very friendly and helpful" and "Our thanks go equally to those on the front line, nurses, care assistants as well as those behind the scenes."

In regard to activities on the three days we visited there was very little meaningful activity taking place on the Sunday and the activities programme on display on each floor was inaccurate and had not been updated. There was no information about what activities people preferred or had taken part in on care plans or other records. However, a new activities coordinator had come into post just prior to this inspection. On the afternoon of the first day of our inspection they had arranged a trip to a local cinema and six people had expressed an interest in going. The home had three activities coordinators although one had left immediately prior to this inspection. The new coordinator was seen to ask their colleagues at a morning management meeting, during our first visit, to ensure that the activities equipment, games, puzzles and art materials, was taken out of the storage room and kept in the lounges for use. We saw these items in lounges on our further two visits but none of it was seen being used whilst we were present.

We asked how staff can ensure personalised care and were told, "Depends on their needs and deal with them individually", "People are different. They have different cultures and different ways" and "Everyone is different."

People's individual care plans included information about cultural and religious heritage, daily activities, communication and guidance about how personal care should be provided. Care plans described people as individuals over and above common aspects of their health and social care needs. Care plan progress was recorded on daily notes and although all of this information was clearly available it was evident that it was not acted upon in all cases.

Relatives meetings had taken place in February, May, August and November 2016. Topics discussed included introduction of the GP who supports Lennox House, recent recruitment, health and safety, support to the home, care plans, DoLS, comprehensive medical reviews, menus, laundry, hospital appointments and escorts to hospital appointments. Also discussed were activities, nutrition, residents satisfaction survey, management cover and administration, management of risk and a record of CQC visit in August 2016 and the reasons for the visit.

Meetings for people who use the service were recorded to have taken place on March, April and May 2016 but none had subsequently been held. Topics discussed were mainly to do with activities.

Inadequate

Is the service well-led?

Our findings

During the inspection, there was limited evidence of documented audits for most aspects of the service apart from a medicine audits in November and December 2016, an infection control audit in January 2017 and an audit of accident and incident trends that was taking place during this inspection. The medicines audits that had been carried out had identified issues for improvement due to medicines not being re-ordered and a staff meeting on 11 January 2017 had noted that medicines were still running out due to a lack of re-ordering in time. Errors in administration and recording had also been noted during the November and December 2016 audits. The operations support manager told us that since coming into post no audits had been carried out on other aspects of the service. This was aside from the current review of accident and incident trends. We were, however, shown the outcome of action taken in response to the housekeeper's infection control audit and the action taken.

The provider had a system for monitoring the quality of care which we had seen at previous inspections. The regional director informed us of the process for oversight and governance that the provider operated although, aside from information we had previously seen about a visit in December 2016, no other information was provided, despite a number of requests. Although the provider subsequently stated that audits had been undertaken, we were not assured that, given previous concerns about the service, there had been on-going and effective oversight of the service. Audits were not being used to effectively assess and improve the service.

Senior members of management told us that due to the concerns raised, an overall review of the service was underway. This had commenced in the week prior to this inspection. We asked for details of the review, but these were not provided.

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There had been significant management change since the last inspection in August 2016. The previous registered manager had left in August 2016. Two managers had managed the service since the registered manager's departure. The provider was in the process of recruiting a new manager.

When we asked relatives what they thought of the leadership and management of the service a few told us they knew there had been changes. One relative expressed more confidence, while another they told us that action on their concerns had been taken. The provider had been transparent by informing people using the service, where possible, and their relatives and other stakeholders about the serious concerns that had arisen during mid-2016.

At our previous inspection in August 2016, we had identified a breach of Regulation 18 of the CQC Registration Regulations 2009 in so far as the provider was not notifying significant incidents as required. Since that time, apart from two incidents that had not been reported just prior to this inspection, other incidents had been reported. The provider had reported these incidents as required but in these two

instances there were senior staff that had not made the reports to the management staff or to the police quickly as required.

The service had undergone a prolonged period of uncertainty due to management and staffing changes and this uncertainty was still evident although with people expressing some positivity in what they had seen being implemented more recently.

Staff we spoke with were critical of the way the service had been managed but they also expressed a hope that things looked to be improving and wanted this to continue. Since the focused unannounced inspection in August 2016, staff meetings took place in October 2016, December 2016 and January 2017. Topics discussed included training, annual leave, cleanliness of the home, activities, kitchen picture menus, staggered mealtimes, documentation and medicines. The visits that had taken place by the local authority and CQC had also been discussed.

Staff told us that they believed their views were more respected which was evident from conversations that we had with staff and that we observed at the morning "take ten" meetings. This daily management meeting had recently been implemented in order for a representative from each unit, catering, housekeeping, activities coordination maintenance and senior management (internal management) to attend. We observed two of these and found that the current situation, significant events and care needs for people, activities and day-to-day matters were discussed and instructions for action were issued.

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 12 HSCA RA Regulations 2014 Safe care and treatment Medicines were not managed safely for everyone using the service. Errors and missed medicines, due to a lack of supply or re-ordering in good time, were occurring. This was not being responded to by the service even when medicines audits had identified this as a concern.

The enforcement action we took:

Issued a warning notice.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Staff must understand their roles and associated responsibilities in relation to any of the provider's policies, procedures or guidance to prevent abuse.

The enforcement action we took:

Issued a warning notice.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had a system for monitoring the quality of care. Audits were being carried out, but these were not being used to assess or improve the service:

The enforcement action we took:

Issued a warning notice.