Larchwood Care Homes (North) Limited

Laureate Court

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

The inspection took place on 28, 29 June and 1 July 2016 and was unannounced on the first day. This was the third rated inspection for this service which had previously been rated inadequate in November 2014. In March 2015 we carried out a focused inspection and a further comprehensive inspection took place in June 2015. We found improvements had been made, but further improvements were required to be implemented and the service was rated as requires improvement. You can read the report from our last inspections, by selecting the 'all reports' link for 'Laureate Court' on our website at www.cqc.org.uk.'

Laureate Court provides residential and nursing care for up to 82 people who are living with dementia and other mental health problems. The home has three units; Byron and Shelley both provide nursing care and Keats which provides residential care. The home is located close to Rotherham town centre. At the time of our inspection there were 56 people using the service, 26 people receiving nursing care and 30 people in receipt of residential care.

The service did not have a registered manager in post at the time of our inspection. 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. A manager had been appointed by the provider in January 2016. This person was present throughout the inspection.

During this inspection we looked to see if improvements had been embedded in to practice from our last inspection. We found insufficient progress had been made. We identified seven breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We spoke with the manager and regional manager who told us the reason was due to the change of management company which had taken place in January 2016, and this had had an impact on progressing the service. However, the provider had remained the same.

During our inspection we observed people had to wait at times for assistance and staff were not always present in communal areas to ensure people's safety. Staff and relatives we spoke with told us at certain times they could do with more staff to ensure people's needs were met in a timely way and maintain their safety.

Systems were in place to ensure people received their medications in a safe and timely way from staff who had been trained to carry out this role. However, we identified these had not always been followed and people did not always receive their medication as prescribed.

We found some people, who were prescribed medication to be given as and when required, were given this regularly as a means to control their agitation. Other methods to monitor and manage anxiety had not been considered.

People were not protected against the risks associated with infection prevention and control. Safe procedures were not followed.

Staff we spoke with were knowledgeable about safeguarding people from abuse. They told us they would report any concerns straight away.

The provider had a system in place to ensure people were recruited in a safe way. The manager was currently working through staff files to ensure that all correct documentation was present.

Staff we spoke with told us communication was poor; there was a lack of staff meeting, supervision and leadership. Staff morale was very low which was impacting on the people who used the service.

Staff told us that they had not received much training until recently. Most training was completed via eLearning although some recent training sessions had been arranged face to face. The provider's training records showed staff training was required.

People were not always supported to eat and drink sufficient amounts to maintain a balanced diet. Some mealtimes were disorganised which led to staff not ensuring people received adequate drinks and meals. We saw lots of plates being taken from people without them eating much, but this was not addressed by staff.

We looked at people's care plans and found their needs were not always addressed and health care services not considered or used when needs changed. For example we found one person had lost considerable weight over three months, there was no nutritional care plan and there had been no referral to a dietician.

The manager was aware of their duties in relation to the MCA 2005, and had arranged for best interest meetings to take place where required.

We observed staff interacting with people who used the service and found that most of the time interactions were task orientated. There were several occasions where there was a lack of regard for people's dignity and respect.

We checked people's care records that were using the service at the time of the inspection. We found that care plans had not always identified people's care needs. Where care plans had been reviewed notes had been recorded in the evaluation record and not the care plan. This made it confusing to the reader as to what people's current care needs were.

The home employed two activity co-ordinators whose role it was to arrange social stimulation for people. We received positive feedback from people living on Keats unit, but negative feedback from Shelley and Byron. In the main activity events took place on Keats unit, which left the other two units with little or no social stimulation.

The service had a complaints procedure and people told us they would tell staff if they had a concern although some people were not confident that things would be resolved. We looked at records and found no evidence to suggest that complaints had been investigated.

We found some systems were in place to monitor the quality of service provision. However, these were not effective and did not always identify concerns. Where concerns had been identified there was little evidence to show what actions had been taken to address them. Some concerns identified at the beginning of March

2016 were still awaiting action.

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 safe.

Staff were not deployed appropriately to meet people's needs.

People were not cared for in a clean, hygienic or well maintained environment.

Risks associated with people's care were not clearly identified and there was no direction regarding how to minimise the risks occurring.

We found people's medication was not managed in a safe way. There was no meaningful process in place for people who were prescribed medication to be given as when required.

Staff were aware of what action to take if they suspected abuse.

Is the service effective?

Inadequate

The service was not effective.

People who used the service were not always supported to have sufficient to eat and drink in order to maintain a balanced diet which met their needs.

From looking at records and talking with staff we found staff training had not taken place until recently. Staff had not received regular supervision sessions or annual appraisals of their performance.

People were not routinely referred to healthcare professionals when required.

The service was meeting the requirements of the Mental Capacity Act 2005.

Is the service caring?

Inadequate

The service was not caring.

We observed staff interacting with people who used the service

and found they were very task orientated. Some staff assisted people without explaining what they were doing.

Staff did not always maintain people's privacy and dignity.

Is the service responsive?

Inadequate

The service was not responsive.

We checked people's care records that were using the service at the time of the inspection. We found that care plans had not always identified peoples care needs.

The service had two activity co-ordinators who provided social stimulation mainly on Keats unit. We observed other units (Shelley and Byron) had no meaningful activities to occupy people.

People told us they would complain if they needed to but were not always confident that issues would be resolved.

Is the service well-led?

Inadequate

The service was not well led.

All care staff we spoke with told us morale was very low. They felt they were not supported and information was not communicated to them.

People who used the service and their relatives told us they had seen numerous changes in the management team. Relatives told us they did not have confidence in the recent management changes.

Some audits took place to monitor the quality of service provision. However they were not effective.

Laureate Court

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 checked 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.

The inspection took place on the 28, 29 June and 1 July 2016 and was unannounced on the first day. The inspection team consisted of two adult social care inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before our inspection, we reviewed all the information we held about the home. We spoke with the local authority to gain further information about the service.

We spoke with 10 people who used the service and 12 relatives, and spent time observing staff supporting with people.

We spoke with 15 care workers, three nurses, five ancillary staff, a cook, the manager, quality manager, regional manager and the nominated individual. We looked at documentation relating to people who used the service, staff and the management of the service. We looked at eight people's care and support records, including their plans of their care. We saw the systems used to manage people's medication, including the storage and records kept. We also looked at the quality assurance systems to check if they were robust and identified areas for improvement.

Inadequate

Is the service safe?

Our findings

At our inspection of November 2014 we found there were insufficient numbers of qualified, skilled and experienced staff to meet people's needs. This was a breach of regulation 22 of The Health and Social Care Act 2008 (Regulated Activities) 2010 which corresponds to Regulation 18 of The Health and Social Care Act 2008 (Regulated Activities) 2014. The provider told us they would be compliant by the 28 February 2015. We completed a second comprehensive inspection in June 2015 and felt the provider had taken action to address this issue, but that this still required embedding in to practice.

At our inspection of 28, 29 June and 1 July 2016 we found similar concerns to those identified in November 2014.

We spoke with relatives of people who used the service and found that not all relatives and friends were confident that their loved ones were safe and well cared for. They felt that people were not always supervised because sometimes there are not enough staff. One relative said, "I just don't think there are enough staff at times. It varies so much." Another relative said, "There are too many people on Keats and not enough staff." Another said, "When I came on Sunday, there was not enough staff."

We spoke with people who used the service and they also felt there were not enough staff. One person said, "'You sometimes have to wait for things when they are short staffed." Another person said, "I get fed up of waiting, staff say, they will do it in a bit but then don't." Someone else said, "Staff do as much as they can for you, but sometimes at the weekend, there aren't enough staff."

Staff we spoke with told us there was not always enough staff to meet people's needs. Our observations identified people's needs were not always met in a timely way and staff were not always present in communal areas.

We observed staff interacting with people and found that there were times when staff were not present, when people required their assistance. For example, we observed a time when five people were in their bedrooms on Shelley unit. One person was calling out, but no staff were available on the unit. We spoke with the manager and were told that staff had been allocated to different areas of the home and therefore there should always be staff available. We spoke with staff who told us there were some staff who were not abiding by the allocation sheet. This was not being managed effectively and it appeared that staff were deciding where they would work. This was putting people at risk.

On the second day of our inspection we saw that a training session was taking place. Some staff who was working that day were taken from their duties to attend the training session. This left staff short and unable to manage people's needs effectively and had not been sufficiently planned to make sure there were sufficient staff to meet people's needs.

However, some people we spoke with felt the home was a safe place to be. One person said, "I like it here, the staff are smashing, they make me feel safe." Another person said, "I can't complain, the staff make sure I

am safe."

We asked to see the dependency tool to determine what staffing levels were required to meet people's assessed needs. We did not receive this, but following our inspection the provider sent us an action plan, part of which stated, 'Dependency tool to be completed and cross referenced against the staffing numbers to ensure that the rotas contain appropriate staff.' The action plan indicates this should be completed by 15 July 2016. It is therefore unclear if the staffing levels seen on inspection were allocated based on people's needs.

Many of the risk assessment we saw were not up to date or accurate. For example one person's nutritional risk assessment was not scored correctly; they had lost weight so the risk increased from medium to high. This meant if there were not up to date risk assessments the dependency of people who used the service was inaccurate so staffing levels were being determined on a lower risk so could be insufficient hours allocated to meet people's needs.

This was a breach of Regulation 18 (1) of the Health and Social Care Act 2008, Regulated Activities 2014. Sufficient numbers of suitably qualified, competent, skilled and experienced staff were not deployed appropriately to meet people's needs.

At our inspection of November 2014 we found that people were not cared for in a clean and hygienic environment. This was a breach of regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) 2010 which corresponds to Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) 2014. The provider told us they would be compliant by the 28 February 2015. We completed a second comprehensive inspection in June 2015 and felt the provider had taken action to address this issue, but that this still required embedding in to practice.

At our inspection of 28, 29 June and 1 July 2016 we found similar concerns to those identified in November 2014.

All relatives we spoke with were aware that not all areas of the home were clean and well presented. There were some unpleasant odours around the home. One relative said, "We know the environment is poor and tired in places. We have been reassured that this is going to change."

During our inspection we carried out a tour of the building and identified some concerns regarding infection prevention and control. We found correct procedures were not followed and areas of the service were not maintained to be able to be kept clean. We saw linen sacks full of dirty soiled washing stacked in communal bathrooms and en-suite bathrooms. Items were not stored off the floor in linen rooms and store rooms which meant they were unable to be thoroughly cleaned. Staff did not adhere to bare below the elbow policy, which would enable staff to be able to thoroughly clean their hands and arms and prevent cross infection from jewellery, which can harbour bacteria. We saw staff with bracelets, watches, stone rings and false nails. We also observed staff give personal care then go into the kitchen to assist with food and they did not wash their hands.

We found various items of equipment were not well maintained to be able to be cleaned for example the Bain Marie was taped on one edge as it was rough but the tape was fraying and old and not clean, this could harbour bacteria and cause cross contamination. There were no soap or hand towels in the sluice and we identified many soap dispensers were not working. Examples of other areas not maintained included carpets badly stained, hoist rusting, wall paper peeling form the wall, underside of toilet seats were stained black, tile grouting and seals behind sinks and wash hand basins were engrained with dirt and not able to

be maintained in a clean condition.

This was a breach of Regulation 12 (h) of the Health and Social Care Act 2008, Regulated Activities 2014. People were not protected against the risks of infections.

At our inspection of November 2014 we found issues relating to the management of medicines. This was a breach of regulation 13 of The Health and Social Care Act 2008 (Regulated Activities) 2010 which corresponds to Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) 2014. The provider told us they would be compliant by the 28 February 2015. We completed a second comprehensive inspection in June 2015 and felt the provider had taken action to address this issue, but that this still required embedding in to practice.

At our inspection of 28, 29 June and 1 July 2016 we found similar concerns to those identified in November 2014.

We looked at the systems in place for managing medicines in the home. This included the storage, handling and stock of medicines and medication administration records (MARs). We found medication storage rooms had air conditioning installed and this was set to18 degrees centigrade, however staff turned this off when they were in the room one said, "It is too cold with it on to stay in the room." We checked temperature recordings and found these were not checked and completed each day and there was no minimum maximum thermometer so it was not possible to determine if the storage room maintained the correct temperatures. We also found the fridge temperatures were not checked and recorded each day which did not follow the provider's policy and procedures.

We found staff who administered medicines did not always record the amount of medicines received or the amount carried forward from the previous month. This made it difficult to account for medicines. For example, we found one person's pain relief medication had not been dispensed for the current monthly cycle, yet we found medicine was in stock which had not been recorded as a carried over amount on the person's MAR.

We found people did not always have protocols in place for medication required on an 'as and when' basis, also known as PRN medicine. These would detail when to give PRN medication and explain how people presented when they were in pain or were agitated. Staff told us people who were prescribed these medications were not always able to tell staff when they were in pain or distressed due to their medical conditions. This meant that people who used the service could be in pain or distressed and not have medication administered as staff did not know what signs to determine when it was required.

We found on occasions people did not receive medication as prescribed. We found one person was prescribed medicine for the treatment of osteoporosis. This had not been given for three weeks as it was not in stock in the service. Another person was prescribed medicine twice a day, but we found this was not given on two occasions in June 2016. We also found staff did not always sign when medication was taken by people who used the service. We found a number of missed signatures. We found amounts of medicines were not always recorded on receipt and carried over amounts not always documented on MAR's, it was therefore difficult to determine if these had been given as prescribed and not signed for or not given.

The medication was administered by staff who had received training to administer medication. The deputy manager told us all staff had received competency assessments, yet we found errors were still occurring so these were not effective. The medication audit was a tick box and did not identify the areas that required addressing so was not effective.

We found people were prescribed medication to be taken as and when required known as PRN (as required) medicine. For example, pain relief and to alleviate agitation. We saw PRN medication was not always used appropriately. One person was prescribed medicine to relieve agitation when required. We looked at the MAR and found that this person had been given this medication regularly; prior to this it had not been given. Staff told us the person had moved units as one had closed for redecoration. They explained the person was blind and found the difference in the corridor length outside their room very confusing and knew it was not their room, so was becoming distressed. The medication was used to calm but other methods had not been considered to manage their distress without the use of medication.

We also saw another person was distressed. When we looked at the care records we found that this person liked to be kept busy and liked to have a purpose. We observed staff asking the person to sit down on several occasions but no meaningful activity was sought. This led to the person's distress. We looked at this person's MAR and found they were prescribed medicine for agitation. We saw this medicine had been given every night for the past 26 days. Staff had not monitored their behaviour or considered alternative methods to manage their anxiety without the use of medication.

This was a breach of Regulation 12 (g) of the Health and Social Care Act 2008, Regulated Activities 2014. People did not always receive their medicines in a proper and safe way.

The staff were aware of the role they play in keeping people safe by reporting any concerns. Staff told us they had received training on how to safeguard people from abuse. We saw a log of safeguarding concerns which had been reported to the local authority but some of them had not been reported to the Care Quality Commission (CQC). We asked the manager about this and they told us this was because they only reported incidents which safeguarding were investigating. This showed that they were not clear about what to report to CQC.

The staff we spoke with were knowledgeable on safeguarding and whistle blowing policies and procedures. Whistleblowing is one way in which a staff member can report suspected wrong doing at work, by telling someone they trust about their concerns. Staff told us they would not hesitate to report any safeguarding concerns. They told us if they felt the manager wasn't responding appropriately they would report to the regional manager or the local authority.

Staff we spoke with explained their recruitment process. They said they could not start work until they had received references and a satisfactory DBS check. Staff told us the induction was not very good. One staff member said, "I was meant to be supernumerary but I was included in the numbers on my first shift, luckily I had done care work before." Staff said they had not received much training although all staff said this was improving.

We looked at four recruitment files and found the provider had a system in place for employing new staff. A satisfactory Disclosure and Barring Service (DBS) check. The DBS checks help employers make safer recruitment decisions in preventing unsuitable people from working with vulnerable people. This helped to reduce the risk of the registered provider employing a person who may be a risk to vulnerable people. We also saw that references were obtained, but two out of the four files contained only one reference which was not in line with the provider's recruitment policy. We spoke with the administrator who had been asked to check all staff files to ensure they contained the correct details and paperwork. We could see that this process had commenced.

Inadequate

Is the service effective?

Our findings

At our inspection of November 2014 we found the provider did not ensure that people who used the service were protected from the risks of inadequate nutrition and dehydration. This was a breach of regulation 14 of The Health and Social Care Act 2008 (Regulated Activities) 2010 which corresponds to Regulation 14 of The Health and Social Care Act 2008 (Regulated Activities) 2014. The provider told us they would be compliant by the 28 February 2015. We completed a second comprehensive inspection in June 2015 and felt the provider had taken action to address this issue, but that this still required embedding in to practice.

At our inspection of 28, 29 June and 1 July 2016 we found similar concerns to those identified in November 2014.

We observed breakfast, lunch and tea on all units. All meals we observed were unorganised, chaotic and task orientated. On Keats staff were trying to serve everyone at once and people kept getting up and walking out. One person continually took other people's meals and drinks. Staff were trying very hard to manage the meal but the dining room was not large enough to accommodate everyone comfortably. Therefore it did not give people space if required or give staff space to sit at tables to offer assistance.

We saw meals being taken to people's rooms uncovered, meals left on the side in the lounge until staff were able to offer assistance these were left a considerable length of time and were most probably cold when staff were able to offer the assistance required. On Shelley we saw three relatives came in at lunchtime to assist with meals, if these relatives were not giving assistance the staff would not have coped with the meal as most people required some degree of assistance to be able to manage their meal.

On Byron we saw staff were struggling to meet people's needs at meal times one person was not able to stand independently to be taken to the dining room so rather than get the hoist the person had their meal in the lounge. Another person was wandering around the dining room and no staff were encouraging them to eat. When we spoke to the person they engaged with us and stopped wandering around, so staff could have engaged with the person to encourage them to eat. People were sliding off chairs and staff were trying to find hoists and slings to be able to make the person safe. The meal time experience was very poor and was not conducive to an enjoyable experience for people. We saw at each meal we observed that people did not eat much and a lot of food was wasted. We also identified from looking at people's care plans that people had lost weight, which meant people were not supported to be able to receive adequate nutrition and hydration.

One person's care notes indicated that they preferred a small meal. However, on all three lunch times we observed staff giving the person a large meal, which the person pushed away without eating it. Only on one occasion was the person asked if they would like a sandwich.

At all meals we saw no picture menus were available for people to be able to see what was on offer for the meal. Pictures are particularly helpful for people who are living with dementia to be able to make better choices. During mealtimes we observed that the menus on display did not relate in any way to the meal that

was served. This could mislead people and their families. The catering staff said that all the menus should have been re-printed and put on display.

We spoke with people who used the service and their relatives about the food people received. One person said, "The food's alright." Another person said, "Sometimes it's [the food] cold, they just slop it on the plate." A relative said, "Good presentation [of food] goes a long way, that's all that's wrong with it." Another relative said, "Sometimes they give [my relative] a really big plate of food, they hate it, [x] likes small portions."

We looked at people's care plans and found their needs were not always addressed and health care services not considered or used when needs changed. For example we found one person had lost considerable weight over three months, there was no nutritional care plan and there had been no referral to a dietician. The nurse we spoke with told us they were following first line treatment, but this stated if weigh loss continued then a referral should be made. We discussed this with the deputy manager who looked for the plan of care and referral and told us, "This is when I have to say it hasn't been done."

This was a breach of Regulation 14 of the Health and Social Care Act 2008, (Regulated Activities) 2014. People's nutritional and hydration needs were not always met.

At our inspection of November 2014 we found the provider did not have suitable arrangements in place to ensure that person's employed were appropriately supported in relation to their role and responsibilities. This was a breach of regulation 23 of The Health and Social Care Act 2008 (Regulated Activities) 2010 which corresponds to Regulation 18 (2) (a) of The Health and Social Care Act 2008 (Regulated Activities) 2014. The provider told us they would be compliant by the 28 February 2015. We completed a second comprehensive inspection in June 2015 and felt the provider had taken action to address this issue, but that this still required embedding in to practice.

At our inspection of 28, 29 June and 1 July 2016 we found similar concerns to those identified in November 2014.

Staff we spoke with told us they received training mainly via eLearning. Some staff told us that they would learn better if the training was face to face so they could ask questions. However, staff told us that they had received some face to face training and that they had been booked on training recently. One staff member said, "We have not been offered much training. I have asked for extra training, and would like to do end of life, but this has not been sorted." Another staff member said, "Training has just started to come back on board. I have done dementia mapping previously but not been able to use it." Another said, "Mainly eLearning, not had training for over a year, mine is due for renewal."

We spoke with the manager about training and were told this was an area they were trying to address and that they would send us an updated training matrix. We received this after our inspection. This showed what training staff had received and indicated statistics which were quite low. For example, only 40 percent of staff had received manual handling practical training and only 47 percent had received manual handling theory.

Most of the staff we spoke with told us they had not received a supervision session. Supervision sessions were one to one sessions with their line manager. One staff member said, "I have not had a supervision session since the last manager was here." Staff also told us they had not had an annual appraisal to discuss their progress and to highlight any training they may require. Staff generally felt unsupported and not involved in the home.

We spoke with the manager about this and were shown some supervision records. These showed that a number of supervision sessions had taken place in June 2016, but there was no plan in place to suggest when the next session would take place. We also found that the agenda for all supervision sessions was the same. Therefore they were not specific to staff member's.

This was a breach of Regulation 18 (2) (a) of the Health and Social Care Act 2008, (Regulated Activities) 2014. Appropriate training, support, supervision and appraisal was not routinely carried out.

During our tour of the building we found many areas were not well maintained. We identified at our previous inspection that redecoration and repairs were required. However, no further works had been completed since our last visit. One staff member told us one bathroom had been out of action for three years. We also identified a number of bathing and toilet facilities were not able to be used. For example, one toilet floor covering was raised causing a tripping hazard. The provider had identified that works were required but had no timescales for the commencement of works. We also saw a hoist in Keats bathroom which had a 'out of service' sign on it dated 1 February 2016. We asked the manager how people were supported to use the bath and they asked a member of staff who told us they used the hoist. We asked the manager to look in to this. We were told that the reason it was out of service as the battery needed changing and told us this had been done. We asked for confirmation of this which was received on 6 July 2016 via email. This confirmed the work required was completed on 7 February 2016 however staff using the hoist were not assured it was safe to use.

We were shown the fire risk assessment and requirements identified at the fire safety visit in October 2015. Many issues identified on this were still outstanding. For example, fire extinguishers had a label date of April 2015. We were also shown a report following servicing of fire extinguishers in the home by a contractor. This stated many had been condemned and required replacing immediately and others needed replacing as soon as possible this was date 18 April 2016. These had not been replaced at the time of our inspection putting people at risk. Another example on the risk assessment was that there was no certificate of service in place and people with sight, hearing and mobility issues were not shown graphically on a site drawing. We spoke with the manager and were shown an evacuation plan, however this had not been updated since the closure of the upstairs Byron unit and did not reflect the changes.

This was a breach of Regulation 15 of the Health and Social Care Act 2008, Regulated Activities 2014.

The manager told us staff had received Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS) training. The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. 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 procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

The manager was aware of their duties in relation to the MCA 2005, and had arranged for best interest meetings to take place where required.

Inadequate

Is the service caring?

Our findings

At our inspection of November 2014 we found the provider did not ensure that people who used the service were protected from the risks of inadequate nutrition and dehydration. This was a breach of regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) 2010 which corresponds to Regulation 10 of The Health and Social Care Act 2008 (Regulated Activities) 2014. The provider told us they would be compliant by the 28 February 2015. We completed a second comprehensive inspection in June 2015 and felt the provider had taken action to address this issue, but that this still required embedding in to practice.

At our inspection of 28, 29 June and 1 July 2016 we found similar concerns to those identified in November 2014.

During our visit we spent time in communal areas observing people who used the service and talking to relatives and staff. Most staff we spoke with wanted to be able to provide good quality care and meet people's needs in a person centred way, but were frustrated by the environment, staffing, and changes which had affected staff deployment.

On Byron unit we observed staff assisting people without explaining what they were doing. One person who liked to be busy doing activities was consistently told to sit down. When we spoke with staff regarding the person's care they told us they were not sure about their needs as they were not involved in care planning. This showed that staff did not know enough about people to support them effectively. We also saw staff standing over people who were being assisted with their meals and not engaging with the person to make it a pleasant experience.

We observed one care worker assisting someone with some ice cream and noted that the person had a bowl of soup on their lap. The care worker did not realise until we pointed this out, they then removed it. The person was left with soup on their clothing while the staff member continued to assist with the ice cream. This showed a lack of respect for the person.

On Byron unit we saw personal information belonging to several people, left in the main lounge area on the first day of our inspection. We raised this with the manager, but still found the information in the same place on the second day. This showed a lack of respect for people's personal information.

We saw that some people's finger nails were very dirty; they were black under the nails and not cleaned. We also saw one person's clothes were covered in dried and encrusted food debris; they were in the same clothes from when we observed this at 11am until at least 4pm. This did not maintain their dignity. Staff had not attempted to address these situations which also showed a lack of concern for the person's dignity.

We saw some positive interactions between people and staff on the Keats unit. However, predominantly most interactions were task orientated. Observations on Keats unit showed that staff treated people with dignity and respect. Staff respected people's privacy by knocking on doors and calling out before entering their bedrooms or toilet areas. However, during mealtimes not all staff attitudes were patient.

Some people were at end of life and were nursed in their bedrooms. We found staff were not always nearby to offer assistance. We spent time on the upstairs unit where people were in bed and at times no staff were available. On one occasion one person was calling out for help and no staff were available to assist them, they were very distressed. We also found one person's room had a foul odour, this person was also nursed in bed at end of life, staff had not attempted to empty the bin or dirty laundry stored in the room to alleviate the odour to make the environment comfortable and pleasant. This showed a lack of respect for the person's dignity.

This was a breach of Regulation 10 of the Health and Social Care Act 2008, (Regulated Activities) 2014. The provider did not ensure that people were treated with dignity and respect.

Inadequate

Is the service responsive?

Our findings

At our inspection of November 2014 we found the provider did not take proper steps to ensure people who used the service received care that was safe and appropriate. This was a breach of regulation 9 of The Health and Social Care Act 2008 (Regulated Activities) 2010 which corresponds to Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) 2014. The provider told us they would be compliant by the 28 February 2015. We completed a second comprehensive inspection in June 2015 and felt the provider had taken action to address this issue, but that this still required embedding in to practice.

At our inspection of 28, 29 June and 1 July 2016 we found similar concerns to those identified in November 2014.

We checked people's care records that were using the service at the time of the inspection. We found that care plans had not always identified peoples care needs. For example, one person's care file we checked showed they were at risk of poor nutritional intake yet there was no nutritional plan of care in place. Another care plan stated the person should be supported with moving and handling by two staff, yet in the notes it stated they had been reviewed by a health care professional and they now required hoisting for their safety. This had not been updated in their plan of care and we saw staff trying to support the person using an inappropriate method that put the person at risk of harm.

We also looked at one person's care file to find the person had no care plans in place. This person had several areas of need which had been assessed prior to the person moving to the service. These issues had not been picked up on and we saw care delivered which was not in line with the persons assessed needs. For example, this person liked small meals, but was constantly given large dinners which they did not eat. Nothing was provided in its place. We asked staff if they were monitoring the person's food and fluid intake and they were unsure. When we looked at the person's daily charts we found some meals were recorded and others were not. These issues could have placed the person at risk as staff did not know how to support the person or meet their needs.

We saw care records were not always reviewed; therefore they did not to ensure people's needs were met. Where care plans had been reviewed we found that the evaluation had been updated but not the care plan. This was misleading to anyone reading the document, and there was a risk that important changes could be missed. For example we saw one person was lifted from their chair to wheelchair using an inappropriate lifting technique. We checked their care plan and they had been assessed and required the use of a hoist. The care staff told us they had not been told this. This showed poor communication which put people at risk of harm.

This was a breach of Regulation 9 of the Health and Social Care Act 2008, (Regulated Activities) 2014. The provider did not ensure that people's care and treatment was appropriate, met their needs, or reflected their preferences.

We spoke with the manager about this who told us they were waiting for new paper work to arrive. This was not expected for at least four weeks. We asked what action they would take to ensure people were not placed at risk. On the third day of our inspection we were told that new paper work would commence and that everyone's needs would be reassessed.

However, Keats unit was using the old paperwork and a care file we check for a person on Keats unit showed their needs had been identified. It was also clearly documented when their needs had changed and detailed the changes so staff were able to meet their needs. Staff we spoke with on Keats unit were able to explain to us what people's needs were and evidenced involvement of professionals when required.

We identified a lack of social stimulation; although there was two full time activity coordinator activities were predominantly held on Keats unit, people who used the service on other units received lack of social stimulation.

People who lived on Keats unit gave positive feedback about activities provided. They told us that events such as coffee mornings, mobile library, and visits from an interactive music group took place. People were also keen to tell us about an evening they attended to watch football which included a Chinese meal. One person said, "We had a great night last night, I had some spare ribs." Another person said, "We get a church service and I like that." Another person said, "I like bingo but we don't play it very often."

People living on Byron and Shelley units did not receive the same stimulation. One relative said, "I feel the activities are not suited to everyone." Another said, "The activity people are lovely but I don't feel they fully understand the needs of the people here."

The provider had a procedure in place for investigating complaints. People we spoke with told us they would speak with someone if they had a concern, but were not confident that they would be resolved. We looked at records in relation to complaints and found there was a concerns and complaints register in place which was blank. However, in the complaints file we found that two concerns had been raised. One in January 2016 when an acknowledgement of the complaint had been sent to the complainant, but no evidence to suggest this had been investigated and resolved. The second one was dated February 2016 and a complaint record had been made. This indicated that the investigation outcome was that the issue had been previously raised with the previous manager about a year ago. In addition to these concerns a relative informed us that they had raised concerns with the new manager, which was resolved; however, this was not recorded in the complaints log. Staff also told us that relatives had raised concerns regarding the quality of the food for people who required a soft diet. We found these had not been recorded in the log, therefore were not able to evidence if these had been resolved.

This was a breach of Regulation 16 (1) of the Health and Social Care Act 2008, Regulated Activities 2014. There was no evidence that complaints received were responded to in an appropriate and timely manner.

Inadequate

Is the service well-led?

Our findings

At our previous inspection in November 2014 we found a breach of regulation 10 HSCA 2008 (regulated activities) regulations 2010. Regarding assessing and monitoring the quality of service provision. This corresponds to regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, good governance. When we visited in June 2015 we found improvements had been made, but further improvements were required to be implemented.

At this visit we found systems to monitor the safety and quality of services had been put in place but were not effective. We spoke with the manager and regional manager who told us the reason was due to the change of management company which had taken place in January 2016. The service had an impact audit which was a tool that looked at all areas of the service. This was last completed in March 2016. We found that individualised care and treatment had been scored at 65 percent and one of the areas highlighted as an area of good practice were that care profiles were up to date and evaluated monthly. We did not see evidence that this was the case. The manager and regional manager knew there were issues with the care plans as they were waiting for new paperwork to arrive. At the time of our visit we were told this was not due for at least another four weeks.

We saw other audits were in place for example a meals and nutrition audit had been completed in March 2016. This had identified issues such as, suppers and snacks were not always available for people who required a soft diet, textured diets were not always served in an appropriate manner and staff were not always speaking with people when assisting them with their meals. This had not been identified in an action plan and we observed that these issues were continuing. This showed that the provider had identified concerns but not actioned them, this was impacting on the people who used the service.

We found that although some environmental improvements had been identified at our last visit we saw no further improvements had been carried out to ensure the environment was well maintained and dementia friendly to meet people's needs. The audits we were shown did not evidence that improvements to the environment to ensure it met the needs of people living with dementia had been identified.

We identified that the actions from the fire safety audit had not been addressed. This had not been picked up by the providers auditing systems.

The manager told us that they completed a daily walk round to ensure the service was operating effectively. However, there was no evidence that these were completed or that issues had been highlighted and acted upon. After the inspection we were sent a new form which was to be used for this purpose and sent to the senior management within the company. The service also introduced a regional manager's visit report which would be completed by the regional manager twice a week.

We spoke with people who used the service about the management of the home. One person said, "I don't know the manager's name but [a senior] is great and knows what they are doing." We asked another person if they knew who was in charge, they said, "No, I don't know who is in charge."

Some relatives did not have confidence in the management of the home due to the recent changes. A number of relatives said they did not see the manager around the home. Relatives we spoke with said, "I don't really know the new manager. They have never made themselves known." Another relative said, "The management changes are so drastic. When will it all settle down?" We asked a relative if they thought the home was well run. They said, "How can it be well run when there are so many changes. I don't know where we are with it all."

At the time of our inspection the service did not have a registered manager. A manager had been employed by the company and they commenced their role in January 2016. The manager was supported by a deputy manager. The nursing units (Shelley and Byron) were managed on a day to day basis by the nurses and the residential unit (Keats) had a unit manager.

All care staff we spoke with told us morale was very low. They felt they were not supported and information was not communicated to them. Staff felt that this was due to the several changes in management in a short period of time. One staff member said, "We are not involved in hand overs so don't get to know any changes, sometimes you could have been off on holiday or just days off and there have been many changes and we don't know. I came back after holiday and didn't realise there was a new resident, I didn't know until another carer told me during my shift, this means things can get missed." Another care worker said, "It's the worst it's ever been, poor communication, not told of changes in people's care." Another care worker said, "We are not told anything, so using incorrect moving and handling techniques, it's very frustrating, I am here for the residents but can't do my job properly." Most staff we spoke with said they did not have any leadership, the nurses were either in the office or doing medications and they didn't see the manager. Although all staff we spoke with spoke highly of the deputy manager.

There had been recent changes in the way staff were deployed due to the temporary closure of the upstairs Byron unit. This was due to be refurbished. Some staff were not happy about the changes and therefore worked against them. Staff were unhappy that the changes had been made without consultation with them.

We spoke with people who used the service and their relatives about their involvement in the service. People told us they were encouraged to speak out at meetings and fill in surveys. A few relatives also told us they had been involved in meetings with the new managers and felt listened to. However, from meeting minutes and speaking with relatives, it was clear that people's thoughts and ideas had not yet been acted upon. At the last meeting held in May 2016, relatives had asked for a suggestion box and were told this would still be used. However, one relative told us, "We asked for a suggestion box, but the managers said they had an open door policy, so no suggestion box." Relatives also raised issues about not knowing who the management team were and felt there was a lack of communication between them. From feedback we received, relatives still felt the same. One relative said, "Apparently there have been meetings with relatives. I wish I could get copies of the minutes then we would know what is happening. I can't always get to the meetings."

They told us that communication between them and the management was poor, however, they were aware of a new initiative to involve people but this was in the early stages. Relatives were hopeful this would improve communication and impact on improvements within the home. One person said, "I once went to a meeting but I'm not bothered anymore."

This was a breach of Regulation 17 (1) (2) (a) (b) (c) (d) (e) (f) of the Health and Social Care Act 2008, Regulated Activities 2014. The system in place for monitoring the quality and safety of the service were not effective.

Following our inspection the company initiated their own special measures procedure. This included seven day management cover to include completion of a report and a twice weekly regional manager visit, also to include a report of actions.

The regional manager also sent an action plan which included issues we had raised on our inspection.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider did not ensure that people's care and treatment was appropriate, met their needs, or reflected their preferences.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints There was no evidence that complaints received were responded to in an appropriate and timely manner.