Larchwood Care Homes (South) Limited

Lauriston House

Inspection report

Lauriston House Nursing Home
Bickley Park Road
Bromley
Kent
BR1 2AZ

Date of inspection visit:
05 November 2018

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14 May 2020

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on the 5 of November 2018 and was unannounced. Lauriston House is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Lauriston House accommodates up to 39 people in one adapted building. There were 30 people living at the service at the time of our inspection. At our last inspection on 29 and 31 August 2017 the service was rated 'good'.

The home had a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At this inspection we found breaches of regulations 9, 10, 12, 13, 17 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and one breach of regulation 18 of the Care Quality Commission (Registration) Regulations 2009. Risks relating to people's care and support were not always managed safely. Care plans were not reflective of people's care needs and were not being followed by staff. Staff had not always referred people to health care services where they had identified concerns with their health. Staff had not always followed the instructions of health care professionals when supporting people. Sufficient numbers of suitably qualified, competent, skilled and experienced staff were not always deployed at the home to meet people's care and support needs. The home relied heavily on agency staff, some of whom were not fully aware of people's needs.

The principles of the Mental Capacity Act 2005 (MCA) had not always been adhered to where people lacked capacity to make decisions for themselves. People were not always supported to have maximum choice and control of their lives and staff did not always support them in the least restrictive way possible. Staff did not always treat people with respect, or in a caring way. People were not consistently provided with a range of appropriate social activities that met their needs. We identified one incident that was a safeguarding concern which had not been properly reported or recorded. The home's quality monitoring systems were not effective.

You can see what action we told the provider to take at the back of the full version of the report. Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

There were safe systems in place for storing and administering medicines, and for monitoring controlled drugs. However, the daily medicine audits and balance checks required improvement because they were not always accurate. Robust recruitment checks were carried out before staff were employed to work at the home. The provider had infection control policies and procedures in place which provided staff with guidance on how prevent or minimise the spread of infections. Staff received training relevant to people's

care and support needs. They told us they had regular training which had enabled them to perform their role efficiently.

People's privacy was respected. Staff received training on equality and diversity, and they supported people according to their diverse needs. People knew how to complain if they needed to. Information was available to people in different formats which met their needs. None of the people living at the home required immediate support with end-of-life care. The service worked with health care professionals in providing end-of-life support to people when required. The provider sought the views of people and their relatives through surveys and meetings. They had acted on some of the suggestions people had made. The registered manager was aware of the legal requirement to display their current CQC rating which we saw was displayed at the home.

This service was selected to be part of our national review, looking at the quality of oral health care support for people living in care homes. The inspection team included a dental inspector who looked in detail at how well the service supported people with their oral health. This includes support with oral hygiene and access to dentists. We will publish our national report of our findings and recommendations in 2019.

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.

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.

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.

Safeguarding concerns were not always reported to the local authority safeguarding team or CQC where required.

Accidents and incidents had not always been reported or recorded appropriately

Risks relating to people's care and support were not always managed safely.

Sufficient numbers of suitably qualified, competent, skilled and experienced staff were not always deployed at the home to meet people's care and support needs.

People were currently receiving their medicines as prescribed by health care professionals.

Staff received training in infection control and food hygiene. They were aware of the steps to take to reduce the risk of the spread of infections.

Is the service effective?

Inadequate

The service was not effective.

People's needs were assessed but care plans were not always reflective of their needs.

Staff did not always make referrals to health care professionals when needed and had not always followed the instructions of health care professionals to help maintain people's health.

Peoples nutritional needs were being met however we observed that people's meal time experience required improvement.

The principles of the Mental Capacity Act (2005) were not always adhered to.

Staff had received training relevant to people's care and support needs.

Is the service caring?

Requires Improvement

The service was not always caring.

Peoples were not always respected or treated in a caring way.

People's privacy was respected.

Staff had received training on equality and diversity and they supported people according to their diverse needs.

People were provided with appropriate information about the service. This ensured they were aware of the standard of care they should expect.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's care and treatment was not always delivered in line with their needs.

People were not always provided with a range of appropriate social activities that met their needs.

People said they knew about the complaints procedure and they would tell staff or the manager if they were unhappy or wanted to make a complaint.

None of the people currently living at the home required immediate support with end of life care however the service had access to health care professionals for this type of support if it was required.

Is the service well-led?

Inadequate

The service was not well-led.

The home's systems for monitoring the quality and safety of the service were not operated effectively.

The home had a registered manager in post. However, they had failed in their responsibility to report a safeguarding concern to the local authority or the Care Quality Commission as required by our regulations.

Staffs views about the support they received from the management team was mixed. Some staff felt they were not listened to by the registered manager and provider.

The provider had introduced a team of senior managers to support the registered manager and oversee the improvements that need to be made at the home.

The registered manager was working with local authority commissioners, the safeguarding team and health care professionals to make improvements at the home.

The provider sought the views of people, their relatives through surveys and meetings and had acted on some of the suggestions made.

Lauriston 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 took place on the 5 November 2018 and was unannounced. The inspection team consisted of an inspector, an inspection manager, a dental inspector, an assistant inspector, a specialist advisor and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. A CQC pharmacy inspector was available to support the inspection team remotely.

The inspection was brought forward following concerns raised by health care professionals, the local authority safeguarding team, relatives and staff. These concerns related to poor staffing levels, staff not understanding people's needs in relation to diet and nutrition, weight loss and pressure sores, peoples care needs not being met, and the unsafe management of medicines at the home.

Before the inspection we also looked at all the information we had about the service. This included statutory notifications that the provider had sent to CQC. A notification is information about important events which the service is required to send us by law. We used this information to help inform our inspection planning. Due to our decision to bring forward the date of this inspection, the provider was not able to complete a Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

During the inspection we looked at the care records of nine people, staff training and four staff recruitment records and records relating to the management of the home. We spoke to seven people using the service and three relatives to gain their views about receiving care. We spoke with the registered manager, the regional manager, two nurses, five care staff and an activities coordinator about how the home was being run and what it was like working at the home.

Not everyone at the service was able to communicate their views to us so we also 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.

Inadequate

Is the service safe?

Our findings

There were safeguarding and whistle blowing procedures in place and staff had a clear understanding of these procedures. Training records confirmed that staff had received training on safeguarding adults from abuse. Staff told us if they thought safeguarding concerns had not been properly handled by the registered manager they would report their concerns to social services or the CQC. They also said they would use the providers whistle blowing procedure to report poor practice if they needed to. Whilst staff demonstrated an understanding of the provider's procedures for reporting any allegations of abuse, we found that safeguarding concerns were not always reported to the local authority safeguarding team or CQC. We were advised of an incident [recorded as a complaint from a relative on the 22nd August 2018] where a person had been administered a specific medicine for two weeks after the prescriber had requested that the medicine should be discontinued. This left the person at risk of harm. The registered manager told us this incident was currently being investigated by the provider. We asked if this had been reported to the local authority as a safeguarding concern and were advised that no referral had been made. The local authority safeguarding team should have been informed so they could assess this concern and potentially take action to keep the person safe. We asked the registered manager to make a safeguarding referral and this was completed after the inspection.

These issues were a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

The local authority told us there were eight safeguarding concerns being investigated their safeguarding team. We cannot report on any of these investigations at the time of this inspection. The CQC will monitor the outcome of the investigations and actions the provider takes to keep people safe.

Risks relating to people's care and support were not always managed safely. Concerns had been raised with CQC by the local authority about how the home managed people's weight loss and pressure sores. Many people living at the home had been assessed as being at risk of developing pressure sores, or their skin breaking down, and required the use of pressure relieving equipment. Two people were currently living with pressure sores. We checked the pressure of eight people's pressure relieving equipment with the regional manager and none of them were set correctly. We asked one staff member what the setting should be for one person's mattress and they responded, "Oh my god, I do not know. We just tick that it is correct." The correct setting was not recorded anywhere, so staff were unable to check pressure settings each day, despite recording that they had done so. The incorrect pressure settings put people's skin integrity at risk. The regional manager checked the settings for each mattress, set the mattresses to the correct settings and wrote this down for staff during the inspection.

One person used an oxygen machine at night to ensure they were able to breathe safely. Although their care plan identified that the machine should be used, there was no guidance for staff regarding how it should be cleaned or maintained. Guidance from the manufacturer stated that the tubing and mask for the machine should be cleaned 'weekly' and 'The back-air filter should be checked monthly and changed when it becomes grey'. Staff were unable to tell us when these tasks had last been completed. The failure to carry

out these tasks placed the person at both a greater risk of infection, and at risk of the oxygen machine not functioning correctly which would have a negative impact on their ability to breathe.

Another person had been hospitalised in 2015 due to constipation. Their care plan stated, '[Person] is on a laxative daily any problems encountered GP is to be called. Staff to document bowel actions.' Records showed that the person had not opened their bowels for over a week and no action had been taken by staff to seek medical advice or support. We discussed this with the registered manager and they told us that the person could sometimes go to the toilet independently, so it was possible their bowels had been opened then. The risk of not being able to accurately record the person's bowel movements had not been assessed and there was no guidance for staff about what actions they should take if there were no recorded bowel movements. This left the person at risk of not getting the support they needed to manage their constipation.

Although there was clear guidance in place regarding how people's drinks should be service, we also observed two instances where people were given non-thickened fluids when they had been assessed by a Speech and Language Therapist as requiring their drinks thickened, because they were at risk if choking. One person was given a carton of orange juice which did not have thickener which was only removed after we alerted staff. We discussed this concern with the nurse on duty and the registered manager. The registered manager confirmed that the person should not have been given the orange juice unthickened and said they would speak to the staff involved. An agency staff member gave another person a drink without thickener, although another staff member intervened and removed it before the person was able to drink it. In both instances there was a risk that the people could have choked.

Another person's oral health assessment carried in December 2016 identified their dentures were over 5 years old and the home needed to consider referring the person to the dentist for replacement dentures. The persons oral health assessment was reviewed again in July 2017, Oct 2018 and Nov 2018. None of the outstanding actions identified from the December 2016 initial assessment had been followed up.

The registered manager showed us the provider's system for monitoring and investigating incidents and accidents. They told us that incidents and accidents were monitored and that they took action to reduce the likelihood of the same issues occurring again. For example, where people had suffered from falls, referrals had been made to health care professionals to enable them to advise on preventative measures. However, we also found that incident and accident forms had not always been completed where required. For example, when we asked the registered manager for the incident record relating to the unreported safeguarding incident we had identified they told us none had been completed. This showed that the service did not have an effective system for monitoring all incidents and accidents to look for trends and learn lessons to keep people safe.

These issues were a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

Insufficient numbers of suitably qualified, competent, skilled and experienced staff were deployed at the home to meet people's care and support needs. One person told us, "Unfortunately they have a bit of a turnover of staff. Some staff know what you are on about, but some don't." A relative told us, "I have recognised total lack of continuity of care. They lost a lost the deputy manager. There are too many agency staff." Another relative commented, "With so many agency staff there is no continuity of care."

The registered manager told us that they tried to use the same agency staff to provide people with consistent care. However, we saw there was a high number of agency staff used which impacted on the consistency of care that people received. On the day of the inspection nine care staff and three nurses were

on duty. Four of the care staff were agency staff and two of these nurses were agency staff. The other nurse on duty was the registered manager. We observed that whilst staff were kind to people, they did not always know how to support people as they did not know them well. For example, a relative told us that their loved one used a wheelchair because it was it's too far for them to walk to the dining room. They said a member of staff told them they didn't know how to use the wheelchair. The registered manager told us that agency staff were unable to complete daily records for people, as they did not know them well, and this meant some tasks had to be completed by the small number of regular staff available, putting additional pressure on them. A member of staff said, "There are too many agency staff. Some are regular, and they know what they are doing, but it takes time to show new agency staff what to do and it has an impact on the work we do."

The registered manager told us that they used a dependency tool to determine staffing levels and plan the staff rota. They said staffing levels had not reduced despite the number of people living in the home decreasing. However, staff told us staffing levels were not sufficient to support people safely. The high usage of agency impacted on the ability of regular staff to carry out their roles. One member of staff told us, "We are pressurised and understaffed. We have a lot to do and aren't given enough time to do it. For example, some people are frail, and they need support with hoisting, getting washed, and eating and drinking. You cannot rush these things so sometimes I and the other staff don't get any breaks." We heard a person calling out for help. They told us they wanted to be changed. A member of staff came in and said they would be back in a minute but didn't return for twenty minutes to assist them. A relative said, "I don't think there are enough staff; they always appear to be running around. Sometimes when you come in you can't see anybody."

These issues were a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

The registered manager and regional manager told us they were actively trying to recruit nurses and care staff to work at the home. They said the introduction of new staff would lead to a decrease in the number of agency staff working at the home.

There were safe systems in place for storing, administering medicines and for monitoring controlled drugs. We checked the medicines administration records (MARs) for seven people; all but one of these indicated that they were receiving their medicines as prescribed by health care professionals. Where people had not received or refused to take their medicines we saw that staff had recorded the reasons for the omissions on their MAR. We saw daily medicine audits and balance checks were carried out. The audits we saw indicated that there were no gaps in recording administration and that omissions of medicines had been recorded on the MAR. However, on one person's MAR we found that staff had not recorded that they had administered a medicine, but the daily balance check and the remaining stock confirmed that the person had received this medicine. The registered manager told us that daily medicine audits and balance checks were carried out on 20 per cent of the MARs each day and as a result the omission had not been picked up.

We observed a nurse during a medicine round. They told us they were an agency nurse and they had not previously worked at the home. They were guided initially by a permanent member of the nursing team. The agency nurse told us they were taking their time administering medicines to people to make sure they administered medicines to people safely. We saw that they carried out this task in a caring and unrushed manner. However, the medicines round took over two hours to be completed. The nurse told us that people with time sensitive medicines were prioritised to ensure they received these as required, however other people had to wait to receive their medicines. We saw a controlled drugs record book that had been signed by two staff each time a controlled medicine had been administered. Regular daily checks of controlled drugs were recorded in a controlled drugs book.

Medicines were stored securely in locked medicines trolleys and cabinets within locked clinical rooms. Where medicines required refrigeration, we saw they were stored in medicines fridges in the clinical rooms. Daily medicines fridge and clinical room temperature monitoring was in place and recordings were within the appropriate range. Controlled drugs were securely stored in line with regulatory requirements. There was guidance in place for staff on when to offer people 'as required' medicines. At the time of the inspection the registered manager was working with the Clinical Commission Group Pharmacist and GP to improve how medicines were managed at the home.

Fire alarm tests and drills were conducted on a regular basis, and people had personal emergency evacuation plans in place which set out the support they required in the event of an emergency. A fire risk assessment was in place and provided staff with guidance on the actions to take in the event of a fire within the home. We saw that fire equipment was subject to regular checks and monitoring to ensure it was effective and safe to use. Emergency first aid kits were available on each floor of the home and these were checked to ensure first aid equipment was in date and safe to use.

The provider also carried out routine maintenance and checks on the environment, including gas safety, portable appliance testing and water safety. Equipment such as hoists, scales, beds and slings had also been checked each month by the home maintenance team and on a six-monthly basis by an external company to ensure they were safe for use.

Robust recruitment checks were carried out before staff were employed to work at the home. We looked at the personnel files of four members of staff. The files contained completed application forms that included their full employment history, employment references, health declarations, proof of identification and evidence that criminal record checks had been carried out. Each Staff member's eligibility to work in the UK had also been verified. The registered manager showed us records confirming that agency staff had been recruited safely by their employer, that nursing staff were registered with the Nursing and Midwifery Council, and that they had completed training that reflected the needs of people living at the home.

The provider had infection control policies and procedures in place which provided staff with guidance on how prevent or minimise the spread of infections. They carried out monthly infection control audits to ensure the home environment was clean and safe for people. We found that the home was warm, clean and tidy and free from any unpleasant odours. We saw hand washing reminders in bathrooms and toilets and hand sanitizer was available. Staff told us they wore personal protective equipment (PPE) when supporting people and we observed this throughout our inspection. Training records showed that all staff had completed training in infection control and food hygiene.

Inadequate

Is the service effective?

Our findings

People had access to a GP and other healthcare professionals when needed. One person told us, "If you need a doctor you can get one." A relative said, "The GP is brilliant. They come here every Tuesday. They are very understanding." However, where there were concerns relating to people's health needs they were not always referred to appropriate health professionals in a timely manner. Records showed that one person had lost significant weight in the six months prior to our inspection. This had been identified as a concern in August 2018 and again in October 2018. On both occasions the person's record had been completed to highlight the need for a dietician referral to be made. However, when we raised this issue with the registered manager, they told us the referral had not been made. They subsequently made the referral during our inspection

We found that advice provided from some health professionals was not being followed by staff or recorded appropriately to ensure people received the care and treatment required. For example, as already reported in safe a person was receiving a specific medicine two weeks after it was discontinued by the prescriber.

These issues were a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

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 with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures 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 had the appropriate legal authority and were being met. The principles of the MCA had not always been adhered to. In one person's care plan we saw a completed mental capacity assessment which related to day to day decisions such as food, clothing and personal care. Staff had recorded that the person was unable to retain information and therefore lacked capacity. During the inspection we observed staff asking the person to make choices about what they wanted to drink and eat, and staff told us they did have capacity to make these simple decisions. There was a risk of staff not familiar with this person not allowing them to make choices because the assessment that had been completed was incorrect. Another person's care plan just contained a 'best interests checklist' and staff told us the person did not have capacity, however, no mental capacity assessment had been completed.

The registered manager had sought authorisations under DoLS in line with the requirements of the MCA. Most conditions on people's DoLS had been met. However, one person's authorisation stated that staff should consult with the GP and mental health team regarding the risks and benefits of the use of anti-

psychotic medicines. The condition stated that this consultation should be included in the person's care plan. The registered manager showed us that some consultation had occurred with the GP but was unable to show us any evidence that this had been discussed with mental health team, as per the condition. After the inspection the registered manager sent us evidence to show the person had seen a doctor from the mental health team. Although their medicines had been changed there was no record of the risks or benefits relating to the medicine use and this had not been included in the person's care plan, as per the condition.

These issues were a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

Assessments of people's care and support needs were carried out before, or soon after they moved into the home. These assessments were used to draw up individual care plans and risk assessments. People's care plans described their needs and included guidance for staff on how to best support them. However, we found that the assessment information had not always reflective of people's needs. For example, one person's assessment documented that they did not wear dentures and had no dry mouth, but the person used dentures, they used a peg feed and they suffered from dry mouth. They told us they had seen a dentist recently and they had some concerns that the dentist was looking into. Their care file did not have an oral health assessment or care plan in place. Another person's assessment indicated that they managed their own dental care routine. However, this person told us that staff brushed their teeth morning and night as they did not have the ability to maintain their oral health.

The providers oral health pre-assessment form consisted of two tick box questions - one asked about whether the person had dentures and the other asked if they have any sores or pains. No information was taken relating to oral health daily routines, products used or the persons preferences. Only two out of the four peoples care records we looked at in relation to dental care did include completed oral health assessments. The lack of proper oral health assessments put people's oral health care needs at risk.

These issues were a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

People and their relatives told us about the food provided to them at the home and their experiences at meal times. One person said, "The food suits me." A relative told us, "They feed [my loved one] a pureed diet, it can take them a long time, up to an hour. They seem to know what they are doing." Another relative said, "My [loved one] eats a normal diet. The food is good, and they are good at giving fluids." A third relative commented, "The website it says that food changes with the season, but it doesn't. It's annoying when they give [my loved one] dessert before their dinner is finished."

We observed how people were being supported and cared for at lunchtime. We saw that pre-prepared meals were supplied by an external company and heated up at the home. On the ground floor people were brought into the dining room at 12 o'clock. People who required special or soft diets received their meals first. This meant some people were waiting up to 25 minutes to receive their meals, watching other people eat. Staff were busy and did not spend time chatting to people whilst they were waiting. An external contractor started to carry out some work on the doors in the dining room which made loud banging noises, and visibly made people jump several times. The doors were also opened, and two people were moved by staff after being asked if they were cold. The atmosphere was not relaxed or pleasant. We spoke to the registered manager about our observations and they told us that, "Lunch time is not normally like that" and "Staff usually bring people in for two sittings." They agreed that it was not appropriate for the work to be completed on the doors when people were eating. Although they agreed what we observed had not been acceptable, they had not taken any action at the time to improve people's experience. The regional

manager told us that after 12:30 when we had completed our observation they had asked for the works to be postponed. On the other unit we saw people entering the lounge at 12.10pm [the dining room was being refurbished]. People's food was brought into the at 12.35, however cutlery was provided 12.40pm. Whilst a member of staff was serving food to people the registered manager called them away for about five minutes, no one stepped in to take over, during which time the food was getting cold.

These issues were a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

Staff had received training relevant to people's care and support needs. All of the staff we spoke with told us they had regular training which had enabled them to perform their role efficiently.

The registered manager told us that staff new to care were required to complete an induction in line with the Care Certificate. The Care Certificate is the benchmark that has been set for the induction standard for new social care workers. We saw a training matrix confirming that staff had completed training in areas such as safeguarding adults, infection control, moving and handling, health and safety, fire awareness, Mental Capacity Act 2005 (MCA), Deprivation of Liberty Safeguards (DoLS), first aid and food hygiene. Some staff had completed other training relevant to people's needs, for example dementia, diabetes awareness and end of life care. Nursing staff had also completed clinical training, for example, on the administration of medicines, venepuncture and syringe drivers. The registered manager confirmed the home's nurses were due to complete training on pressure area care on 22nd November. Records showed that staff received regular supervision and annual appraisals in line with the provider's policy. Staff told us the supervision and appraisal sessions were beneficial to their development.

People did not comment on the living environment at the home but appeared comfortable in their surroundings. People had bedrooms with on-suite bathrooms. Parts of the home was being refurbished at the time of the inspection and new furniture had been purchased.

Requires Improvement

Is the service caring?

Our findings

Staff did not always treat people with care or compassion. We observed staff ignoring people on the two units of the home when they asked for help during the lunchtime period. One person had a drink placed in front of them, too far away to be able to reach. They called out for help from staff but received no response. Another person became distressed and asked for help however they were ignored by staff. A third person had dropped a spoonful of food onto the floor and was attempting to eat the food off the floor. Staff had not noticed this until we brought it to their attention because of the health risk. We observed that one person [who was sitting in their room] asked a member of staff what was for lunch and was ignored. When the member of staff returned we told them the person had a question for them. The person asked what was for lunch and the member of staff said they didn't know. They did not return to tell the person what was for lunch. One person told us, "The morning staff are good. I don't know what the night staff do, they don't help me." Another person said, "Some of the staff are very nasty; sometimes they don't water me. If you call them they just ignore you. The day staff are very good, most of the staff are agency." A third person commented, "The staff don't comb my hair. I used to tell them to comb my hair but it's not often they do."

These issues were a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

We also observed some positive interactions during our inspection. We saw some staff speaking with and treating people in a respectful and dignified manner. For example, one member of staff was joking with one person who commented to us, "It's a good job I have some nice people to help me out." A relative told us, "They do change the staff quite a bit. They talk to [my loved one] nicely."

We asked people if they had been consulted about their care and support needs. One person told us, "I look after myself and I make my own decisions." A relative told us that staff always asked them about how their [loved one] liked to be supported and what their likes and dislikes were.

People's privacy and dignity was respected. We saw staff respected people's wishes for privacy by knocking on doors before entering their rooms. One person told us, "'The staff knock on my door before they come in to my room. They close the door when they are giving me personal care." Another person said, "'Some staff, I find them caring. They knock on the door when they come to my room." Staff told us how they ensured people's privacy and dignity was respected whist personal care was provided. A member of staff told us they closed people's doors and curtains when supporting them with personal care. They tried to maintain people's independence as much as possible by supporting them to manage as many aspects of their care that they could by themselves.

Training records confirmed that staff had received training on equality and diversity. One member of staff told us, "I would support people no matter what their background or beliefs are." Another member of staff said, "I have passion. I want to treat them [people] like my parent or my grandparents."

People using the service were provided with appropriate information about the home in the form of a

'Service Users Guide'. This included the complaints procedure and the services the home provided and ensured people were aware of the standard of care they should expect. The registered manager told us this was given to people and their relatives when they moved into the home.

Requires Improvement

Is the service responsive?

Our findings

People's needs were assessed, however care and treatment was not always planned and delivered in line with their needs. There was little evidence in people's care plans to suggest that their mental health needs were assessed or addressed, and some of the language used in care plans was inappropriate and judgemental. For example, one person's behaviour care plan highlighted the different behaviours they presented. Their behaviour care plan recorded, 'I like to disrupt each and everybody' and 'I deliberately tip myself out from my chair to get sympathy from staff' and 'I would like registered nurses to liaise with the mental health team and GP to manage my behaviour.' However, there was no specific mental health care plan in place. Their behaviour care plan failed to identify the support they required from staff, or any interventions that would help avoid an escalation in their behaviours. Another person's care plan stated, "I require a lot of reassurance from staff as I do get depressed due to my condition." There was no further detail in the care plan advising staff how they should support this person when they were depressed.

People's care files included assessments of their nutritional needs, food likes and dislikes, any known allergies and the support they needed with eating and drinking. However, we could not be assured that people always received the food they had chosen or in line with their preferences. Two people were documented as being vegetarian. One relative confirmed that this was the case for their loved one. Records showed that these people had eaten meat on multiple occasions. The registered manager told us that they believed this to be a recording error, and they thought that the people would recognise meat if they were given it. However, both people were on a soft diet, and meat served in this way would be either cut up or pureed making it harder to accurately identify without tasting it.

A relative told us, "The care plans are a big issue; [my loved one] had theirs done. The nurse was trying to do behaviour charts, but all that sort of stuff just went to pot. They were agency staff that didn't know [what my loved one needed]. Things have improved these last few days."

People were not always provided with a range of appropriate social activities that met their needs. The home employed two activities coordinators, one worked from 10 - 4pm each day and the other worked from 1 - 6.30pm. One person told us, "I watch TV and that's it. Occasionally they take me out to lunch in the dining room." A relative told us, "They just leave [my loved one] in the bed." Another relative said, "The two activities staff will go out together with two residents leaving the rest with nothing to do. Every week there is programme of activities. Run of the mill things that never happen on time."

On the morning of the inspection there were no activities taking place. The registered manager explained that the morning activities co-ordinator was on leave. The other activities member of staff arrived after lunch and advised that they had planned to take some people out to a fireworks display. They then facilitated an activities session in one of the units. Six people were participating, the session began with a sing along followed by a quiz. People appeared to be actively engaging and enjoying the activities and they were shouting out the answers.

These issues were a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities)

Regulation 2014.

From April 2016 all organisations that provide NHS care or adult social care are legally required to meet the requirements of the Accessible Information Standard. The standard aims to make sure that people who have a disability, impairment or sensory loss are provided with information they can easily read or understand to support them to communicate effectively. The registered manager told us that people could communicate their needs effectively and could understand information in the current written format provided to them, for example the service users guide. They told us documents were provided to people with poor eyesight in large print. They said information could be provided in different formats to meet people's needs for example, in different written languages.

People said they knew about the complaints procedure and they would tell staff or the registered manager if they were unhappy or wanted to make a complaint. One person told us, "They [staff] sort it out." We saw copies of the complaints procedure was displayed throughout the home. Complaints records showed that when concerns had been raised, these were investigated and responded to appropriately. Where necessary discussions were held with the complainant to resolve their concerns. We also saw a number of compliments had been received from relatives relating to the standard of care provided.

The registered manager told us that none of the people currently living at the home required immediate support with end-of-life care. They said that when required advice was always available from the GP and a palliative care team to help ensure people received appropriate end-of-life care. We saw Do Not Attempt Cardio-pulmonary Resuscitation (DNAR) forms in some of the care files we looked at. Where people did not want to be resuscitated, we found DNAR forms had been completed and signed by people, their relatives [where appropriate] and their GP to ensure their end-of-life care wishes would be respected. A relative told us, "The home discussed DNAR and end-of-life with us."

Inadequate

Is the service well-led?

Our findings

We found that the home's systems for monitoring the quality and safety of the service were not operated effectively. For example, we saw that regular care plan audits were being carried out. However, information in some people's care plans and risk assessments was not reflective of their care and support needs. Assessments relating to people's specific care needs were not always carried out, for example regarding their mental health or oral health care. We found that advice provided from some health professionals was not always followed by staff or recorded appropriately, to ensure people received the care and treatment they required. Some people required the use of pressure relieving mattresses to reduce the risk of pressure sores however no regular checks on the settings of the mattresses had been carried out and the registered manager was not aware of what the correct pressure settings should be for people. A medicine audit documented there had been no gaps on people's MAR, despite an instance where a person's prescribed medicines had not been signed as given to people by staff. We found instances where the principles of the MCA were not being adhered to. None of these significant issues had been identified by the provider's monitoring of the quality and safety of the service.

These issues were a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

The home had a registered manager in post. They had worked at the home since December 2017. They were aware of the legal requirement to display their current CQC rating which we saw was displayed at the home. However, an incident involving the incorrect administration of a person's medicines amounting to a safeguarding concern had not been properly recorded. The incident was being investigated internally by the provider however it had not been reported by the registered manager to the local authority safeguarding team or the Care Quality Commission.

This was a breach of regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

Following concerns raised by health care professionals, safeguarding, relatives and whistle blowers the host local authority that commissions some services from the provider placed an embargo on admissions to the home. Meetings had and continue to be held with local authority and health care professionals to make sure that the provider takes steps to improve the safety and quality of the service that people receive. The regional manager told us that the home would not be admitting any private placements to the home for a minimum of two months. The provider had introduced a team of senior managers to support the registered manager and oversee the improvements that needed to be made. The team included two peripatetic managers one of who attended the home five days a week and the other two days a week; the regional manager who attended the home four days a week and the director of operations who attended the home twice each week.

The regional manager showed us a development plan for the home that included identified areas of non-compliance, objectives and progress, and due dates for completion. The development plan covered areas such as medicines, Deprivation of Liberty Safeguards (DoLS), care and treatment, rota planning, staff

supervision and appraisals, training and induction, staff meetings, flash meetings, nutrition and catering, accidents, complaints, care planning, risk assessments and dining experience audits. Some of these actions had been recorded as completed. For example, the introduction of flash meetings and rota planning and were recorded as on target.

The registered manager told us they had introduced a staff recognition scheme where staff recommended by colleagues received a monetary award. They also held cake afternoons for staff and some staff were given thank you cards in recognition of their good work. We were not able to make a judgement on the impact of the development plan or the staff recognition scheme on people's care needs at the time of this inspection, as the due dates for meeting some the objectives had not yet arrived. We will continue to monitor the home and the actions taken by the provider to make improvements at the home.

People and their relatives expressed mixed views about the running of the home. One person told us, "The home is not as well organised now as when I first came in here. They have a lot of staff changeovers. Although the manager might do their best, in my opinion it could be better." A relative explained there had been a lot of problems over the five or six months and they had spoken with the provider's Chief Executive Officer about their concerns. They said, "Once the management came in it was brilliant, I have more trust, but I believe it will take time." Another relative commented, "It hasn't been the same as it was when [my loved one] first came in here. It felt alive then and friendly, and things were going on. I trust it's going to get better." A third relative told us, "The registered manager has been more approachable in the last four weeks. If I knock on the door and ask if they have a couple of minutes, they say 'if it's only a couple'."

Staff views about the support they received from the management team was also mixed. Comments included, "Every day at 11am we have the flash meeting and once a week we have a big meeting with the registered manager and regional manager. They have started to listen. We have five staff on now every day which helps. Most of our previous problems have been down to a lack of staff.", "There have been some positive changes recently. The registered manager listens now and acts immediately. I think we are working together now as a team.", "This is a brilliant home. The last few weeks have been better than they were before, but adjustments still need to be made to make things better for people and staff.", "I can go to the registered manager and she will support me. She listens to me. But the company needs to appreciate staff more. When anything goes wrong the carers get the blame. The company needs to look at what they are doing and take some responsibility themselves." And, "As far as managers go I don't think the support is there for staff. When staff complained about being overworked they were not listened to and some of them left. I am thinking about leaving too."

The provider sought the views of people, their relatives and staff through surveys. The registered manager told us they were about to resend surveys to relatives and staff. They said only two surveys were received back from relatives and none of the staff had returned a completed survey, so they could not form a judgement of the quality of the service people were receiving.

The provider also held regular residents and relative's meetings. Issues discussed at the last meeting on 2nd October 2018 included meals supplied to the home, entertainment, new furniture and redecorating in the one of the units, problems relating to the stability of management and staff, and care plans. The meeting was attended by the provider' Executive Chairman, the regional manager, the registered manager and the relatives of nine people that lived at the home. The minutes included an action plan with dates for completion. We saw that some of the actions had been addressed for example, one unit was being decorated and new furniture had been purchased as had been discussed. Staff picture boards had also been installed, hoisting equipment was being stored in empty bedrooms and an activities newsletter had been developed. Another relatives meeting was due to take place the day after 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	Regulation 18 Registration Regulations 2009 Notifications of other incidents The registered manager failed to report a safeguarding concern to the local authority or the Care Quality Commission.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People's needs were assessed, however care and treatment was not always planned and delivered in line with their needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People were not always treated with dignity and respect.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Safeguarding concerns were not always reported to the local authority safeguarding team or CQC where required.

Regulated activity	Regulation
Accommodation for persons who require nursing or	Regulation 18 HSCA RA Regulations 2014 Staffing

personal care

Sufficient numbers of suitably qualified, competent, skilled and experienced staff were not always deployed at the home to meet people's care and support needs.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks relating to people's care and support were not always managed safely.

The enforcement action we took:

We served a warning notice on the registered manager and registered provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The home's systems for monitoring the quality and safety of the service were not operated effectively.

The enforcement action we took:

We served a warning notice on the registered manager and registered provider.