Lawnbrook Care Home Limited

Lawnbrook Care Home

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?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This inspection took place on 22 and 24 February 2017 and was unannounced. It was the first inspection of Lawnbrook Care Home since it was purchased by the current provider in April 2016 and was undertaken in response to concerns raised about the safety and quality of the service being delivered.

The home provides accommodation for up to 30 people, including people living with dementia care needs. There were 29 people living at the home when we visited. The home is a large building based on three floors, connected by two stairways and a passenger lift. The bedrooms are all for single occupancy and have en-suite toilets and wash basins. There are four bathrooms, although only two of these were use; one was being used for storage and one was awaiting refurbishment to turn it into a shower room. The kitchen and laundry were based on the ground floor, as was a communal lounge/dining room. There were two smaller lounges that people could use on the upper floors of the building.

The home had a registered manager. 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.

People's safety was compromised in some areas. Infection control guidance was not always followed; some areas of the home smelt of urine and others were not clean; there was no clear process in place to prevent cross contamination in the laundry room; there had been three outbreaks of infection since April 2016; and appropriate 'barrier techniques' were not in place to prevent the spread of infection while staff were supporting a person with diarrhoea.

Medicines were not always managed or administered safely. Records did not confirm that people had received their medicines or topical creams as prescribed; there was no clear guidance for staff on when and how to administer 'as required' medicines; and the risks associated with blood-thinning medicines had not been assessed.

Individual risks to people were not always managed appropriately. People's risk assessments were not reviewed when they experienced falls; people were not protected from the risk of pressure injuries; and there were no risk assessments in place for the environment. However, some risk management measures were in place, including appropriate fire safety systems.

The induction process was not structured and there was no process in place to monitor staff training. Although most staff said their training was up to date, we found some were not suitably skilled. Moving and repositioning techniques used were not always safe or appropriate and put people at risk. Staff said they felt supported in their work, but did not always receive one to one sessions of supervision to enable them to raise concerns or discuss their training needs.

A choice of meals was available to people, but choices were not offered in a meaningful way for people living with dementia. People who ate very little of their meals were not offered alternatives unless they had the capacity to request them. Charts used to monitor the amount people had eaten were not completed fully; although action was taken when people lost weight.

Staff did not follow legislation designed to protect people's rights. They were not aware of people who had had restrictions placed on their freedom to keep them safe.

The premises were not maintained in a suitable condition. As a result, hot water was not available in all parts of the home and the passenger lift had experienced repeated failures. The décor did not support people to be able to navigate around the building, although the provider had recently employed a specialist to enhance the experience of people living with dementia.

New recruitment and selection procedures had been introduced as relevant pre-employment checks had not always conducted before staff started work. The new procedures were more robust and would help ensure only suitable staff were employed in the future.

People told us staff treated them with kindness and compassion. We observed positive interactions between people and staff. However, we also found that people and their families were not always treated with consideration. People's privacy was protected in most cases, although some confidential information was visible in people's rooms.

People said they received personalised care and staff demonstrated an understanding of people's needs. However, care plans were not reviewed regularly and did not always contain sufficient information. Staff did not promote people's continence effectively.

There was a lack of resilience in the management structure of the home and the registered manager undertook all management tasks without having anyone to delegate to. However, a deputy manager was being recruited to support them.

The registered manager was developing an appropriate quality assurance system and was aware of the strengths and weaknesses of the service. They acted as a role model for staff. Staff enjoyed working at the home and described the registered manager as approachable and supportive. They expressed a shared a commitment to improving the quality of care for the benefit of people.

People told us they felt safe living at the home. Staff were aware of their safeguarding responsibilities and had been trained to identify, prevent and report incidents of abuse. There were enough staff available to meet people's needs.

People who could communicate verbally told us they enjoyed their meals. They were supported to access healthcare services when needed.

People were encouraged to remain as independent as possible and were involved in planning the care and support they received. They had access to a range of activities designed to meet their individual interests.

There was an open and transparent culture. The provider sought and acted on feedback from people. People knew how to make a complaint, although the complaints procedure was still being developed.

We identified breaches of regulations of the Health and Social Care Act 2008 (Regulated Activities)

Regulations 2014. You can see what action we have taken at the back of the full version of the report.

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.

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.

People's safety was compromised as appropriate infection control procedures were not followed. Parts of the home smelt of urine and there had been three outbreaks of infection since April 2016.

People's medicines were not always managed safely. There were gaps in medication administration records and a lack of guidance for staff about how and when to administer some medicines.

More robust recruitment selection procedures had been introduced as pre-employment checks had not always been completed to make sure that staff were suitable for their role.

Individual risks to people were not always managed appropriately. Risk assessments were not reviewed when people experienced falls; they were not always protected from the risk of pressure injuries; and risks posed by the environment had not been assessed.

However, people told us they felt safe living at the home and staff knew how to identify, prevent and report allegations of abuse. There were enough staff available to meet people's needs.

Is the service effective?

Inadequate

The service was not effective.

Staff were not skilled at supporting people to move or reposition effectively. The induction process was not structured and there was no system in place to monitor training that staff had completed. Staff were not supported through one-to-one sessions of supervision, although most said they felt supported in their work.

A choice of meals was available to people, but meal choices were not offered in a meaningful way to people living with dementia. When people ate very little of their meals, they were not offered alternatives.

Some staff did not know which people required special diets or how to meet their dietary needs. Records used to monitor how much people had eaten were not completed fully, although appropriate action was been taken when people lost weight.

During the care planning process, senior staff did not always follow legislation designed to protect people's rights. Staff did not know which people had their liberty restricted by law.

The premises were not maintained in a suitable condition. Hot water was not always available to people on the upper floors of the home; the lift had repeatedly broken down in recent months; and the décor was not supportive of people living with dementia.

People were supported to access healthcare services including doctors and specialist nurses.

Is the service caring?

Requires Improvement

The service was not always caring.

We observed positive interactions between people and staff; but staff did not always treat people or relatives with consideration.

People's privacy was protected in most cases, although confidential information was displayed in some people's rooms.

People were encouraged to remain as independent as possible and were involved in planning the care and support they received.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans were not reviewed regularly and did not always contain enough information to enable staff to provide personalised care that met people's individual needs. Staff were not clear about how to promote people's continence.

People had access to a range of activities. People were supported and encouraged to make choices about day to day aspects of their lives.

The provider sought and acted on feedback from people to help improve the service. A complaints procedure was still being developed, although people knew how to make a complaint.

Is the service well-led?

Requires Improvement

The service was not always well-led.

There was a lack of resilience in the management structure of the home. The registered manager had little support, but was recruiting a deputy manager to enable them to delegate some responsibilities.

An appropriate quality assurance system was still being developed, but the registered manager had a clear view of the strengths and weaknesses of the service.

Staff enjoyed working at the home and had a good working relationship with the registered manager. They expressed a shared commitment to improving the quality of care for the benefit of people living at the home.

There was an open and transparent culture. Visitors were made welcome at any time. There were good working relationships with external professionals and the provider notified CQC of all significant events.

Lawnbrook Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014. The inspection was also in response to concerns raised about the safety and quality of the service.

This inspection took place on 22 and 24 February 2017 and was unannounced. It was conducted by two inspectors and an expert by experience in dementia. 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 the inspection, we reviewed information we held about the service including notifications. A notification is information about important events which the service is required to send us by law.

We spoke with 12 people living at the home and three family members. We also spoke with the registered manager, three senior care staff, five care staff, two housekeepers, the activity staff member and the cook. Following the inspection we received feedback from a GP who had regular contact with the home.

We looked at the care plans for five people in depth, and aspects of care plans for a further four people. We looked at staff training records, staff recruitment files, duty rosters, accident and incident records, cleaning records and quality assurance records.

We observed care and support being delivered in communal areas of the home. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

This was the first inspection of the home since it was registered with a new provider in April 2016.

Inadequate

Is the service safe?

Our findings

People's safety was compromised as appropriate infection control procedures were not followed. On the first day of the inspection, all three floors of the home smelt of urine and the middle floor smelt strongly of urine. Staff told us the malodour on the middle floor was because a person living there was incontinent. On the second day of the inspection, the only smell of urine was on the middle floor, outside of this person's room. Staff told us they had cleaned the carpet in the person's room, but this had not reduced the odour.

Most other areas of the home were visibly clean and cleaning check sheets showed they had been cleaned by housekeeping staff on a regular basis. However, there was no cleaning check sheet in place for the dining room and we saw the floor was dirty and sticky underfoot. The registered manager told us night staff should clean this daily, but they were unable to confirm when it had last been cleaned. There was also a check sheet in place for the laundry room, but this had not been completed to say when it had last been cleaned. The registered manager told us it should have been cleaned daily, but a member of the housekeeping staff told us it was "probably only cleaned about once a week". They attributed the lack of cleaning to the volume of laundry piled up, which would have to be moved before they could do any cleaning.

There were no clear processes in place to prevent cross contamination in the laundry room. On the first day of the inspection, laundry bags were piled up on two trolleys in the laundry. Bed linen and clothes soiled with body fluids had been put in special soluble red bags that could be put directly into a washing machine to avoid the need for them to be opened. These bags were piled up amongst white bags containing ordinary washing; one of the red bags was open, having not been tied securely. Staff told us it was difficult to keep on top of the laundry as there was only one washing machine and tumble dryer. Dirty linen and clothes entering the laundry had to be carried past clean clothes hung up on a rail. The lack of safe working practices put people at risk of infection. On the second day of the inspection, the laundry was more organised and bags were not piled up.

We saw staff, including staff who prepared food and drinks, repeatedly walked through the laundry room to access a smoking area at the rear of the building. Immediately outside the laundry room was a drinks preparation area containing a milk dispenser, water boiler, tea, coffee, cups, etc. The person responsible for processing the laundry was also required to do a drinks round for people twice a day and used the facilities adjacent to the laundry. The infection control risks associated with staff repeatedly passing through the laundry and the potential cross contamination when staff prepared drinks for people had not been assessed, nor had measures been put in place to mitigate them. Staff who had worked night shifts told us they were required to prepare food at night in between supporting people with personal care and operating the laundry; they felt this posed a further infection control risk which had not been assessed.

Providers are required to take account of the Department of Health's publication, 'Code of Practice on the prevention and control of infections'. This provides guidance about measures that need to be taken to reduce the risk of infection. The code of practice requires providers to complete an annual statement detailing what policies and infection control risk assessments were in place, and any staff training or outbreaks of infection that had occurred. The provider had not completed an annual statement or any

infection control risk assessments. The registered manager told us they did not have an infection control policy, as it was still being developed by an external contractor. Consequently the provider could not demonstrate that the risks of people acquiring an infection had been identified, assessed and mitigated effectively.

The home had experienced three outbreaks of infection since the provider started operating the service in April 2016. These had resulted in people experiencing sickness and diarrhoea symptoms. The incidents had been reported to the relevant authorities, as required. Staff told us they completed extra cleaning during the outbreaks and paid particular attention to door handles and hand hygiene. In addition, people showing symptoms were isolated in their rooms and visitors were not permitted to enter the home. On the second day of the inspection, a person was being isolated in their room as they had experienced diarrhoea for the previous 48 hours. Staff told us they were using "barrier techniques" when supporting the person. However, these were not being used consistently. We observed staff entered and left the person's room without using any personal protective equipment, such as disposable gloves or aprons. In addition, staff gave inconsistent replies about where they cleaned their hands after supporting the person. One staff member said they would clean their hands in the person's en-suite bathroom, another said they would clean their hands in a nearby bathroom and a further staff member said they would do both. However, the person's room did not contain suitable hand-washing facilities for staff, such as liquid soap or disposable paper towels. Therefore, we could not be assured that staff were able to follow appropriate infection control procedures to prevent the spread of infection to other people.

The failure to assess the risk of, and prevent and control the spread of infection was a breach of Regulation 12 of the Health and Social Care 2008 (Regulated Activities) Regulations 2014.

Medicines were not always managed safely. Medicines were administered by staff who had received the appropriate training and were stored correctly. Storage was clean, tidy and secure so that medicines were fit for use and there were procedures in place for the ordering and safe disposal of medicines. However, we found medicines were not always administered safely. There were some gaps in the medication administration records (MAR) where staff had not recorded whether they had administered people's medicines. For example, one person was prescribed an iron supplement three times a day, but their record showed they had only received it twice a day. Where people were prescribed a variable dose of a medicine, staff did not always record the amount they had administered. Therefore, if they had needed a further dose, staff would not have known how much the person could receive safely within a specified period.

Some people had medicines which were prescribed to be given 'as required' (PRN), for example for anxiety or for pain relief. There were not always protocols in place for these medicines which meant there was no clear guidance for staff on when and how to administer these medicines safely; and when they were administered, staff did not record the time or reason they had been given. Staff would not have known when it was safe to administer a further dose, so the person was at risk of overdosing, if medicine was given to soon, or being in pain or discomfort if it was not given soon enough.

Three people were receiving a medicine to thin their blood, but there was no information available for care staff on the risks associated with this medicine. Care staff were not aware of the increased risks of injury or harm to these people should they fall or injure themselves. Other people were self-administering some of their medicines, but risk assessments had not been completed to assess whether they were able to do this safely.

Some people were given their medicines in a pot to take themselves. We saw one person with their tablets. They were able to take out most tablets; however, they were left with a white powder at the bottom which

could not be removed. Staff told us it could have been a calcium supplement which had dissolved as the pot was still damp. Therefore, the tablets had not been administered in safe manner.

People had folders in their room which contained records of their care. These also included a record for any creams or lotions that had been prescribed. Senior staff told us staff were expected to initial these records when they had applied any creams, but we saw they had not always done this. Therefore, the provider was unable to confirm that people's creams had been applied as prescribed.

The failure to record and administer medicines in a safe was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Individual risks to people were not always managed appropriately. A 'falls log' was kept in each person's care plan to record when they had fallen; but this did not always tally with the 'accident book', which showed people had experienced more falls than were recorded in their falls log. Although initial risk assessments had been completed to identify factors that could make people prone to falls, these were not routinely reviewed when a person experienced further falls. In addition, there was no process in place to enable the provider to identify any patterns in the incidence of falls across the home, such as the time of day they occurred most frequently, so they could consider remedial action.

People were not always protected from the risk of pressure injuries. Staff used a nationally recognised tool to assess people's level of risk. This was recorded in their care plans, together with actions to reduce the level of risk. Some people had been provided with special pressure-relieving mattresses and cushions, but these were not used consistently. Two people who needed to use pressure-relieving cushions were not given them when they transferred to hard dining chairs, where they spent the whole afternoon; this put them at risk of skin damage. In addition, one person's pressure-relieving mattress was not set correctly, according to their weight, so may not have been effective.

There were no risks assessments in place to manage risks posed by the environment. For example, the home had four stairways which posed a risk to people with limited mobility or people whose ability to recognise risk had been compromised by cognitive impairment. These risks had not been considered or measures put in place to mitigate them.

The failure to assess the risks to the health and safety of people and to do all that was practicable to mitigate the risks was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider was using a fire safety risk assessment conducted by the previous provider to manage the risks posed by fire. In addition, they had enhanced fire safety systems following advice they had commissioned from a fire safety specialist. Fire safety systems were tested regularly and people had personal evacuation plans in place that included details of the support they would need if they had to be evacuated. Staff had been trained in the use of evacuation equipment and were aware of the action to take in the event of a fire. Other risk management measures were also in place. For example, upper floor windows had restrictors in place to prevent people falling through them and the temperature of hot water outlets was regulated to prevent scalding. Fire exits were alarmed, so staff would be aware if anyone left the building unaccompanied; records showed this had recently happened twice and staff had been able to provide support to the person to keep them safe.

The registered manager used learning from some accidents to reduce the risk of recurrence. For example, following an incident where a person was injured while using a bath hoist, they reminded staff of the correct

safety procedures to follow. When we spoke with staff, they were aware of the incident and confirmed they now followed safe working practices.

The registered manager had introduced a new recruitment and selection procedure, having identified that relevant checks had not always been carried out on previous staff who had been employed by the service. For example, references had not been obtained for two staff members, including one who was later found to have provided inaccurate information about their qualifications; this person had since left the service. DBS checks had been completed for all staff members. DBS checks identify whether applicants have a police record and help employers to make safe recruitment decisions. The new procedures were robust and would help ensure only suitable staff were employed.

People told us they felt safe living at Lawnbrook Care Home. One person said, "I feel safe as there's always someone around; and I lock my door at night which works well." A doctor who had regular contact with the home told us, "Patients appear well looked after with no signs of neglect." Staff were aware of their responsibilities to safeguard people from the risk of abuse. They knew how to identify, prevent and report abuse and had received recent training. A staff member told us "If I was concerned, I'd speak with [the registered manager]; I know she would deal with it. Or, I could go to the owner as I see him several times a week." Records showed that safeguarding was discussed with people at every 'residents meeting' and people were encouraged to raise any concerns. Following a recent safeguarding concern, the registered manager had engaged well with the local safeguarding team. They conducted a thorough investigation and took robust action, using the provider's disciplinary procedures, to address the concern raised. The provider had also installed a CCTV system to help monitor people's safety in communal areas of the home.

We judged that there were sufficient staff on duty to meet people's needs, although we received mixed views from people and staff about this. For example, one person said, "There's always someone about if you need them." Another person confirmed this by saying, "If you buzz for them [staff], they come as quick as they can"; but added "Sometimes they have to rush away if another buzzer goes; it's a bit of a nuisance." Staff told us there were enough of them to meet people's needs. One told us, "We can be very busy, but we manage." Another said, "Sometimes it's tight if staff go sick; but they [management] do get agency [staff] in." However, comments from other staff included, "We all complain there aren't enough staff"; "[The staffing levels] are not really enough. The workload is so demanding; the buzzers are going all the time"; and "We need more care staff. Sometimes there are only three or four in the mornings and people end up waiting to get up and have their breakfast".

The registered manager had recently changed the shift times, which they said had increased the availability of staff at key times. The change enabled all staff to receive an appropriate briefing at the start of their shift and had led to fewer interruptions in the medicine round. The registered manager told us had resulted in a reduction in the number of medicine administration errors.

Staff absence was covered by existing staff working additional hours or by using agency staff. The registered manager told us the use of agency staff had reduced significantly in recent weeks, as more permanent staff had been recruited.

Inadequate

Is the service effective?

Our findings

People told us they felt they received effective care. One person said, "The carers like their job and they do the best they can for you. On the whole, they do a very good job." Another person told us, "We are so well looked after." A family member said they were "very happy" with the care provided. However, our observations showed people did not always receive effective care and staff lacked the necessary skills and experience.

For example, the moving and repositioning techniques we observed being used were not always safe or appropriate. During lunch, we saw a person return to their chair after visiting the bathroom. Two staff members were trying to support the person to transfer from their walking aid to a dining chair. In the process, the person fell heavily to the floor. The two staff members immediately pulled the person up to their feet by lifting them under their armpits. A senior staff member who attended shortly afterwards said of the staff, "They [staff] should have assessed [the person] and used the hoist to recover him rather than picking him up." We observed another instance where a person was supported to transfer from a wheelchair to a lounge chair; the staff members again lifted the person by their armpits. This technique is not best practice and puts the safety of the person and the staff members at risk. Later, we saw a staff member pushing a person in a wheelchair; the footplates were not in place and the person's feet were skimming along the floor. This put their feet and legs at risk of injury and further demonstrated a lack of competence by the staff member concerned.

Staff told us they received an induction into their role, including shadowing. Shadowing is where staff work alongside more experienced staff to learn how the service operates and how people's needs should be met. However, the induction process was not structured and did not enable the provider to check that staff had the appropriate level of knowledge and skills to work unsupervised.

Of the eight staff files we viewed, there was no record to confirm that three of them had completed any induction training. Staff new to care had not begun working on the Care Certificate to further support them in their role. The Care Certificate is the standard employees working in adult social care should meet before they can safely work unsupervised. It gives people confidence that workers have the necessary skills, knowledge and behaviours to provide compassionate, safe and high quality care and support.

Staff told us all their essential training was up to date or was booked and this was confirmed, verbally, by the registered manager. However, there was no system in place to monitor and record staff training and this made it difficult for the provider to identify what training staff had undertaken and when it needed to be updated. The registered manager showed us a spreadsheet they intended to use for this purpose. Once in place, it would help ensure staff training is kept up to date.

People were not cared for by staff who were supported appropriately in their role through the use of supervision. Supervision provides an opportunity for management to meet with staff, feedback on their performance, identify any concerns, offer support and identify training needs. Of the eight staff files we looked at, records showed only two members of staff had received a session of supervision. This was

confirmed by staff, some of whom said they had not received any sessions of supervision "for some months". A staff member who had benefitted from supervision told us, "[The registered manager] does support you and you can ask for advice. I had a supervision in December [2016]; we discussed any issues, any improvements and training. I feel appreciated and am thanked."

The failure to ensure staff were suitably skilled, competent and received appropriate support, training and supervision was a breach of Regulation 18 of the Health and Social Care 2008 (Regulated Activities) Regulations 2014.

A choice of meals was available, but meal choices were not offered in a meaningful way for people living with dementia or cognitive impairment. Shortly after lunch, when most people were sleepy, a staff member went round with the menu, asking people to choose their meals for the following day. They reeled off a list of options, which appeared to confuse most people. No visual aids, such as photographs of the meals were used. Some people were not able to make a choice. Others selected the first or the last options they heard.

At lunchtime, we observed that people had been given the meals they had selected the previous day. People in the dining room all received the same meal, which was cottage pie with peas and sweetcorn, followed by sponge and custard. Staff did not interact with people while delivering their meals; they did not explain what the meals were or check people were still happy with the option they had chosen the previous day. Several people ate very little of their meals. Staff asked people questions such as, "Are you going to eat that?" "Aren't you hungry?" and "Have you finished?" However, most of the people who had not eaten well were unable to verbally respond to these questions; their meals were taken away and staff did not tempt them with any alternatives. One person sat in front of their meal for nearly two hours and ate none of it; although staff occasionally checked the person was okay, none offered to warm the meal up or suggested an alternative.

Some staff did not know which people required special diets or how to meet their dietary needs. They were confused about whether a person had diabetes and whether they could have biscuits. At teatime, another person requested a different meal to the one they had been given. They were told by a member of staff that they could not have the meal they were pointing at as they were on a special diet. The person said "They always say that", and was adamant they wanted something else. The member of staff did not know what the person was able to eat and had to be advised by another member of staff who had more information but was also not fully aware of foods that were suitable for the person's diet. The person was eventually given a baked potato, which met the needs of the person's diet. A staff member asked the person if that was alright, to which they replied, "No, but I will put up with it; I am not happy in this place."

Where people were not eating and drinking enough to maintain their health, there were food and fluid charts to monitor the amount of food and drink they had consumed. However, these were only partially completed so did not provide sufficient information for staff to assess whether the person had consumed enough or whether additional support was needed. On some charts, there were no entries for up to a week at a time. In addition, the fluid charts did not indicate the amount each person should be encouraged to drink to keep them well. One person's care plan identified they were at risk of urine infections and directed staff to encourage the person to drink well. However, there was no fluid chart in place to monitor how much they had drunk. A doctor who had regular contact with the home told us there had been recurrent requests in the summer for GP attendance to ensure people were sufficiently hydrated. They said this had been "a source of frustration" for them. People's care plans directed staff to weigh people each month to help identify if they lost unplanned weight. However, we saw people had not been weighed between September and December 2016, which the registered manager told us was because the battery charger for the weighing chair had gone missing.

The failure to ensure people received personalised care and support that met their needs and reflected their preferences was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The risk of people becoming malnourished had been assessed using a nationally recognised tool. Although most assessments had not been reviewed since May 2016, we found staff did take action when they identified that people had lost weight. For example, one person had been referred to a dietician through their GP. The family of another person had been contacted to help identify foods that the person might prefer to eat and these had been provided. A further person was receiving high calorie drinks and had managed to gain a little weight.

Two people required full support to eat and were given this in a patient and dignified way. Some people were also given bowls with rims to make it easier for them to pick up their food with the utensils and they ate most of their meals. People were offered a variety of drinks and had access to drinks throughout the day. One person asked for an alcoholic drink at lunchtime and was given one.

People who were able to communicate verbally told us they enjoyed the meals and were able to ask for an alternative. For example, one person asked for, and received, a yoghurt for dessert. Another person said, "You usually get a couple of choices and I usually find something I like. If I don't like the puddings they will bring me a yoghurt." A further person told us, "The food is lovely, given how many people there are. They [staff] do very well." The cook told us they tried to make "homely meals" that people were familiar with, such as sponge puddings. They had recently introduced the option of cooked breakfasts each morning which were proving popular and had changed their shift start times to accommodate these. They also described how they fortified meals with butter and cream to add extra calories for people who needed them as well as low-sugar desserts for people with diabetes.

Staff were not following the Mental Capacity Act 2005 (MCA) or its code of practice. The 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 decisions made on their behalf must be in their best interests and as least restrictive as possible.

During the care planning process, senior staff had made decisions on behalf of people, including decisions to deliver personal care, to administer medicines and to use equipment to monitor people's movements. For some people, staff had assessed and recorded that the person lacked the capacity to make the decision, but had not documented decisions they had made on behalf of the person, nor why they were in the person's best interests. In some care plans, there was conflicting information about people's capacity. For other people with a significant cognitive impairment, neither MCA assessments nor best interests decisions had been completed. This meant the registered manager was unable to confirm that the care and support staff were delivering was with the consent of the relevant person or in the person's best interests.

Where people had capacity, we saw they had signed their care plans to indicate their agreement with the care and support planned. However, a consent form for one person had been signed by a family member who did not have authority to make care and welfare decisions on behalf of their relative and staff had not checked this. The registered manager showed us a tool they had obtained to help document MCA assessments and best interests decisions which they said they would implement with immediate effect.

The failure to ensure that care and support were only provided with the consent of the relevant person was a breach of Regulation 11 of the Health and Social Care 2008 (Regulated Activities) Regulations 2014.

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 are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and found they were not. DoLS authorisations had been made for five people. However, staff did not know which people these applied to. For example, a staff member said, "There are people on DoLS, but I don't know who they are. We just have to watch people." Other staff told us there was a list of people subject to DoLS on a notice board in the registered manager's office; however, the list was not accurate as it did not include two people who had authorisations in place. This meant staff might not have taken the appropriate action if these people had attempted to leave the home unsupervised.

The failure to ensure people were not deprived of their liberty unlawfully was a breach of Regulation 13 of the Health and Social Care 2008 (Regulated Activities) Regulations 2014.

The premises were not always maintained in a suitable condition to support the needs of the people living at the home. The home's boilers did not always provide hot water to all areas of the home. Staff told us this meant they sometimes had to carry hot water in jugs or bowls from the kitchen to rooms on the upper floors of the building. The registered manager told us this was not safe and they had recently stopped this practice. Instead, a boiler engineer was being called each time there was a lack of hot water. The engineer attended on both days of the inspection due to low water temperatures. The registered manager told us additional remedial work was needed to permanently address the problem; however, as this required the boilers to be taken out of service, it was being been postponed to the summer when it would have the least impact on people. Staff told us the lack of hot water had affected the frequency with which people were offered baths. A staff member told us, "[People] who like regular baths do have them, but others don't as a lot of the time the water's cold. The system isn't working." This was confirmed by people's bathing records which showed some people had only had one bath a month since October 2016.

The home had experienced repeated failures of the passenger lift in the previous nine months, which had prevented people on the upper floors of the building from accessing the communal areas on the ground floor, such as the lounge and dining room. A family member told us, "There was a bit of trouble with the lift last year. It was out of action for weeks and the residents couldn't get downstairs. Our [relative] was OK because her room is on the ground floor but her friends could not get downstairs to be with her." The registered manager told us further repair work had recently been completed and they were confident the underlying fault had been rectified.

The environment was not supportive of people living with dementia. There was a lack of signage or colour contrast to help people navigate around the building and find the bathrooms. Doors to people's rooms looked identical and were not personalised; this would make it difficult for people with cognitive impairment to find and recognise their own rooms.

The failure to ensure that the premises were properly maintained and suitable for the purpose for which they were being used was a breach of Regulation 15 of the Health and Social Care 2008 (Regulated Activities) Regulations 2014.

People were supported to access healthcare services when needed. Records showed people were seen regularly by doctors, specialist nurses and chiropodists. They also had access to dental care and eyesight tests when needed. One person said, "If I need a doctor, the carers tell the senior and they get me one." A doctor who had regular contact with the home told us staff were "generally proactive and will call us if concerned". Records showed a community nurse was called when staff identified that a person's catheter was blocked. A catheter is a device used to drain a person's bladder through a flexible tube linked to an

external bag.

Requires Improvement

Is the service caring?

Our findings

People told us most staff treated them with kindness and compassion. One person said, "[Staff] are all willing to oblige." Another person told us, "They [staff] are very gentle with me. I've got a good relationship with the regular [staff]." A further person said, "The younger ones (staff) are lovely." Family members also described staff as "lovely".

Staff did not always treat people with consideration. For example, at each mealtime, staff positioned the food trolley in the doorway of the dining room. This made it difficult for people to enter or leave the dining room, particularly if they used a walking aid. During the drinks rounds, the trolley was positioned in front of the television in the lounge, which obstructed people's view of the television. When lunch was served, a person asked for a sauce, which they said they had with all their meals. The staff member asked the person to wait until they had served everyone else and then returned with the sauce later; during this time, the person had been left waiting, while their lunch had started to go cold. Another staff member gave a person a meal in their room; the meal contained sweetcorn, which the staff member acknowledged the person did not like. They said to the person, "You have told us you don't like sweetcorn haven't you? Never mind, one day we might listen." A further person told us, "When [a particular staff member] has to rush away, she will give me a time when she will come back, but then she doesn't come back. On two occasions [staff] have brought me a cup of tea instead of the Horlicks I usually have at night. When I told them, they didn't come back til gone 11[pm] which is no good. I should have had it before 9[pm]."

After lunch, a person fell asleep while sat on a dining chair, with their head hanging forward nearly touching the table. They looked very uncomfortable, but staff did not approach the person or offer them a more comfortable chair. During the afternoon, another person who had been sat on a dining chair since before lunch told a staff member their legs hurt. The staff member left to find a colleague to help them support the person to move. They returned shortly afterwards and said, "I couldn't find anyone. Shall I take you to your room?" The person responded "Yes", but the staff member gave them another cup of tea. They did not support the person to their room, but left them sat on the uncomfortable dining chair.

At teatime a staff member tried to tempt a person to eat by suggesting different foods. It was clear that the person was unable to process the information or express their wishes. The activity staff member then intervened and showed the person a banana, as a visual prompt, which the person accepted. Once the person had finished the banana, they started eating the skin. The first staff member tried to remove the skin from the person's mouth by tugging at it, which did not work as the person resisted. The activity staff member again intervened. They distracted the person by showing them a yoghurt and asked the person if they could have the banana skin; the person accepted the yoghurt and the situation was resolved.

We saw another person's trousers had a damp patch on the rear. A staff member took the person to the bathroom to attend to them, but supported them back into the lounge in the same trousers. A further person asked for help to take their jumper off as it was itchy. Two staff members tried to find other staff to support the person but were unable to do so. The (male) person eventually took their jumper off and sat topless in the dining room for 10 minutes until another staff member attended with an alternative top. This

showed a lack of respect for people's dignity.

On the first day of the inspection, a family member visited the home. They were told that their relative had been taken into hospital, having become unwell during the night. When asked if the home had called them, the family member said, "No, but they knew I was coming in today". A senior staff member apologised to the family member and said this was an oversight as family members were usually informed when a person has been taken into hospital. The failure to notify the family member had resulted in them making an unnecessary trip to the home when they could have gone directly to the hospital.

The failure to treat people with dignity, consideration and respect at all times was a breach of Regulation 10 of the Health and Social Care 2008 (Regulated Activities) Regulations 2014.

At other times, staff spoke warmly about the people they cared for and interacted with them positively. They used people's preferred names and approached them in a friendly and relaxed manner. They also used plain English and repeated messages as necessary to help people understand what was being said. Staff were patient when speaking with people; they understood and respected that some people needed more time to respond. When a person's sleeve fell in their meal, a staff member offered to roll it up and clean it for them. When another person spilt some tea on their skirt, a staff member placed a towel on the person's legs while they finished their drink. Staff gave people the option of wearing clothing protectors at lunchtime, which some people accepted. When people became anxious, staff took time to engage with them at eye level and provide reassurance. When the activity staff member put music on, they checked the volume was suitable for everyone and explained that they needed it turned up a little so a hearing impaired person could hear it. On another occasion a staff member supported a person with sight impairment to carefully navigate their way around the lounge. They helped the person adjust the direction of their frame and moved from one side of the person to the other to protect them from obstacles.

People's privacy was protected in most cases. Staff knocked and sought permission before entering people's rooms. They took care to make sure toilet and bathroom doors were closed when they were in use and described practical steps they took to protect people's privacy when delivering personal care. These included keeping the person covered as much as possible, explaining what they were about to do and checking people were ready and willing to receive the proposed care and support. A staff member told us, "I always close curtains and doors and put towels over [the person's] lap when they're sat on the toilet." When a person in the lounge showed signs of needing to visit the bathroom, a staff member asked them quietly and discreetly whether this was the case and calmly supported them to leave the lounge without fuss. However, we noted that confidential information was sometimes displayed in people's rooms which could be viewed by visitors or people passing by their open doors.

Staff encouraged people to remain as independent as possible within their abilities and to do as much as possible for themselves. For example, they described how they let people attend to their own personal care when they could, but supported them by washing areas they were unable to reach. Guidance in people's care plans also helped promote independence. For example, one said, 'Encourage me to wash as much as I can'; and another said, 'I am able to wash my hands and face……but need help pulling on jumpers'.

When people moved to the home, they (and their families where appropriate) were involved in assessing and planning the care and support they received. Comments in care plans showed this process was on-going and records showed family members were usually kept up to date with any changes in the health of their relatives.

Requires Improvement

Is the service responsive?

Our findings

Most people told us their care needs were met in a personalised way. One person said, "Some staff are exceedingly good; they do what I ask them to do. I'm surprised how they remember so much; they just do it [provide support] without me having to say a word." A family member said, "We are very happy [with the care provided to our relative] and the activities are good."

Staff demonstrated an awareness of the individual support needs of people living at the home. They knew how each person preferred to receive care and support, and when people liked to get up and go to bed. They recognised that some people's mobility varied considerably from day to day and were able to assess and accommodate the level of support they needed at a particular time. For example, a staff member told us "[One person] is sometimes unbalanced, so I help her up the stairs, but normally she can manage. [Another person] could manage to stand on his own today, but sometimes he needs two staff [for support]." Staff had recognised that they were no longer able to meet the needs of a further person and the registered manager was liaising with social care professionals to identify a more suitable home for the person.

However, people care plans did not always contain sufficient information to enable staff to deliver care and support in a consistent way. For example, some people had diabetes. Although their care plans specified the need for a 'low-sugar' diet, there was no further information about this or the support each person needed with their diabetes, including the signs they might display if their blood sugar levels became too high or too low. However, we saw they were supported to attend diabetes screening clinics with healthcare professionals.

Other people needed support with their continence. They had been assessed for, and were using, continence products such a continence pads and there was some information in people's care plans about the need for staff to prompt people to use the toilet regularly throughout the day to promote their continence. However; the information was not specific to each person and staff were unclear about how often they needed to prompt people. For example, one care plan simply stated: 'promote use of toilet'. A staff member told us, "We used to [prompt people to use the toilet] at certain times of the day. We used to have allocations of people to support, but it doesn't happen anymore." The failure to support people's continence effectively may have contributed to the malodours we smelt in areas of the home. The registered manager told us senior staff had recently qualified to reassess people's continence needs. They were planning to introduce personalised prompting routines for people once the reassessments had been completed.

Care plans were not reviewed regularly to help ensure they reflected people's current needs. Most people's care plans had not been reviewed since July 2016. The registered manager was in the process of updating people's care plans to help ensure they included sufficient information to enable staff to support people appropriately and consistently. They told us "The monthly care plan reviews are done by seniors, but we have let some [senior staff] go, so they [care plans] are not fully up to date and are only a brief evaluation." They agreed this was an area for improvement.

People had access to a range of activities. One person told us, "People come in and do turns, mostly in the afternoon; they are very good." Another person said, "I like the music, it perks you up." Some people took part in chair-based exercises on the first day of the inspection, followed by a singing activity in the afternoon. People were encouraged to join in and those who took part appeared to enjoy the activities. Other people chose to engage in individual activities in their room. For example, one person enjoyed reading the paper and doing crosswords. They told us, "It's good to know what's happening in the world." Another person said, "There's enough for me to do. If they're on their rounds and they can spare a bit of time, they [staff] pop in for a chat."

People's care plans contained information about their life history to assist staff in understanding their background, likes and dislikes, and what might be important to them. In addition, the activities staff member had spent time with people identifying their individual interests; they had then tailored the activities to meet people's needs. For example, one person supported the local football team and had been shown some of the matches on a handheld computer. Staff also chatted with the person about forthcoming matches. People's birthdays and special events were celebrated. A Valentine's Day tea party had been held for people and their loved ones to attend; and Easter and summer fairs were organised, including a raffle to raise money for a local charity. A staff member told us, "They [people] get most joy if you're there listening to them. I printed off some old photos and [a person] was delighted. It's the best medicine."

Although people were not offered food choices in a meaningful way, they were encouraged to make other day to day choices. For example, they could choose when they got up and went to bed, and how and where they spent their day. One person told us, "I get up when I want and someone will take me downstairs." Another person said they were happy living at the home because "there aren't too many rules". Some people chose to take their meals in their room, including a person who chose to spend their day in their night clothes in their room. A staff member told us, "[The person] just likes to change into clean night clothes and doesn't get dressed." Another staff member added, "It's their home and they [people] are entitled to choose for themselves." When another person chose to stop taking their medicines, staff respected their decision but sought advice from the GP. The GP provided the person with additional information and they decided to start taking their medicines again.

Staff sought and acted on feedback from people. In particular, the activity staff member organised 'residents meetings' to talk to people about their experience of living at Lawnbrook and update them on any changes, such as new staff members. Any comments or requests from people were acted on. For example, a cooked breakfast option had been introduced and a lighter summer menu was being developed. In addition, arrangements had been made for a shower room to be built, at people's request, to replace one of the bathrooms. People and their relatives were also able to leave written feedback on an independent website. Recent comments posted on this website by friends or family members showed they were satisfied with the care provided.

The registered manager told us they were still developing a written complaints procedure. In the interim, they had informed people and their relatives verbally that they could address any concerns or complaints to them directly. A person confirmed that they would do this. They said, "If I needed to make a complaint, I would ask to see the manager or a senior [staff member] urgently."

Requires Improvement

Is the service well-led?

Our findings

Most people were happy living at Lawnbrook and felt the home was run well. One person said, "On the whole, it's well organised."

The provider took over the running of the home in April 2016. They continued to accommodate the same people, employ the same staff and use the same policies, procedures and records that the previous provider had used. The current registered manager had been managing the service since November 2016 when the previous manager left; they were registered with CQC in February 2017.

We found there was a lack of resilience in the management structure of the home. The registered manager was responsible for all management tasks, including the payroll, recruitment, staff training, staff duty planning, developing people's care plans and monitoring the quality of service. In addition, they were permanently 'on call' for staff for advice and guidance out of hours. A director of the provider's company had regular contact with the registered manager and senior staff were responsible for organising staff on a day to day basis, but none had any delegated responsibilities. The registered manager had recognised the need for additional support and had recruited a deputy manager, who was due to take up their post in the two weeks following the inspection. They were also trying to recruit additional senior staff and identify care staff to act as 'champions' to promote greater awareness of issues such as dementia, dignity and infection control. Once in place, this would make the management structure more robust and effective.

The provider was developing an appropriate quality assurance system. However, this was not yet in place or embedded in practice. As a consequence, we identified shortfalls in the quality and safety of the service and breaches of seven regulations. There were no effective systems or processes in place to ensure that people were protected from risks to their health, safety, rights and freedom; that people received care and support in a personalised way; that they benefitted from a suitable environment; or that their needs were met by skilled staff who were of good character.

The provider's failure to operate effective systems to assess, monitor and improve the quality of service was a breach of Regulation 17 of the Health and Social Care 2008 (Regulated Activities) Regulations 2014.

The registered manager had a clear view of the strengths and weaknesses of the service and told us there were "years of bad practice" that needed to be addressed. They were already aware of all the concerns that we identified during the inspection and showed a willingness to accept and rectify the areas of weakness to improve outcomes for people receiving the service. To help them with this task, they had already employed external specialists to support them. These include a contractor to update and develop the home's policies and procedures and a social care consultant to advise them on compliance with the regulations. They had also joined a registered managers' network to help them keep up to date with best practice guidance. The social care consultant had completed a review of the service, which the registered manager shared with us. From this, they were developing an action plan to provide a pathway to improvement.

The registered manager had also conducted a range of audits and had used the findings to help improve the

service. For example, an audit of staff files had identified failures in the recruitment processes and they had used the provider's disciplinary procedures to manage unsuitable staff who had previously been employed. They had recognised that care records were not being completed fully and were supporting staff to improve in this area. A staff member confirmed this, saying, "I know there are gaps in things like food and fluid charts, but it has got better. We are working on it."

The registered manager acted as a strong and positive role model for staff. They were visible around the home, set clear expectations for staff and worked alongside new senior staff when they started work at the home. This included working regular night shifts to monitor the quality of the service delivered at night time. A hand hygiene audit had identified that staff were wearing nail varnish, which posed an infection control risk; this had been addressed and the registered manager set an example to staff by not wearing nail varnish herself.

Staff told us they enjoyed working at the home and had confidence in the registered manager, who they described as "approachable", "competent" and "supportive". They said their morale was "good" and expressed a shared commitment to improving the quality of care provided for the benefit of people living at the home. Comments from staff included: "[The registered manager] is approachable and makes me feel appreciated"; "I love it here. We work well as a team and morale is good"; "[The registered manager] is supportive; she works a night a month with us which is good"; and "In the past, we weren't really listened to, but we are now. [The registered manager] is sorting things out."

The provider's vision was to create a specialist dementia-friendly environment for people. A director of the provider's company and the registered manager recognised the areas of improvement that were required and told us they were committed to achieving it in the near future. They recognised that key to this aim was additional support and training for staff. To address this, they had recently employed an external specialist to complete 'dementia mapping' of people living at the home. The work started on the second day of our inspection and involved the specialist delivering additional dementia awareness training to staff, followed by observations of their interactions with people and identification of people's individual needs. The registered manager told us, "The staff's approach [to people living with dementia] is not always right at the moment and we think this [dementia mapping] will help."

There was an open and transparent culture. The registered manager shared with us a report they had commissioned from a social care consultant to help identify areas for improvement in the home. They told us, "Everything is a mess; I know that, but I'm going to make it better." Visitors were welcomed any time and were able to come and go as they pleased. There were good working relationships with external professionals and the provider notified CQC of all significant events. A duty of candour policy had been developed and was being followed to help ensure staff acted in an open and honest way when accidents occurred. The home operated a CCTV system to monitor communal areas. As well as being used as a safety aid, it also served as an incentive to help ensure staff followed appropriate working practices. The registered manager told us, "If staff think you're watching, they're more likely to follow correct procedures."

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 9 HSCA RA Regulations 2014 Person-centred care The provider had failed to ensure that people received personalised care and support that met their needs and reflected their preferences. Regulation 9(1) & 9(3)(i).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The provider had failed to ensure that people were treated with dignity, consideration and respect at all times. Regulation 10(1).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had failed to ensure that people were only provided with care and treatment with the consent of the relevant person. Regulation 11(1).

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 The provider had failed to ensure that people were not deprived of their liberty without lawful authority. Regulation 13(5).

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The provider had failed to ensure that the premises was suitable for the purpose for which it was being used and properly maintained. Regulation 15(1)(c)&(e).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to ensure staff were suitably skilled and competent and received appropriate support, training and supervision. Regulation 18(1)&(2)(a).

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 The provider had failed to ensure that care and treatment was provided in safe way; that risks were assessed and mitigated effectively; that medicines were managed safely; and that infection control risks were assessed and managed appropriately. Regulation 12(1) and 12(2)(a),(b),(g)&(h).

The enforcement action we took:

We issued a warning notice requiring the provider to make improvements by 31 May 2017.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to operate effective systems to assess, monitor and improve the quality of the service. Regulation 17(1)7(2)(a).

The enforcement action we took:

We issued a warning notice requiring the provider to make improvements by 30 June 2017.