Vaghjiani Limited

The Laurels Nursing Home

Inspection report

Lincoln Road
Holton-cum-Beckering
Market Rasen
Lincolnshire
LN8 5NG

Tel: 01673858680

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**
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 the 20 and 21 March 2017 and was unannounced. The Laurels Nursing Home provides accommodation and personal care for up to 30 people. On the days of our inspection there were 16 people using the service

At the time of our inspection there was no registered manager in post as the last registered manager had left the service in December 2016. However the present manager had applied to the Care Quality Commission to register as manager at the service.
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 were protected from the risk of abuse and staff had a good understanding of their roles and responsibilities if they suspected abuse was happening. The manager shared information with the local authority when needed.

People who used the service were not always protected from risks to their safety as some people had not had the risks assessed when they were admitted to the service and the risk assessments in place for some people did not reflect their current needs.

Staffing levels did not always meet the needs of people and there were times when people who required supervision were left unsupervised for long periods of time. Although people were given their medicines safely the storage of medicines were not always managed safely. Staff were given training to assist them in their roles

The principles of the Mental Capacity Act were not always followed as people had been deprived of their liberty without the required authorisation to do so. There was a lack of mental capacity assessments and best interests meetings for people who may lack capacity to ensure the care they received was appropriate for their needs

People were not always protected from the risks of inadequate nutrition and although referrals to health care professionals were undertaken the information from the health professionals was not always recorded in their care plans.

There were times when people were not treated in a caring and respectful manner and staff did not always engage with people when given the opportunity. People, who used the service, or their representatives, were not always encouraged to contribute to the planning of their care.

People did not receive person centred care as the care records did not give adequate or up to date

information required for individualised care. People were not supported to undertake social activities to prevent them becoming isolated or bored.

People felt they could raise complaints and concerns to the manager who would deal with them in a satisfactory way.

Staff did not receive regular supervision and observation of their practice to monitor the quality of the care they gave to people.

Systems in the service that were meant to monitor and identify improvements were not effective and records were not always maintained and completed in full. This lack of effective governance led to some people not receiving safe and consistent care.

This resulted in us finding multiple breaches in regulations and negative outcomes for some people who used the service. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe

People were protected from potential abuse as staff understood their responsibilities in relation to protecting them.

Risks to people were not always appropriately assessed when they were admitted to the service and as people's needs changed the risk assessment did not reflect the changes to their needs

There was not always enough staff to meet people's needs in a timely manner.

People received their medicines as prescribed however medicine were not always stored safely.

Is the service effective?

Requires Improvement

The service was not always effective

Staff received mandatory training to assist them in their roles.

The principles of the Mental Capacity Act were not followed and procedures were not always in place to protect people who lacked capacity to make decisions.

People were not always supported to maintain a nutritionally balanced diet and fluid intake.

People had access to health professionals when they required this.

Is the service caring?

Requires Improvement

The service was not always caring

People's choices, likes and dislikes were respected however staff did not always show people respect or engage socially with people when they had the opportunity.

People's privacy and dignity was maintained

Is the service responsive?

Requires Improvement

The service was not always responsive

People did not have their care planned for consistently and this resulted in care which was not always safe or effective.

People were not always supported to undertake social activities within the home and the broader community.

Complaints and concerns made to the management team were responded to effectively.

Is the service well-led?

Requires Improvement

The service was always not well led

Whilst the manager was visible and open there was a lack of support for staff as a result of lack of regular supervision and appraisals.

The service lacked appropriate governance and risk management frameworks which resulted in poor outcomes for people who used the service.

The Laurels Nursing 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.

This unannounced inspection took place on 20 and 21 March 2017. The inspection team consisted of one inspector 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.

Prior to our inspection we reviewed information we held about the service. This included previous inspection reports, information received and statutory notifications. A notification is information about important events the provider is required to send us this by law. We contacted commissioners (who fund the care for some people) of the service and asked them for their views.

During the inspection we spoke with seven people who were living at the service and five people who were visiting their relations. We spoke with, three members of care staff, one housekeeper, the cook and the manager. 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.

We looked at the care records of six people who used the service, four staff files and a range of records relating to the running of the service.

Requires Improvement

Is the service safe?

Our findings

We viewed a number of people's risk assessments and found they did not reflect their current needs to keep them safe. One person's care plan had a risk assessment which stated the person had full mobility using a frame and required the assistance of one staff member. Our observations of the person and information from staff showed the person's condition had deteriorated and they could only walk a few steps from the bed to the chair with the assistance of two staff. The person had also fallen a number of times since their admission to the service and the information in their record was contradictory. One care record recorded the person had no falls in a particular month, however other records showed the person had fallen four times in that month. This information had not been used to assess the risk of falls correctly. As a result the assessment showed the person to be a lower risk than they actually were and put them at risk of receiving inappropriate care as staff using this information may have an unrealistic expectation of the person's capabilities. We discussed the person's care with their relatives who told us the person had fallen a number of times before staff had put a sensor mat to alert them to the person's movement. This meant the person had been placed at un-necessary risk during this time.

The same person had sustained a pressure ulcer whilst living at the service which was being treated by district nurses. Despite this their risk assessment for tissue viability showed the person to be at low risk of sustaining any skin damage as the assessment tools for this had not been used correctly. This meant staff did not have the correct information in this person's plan to ensure they received appropriate care. Whilst permanent staff we spoke with had knowledge of the different risks to people the service relied on agency staff to cover any staff short falls. This lack of up to date information in people's plans put people at risk of receiving unsafe care and treatment.

The risks to individuals were not always assessed when people were admitted to the home and consequently they were not always protected from individual risks to their safety. We saw two people who had been admitted to the service over a month prior to our visit had not had any assessments of the risks to their safety undertaken. One person required a hoist to support them when moving from one place to another. There was no documentation to show how the person had been assessed for the use of the hoist and to determine the appropriate sized sling. This meant staff had no guidance to ensure they were using the most appropriate sling for this person and as a result put them at risk of receiving unsafe care.

While it was clear there was lack of adequate risk assessments in place for people, staff we spoke to were able to give examples of how they managed the risks to people and worked to improve their independence. One person had poor mobility and lacked confidence in their ability to walk as they had fallen a number of times at home prior to coming to the service. The person's relative and staff told us how they had worked with the person to develop strategies to increase their confidence and improve the person's mobility. However this was not recorded in the person's care record.

Further concerns were the lack of documented assessments in all the care records we viewed around the correct equipment used to assist people who required help to move from one place to another. The service had a number of different sizes of slings that could be used with the hoist to move people safely. However

people had not been allocated their own slings and there was a lack of information in the care plans about the type and size of sling each person required. This put people at risk as use of a sling that has not been assessed for safe use for them and could result in people being moved in an unsafe way causing them harm.

This lack of effective monitoring of people's health needs is a breach of Regulations 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People who lived at the service were not always protected from environmental risks to their safety. During our inspection visit we saw a fire door that was faulty and could not be opened. We did not see any evidence to show that regular fire door checks had been carried out. This posed a risk to the people who lived in that area of the home in the event of a fire. We highlighted the risk to the manager and shared our concerns with the local fire safety team. We asked the manager to undertake measures to mitigate the risks to people whilst the fire door was repaired and we received confirmation that this had been done.

We also found that when some fire doors were opened the alarm to alert staff did not sound in all parts of the building. This meant there was a risk that people could leave the building without the knowledge of the staff on duty. We highlighted this to the manager who told us they would address this with the owner to rectify as soon as possible.

During our visit we asked for information about how the environment was monitored to ensure the premises were well maintained. There was a lack of regular environmental monitoring and a lack of cleaning schedules in place to ensure regular cleaning of all areas took place. Over the previous months there had been insufficient cleaning hours allocated to allow regular cleaning of all areas. As a result some equipment showed visible signs of dust and debris. This meant we could not be sure people were being cared for in a way that reduced the risk of the spread of infections.

The failure to ensure the premises and equipment used by people is properly maintained is a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People we spoke with told us there was not always enough staff to meet their needs. One person said, "It depends on what they are doing, they are usually pretty good, but odd times they're busy with someone else and there's not many care workers really. They went on to say, "They sometimes come and say they are very busy they'll come back in a minute, they do come back but it's longer than a minute or two." We asked people how quickly staff responded to their call bells. Another person said, "It depends how busy they are with others, one (care staff) said the other night 'we've got others you know'." A third person told us they had to wait, "Sometimes ten or 15 minutes."

A relative we spoke with told us staff treated their relation very well, but said, "Sometimes there are not enough of them (staff), they are running around all day." They went on to say, "There's even less of them at weekends."

Staff we spoke with also told us there was not always enough staff on duty. One member of staff said, "We do struggle with staffing." They went on to say there were a number of people who had high care needs and some people who were a high falls risks and it was difficult to monitor these people. Another member of staff said, "No not really (enough staff) in the morning one person has to do the medicines first, there isn't a member of staff in the lounge all the time and there is no call bell for people." A further member of staff told us, "Because there isn't always enough staff the people in the lounge are largely ignored." Staff told us that at a weekend there were usually three care staff and one cook in the building to manage people's care, laundry and cleaning needs and nutritional needs they said, "We often struggle."

Our observations reflected the comments made by people, visitors and staff. We also saw one person try to get up out of their chair a number of times whilst they were in the main lounge. The person could only walk safely with a frame but attempted to move without it. A number of people in this lounge area called to the person to sit down due to worries they may fall. However there were no staff present to see what was happening. Additionally there was no call bell for people to use to alert staff to this person's risk of falling. We felt it was necessary for us to intervene and alert staff to the risk of this person falling and assist the person back to their chair.

We saw yet another person was left to sit alone in a small lounge with the door closed for approximately two hours. The person had been given some breakfast but we did not see them being offered drinks during this time. When we asked staff about this they told us they were unable to safely keep the door open, the person did not have a call bell but staff told us the person would not have the capacity to use it. We saw that staff were not monitoring the person regularly. The person although mobile was frail and did not have the capacity to recognise risks to their safety.

Staff also told us there had been occasions when they had not been able to attend planned training due to a lack of staff. We discussed the staffing levels and the issues we found with the manager and asked how the staffing levels were determined. We found there had been no analysis of people's needs to determine the levels of staff required. This lack of analysis meant that at particular times during the day the staffing levels did not always meet the needs of people who lived at the service.

Not having sufficient numbers of staff is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The management of people's medicines was not always safe. Although people told us they received their medicines in a timely way majority of the time and staff we spoke with told us they had received training on safe handling and administration of medicines, we found some medicines had not been stored correctly. Some medicines had been received in December 2016 for one person and staff were required to enter them into their register and check them on a regular basis. We found this had not occurred. We highlighted this to the manager who assured us they would rectify this oversight. We also found there were some occasional gaps in individuals' Medicine administration record sheets (MARS). This meant some people had not been given their medicines and staff had not recorded a rationale as to why they had been omitted or the medicines had been given and staff had not signed to say they had been given. There was a lack of oversight around medicines management which meant these omissions and errors were not picked up and there was a continued risk that people may not receive their medicines as they should.

People we spoke with at the service told us they felt safe living at the home. One person told us, "Safe, yes definitely." Relatives we spoke with told us staff worked to keep their relations safe.

Staff we spoke with showed an understanding of the types of abuse people who they care for could be exposed to and what their responsibilities were in protecting people from abuse. One member of staff told us if they suspected or saw any inappropriate behaviour towards people they would feel comfortable raising this with the manager. They told us they had confidence the manager would deal with any issues related to safeguarding. They also told us they were aware they could report safeguarding issues to the local safeguarding team and the Care Quality Commission if their concerns continued.

We discussed safeguarding issues with the manager and saw they had responded to safeguarding issues that had been raised to them. They had worked with the local authority to keep people safe. We saw staff had received training to help them recognise and deal with safeguarding issues.

Requires Improvement

Is the service effective?

Our findings

People could not be assured that staff followed the principles of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS). 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 made on their behalf must be in their best interests and as least restrictive as possible.

People did not have their capacity assessed in a way that showed this had been done in accordance with the MCA. Although there were some references to people's mental capacity in some care plans the information was minimal. For example one person's care plan had documentation stating the person had mental capacity. However there was no information about how this assessment had been made or what aspect of the person's care it related to. Another person's care plan contained information in their communication care plan about the person's lack of coherent speech. The care plan noted the person lacked mental capacity. However there was no evidence to show the MCA had been followed in assessing their capacity or if and how a decision then needed to be made in their best interest and in the last restrictive way.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).
One person who was living with dementia attempted to leave the building during our visit, however they were unable to do so because staff told us the person would not be safe to leave the building alone. Another person living with dementia had resided at the service for a number of years. Their care plan showed that over the years the person had made numerous attempts to leave the building. There had been no application made for a DoLS order for these people. This meant the manager was not acting lawfully and complying with the MCA and people were being deprived of their liberty illegally.

Depriving someone of their liberty without lawful authority is a breach of Regulations 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not provided with the nutritional support they needed to maintain their health and wellbeing. During our visit we examined the records of one person who had lost 20kg in weight in six months. The person's dietary assessment in their care plan did not reflect their current needs. There were some contradictions in the person's assessment as it was noted they required some assistance when eating but also noted they were independent. The person's relatives and staff we spoke with told us the person required a great deal of assistance and encouragement to eat and drink. Despite the person's significant weight loss we were only able to find one entry to show staff had consulted the person's GP about their diet. Other than dietary supplements which had proved unsuitable for this person staff had not followed instructions from the GP and provided the person with a fortified diet. Whilst we found some fluid and nutrition charts there was lack of regular and continued recording of the person nutritional intake and

output, this meant there was a lack of oversight in relation to this person's diet and continued weight loss.

Fluid and nutritional charts had not been completed properly resulting in no oversight of this person's diet and identifying what additional support could be provided. This person was continuing to lose weight due to the lack of nutritional support.

People we spoke with gave mixed feedback about their meals. One person told us there was a lack of choice and we saw on the day of our visit there was only one option available for people at lunchtime. This contradicted information in the service's welcome pack which informed people there were two choices provided at each meal. Staff we spoke with told us it had been a recent management decision not to offer a meal choice at lunchtime due to the reduced numbers of residents to reduce waste.

We discussed people's different dietary needs with the cook and although they had knowledge of people's allergies and diets there was no records in the kitchen relating to people's individual needs. People's nutritional care plans did not always contain appropriate information for staff on people's dietary needs and this lack of recorded information put people at risk of receiving inappropriate diets. For example one person had an allergy to a certain food product and although this was recorded on their admission sheet it was not recorded in their nutritional care plan.

Failing to meet people's nutritional needs is a breach of Regulations 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People we spoke with told us they felt the staff were trained enough to know how to support them. One person said, "Yes they help me in and out of bed, they do that fine, they put the (bed) side up and I feel safe then." They went on to say, "They (staff) always put this (call bell) handy so I can reach it." Relatives we spoke with also felt the staff had the right training to support their relations. One Relative said, "One or two (staff) have been here a long time so they should be (trained)."

Staff we spoke with told us they had received training for their role and the new manager was arranging update training for them in areas such as first aid, fire safety, infection control and safeguarding adults. Staff said they were not always able to access on line training or attend face to face training as planned. They told us the manager had arranged for them to access the training online and a lap top computer had been purchased to ensure staff had access to a computer to enable them to undertake the training.

People told us they were able to see a GP and other health professionals when necessary. The service worked with two of their local GP surgeries but their welcome pack informed people they had the choice of staying registered with their own GP if they wished. One person told us, "I needed a doctor once and they got him, a district nurse comes in now and again, and a chiropodist." Relatives we spoke with confirmed that staff called the GP quickly if there were any health concerns and told us the staff fed back issues to them.

Staff we spoke with told us they tried to involve the families if there were health issues that needed addressing and work with health care professionals to ensure people received the healthcare they required One member of staff told us, "We have support from the district nurses." They went on to say they were trying to build relationships with the health professionals to ensure people's health needs were met. The service's welcome pack also informed people the service had a regular chiropodist service every six weeks.

Requires Improvement

Is the service caring?

Our findings

Whilst people told us some staff were caring and did anything they asked there were also some staff who people felt were not caring or interested in their welfare. One person said, "Some staff are more bothered than others". Another person said, "Some (staff) are (caring) some aren't." when asked for an example the person said, "If you ever speak and say I want this, they are not interested."

The feedback from relatives was that staff were caring towards their relations. One relative said, "The care they give (name) is good, they are lovely to them, but it's while they are doing things, there's no time for social chit-chat." Staff we spoke with felt there was a caring attitude among their colleagues. One staff member said, "Yes a lot of us have been here a long while and we care about people."

During our observations we saw there were occasions when staff did not acknowledge people or respond to their needs. Interactions were task orientated and many were performed by staff without any interaction with people. For example at lunchtime there were seven people seated in the dining room. We saw a member of staff walk the length of the dining room get something out of the dresser and walk out of the room without any interaction or acknowledgment of the people sitting in the room. On another occasion a person who for over an hour made loud vocal sounds whilst sitting with other people in the lounge area. It was clear that this was agitating other people in the room and during this staff made no attempt to engage positively with the person and see if there was anything they could do to support them. We were told this was a known behaviour for this person but there were no strategies in place to manage this.

Failure to treat people with dignity and respect is a breach of Regulations 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The people we spoke with told us they were able to express their views and make basic day to day decisions about their care. They told us they chose when they got up, the clothes they wore where in the service they spent their day. However, we could not find any further evidence that people or their relatives were involved with planning their care and relatives we spoke with told us they had not contributed to their relation's care plans.

People had access to an advocacy services when this was needed. An advocate is a trained professional who supports, enables and empowers people to speak up. The manager explained they had requested the support of an advocate for one person who was previously living at the service. There were no information displayed in the service for people on advocacy, however the manager told us they ensured people who may require the service were aware of the services available in the area.

People told us staff respected their privacy when providing care and treated them with dignity. Relatives we spoke with felt their relations were treated with respect. One relative said, "I have never seen staff talk to people disrespectfully."

Staff we spoke with told us they understood their role in relation to maintaining people's privacy and dignity. One staff member said, "Yes when we give personal care we close doors and knock on doors before going into someone's room."

However our observations showed that staff did not always treat people with care and respect and whilst they were discreet when discussing personal care the lack of positive interactions and management of people's behaviours showed their lack of understanding of manging people's dignity.

Requires Improvement

Is the service responsive?

Our findings

People did not receive the care and support they needed because known risks were not used to inform people's care plans of the care and support they needed. We looked at care records for a person who had been admitted to the service for respite care a month previously. Their care record contained a pre-admission assessment but no other information in the form of risk assessments and care plans to assist staff with this person's care. The person had been admitted to the service as they had fallen a number of times at home. Since being admitted to the service the person had fallen again and sustained a serious injury. The person told us they needed a frame to assist them when walking but they often forgot to use it and staff needed to remind them. This information was not recorded in the person's records to assist staff manage the person's care.

People's care plans did not contain the information needed to provide them with care that was individual to them and addressed their specific needs. One person's care record contained two nutrition care plans, one was undated and gave some information on the person's nutritional likes and dislikes. The second plan was dated as being completed in February 2013. The plan noted the person had lost weight since admission and they had a tendency of taking other people's food. The care plan noted that staff should prevent the person from taking other people's food but gave no information about the way this should be done or any strategies on avoiding this behaviour. The plan also lacked any information about what measures were in place to manage the person's weight loss.

This person's care plan had dates to show there had been monthly reviews of its contents up to December 2016, however one of the reviews stated the person still needed supervision when eating, but this was not in the care plan. This review should have triggered changes to the care plan to ensure staff had up to date knowledge of the person's needs.

We examined other aspects of the person's care plans, all of them were completed in 2013 and had been reviewed monthly. One care plan which covered maintaining a safe environment for the person noted they had no insight to their own or other people's safety but lacked information on how staff should manage this. One monthly review noted the person had challenging behaviour at times, again this was not noted on the care plan and there was no information for staff on how this behaviour could be managed. Further information in the care plan noted when the person was first admitted to the service they regularly tried to leave the building but staff we spoke with told us the person no longer did this.

Whilst people told us staff were quick to get support from health professionals and we saw these visits recorded on the visiting health professionals sheets in people's care plans, the outcome of the visit was not always transferred into their care plans. For example one person who had a number of falls had been diagnosed with a health condition. This information and how to manage the person's health condition was not in their mobility risk assessment or care plan. This meant staff may not have been managing the person's need appropriately.

Failing to assess and mitigate risks to people is a breach of Regulations 12 of the Health and Social Care Act

2008 (Regulated Activities) Regulations 2014.

There was a lack of support for people to follow their interests and take part in social activities. The people and relatives we spoke with told us there was a lack of stimulation for people. We asked people what they did during the day and one person said, "Nothing they (staff) are too busy." Another person said, "Just sit about, do nothing. All they've got is that box to watch (television). The television bores me after watching it all day." We spoke to one person who preferred to spend time in their room rather than sit in one of the lounge areas. They said "I used to sit down there in the front lounge with two friends but they've gone now. Here I can knit, watch telly, do my crossword rather than just sit and look at one another."

People and relatives we spoke with raised concerns about the outside of the home which was in need of maintenance, two sides of the garden were uncultivated, and there were black plastic sacks laying on the ground in the court yard. One relative said, "They are trying to tidy it up but I wish they'd do something with the outside, there's nowhere for them (relation) to sit." We spoke to the manager who told us they were planning to improve the outside areas so people could sit out in the summer.

Staff we spoke with told us there were no organised daily activities for people, but that a person came in twice a month to facilitate a reminiscence session and there was another person who facilitated an exercise session twice a month.

Our observations supported the comments regarding the lack of a stimulating environment for people. Although the television in the main lounge was switched on it was positioned in a way that meant only two of the seven people in the lounge could view it. The volume was insufficient to enable programmes to be followed and the remote control was place on a high shelf that people could not reach. Throughout the service there was a lack of signage to help people with orientation around the home. The pictures and clocks on the walls were mounted above six feet and were out of eye line of people who lived in the home.

The lack of person centred care for people is a breach of Regulations 9 of the Health and Social Care Act 2008 (Regulated activities) regulations 2014.

There was a complaints procedure on display to inform people how to raise concerns and people and their relatives told us they knew who to raise concerns with when they had them. One relative told us they had raised things with the care staff and these had been addressed.

Staff we spoke with understood their responsibilities in managing complaints and concerns made to them. One member of staff told us, "If it was something could deal with I would. If it was something I couldn't sort I would go to [manager] and I would document it."

We saw the manager had kept a record of complaints and concerns and their responses to them and had followed the company's complaints procedure for responding to concerns and complaints.

Requires Improvement

Is the service well-led?

Our findings

During our visit we asked to view a range of quality audits that would show how the quality of the service was being managed. For example environmental, care plan and medication audits, an also any audits and analysis undertaken on falls and accidents in the home. From our observations of the documentation relating to people's care we saw there were a number of areas that would have benefited from a regular auditing and analysis. For example the care plans we viewed had been reviewed monthly but an analysis of the contents would have shown that the information contained in a number of them was not reflective of people's needs.

There was also a lack of records relating to environmental checks such as checks on emergency lighting and that unoccupied rooms had infrequently used water outlets (including showerheads and taps) flushed out at least weekly to prevent legionella bacteria forming. Regular auditing of these activities would have established that this essential maintenance had been undertaken. However none of these audits were available to us and since being in post the manager had not undertaken any of these quality audits.

Although the owner of the company came to the service regularly, this did not provide effective oversight of the service. We asked relatives if they had met or seen the owner. One relative said they had seen them in the service but had not been introduced or spoken to them and they were not a visible presence at the service. The owner did not carry out any audits or commission companies to carry out audits such as health and safety audits. This meant the owner did not have effective oversight of the service and as a result were not aware of the lack of issues that affected people's safety. This systematic failure to manage and maintain the quality of the service has led to the reported breaches of regulations in other areas of the service which resulted in people being placed at significant risk of physical and psychological harm.

The failure to establish and operate systems to assess, monitor and mitigate against risks relating to the health, safety and welfare of people who used the service is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service was in the process of deregistering the regulated activity 'Treatment of disorder, disease or injury' and as a result no longer had nurses working at the service. This change had impacted on the roles of the care staff at the service. Staff told us there had been some big changes to their roles in the last three months. One member of staff said, "There is a lot of responsibility on the carer's heads now there are no nurses." This change had had a negative effect on staff morale.

Staff were not supported with regular oversight of their roles or practice. Staff we spoke with told us they had not received regular supervision to support them in their roles and could not recall when they had last had an appraisal. The records we viewed showed staff had not received any formal supervision since June 2016. Staff told us there had been one staff meeting arranged when the manager was first in post but we were unable to view the minutes of the meeting to establish what issues were discussed. The manager told us they had been observing staff whilst they undertook their safe management of medicines training but there had been no other recorded checks on staff practices. The lack of a clear staffing structure contributed

to the lack of support for staff and the lack of regular formal supervisions and appraisal meant the manager could not be sure that all staff had an understanding of what was expected of them in their roles. This could impact on the quality of care given to people.

The lack of support from the provider had meant the manager had not been as effective in their role as they could have been. The manager had been working with the local authority to improve aspects of the service and we saw from the action plan in place the manager had not completed a number of the actions set. Such as improving the quality of the care plans and reviewing some of the service's policies to ensure they met the needs of the service. This was as a result of a lack of recognition from the provider of the manager's workload. And the expectation that the manager should to cover short falls in staffing by working shifts as a care worker as well as undertaking their own role.

However people, relatives and staff told us the manager was approachable and open with them. One relative said, "Yes I have been able to discuss things I am worried about with (manager)." Another relative told us the manager had approached them when they had visited their relation and was easy to talk to.

Staff we spoke with told us the manager had an open door policy. They told us the manager was approachable. They said they felt comfortable making any suggestions to make improvements within the home.

The previous registered manager had left the service in December 2016 and the present manager was not yet registered with the Care Quality Commission (CQC) for registered manager status however their application was in progress. It is a condition of their registration for the provider to have a registered manager in post to manage the service who is aware of their responsibility for reporting significant events to the Care Quality Commission (CQC).

We found staff were aware of the organisation's whistleblowing and complaints procedures. They felt confident in initiating the procedures and told us they felt the manager would act appropriately should they raise concerns. One member of staff told us, "If I had concerns I would be listened to."

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 Lack of person centred care for people

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect Failure to treat people with dignity and respect

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Failing to assess and mitigate risks to people and lack of effective monitoring of people's health needs

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 Depriving someone of their liberty without lawful authority

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs Failing to meet people's nutritional needs

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment Failure to ensure the premises and equipment used by people is properly maintained

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Failure to establish and operate systems to assess, monitor and mitigate against risks relating to the health, safety and welfare of people who used the service

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Not having sufficient numbers of staff to meet the needs of people who use the service