MPS Care Homes Limited

Lound Hall

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

We inspected Lound Hall on 14 and 15 March 2017. The inspection was unannounced. Lound Hall is a situated in the village of Lound in North Nottinghamshire and is operated by MPS Care Homes Limited. The service is registered to provide accommodation for up to 30 older people some of whom are living with dementia. At the time of our inspection 16 people lived at the home.

We inspected this service in October 2016 and the service was rated as requires improvement. During this inspection we found that the required improvements had not been made and found concerns in relation to the quality and safety of the service. This resulted in us finding multiple breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These breaches were in relation to person centred care, dignity and respect, safe care and treatment, meeting nutritional and hydration needs and good governance.

There was no registered manager in post at the time of our inspection, the previous registered manager deregistered in June 2016. 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. There was a service manager in place during our inspection who had taken over responsibility for the day to day running of the service in October 2016. They informed us that they would be submitting an application to register as manager for the service. We will monitor this.

During this inspection we found that the systems in place to reduce risks associated with people's care and support were not always effective and this exposed people to the risk of harm. In addition to this people were not protected from risks associated with the environment.

Medicines were not managed safely and people did not always receive their medicines as prescribed. We found multiple concerns relating to how people were supported to eat and drink. People were not supported to maintain adequate hydration or nutrition and this placed people at risk of malnutrition and dehydration.

People did not always receive appropriate care and support as there were not enough staff employed and staff were not always deployed effectively. Staff did not always receive suitable training or support to enable them carry out their duties effectively and meet people's individual needs. Staff were not provided with regular supervision and support.

People's day to day health needs were met, however, there was a risk that people may not receive appropriate support with specific health conditions due to a lack of information in care plans.

People's rights under the Mental Capacity Act (2005) were not always respected. Where people had capacity

to make decisions they were not consistently asked for their consent before staff provided support or assistance.

People's right to privacy was not respected and they were not treated with dignity. Some staff were kind and caring in their approach, however other staff were focused on tasks and had limited interaction with people who used the service.

People were not provided with the opportunity for meaningful activity and many people who used the service spent their time unoccupied. Staff did not always respond appropriately to people's needs for support and reassurance.

People were at risk of receiving inconsistent and unsafe support as care plans did not provide an accurate or up to date description of people's needs. Action was underway to improve care plans and people and their families were involved in this work.

People and their families knew how raise issues and concerns, however systems in place to monitor and respond to complaints were not used effectively.

There was a lack of effective governance which put people at risk of receiving poor care. There was an absence of quality monitoring systems which meant that areas of concern had not been identified. In addition to this timely action was not taken in response to known issues.

People who used the service were not offered opportunities to give their views on how the service was run. Despite this people felt able to share concerns with the management team.

The management team were responsive to our feedback and developed an action plan in response to the concerns identified during this inspection.

Given the issues identified above the overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration. For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Systems in place to reduce the risks associated with people's care and support were not always effective and this exposed people to the risk of harm.

People were not protected from risks associated with the environment.

People did not always receive appropriate care and support as there were not enough staff employed and staff were not always deployed effectively.

Medicines were not managed safely and people did not always receive their medicines as prescribed.

Is the service effective?

Inadequate

The service was not effective.

People were not supported to maintain adequate hydration or nutrition and this placed people at risk of malnutrition and dehydration.

People's rights under the Mental Capacity Act (2005) were not always respected. Where people had capacity to make decisions they were not consistently asked for their consent before staff provided support or assistance.

Staff did not always receive suitable training or support to enable them carry out their duties effectively and meet people's individual needs. Staff were not provided with regular supervision and support.

People's day to day health needs were met, however, there was a risk that people may not receive appropriate support with specific health conditions.

Is the service caring?

Inadequate

The service was not caring.

People's right to privacy was not respected and people were not treated with dignity.

Some staff were kind and treated people with respect, however other staff were focused on tasks and had limited interaction with people who used the service.

People were not provided with information in a way that was accessible to them.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People were not provided with the opportunity for meaningful activity and many people who used the service spent their time unoccupied.

Staff did not always respond appropriately to people's needs for support and reassurance.

People were at risk of receiving inconsistent and unsafe support as care plans did not provide an accurate or up to date description of people's needs.

People and their families knew how raise issues and concerns, however systems in place to monitor and respond to complaints were not effective.

People and their families were involved in planning their care and support.

Is the service well-led?

Inadequate

The service was not well led.

There was a lack of effective governance which put people at risk of receiving poor care. There was an absence of quality monitoring systems which meant that areas of concern had not been identified.

Timely action was not taken in response to known issues.

People who used the service were not offered opportunities to give their views on how the service was run. Despite this people and staff felt able to share concerns with the management.

The management team were responsive to our feedback and developed an action plan in response to the concerns identified

during this inspection.

Lound Hall

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, to follow up on information received and to provide a rating for the service under the Care Act 2014.

We inspected the service on 14 and 15 March 2017. The inspection was unannounced. 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 which the provider is required to send us by law. We also contacted commissioners (who fund the care for some people) of the service and asked them for their views.

During the visit we spoke with eight people who used the service and the relatives of three people. We spoke at length with three members of care staff, a member of the catering team, a nurse, the deputy manager, the service manager and the managing director. We also spoke with a health and social care professional who regularly visited the service.

To help us assess how people's care needs were being met we reviewed five people's care records and other information, for example their risk assessments. We also looked medicines records, staff recruitment and training records, as well as a range of records relating to the running of the service.

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.

Inadequate

Is the service safe?

Our findings

We found serious concerns about the safety of the service and the ability of staff to protect people from the risks associated with their care and support. Risks to people's health and safety were not always appropriately assessed and steps were not taken to reduce the risks.

People were not protected from the risk of choking. One person's care plan stated they were at risk of choking, however the care plan and risk assessments did not detail any measures to reduce the risk of choking and the information was contradictory and confusing. On the first day of our inspection visit we observed the person eating food which their care plan stated put them at risk of choking. Throughout this period there were no staff present in the area which meant had the person choked staff would not have been aware of this and consequently would not have been able to respond to provide emergency first aid. The lack of clear guidance and failure to ensure staff supervision put the person at risk of choking and consequent harm. We brought this to the attention of the service manager who acknowledged that this risk had not been addressed appropriately.

On the second day of our inspection visit we observed that the person referred to above was served pureed food. Again they were left alone to eat the food. A pureed diet had not been recommended in the most recent speech and language therapy report and the risks of the person aspirating on the food had not been considered or planned for. Despite bringing the risk of this person choking to the attention of the service manager the previous day the person was again placed at risk of harm.

Safe moving and handling techniques were not always followed. We observed staff attempting to move a person by lifting them under their arms, this is not a safe moving and handling technique and could result in harm or injury. Part way through this manoeuvre staff changed technique and brought a hoist and sling to transfer the person. We observed that the sling used for the transfer was not the correct type and this put the service user at further risk of harm and injury.

People were not always protected from the risk of skin damage. Although people had equipment and checks in place to reduce the risk of pressure ulcers staff did not consider the impact of other factors on people's skin integrity. For the duration of our visit the service was exceptionally warm and despite this a number of people were in bed under multiple blankets and sheets for long periods. We listened to a staff handover in which a nurse shared information about the health of each person who used the service. The nurse shared that one person had sustained skin damage, they stated that "it had been a very hot day" and this had potentially led to the person sweating and consequent skin damage. This may have been preventable had timely action been taken to identify the risk and act upon it.

Accidents and incidents were not consistently recorded which may mean that opportunities to prevent future incidents may be missed. One person slipped from their chair on the first day of our inspection visit, although staff had taken appropriate action to reduce the immediate risk we reviewed accident and incident records and found that this incident had not been recorded. We discussed this with the management team who had not been made aware of the incident and were unsure if it should be recorded

as an accident. Furthermore the service manager informed us there was no system in place for analysing patterns of accidents and incidents across the service. This inconsistency of recording, lack of clarity in accident reporting processes and absence of accident analysis meant that clear information was not available about incidents and consequently posed a risk that opportunities to reduce the likelihood of further incidents may be missed.

Call bells were not always left within people's reach and we found instances where call bells did not reach beds resulting in people potentially being unable to summon help in the event of an emergency. One person resided on the second floor of Lound Hall, an area which was not always supervised by staff. This person's call bell lead did not extend to reach their bed. This placed them at risk of not being able to summon help in the event of an emergency. Records showed that the person was checked hourly overnight which meant that they could potentially go up to an hour without being able to summon help from staff if required.

We also observed that another person, who spent the day in bed, was left without access to a call bell for a period of three hours. Of particular concern was the fact that staff had recorded that the call bell was 'accessible' to the person, which was incorrect. This inability to summon help in the event of an accident or emergency exposed people to the serious risk of harm. We discussed this with the service manager who was not aware of this issue and told us that many people didn't routinely use their call bells. We were informed later in the inspection visit that improvements would be made to the call bells to ensure that people could access them.

People were not protected from risks associated with the environment. We saw large heavy items in rooms, such as wardrobes, were unstable and had not been secured to the walls. This put people at risk of sustaining injury from falling objects. This risk was exacerbated by the nature of people's support needs which meant that some could be unsteady on their feet at times and may potentially hold on to furniture to steady themselves. Records showed that one person was at risk of falling. We found furniture in their bedroom which had not been secured to the wall and may have of become unstable should they have used it to steady themselves. This put people at risk of serious harm and injury.

Window restrictors had not been installed on all windows and consequently people were not always protected from the risk of accident and injury. There were no effective window restrictors in two bedrooms on the second floor of the building, windows opened allowing adequate space for a person's body to fit through. A resident of one of these rooms was independently mobile and consequently this posed a risk of them falling from the window and resultant injury. This exposed people to the serious risk of harm which could have been avoided had adequate risk assessments and maintenance checks been in place.

We informed the service manager and managing director about our concerns of environmental risks and during the second day of our inspection visit they took action to secure large items and to install window restrictors. However it remains of concern that these risks had not been identified prior to our inspection.

People were not adequately protected from risks to their health. We identified risks in relation to legionella. Legionella is a bacteria that can develop in stagnant water and can lead to a fatal form of pneumonia. There was no legionella risk assessment in place and formal checks and maintenance of the water system had not been conducted since December 2016.This meant that not all steps had been taken to reduce the risk of legionella developing in the water supply. This risk was exacerbated due to the age of the building, number of empty rooms and in addition, people living at Lound Hall were at increased risk of developing Legionnaires disease due to their age. Following our inspection the provider informed us that checks had been reinstated and a risk assessment was planned.

Medicines were not always administered safely. On the first day of our inspection visit we observed that a member of staff found a tablet tucked into a person's clothing. We spoke with the nurse who informed us that the person should be observed when taking medicines to ensure that they had taken them safely. We also reviewed medicines records which documented that the person had taken all of their medicines as required. This demonstrated that the correct procedures were not being followed and this resulted in people being placed at risk of not receiving their medicines as prescribed.

Furthermore, after finding the tablet the member of staff, who was not authorised to administer medicines as part of their role, handed the tablet to the person who swallowed it. The staff member did not consult the nurse to ensure that the medicine belonged to the person. This put the person at risk of ingesting medicine that may not have been prescribed for them.

People did not always receive their medicines as prescribed. We found multiple gaps in Medicine Administration Records (MARs). Although some of these were recording errors there was one case when a person had not received their medicines as required. This person was prescribed patches for pain relief which were changed daily. MARs showed that the patch was not administered for one day the week prior to our inspection. This failure to administer medicines as required exposed the person to the risk of experiencing unnecessary pain and suffering. Where people were prescribed creams for topical application there were not always clear details of how, where and why these creams should be applied and staff did not always record the application of these creams.

Medicines errors had not always been identified and this posed a risk that people may not receive their medicines as prescribed due to medicines running out. We found a dose of medicine was missing from one person's medicines. We reviewed incident records and found no evidence that this had been reported and consequently no action had been taken in response to this. This put the person at risk of not receiving their medicine as prescribed.

All of the above information was an ongoing breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The people we spoke with gave mixed feedback about staffing levels. One person told us they felt staff would respond quickly if they pressed their call bell for assistance, however another person told us this was not always the case and they sometimes had to wait up to 30 minutes. The relatives we spoke with also provided mixed feedback. Whilst the relative of one person told us there were sufficient staff, another relative gave specific examples of instances when there had not been enough staff to support their relation when they required it.

During our visit we observed that there were occasions where staff were not deployed effectively to meet people's needs in a timely way due to them being busy elsewhere in the home. For example, the lunch period lasted for nearly two hours because staff were not deployed effectively to assist all the people who needed support to eat. Lunch started at approximately 12:15pm however one person did not receive their lunch until 1:40pm as staff were busy supporting others.

There were occasions where there were not sufficient staff employed to ensure that the service was staffed to the level determined as safe by the provider. This was a particular issue when there were last minute staff absences such as sickness. The service manager told us that three staff were required during the day to provide safe care and support. We reviewed the rota and found two occasions within the three weeks prior to our inspection where there had only been two care staff on shift during the day. A member of staff told us this made it hard to meet people's needs in a timely way.

We discussed staffing levels with the service manager who told us that some care staff had recently left and they were in the process of recruiting to these posts. Following our inspection visits the provider submitted an action plan which stated that they would implement a dependency tool to ensure that staffing levels were based upon the needs of the people living at Lound Hall.

People could not always be assured that safe recruitment practices were followed. We found that staff had been employed without disclosing a reason for leaving their previous employment which meant that the provider was not able to take all information into account when making a decision about recruitment. References had been sought from previous employers. However, where previous employers had provided a very basic reference which only included confirmation of the dates the person was employed, further character references had not been sought. In addition to this we found that identification and photographs were not always retained in staff files as required. This put people at risk of being supported by unsuitable staff. We discussed this with the service manager who informed us that provider's human resources department were planning to do some work on staff recruitment processes.

There were systems and processes in place to minimise the risk of abuse. Staff we spoke with had an understanding of how to recognise allegations or incidents of abuse and understood their role in reporting any concerns to the management team and escalating concerns to external agencies if needed. Records showed that the service manager had shared information with the local authority safeguarding adult's team for two recent incidents. However we were informed about a number of incidents where people had missed their medicines. Although the manager had taken action to investigate the incidents and remove the immediate risk to people's safety this information had not been referred to the local authority safeguarding team. This meant that opportunities for sharing information to safeguard people who use services may have been missed.

Inadequate

Is the service effective?

Our findings

People were not supported to maintain adequate hydration or nutrition. During this inspection we found multiple concerns relating to how people were supported to eat and drink.

Where people were prescribed specific diets, food was not always served in line with that recommendation. The advice contained in care plans in relation to dietary requirements lacked detail and was not always accurate. One person had recently lost weight, the information in their care plan about their diet was confusing, contradictory and incomplete. We observed that the food served to the person differed from guidance in their care plan and speech and language therapy (SALT) assessment. For example their care plan stated the person should not eat the crusts of bread however on the first day of our inspection we observed that the person was served sandwiches with crusts on. On the second day of our inspection the person was served a pureed diet, this was not referred to anywhere in their care plan or advised by the SALT. This failure to provide the correct diet not only exposed the person to the risk of further weight loss but also put them at risk of choking.

People did not receive the necessary prompts and encouragement to promote good nutritional intake. The interaction between staff and people who used the service at meal times was minimal and task focused. The care records of another person showed that they had recently lost weight and a recent reduction in their appetite placed them at risk of further weight loss. At lunchtime on the second day of our inspection this person was served food but did not make any attempt to eat it. They were not prompted, encouraged or assisted to eat and after a short time a member of staff cleared their untouched meal away. This failure to offer any support or assistance put the person at risk of further weight loss.

People were not always served food at an appropriate temperature. On the second day of our inspection visit one person was served their lunch in their bedroom, this was left on their overbed tray. They did not make any attempt to eat the food and thirty minutes later a member of staff offered to assist them to eat. At this point we intervened to enquire if the food was still warm, the member of staff told us it was warm, however we checked and found the food to be cold. This failure to ensure food was served at an appropriate temperature did not promote good nutritional intake and put the person at risk of malnutrition.

Recording in relation to nutritional and hydration intake was not completed accurately or effectively so as to reduce the risk of dehydration or weight loss. Although fluid charts were kept for people who had been identified as being at risk of dehydration these were not effective as they had not been fully completed and there was no evidence that the records were analysed to identify if people had consumed enough fluid. For example fluid records for one person documented that they had only consumed 1400ml for a period of nine days. As no analysis had been conducted on these records this person's lack of fluid intake had not been identified by the staff team. This placed the person at extreme risk of dehydration and following our inspection the local authority safeguarding adults team were informed of these concerns.

Other fluid records were completed in a tokenistic manner which made it hard to ascertain how frequently people were being offered fluids, for example one person's fluid records documented that they had been

offered drinks whilst they were asleep. We found that records of nutritional intake were also inaccurate. The food records of another person documented that they had 'toast and yoghurt' for breakfast however we observed that they were actually served porridge. The above inadequacies in recording meant that we could not be assured that timely action would be taken to identify or address any concerns and exposed people to the risk of malnutrition and dehydration.

Systems in place to ensure that people received prescribed dietary supplements were not effective. Recording was confusing and inaccurate which made it very hard to ascertain whether or not people had taken their supplements as prescribed. One person was prescribed dietary supplements twice a day due to recent weight loss, medicines records showed that the person had taken their supplement, however this was not recorded on food and fluid charts and a member of staff told us that the person had not taken their supplements for 'the past couple of days'. These inadequacies in recording put people at risk of malnutrition and dehydration.

Although drinks were made available throughout the day staff did not always ensure that they were left within people's reach. One person had been provided with drinks which were left on their overbed table, however we observed that they were unable to reach the drinks. A representative from the local authority, who was visiting the home, intervened and assisting the person to drink and they consumed a significant amount. This failure to ensure that drinks were accessible to the person placed them at risk of dehydration.

Where people required thickened fluids care plans did not contain adequate detail and staff were not appropriately skilled to ensure these were administered as intended. One person's care plan stated that they required their drinks thickened to 'yoghurt consistency'. There was no guidance in the care plan about how much thickener should be used to achieve this and staff knowledge in this area was variable. During our inspection we found that this person's drink had been thickened too much and a member of staff told us that this happened frequently. This failure to ensure the correct consistency fluids were provided put the person at risk of dehydration, as thickened fluids can take longer to drink, and this also posed a risk of choking.

All of the above information was a breach of regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People received care and support from staff who did not all have the skills and qualifications necessary to support them safely. We were not provided with any evidence that staff had been trained in the safe administration of medicines. The service manager told us that they were unable to locate any records of this and were assuming the position that staff had not had training in this area. In addition to this, although records showed staff had training in dementia, we observed that staff did not have a good understanding of dementia and the impact this could have on people. This was supported by feedback from the relative of a person who lived at the home who told us that staff did not have an understanding of their relation's condition, they went on to tell us that they had created an information resource for staff to try to increase staff knowledge.

The above insufficiencies in staff knowledge and skill placed people at risk of not having their needs met appropriately or safely. We spoke with the service manager about this who informed us that they were planning to arrange training focused on the needs of people who live with dementia. Following our inspection visit the service manager also shared their plans to ensure that all nurses had up to date medicines training.

In spite of the above, training records showed that most staff had received training in other areas such as

safeguarding, moving and handling and infection control. Some staff had also received training about the specific needs of people who used the service including diabetes and sensory impairment. Staff we spoke with told us they felt they had enough training and were supported to undertake further qualifications.

The service manager told us that staff did not currently complete the Care Certificate but added that they may be introducing this in the future. The Care Certificate is a set of national standards for staff working in health and social care to follow and equip them with the knowledge and skills to provide safe, compassionate care and support.

Staff did not receive regular supervision. Records showed that although most staff had received one recent supervision session they had not had any supervisions prior to this. This meant that staff were not given regular formal opportunities to access support and reflect on their practice. We discussed this with the service manager who was aware of this and informed us that they had put a plan in place to rectify this.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. We checked whether the service was working within the principles of the MCA.

People could not be assured that their rights under the MCA were protected as the principles of the Act were not always correctly applied. As the result of a recent audit conducted by the local authority the service manager had taken action to implement some new mental capacity assessments. We found that these new assessments respected people's rights and were compliant with the MCA, however this was not the case for all people who used the service. We found decisions were made on some people's behalf without first assessing if the person had the capacity to make the decision themselves. For example, one person lacked the capacity to consent to the presence of a motion sensor in their bedroom which monitored their movements, there was no mental capacity assessment or best interests decision in place for this decision. We also found people's capacity had been assessed when there was not a specific decision being made. This approach did not respect people's rights under the MCA. The service manager informed us that improvements to the assessment of people's mental capacity were ongoing.

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). During our October 2016 inspection we found that DoLS applications had not been made as required, this was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. During this inspection we checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We found that the required improvements had been made in this area. The service manager had made applications for DoLS where appropriate, the majority of these were awaiting authorisation from the local authority DoLS team. Where DoLS had been granted the conditions were being met as required.

People were not always asked for their consent before staff provided support or assistance. Although we saw occasions where staff did gain people's consent we also saw other instances where staff did not interact with the person they were supporting to let them know what they were going to do or to gain their consent. For example, at lunch time we saw staff put clothes protectors on people without offering a meaningful choice of whether they wanted to wear a clothes protector or not.

People were supported to attend appointments and access healthcare. Staff we spoke with told us that people were enabled to attend appointments as needed. Records showed that people were supported to access the GP and other health professionals such as dentists, opticians and attend hospital appointments. The outcomes of these appointments were recorded in people's care records.

Where people had specific health conditions we found that care plans did not consistently contain adequate detail in relation to people's health needs. Whilst some people's care plans contained some information about health conditions other plans contained very limited or contradictory information. For example, an assessment conducted prior to a person moving into Lound Hall stated that they had a particular health condition, however their care plan did not contain any further information about this condition. Although we found that this has not resulted in any impact on the person this did place them at risk of not receiving the appropriate support.

Inadequate

Is the service caring?

Our findings

Throughout our inspection we observed instances where people's dignity was not respected by the staff team. One person who used the service was reliant upon staff to attend to their personal care needs and to promote their dignity. This person was unable to leave their bedroom and throughout our inspection visit we found instances where this person had been left in an undignified state by staff. Their bedroom had an unpleasant odour and on two occasions we found that their room had been left in an unhygienic state with crumbs and dried food on the table they were sitting at. On the second day of our inspection visit we observed this person had dropped a significant amount of food on their clothing. They were not assisted to change their clothes for a further three hours. This left the person in an undignified and potentially degrading state for a prolonged period of time and did not respect their right to dignity.

Where people did not have capacity to consent to their care and treatment staff did not always respect their dignity. One person lacked the capacity to make decisions in many areas of their life. On the second day of our inspection visit we went into this person's rooms and found that they were having their hair styled by the hairdresser, at the same time as they were being assisted to eat by a member of staff. We questioned this arrangement and the hairdresser told us they were busy and they needed to 'fit it in' before they left. This did not respect the person's right to be treated with dignity and respect and could have been confusing and potentially distressing to the person.

People's privacy was not always respected. On the first day of our inspection visit a staff handover was held in the foyer of the service. This was a communal area and people were free to access the area during the meeting. Sensitive personal information about each person who used the service, including health conditions and personal care needs, was shared in the meeting and could potentially be overheard by others. This did not respect people's right to privacy. We spoke with the service manager who told us they had not considered that this arrangement did not respect the privacy of people who used the service. They informed us that handover would now be held in a private area, however it remains of concern that this had not been identified prior to our inspection.

Signs displayed in people's rooms did not promote their dignity or respect their privacy. We saw signs relating to people's continence needs displayed in two bedrooms. This information would be visible to family, friends and other visitors. This did not promote people's dignity or respect their right to privacy. We spoke with the service manager about this who informed us that they had asked for the signs to be implemented in response to incidents of staff using the wrong continence aids on people. It is of concern that this was deemed an appropriate way of sharing information with staff.

The language used by staff to describe people who used the service was not always dignified. We heard staff referring to 'toileting' people and the care records of one person stated that they were 'self-washing' to describe the fact that they were independent in their personal care. This language did not promote respectful, dignified support.

We observed multiple occasions where staff entered people's bedrooms without knocking or requesting

permission to enter, demonstrating a lack of regard for their private space. For example, we observed two occasions where a member of staff entered one person's bedroom without knocking or announcing their presence. This failure to request permission before entering people's bedrooms did not respect their right to privacy.

All of the above information was a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following our inspection the provider submitted an action plan which stated that all staff would attend dignity and respect training and group supervision would be provided to staff to try and address cultural practices within the home.

Despite the above, people told us they felt staff were caring. One person told us, "Yes I am very happy with the care here. They (staff) are always courteous and polite." Another person commented, "We are lucky to get looked after." Feedback from relatives was more variable, whilst some relatives were positive about the support provided at Lound Hall, one relative commented on the lack of person centred care and told us, "Everyone with dementia is treated exactly the same."

We observed some positive interactions throughout our visits. Some staff treated people as individuals and demonstrated an understanding of how to encourage and support them to be involved in day-to-day decisions. For example, we observed a member of the nursing team who had a good rapport with a person who used the service, they discussed the person's history and offered the person a choice about the administration of their medicines. In contrast, other staff were focused on tasks and had limited interaction with people who used the service. For example we observed one person, who was unable to communicate verbally, being assisted to eat their lunch. The support provided was task focused with very little communication from the member of staff, they did not describe their actions or demonstrate any knowledge of what mattered to the person.

People could not always be assured that information would be communicated to them in an accessible manner. Some aspects of the environment and systems within the home did not take account of people's communication needs and memory impairments and therefore did not maximise people's decision making ability or promote choice. Adaptations had not been made to the environment to take account of people's dementia related needs. There was no accessible signage around the building to facilitate people's orientation, people's bedroom doors did not have any unique signage to enable them to identify their own rooms. During our visit we found that a number of people were confused about where there rooms were, although it is acknowledged that this was, in part, the nature of the conditions that people lived with no effort had been made to adapt the environment. We also observed a number of clocks in bedrooms and communal areas that were not working or were inaccurate, this may have been confusing and disorientating for people who were living with dementia.

In addition to this staff did not always communicate with people in the most appropriate or accessible manner. One person who used the service told us that they felt that staff sometimes spoke to them in a childish manner. Staff didn't always know how best to communicate with people, one person required more time to process information, however we were informed that staff did not all have an understanding of this and instead giving the person time repeated instructions.

People's care plans contained limited information about their interests, preferences or their life history. Whilst we found that some staff had an understanding of what mattered to people we saw little evidence that this was used to inform their care and support. We spoke with the service manager about this who told

us that they knew what was important to people and the next step was to ensure that those things were present in people's lives. However this work had not yet started. This meant that people's individual needs were not always considered.

People were involved in some decisions related to their care and support. The service manager was in the process of developing new care plans for every person who used the service. As part of this process they had met with the person and, where appropriate, their families to ensure that they were involved in decisions about their care. The service manager told us that they had learnt a lot about what was important to people as a result of this, however much of this information had not yet been incorporated into care plans and so had not yet had an impact on people's care and support.

During our visit we observed that there was no information about advocacy displayed in the service and there were no links with a local advocacy service. This meant people may not be enabled to access an advocate to support them to express their views if they wished to. Advocates are trained professionals who support, enable and empower people to speak up. The service manager explained that as they were not aware of a local advocacy provider, they would contact the person's social worker if they thought someone might need an advocate to help them speak up.

Whilst we observed that people's bedrooms were personalised and homely we also saw that some bedrooms had a toilet within the room rather than a separate en-suite. Although toilets were surrounded by a curtain this was not dignified. However we observed that at present the majority of these rooms were vacant.

Requires Improvement

Is the service responsive?

Our findings

The care and support provided at Lound Hall did not always meet people's needs or reflect their preferences. There was a significant lack of any meaningful activity. During our inspection we observed that people living at the home lacked meaningful occupation, other than visits from friends and relatives. People's routines were dominated by meals and personal care and the remainder of the time people were in their bedrooms or communal areas listening to music, watching TV or sleeping. One person who used the service told us, "I spend most of my time in my room, we don't have much to do, no activities and things. I do go down to eat and that's it really."

A number of people spent long periods of time in their bedrooms alone and staff made little attempt to interact with people socially or provide the opportunity for occupation. This did not meet people's social needs and may have had an impact on their wellbeing. Due to a health and safety issue one person was unable to leave their room to access other areas of the service. Throughout our inspection we observed that this person was unoccupied, other than for the purposes of personal care and meals. Even though it was known that this person was unable to leave their room to no plans were put in place to provide meaningful interaction and stimulation. This lack of interaction did not meet the person's needs and put them at risk of social isolation.

We discussed the lack of meaningful occupation with the service manager who was aware that people were not provided with any opportunities for activity. They told us that this was an area for development but work had not yet started.

Staff did not consistently demonstrate insight or compassion into the impact of people's conditions on their mental health and did not act appropriately in response to people's distress and anxiety. One person who used the service had dementia. They were in bed for the duration of our visit and throughout this time we observed that interactions with staff were task focused and brief. Over the lunch time period on the second day of our inspection we observed that the person cried and appeared distressed. This behaviour was largely ignored by two staff members who were in the vicinity. We spoke with a nurse who told us that this person frequently cried for "no reason". The staff team had little understanding of the impact of dementia on people's mental health and wellbeing and as a result this person was not provided with appropriate support in relation to this. This placed the person at risk of unnecessary distress.

People were not always provided with appropriate support that promoted their acceptance and inclusion. We observed one person who expressed themselves with loud vocalisations which had the potential to disturb others. On the second day of our inspection we heard this person in the main communal lounge vocalising loudly. There was no attempt made by staff to occupy the person to reduce their vocalisations. Instead they were assisted to move into a different communal area where their behaviour would not impact on others to the same extent. This put the person at risk of social isolation and boredom and did not meet their needs.

This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations

2014.

During our October 2016 inspection we found that systems in place to record and respond to complaints were not effective. This was a breach of regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. During this inspection we found that although there was some evidence that complaints were being responded to further improvements were still required.

People could still not be assured that their complaints and concerns would be handled appropriately as systems in place to log and record complaints were still not effective. The service manager informed us that there were currently two complaints ongoing. Despite there being a process in place to log, record and handle complaints neither of these complaints had been recorded. This made it hard to ascertain whether these complaints had been responded to in a timely and appropriate manner. We discussed this with the service manager who explained that they had not recorded anything yet as the complaints were still in progress.

The lack of recording also made it difficult to assess whether appropriate action had been taken in response to complaints. One complaint related to the conduct of a staff member. We were shown a letter addressed to the complainant which stated that a formal apology would be made. However, due to the absence of any records it was not clear what, if any, action was planned to address the practice of the staff member.

As a result of subsequent conversations with the service manager and managing director we were informed that they were in the process of taking action in response to the practice of this staff member. Following our inspection the provider submitted an action plan which stated that complaints would be investigated and recorded fully.

Despite the above people and their families told us that they knew how to raise concerns or make a complaint and also said that they felt that any issues would be dealt with appropriately by the management team.

People were at risk of receiving inconsistent support as the content and quality of information in care plans was variable. Some care plans were task focused and did not contain information about people's interests and preferences. This meant that staff did not always have access to information in relation to what was important to some people.

Care plans relating to people's health needs did not always contain an adequate level of detail to ensure support was responsive to their needs. For example one person had a condition which affected their eyesight, however their care plan did not contain any information about the impact of this or guidance about how best to support the person. We also found instances were plans contained contradictory information. For example the same person's care plan stated they had a history of chest infections, however this was not referred to in their 'breathing' care plan.

Furthermore care plans did not consistently contain adequately detailed information about how staff should support people whose behaviour may put them and others at risk. One person was, at times, resistant to personal care, their care plan directed staff to use distraction and 'minimal restriction techniques' but did not provide any description of how to do this. Some care plans were complicated and information was spread across multiple sections making them hard to use. We spoke with a member of staff who told us that they sometimes read care plans but also said that plans did not always accurately reflect people's needs.

Although care plans had been marked as having been reviewed monthly we found that plans were not updated in response to people's changing needs. For example, one person's support needs had changed but their care plan had not been amended to reflect this, their care plan stated that the person was able to walk with the use of a mobility aid, but we observed that the person was no longer able to walk and now used a wheelchair, this was not reflected in their care plan.

The above inadequacies in care planning meant that staff did not always have access to information about how to support people safely and effectively and this put people at risk of receiving inconsistent, unsafe support.

The service manager was in the process of developing new care plans for every person who lived at Lound Hall, this was being completed in partnership with the person, their family and external professionals. We reviewed a recently written care plan and found these to be more person centred and detailed. Despite this there was still some discrepancy about the care and support people required. Records of a recent review of one person's support needs, stated that '[Person] is able to walk around the garden but needs to be observed to ensure their safety'. During our visit we saw that the person was not consistently observed by staff when in the garden. We discussed this with the management team who told us that they did not directly observe the person, instead they ensured that staff were aware of their whereabouts. This approach did not take into account the fact that the garden gate could be opened by visitors or members of the public and this put the person at risk of leaving the service unescorted and potential harm.

People were supported to maintain relationships with family and friends. During our visit we saw people's relatives and friends visiting. People spent time together in communal areas and appeared to feel comfortable and relaxed.

Inadequate

Is the service well-led?

Our findings

In our October 2016 inspection we found that systems were not in place to audit the quality and safety of the service. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. During this inspection we found that improvements had not been made in this area. There had been an ongoing lack of effective leadership and governance at Lound Hall which resulted in people being placed at significant risk of physical and psychological harm.

Following our October 2016 inspection we received an action plan from the provider stating that all required improvements would be made by 31 January 2017. Yet during this inspection we found that areas of non-compliance had not been adequately addressed. For example the action plan stated that a log of complaints would be maintained in order to track and monitor complaints. This was to be completed by 14 December 2016. However during our inspection we found that there was still no effective system in place to track and monitor complaints.

There had been an ongoing failure to implement systems to monitor the quality and safety of the service. We requested copies of audits and quality assurance systems in place to ensure the safe and effective running of the service. However we were informed by the management team that other than a medicines audit there were no other audits in place at Lound Hall as work had been prioritised in other areas. This lack of governance resulted in us finding multiple risks to people who used the service such people being exposed to the risk of choking, people not having any means to summon help in the event of an emergency and risks to people's health and wellbeing. Following our inspection visits the provider informed us that they had implemented a range of audits.

The safety of people who used the service had not been prioritised and there had been an over-reliance on feedback from external agencies to inform quality assurance and improvement at the service. This had resulted in a failure to identify and address some issues relating to the quality and safety of the service. For example, risks associated with people's care and support had not been identified, and this put people who used the service at risk of harm. We identified that one person was exposed to the risk of choking as measures had not been taken to reduce this risk. We discussed this with the service manager who informed us that this issue had not been identified 'yet' because they had not yet reviewed this person's care plan. This was not an acceptable risk management framework and this approach exposed people to the risk of harm.

There were no formal systems in place to identify issues with the day to day practice of staff. For example we found that daily records of care and support had not been completed as intended and this put people at risk of harm. For example records for one person stated that their call bell was 'accessible' to them when in actual fact the call bell was hung on the wall out of the person's reach, this meant they would not be able to summon support in the event of an emergency. We also found that other records were inaccurate or had been completed in a tokenistic manner. We discussed this with the service manager who was unaware of these issues, they told us that due to other priorities they had been unable to effectively monitor the practice of staff. This failure to identify issues with staff practice and placed people at risk of receiving unsafe

support.

In addition to the above we also found concerns about other areas of governance which had an impact on the safety of people who used the service.

Timely action had not always been taken in response to known issues and this resulted in action not been taken to mitigate known risks to people's health and safety. For example on the first day of our visit we observed an incident involving the unsafe administration of medicine. On the second day of our visit we reviewed incident records and found that this incident had not been recorded. This could pose a risk that this incident was not investigated. Furthermore the service manager informed us that a number of medication errors had recently been reported to them but they had not yet had opportunity to review these. Despite this timely action had not been taken to investigate the errors to prevent the likelihood of reoccurrence.

There was no system in place for analysing patterns of accidents and incidents across the service. Trends, such as the location or timing, were not considered which meant that opportunities may have been missed to identify ways of preventing future incidents and exposed people to the unnecessary risk of potential harm and injury. We spoke with the service manager about this who informed us that they were aware of the need for analysis of accidents and incidents however they had not prioritised this work.

During our October 2016 inspection we found that sensitive personal information was not stored securely. During this inspection we found this still to be the case. Medicine administration records (MAR) were stored on top of the medicines cabinets in the foyer of the service and were accessible to staff, service users and visitors. These files contained private information about the health and medicines of people who used the service. This was not only a breach of confidentiality but this also posed a risk that the records could be removed or tampered with which could have had an impact on the safe administration of medicines. We discussed this with the service manager who told us the records would be moved but we remained concerned that they were unaware that this was breach of confidentiality.

All of the above information was an ongoing breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were limited opportunities for people who used the service and their families to get involved in the development and running of the service. We saw records of a recent meeting held for relatives of people living at Lound Hall which had been organised at the request of the local authority to inform people about the findings of their audit. There had been no recent meetings or surveys for people who used the service and none were planned. The service manager told us they would, in the future, be developing formal ways for people to provide feedback but added that at present the approach to this was informal. Despite the lack of formal opportunities to contribute to the running of the service people and their families told us they would feel comfortable approaching staff or the management team with any concerns.

Staff were positive about working at Lound Hall. They were given an opportunity to have a say about the service in meetings. Records of staff meetings showed that these were used to provide feedback to the team, to share information and to address issues within the service. Staff we spoke with told us they felt supported and would feel comfortable in reporting any issues or concerns to the management team.

There was no registered manager in post at the time of our inspection, the previous registered manager deregistered in June 2016. The service manager had been in post since October 2016 and had recently started the process of registering as manager of Lound Hall. Since managing the service, the manager had

focused on working with the local authority to improve the quality of care plans within the service and on developing other aspects of the service. During our inspection we saw that this work was still in progress.

We checked our records which showed that the management team had notified us of events in the service. A notification is information about important events which the provider is required to send us by law.

We provided feedback to the service manager and managing director during our visit to Lound Hall and they took swift action to resolve some of the issues during our inspection to lessen the immediate risks to people who used the service. Following our inspection the management team provided us with an action plan detailing other actions taken or planned. This included action taken to reduce the risks associated with people's care and support. The provider also shared evidence of new governance systems including audits and incident analysis which had been put in place following our visit.

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 Care and treatment was not provided in a safe manner. People were not protected from risks associated with their care and support or the environment. Medicines were not administered safely. Regulation 12 (1) (2) (a) (b) (c) (d) (e) (f) (g) (h)

The enforcement action we took:

We took urgent action to restrict admissions to the home.