Friends of the Elderly

The Lawn Residential Care Home

Inspection report

119 London Road
Holybourne
Alton
Hampshire
GU34 4ER

Tel: 0142084162
Website: www.fote.org.uk

Date of inspection visit:
12 November 2015
17 November 2015
18 November 2015

Date of publication:
27 January 2016

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

The inspection took place on 12, 17 and 18 November 2015 and was unannounced.

The Lawn Residential Care Home provides accommodation for up to 31 older people, some of whom may also be living with dementia. The home is situated in the village of Holybourne and is a period house which has been altered and extended for use as a care home. There is access to landscaped gardens and grounds. At the time of our inspection 31 people were using the service.

The Lawn Residential Care Home had a registered manager in post at the time of our inspection. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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 were not enough staff on duty to meet the needs of people using the service. When we arrived for our inspection three staff instead of five were providing care and people were distressed and upset at having to wait for breakfast and personal care. Recent changes in staff employment contracts had unsettled staff causing some staff to leave and leading to a rise in the use of agency staff. People told us they did not like agency staff providing their care because they did not know their individual needs. There was no formal method of ensuring that agency staff were informed about people's individual care needs.

There was an atmosphere of uncertainty in the home. People told us they were unsettled and distressed about recent changes and the numbers of staff leaving the home, which had impacted on their care and welfare. There was a general feeling from people of unrest. They felt that too many changes were happening too quickly and that the home didn't feel like a community.

A range of tools were used to assess and review people's risk of poor nutrition or skin damage such as Malnutrition Universal Screening Tool (MUST) and Waterlow. However, the provider did not always identify risks or take actions to mitigate risks, for people. The provider had not assessed the risks associated with ongoing building work in the home.

There was a risk that records in relation to medicines administration were not accurate. People were left medicines to take and staff did not check if they were taken or record which member of staff left the medicines with the person. One person did not receive a blood test in a timely manner. The blood test was required to ensure they were receiving the correct dose of their medicine. There was a risk they did not receive the correct dose.

People were not always safe. Not all staff had received safeguarding training or knew how to report safeguarding. One person was living under Deprivation of Liberty Safeguards (DoLS) was not kept safe.

People were asked for their consent before care and treatment was provided. A member of staff gave examples of how they sought permission to provide care. However, where people lacked capacity to make specific decisions, the provider did not act in accordance with the principles of the Mental Capacity Act 2005 (MCA), by ensuring that people gave valid consent for care and treatment. Appropriate DoLS applications may not have been made. There was a risk that people were deprived of their liberty without the relevant authority.

Staff had completed an induction and a probationary period of employment, to ensure they knew how to provide effective care for people. However, fire safety training was out of date and staff had not received appropriate support through supervision meetings and appraisals. Staff did not receive appropriate support from the provider to ensure they effectively carried out their role.

Menus demonstrated that a balanced diet was offered and people were supported to eat and drink sufficiently. People were served food which met their assessed dietary needs.

People were supported to maintain good health through access to ongoing health support. A GP surgery was held in the home once a week and access to other health professionals was evident from records, such as district nurse, an optician and a chiropodist.

People told us the standard of care in the home had slipped. There was a general feeling from people of unrest. They felt that too many changes were happening too quickly and that the home didn't feel like a community. People told us they did not like agency staff, providing their care because they felt such staff did not know them and did not know their needs. People's dignity was not always respected.

Staff encouraged people to be involved in day to day decisions about their care. However, there was no evidence, within care plans, of people's involvement in determining their plan of care. Care plans did not demonstrate that people had been involved. Relatives said they would like to be more involved.

Care planning in response to people's needs required improvement. Care plans did not provide staff with guidance to manage people's specific conditions, illnesses or behaviours, such as diabetes. Care provided was not responsive to people's needs.

It was not possible to determine how staff were made aware of people's specific needs and how they were updated about people's changing needs. There was no handover sheet or documented handover process which would have provided staff with specific information about people's needs.

The provider was responsive to concerns from people and staff in terms of holding meetings to discuss concerns raised about the proposed restructuring programme which was affecting all staff. The complaints policy was displayed on the notice board to ensure people and relatives knew how to complain.

People were supported to take part in social activities. There was an activities co-ordinator, and a variety of social activities were available.

The provider had a quality monitoring system in place; however this had not been effective. Issues we identified during our inspection had not been found as a result of the provider's quality monitoring processes. There was no evidence that actions had been taken as a result of quality monitoring audits.

There was an atmosphere of uncertainty in the home. People were unsettled and distressed about recent changes and staff were unhappy they were leaving in significant numbers. The reaction from staff has

impacted directly on people's care and welfare.

The registered manager told us that the goals of the home were to provide a good standard of care in an environment similar to people's homes where they have choices and the service is personalised to them. Our inspection has demonstrated that these goals were not being achieved in the home. The registered manager acknowledged that the home was struggling to provide this level of service.
Staff told us the registered manager was approachable however this view was not replicated by people who said they hardly saw the registered manager.
The registered manager and the operations manager were clear that the changes were positive and would secure the future of the home for people and staff. Whilst they recognised that the home was going through a difficult time they were confident that things would improve in time.

During our inspection we found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we asked the provider to take at the back of the full version of the report.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'. The service 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.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

People's identified risks had not always been addressed in their plan of care.

Risks in relation to refurbishment in the home had not been planned for, assessed or mitigated.

Staffing levels were not sufficient to meet people's needs in a timely way to ensure their safety.

There was a risk that medicines were not always administered safely or appropriately.

Not all staff had received safeguarding training and knew how to recognise and report the signs of abuse. People were not always safe.

Is the service effective?

Requires Improvement

The service was not always effective.

The principles of the Mental Capacity Act 2005 (MCA) had not been followed. There was a risk that valid consent was not obtained for care and treatment.

Appropriate DoLS applications had not been made. There was a risk that people were deprived of their liberty without authority to do so.

Refresher training for staff to carry out their roles and responsibilities effectively was required.

People received sufficient fluids and nutrition to meet their needs.

Is the service caring?

Requires Improvement

The service was not always caring.

Permanent staff treated people in a kind and compassionate

way, however staff were leaving and there was an increasing use of temporary staff. People did not like receiving care from temporary staff who did not know their needs. People's dignity was not always respected.

There was no evidence, within care plans, that people were involved in developing their plan of care.

Is the service responsive?

Inadequate

The provider was not responsive to people's care needs.

People's care plans did not always address or identify risks.

There were no care plans in place in relation to specific conditions such as diabetes and osteoporosis.

There was no effective system in place to ensure that both permanent and agency staff were informed about people's specific care needs. There was a risk they would not provide individualised care for people.

People were supported to take part in activities although some people requested more male orientated activities.

Is the service well-led?

Inadequate

The service was not well-led.

Quality assurance audits had been undertaken but were not effective in improving the quality of the service.

The registered manager was new to the service and was aware that improvements needed to be made. Recent changes had upset people and staff and the culture in the home was affected by this.

The provider had instigated a programme of restructuring without due regard to the major impact the changes would have on people and staff. The response from staff was not anticipated or mitigated leading to a large reduction in the number of permanent staff, which impacted directly on the care people received.

The Lawn Residential Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 12, 17 and 18 November and was unannounced. The inspection was carried out by two inspectors, a pharmacy 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 care services.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed all the information we held about the home including the PIR, previous inspection reports and notifications received by the CQC. A notification is information about important events which the provider is required to tell us about by law. We used this information to help us decide what areas to focus on during our inspection.

We spoke with 18 people using the service and one relative. We also spoke with the registered manager, the operations manager, the chef, four care workers and the activities co-ordinator. We reviewed records relating to five people's care and support such as their care plans, risk assessments and daily monitoring records. We reviewed medicine administration records (MARs) and looked at various records in relation to the running of the service such as staff rosters and training and recruitment records.

During our last inspection on 5 February 2015, we found no concerns.

Inadequate

Is the service safe?

Our findings

There were not enough staff on duty to meet the needs of people using the service. When we arrived in the home we heard call bells ringing constantly, often for long periods of time without being answered. People were distressed and we were unable to locate staff who were working 'on the floor.' One person was walking around looking for staff and they were very upset. They told us they had waited over an hour for their breakfast. They were so upset they became breathless and had to sit down to recover their breath before returning to their room. One person had been left by an agency member of staff who needed to assist another member of staff with supporting a person to mobilise. When the agency staff member returned they were called away again before being able to help the person. At 9.40am the person was still in bed, with the curtains drawn and had not had their breakfast. They told us "I usually have my breakfast at 9am. I don't know what's going on this morning." Another person said, when asked if they had had their breakfast, "I'm hopping mad – it's an hour late." One person was waiting for support to get washed and dressed, they told us "I just want to be washed and dressed. My (relative) is coming in a while and I don't want to be sitting here in my pyjamas."

People were concerned about the changing staff situation and the impact on their care. Permanent staff were leaving and there was an increasing use of agency staff. One person said "I don't have to wait too long when I ring the bell – but they do seem busier these days. I'd like my breakfast at 8am but it's usually 9am, or later." Another person explained how they needed to wear special pressure socks which they needed support to put on. They told us that no one had been available to support them until 11.30am on the day of the inspection. They were unable to mobilise without the support of the pressure socks. Due to the lack of staff people did not receive the care and treatment they needed in a timely way.

The registered manager told us that normal staffing was five care workers for a morning shift, four care workers for an afternoon shift and two care workers for a night shift. On the morning of our inspection one member of staff had called in sick and an agency member of staff had failed to arrive for work. This meant that one senior care worker, one care worker and an agency worker were supporting people instead of the five staff rostered. During the period from 1 October 2015 to 17 November 2015 rosters showed that there were six occasions when four instead of five staff worked a morning shift and there were five occasions (including the day of the inspection) when three instead of five staff worked a morning shift. Additionally there were nine occasions when three staff instead of four staff worked an afternoon shift and one occasion when only two staff worked an afternoon shift. The night shift was always fully staffed with two members of staff. The registered manager told us these gaps in the roster had been caused by staff calling in sick at the last minute or agency staff failing to arrive for duty.

The registered manager explained that staff were unhappy due to a restructuring programme put in place by the provider. Staff had been asked to sign new employment contracts with revised terms and conditions which they were unhappy with. This had caused two members of staff to leave and a further six members of staff to hand in their notice of resignation. This had unsettled both staff and people. One person told us "A lot of staff have gone; some of them were very nice. I gather they are leaving because they're not getting a full wage." Another person said "That nice girl is leaving for a local job, paying more. You can't blame her." A

member of staff described what was happening, they said "The main concern is that we'll need to use agency. People won't get the same care. I can see residents aren't happy already. We don't want to see residents distressed. We've got anxious people at the moment. We're mostly down to four staff." A health and social care professional expressed concern about the staffing situation at The Lawn. They said "My concern is that experienced staff are leaving." The loss of regular staff impacted upon the morale of both people and staff and therefore impacted people's care. People did not receive care from regular staff members who they knew and liked.

Due to the loss of regular staff, the provider was using increasing numbers of agency staff. The provider checked profiles of agency staff before they worked in the home to ensure they had the right skills and experience. However, we were unable to find a profile for the agency staff member who was working in the home on 17 November. Therefore, the provider was unable to check whether they had the right skills and experience before they started work. The provider used five different staffing agencies. We reviewed profiles from three different agencies and found there were profiles for more than 40 agency staff. The high number and variety of agency staff being used by the provider at the home had a detrimental effect on morale for staff and care for people. Staff told us it was difficult to find a good agency member of staff. One person said "We get all sorts of agency staff – often they don't know what to do, and we have to tell them." Another person told us "Yesterday I was washed by an agency girl – fairly ineffectively – she had no real English. I nearly fell off my chair as she was leaving the room. I called out to her, but she just kept walking. She must have heard me." The care people received was adversely affected by the high use of agency, which was predicted to increase as regular staff left.

The lack of care staff meant there were not sufficient numbers of suitably qualified, competent, skilled and experienced staff deployed to meet people's needs. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, relating to Staffing.

We saw a range of tools were being used to assess and review people's risk of poor nutrition or skin damage such as Malnutrition Universal Screening Tool (MUST) and Waterlow. The Waterlow tool assesses the risk of a person developing a pressure ulcer. We found that the provider did not always identify risks or take actions to mitigate risks. For example one person's Waterlow score indicated they were at high risk of developing skin damage. Their care plan identified creams which needed to be applied topically to mitigate the risk; however records showed that these creams had not been applied as prescribed twice daily. During one month records showed that cream had only been applied seven times. Another person was living with diabetes but their risk assessment had failed to identify their high risk of foot disease due to their diabetes and therefore take mitigating actions. There were three people living with diabetes, but there were no assessments in place which identified and addressed the risks in relation to diabetes. These would have included skin integrity, diet, foot and eye care. One person was at extremely high risk of falls and had had several falls over a two day period. There was no evidence that the person had been referred to a falls clinic for advice about how to reduce and manage the person's falls. Another person had a risk assessment which contradicted evidence noted in their daily records. Their risk assessment stated that they were unsafe to use the stairs, needed to be constantly monitored and reminded to use the lift. However daily records stated '(the person) continues to mobilise around the building independently. (The person) uses the stairs independently." We discussed this with a member of staff who said "I think the paperwork needs to be updated."

The provider had identified generic risks in relation to the building, affecting staff, people and visitors to the home. These included risks associated with visiting the greenhouse, using the stairs and various storage areas within the home. However, during our inspection we noticed the main dining area in the home was being refurbished. This included decoration, new lighting and new flooring. People needed to walk through

the dining room while the work was being undertaken to access the main sitting areas in the home, and also to move between their own rooms to the temporary dining area. At 10am on the day of the inspection we observed a workman carrying long planks of wood through the hallway and communal areas of the home. There were no risk assessments in place in relation to the risks to people accessing the area while work was continuing. These would have included hazards leading to trips and falls, excessive noise, strong odours, exposed electrics and the general difficulty and inconvenience for people, mobilising with aids. A Health and Safety inspector visiting the home at the time of our inspection expressed concern about the lack of a project management plan. A project management plan should have been put in place to ensure that the refurbishment work did not disrupt the normal daily running of the home too much. Risks to people in relation to the refurbishment work had not been identified or planned for to ensure they were minimised and mitigated as far as possible.

The failure to identify and mitigate risks to people was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, relating to Safe care and treatment.

Staff gave some people their medicines to take in their own time, so they could be more independent. Risk assessments and regular reviews were in place to make sure this was safe. This was included in the provider's medicines policy. Staff used a code to show the medicines had been provided for people, but not administered. They told us they checked later that people had taken their medicines. However, the administration records did not show which member of staff had put out the medicine for these people or whether staff had checked that people had taken the medicine. This increased the risk that records made may not be accurate.

Some people were prescribed a medicine which required regular blood tests to check the dose to be given. Results of the blood tests and the current dose were kept with people's medicines administration charts so staff could give the correct dose. Staff kept clear records of the dose they had given. However we saw the blood test for one person had been due on 26 October 2015 but there was no record of any result. A note in the home's diary on 2 November 2015 asked staff to find out if the test had been done, but there was no record of any action taken. During the inspection staff checked and found the blood test had not been done; a test was then arranged. Missing the blood test increased the risk of this person receiving the wrong dose of their medicine which could have caused them harm.

Medicines were kept safely and stored securely. Suitable storage was available for controlled drugs which need additional security. Registers were in place to record the safe handling of these medicines. However we saw two discrepancies in the records in one area. Some medicines no longer needed had been recorded as having been returned to the pharmacy, although they were still in the cupboard awaiting collection. Another medicine in the register was not in the cupboard because staff had transferred it to a different area. Staff made regular checks of these medicines but had not identified these discrepancies. This increased the risk that medicines could be misappropriated, as the medicines had been recorded as disposed of but were still in the cupboard and could be accessed by staff.

The risks in relation to safe administration of medicines were a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 relating to Safe care and treatment.

Suitable arrangements were in place for the ordering of medicines. Staff recorded the medicines received into the home. They told us that the pharmacy staff checked the receipt with them to reduce the risk of errors. We saw that people's medicines were available for them, although the supply of a medicine for one person had been delayed because a prescription had not been received by the pharmacy. Arrangements were in place to obtain medicines urgently if needed, for example a course of antibiotics.

We looked at the medicines administration records in use at the time of the inspection and those from the previous month. These showed the medicines received into the home and those given by staff. We checked a sample of medicines which had been supplied in standard packs. The amounts remaining agreed with the records made by staff to show that people had received their medicines as prescribed for them.

We saw some people given their morning medicines in a caring and respectful way. People were able to look after their own medicines if they wished to. Risk assessments were used to make sure people were safe to do this. Staff had received medicines training and checks to make sure they were able to give medicines safely. Additional training had been arranged with the home's pharmacy for the week following our inspection. This helped to ensure staff had the knowledge to manage people's medicines safely.

People were not always safe. One person was living under Deprivation of Liberty Safeguards (DoLS). The DoLS are legally authorised restrictions on a person's liberty in order to keep them safe. On two occasions since the DoLS had been put in place the person had left the building unnoticed and been found by members of the public walking along the streets in the local town. This meant the person was not being kept safe under the safeguards in relation to Deprivation of Liberty. These two incidents had not been reported to the local authority or the Care Quality Commission (CQC) as a safeguarding.

Records showed that most members of staff had completed safeguarding training. However one member of staff, we spoke with, had not completed the training, did not know what safeguarding was and did not know how to report any concerns outside the organisation. The registered manager told us that the safeguarding policy was not easily accessible to staff and this was something she intended to change.

Staff were supported to report concerns or 'whistleblow' if necessary. The registered manager told us the policy was displayed on the noticeboard. She said that if any member of staff felt the need to whistleblow she would work with the member of staff to put the concerns right and make it a positive experience for them. She told us "If we make a mistake, we learn from it." It was clear though, that staff were unhappy and unsettled with the current upheaval in the home and were reluctant to speak out. The message of support had not been communicated to staff effectively to ensure staff were encouraged and empowered to speak out. One member of staff told us they had never heard to the term 'whistleblowing.'

People were not protected from abuse because not all staff knew how to report safeguarding concerns or keep people safe; this was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, relating to Safeguarding service users from abuse and improper treatment.

Recruitment practices for staff were safe. Relevant checks such as identity checks, obtaining appropriate references and Disclosure and Barring Service (DBS) were completed. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services. Records we reviewed showed that a full employment history had been obtained. The provider ensured that potential employees had no unexplained gaps in their employment history which might make them an unsuitable candidate.

The registered manager told us the home had a 'disaster plan' in place. This plan was reviewed monthly and gave key information and actions about what to do in the case of an emergency. She told us there was an evacuation plan but that it had not been practised.

Health and safety monitoring checks were completed by the person responsible for maintenance. These included regular water temperature checks and flushing of systems to reduce the risk of legionella. A legionella risk assessment had been carried out by an external consultant and the risk had been determined

as low.

Requires Improvement

Is the service effective?

Our findings

People were asked for their consent before care and treatment was provided. A member of staff gave examples of how they sought permission to provide care. They added that if people refused, they respected this. They said "It's their choice, even if it's not what I want."

However, where people lacked capacity to make specific decisions, the provider did not act in accordance with the principles of the Mental Capacity Act 2005 (MCA). The MCA provides a legal framework for making particular decisions on behalf of people who may lack the 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. Where they lack mental capacity to make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. Although there were a number of people living with a cognitive impairment there were very few mental capacity assessments within people's care plans. We reviewed an assessment for one person which had not been fully completed and no outcome was recorded. This showed the provider did not fully understand the legal process required for people to consent to care and treatment. Another person's care plan had recorded that the person's relative had lasting power of attorney to make decisions about the person's care and welfare. There was no copy of the power of attorney on the person's care plan and it was not clear whether the relative was authorised to make decisions about care or not. Although records showed that most staff members had completed training in respect of mental capacity, a permanent member of staff we spoke with, had not heard of the term mental capacity and did not know what it meant.

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). 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 two people were living in the home under a DoLS, however for one person appropriate paperwork was not in place including a mental capacity assessment to determine whether the person had the capacity to consent to the deprivations. After discussion with the Registered Manager, she identified further people living in the home with a cognitive impairment and whose care plans should be reviewed to check whether any further DoLS applications were required. Therefore, appropriate applications may not yet have been made.

Valid consent for care and treatment had not been obtained because the provider had not complied with the MCA or the DoLS. This was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, relating to need for consent.

Staff had completed an induction and a probationary period of employment. Most staff were up to date with their training in areas such as moving and handling and food hygiene. However there were a large number of staff who had not had their fire safety training updated. This needed to be updated annually and most staff members were between two and five months overdue. One staff member was overdue by 14 months. Other areas of training which required updating were hoist and slide sheet training and control of

substances hazardous to health (COSHH). Staff had not received sufficient training to carry out their role effectively. Staff were not appropriately supported in their role. Regular supervision meetings had not been held with staff and appraisals had not been completed. There was a lack of support for staff to ensure they were able to carry out their role effectively. The registered manager had been in post for four months and told us she planned to start carrying out staff appraisals shortly.

Staff did not receive appropriate support, training and supervision. This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, relating to Staffing.

Menus demonstrated that a balanced diet was offered. The food did not meet everyone's tastes and preferences, however. One person said "The food? I have what's there; but it tends to be easy and bland. I like sweet and sour – why can't we have something like that sometimes?" One person said the quality of the food had improved but still commented that the chicken served was tough. A dietary requirements book was held in the kitchen. It included key information such as who required a certain consistency of food, such as a soft diet, or who had diabetes. It also included people's preferences for certain types of food and drink. We found that information held in this folder matched information in people's care plans and also our observations of what people ate. People were served a diet which met their assessed needs, but not always their preferences.

People were supported to eat and drink sufficiently. During lunch, which was served in the conservatory and activities room due to refurbishment, we observed that the tables were attractively laid, with a choice of fruit squash in jugs at each table. Light classical music was being played at low volume. The lunch looked good and there was a choice of fried fish or macaroni cheese. Two people had alternatives of chicken because they did not like the choices offered. Vegetables were served in a large dish in the middle of each table, so people could help themselves to whatever amount they wanted. Most people ate without support from staff. Staff were attentive and chatty and lunchtime was unrushed. Tea and coffee was served after the meal.

People were supported to maintain good health through access to ongoing health support. A GP surgery was held in the home once a week and access to other health professionals was evident from records, such as district nurse, an optician and a chiropodist.

During the refurbishment of the dining room, the environment was not suitable to the needs of people living in the home. Meals were being served in the conservatory and the activities room. The floor area of these rooms did not allow for easy use of wheelchairs, or walking aids. Most people chose to stay in their rooms for meals while the refurbishment was going on.

Requires Improvement

Is the service caring?

Our findings

People told us the standard of care in the home had slipped. There was a general feeling from people of unrest. They felt that too many changes were happening too quickly. One person said "It was all so nice when I first chose to live here in August. It was absolutely fine until the previous manager left; since then, I don't think it's so happy amongst the staff, some have left. I miss (a member of staff), we all miss her, she was very popular." Another person told us, when asked about the staff, "Most of them are nice – some are impatient. The girl who brings the pills told the organisation about something I said so I don't say much these days." One person said "It doesn't feel like a community here anymore; we're not even informed if someone dies."

One person had a catheter removed and was using incontinence pads. They told us they were very embarrassed by this and as a result chose not to leave their room to join people for meals or activities. This meant they were isolated in their room. When we discussed this with the registered manager she told us that staff had noticed that the person didn't leave their room but that they didn't know why. Following our discussion the registered manager arranged for the person to discuss this further with the GP. This person's dignity was not respected. A recent survey conducted by the provider in October 2015 asked people whether they felt their dignity was respected. The results of the survey showed that 14% of people felt their dignity was not respected and a further 14 % of people felt their dignity was respected only sometimes. The provider did not always ensure that people's dignity was respected.

Staff told us they encouraged people to be involved in their care, for example by determining the level of assistance required in the day and at night. Whilst people were encouraged to make day to day decisions about their care, there was no evidence of people's involvement in determining their plan of care. Care plans did not demonstrate that people had been involved. During a recent survey in October 2015, people were asked if they had personal involvement in their care plan. 21% of people said 'no.' One relative we spoke with told us they had had input into their family member's care plan and she had also asked for more communication between themselves and the home which had been facilitated. However relatives who completed the recent survey said they were not always involved in care planning and not always informed about changes. One relative said they would like 'Better communication regarding changes to care plans and medicines.' Another relative said they would like to be notified if their family member needed to see the GP because sometimes they only found out afterwards.

People were clear they did not like agency staff, providing their care because they did not know them and did not know their needs. A relative told us that agency staff did not understand their family member's care needs. We noticed that permanent staff treated people with kindness and used preferred names. Staff and the registered manager told us about a document called 'Life story' which was kept in people's rooms. It was maintained like a live diary and was useful for relatives to keep up to date with activities in their absence. The diary included photographs and descriptions of recent outings or activities. For example people from The Lawn had been involved a recent remembrance day parade. The registered manager told us that sometimes families found the document comforting, when their relative passed away.

The registered manager told us she encouraged staff not to be task focused. She said 'It is a privilege to be in their (people's) home and we should make it a social event.' She went on to explain that independence was encouraged by really getting to know people, understanding what was important to them and then offering opportunities around their goals and aspirations. She told us about one person who really enjoyed playing the piano. She ensured there was an opportunity for the person to play the piano daily. One person had also requested a special Christmas service in the home, and this was being arranged. Staff told us they encouraged people to be as independent as possible. They gave an example of a person who liked to walk to the bathroom themselves even though this took 45 minutes.

Care in the home was characterised by permanent staff who knew people well and had developed close relationships with them. However, there was current disquiet from staff who were upset they were leaving and from people who were losing contact with their favourite staff members. Additionally agency staff were varied, with little consistency and the quality of care provided was inconsistent. Often agency staff didn't know how to meet people's needs and didn't know people very well. Agency staff were not given appropriate information about meeting people's specific care needs. Some agency staff were male, and people told us, this was also upsetting for some females using the service. A male agency staff did tell us that he asked people whether they were happy to receive personal care from a male, but if they said no, they would have to wait until a female member of staff was available. People told us the staffing situation gave them cause for concern. The recent change of registered manager and the ongoing refurbishment work in the home, coupled with significant staff changes left people feeling that there was too much change all at once.

Inadequate

Is the service responsive?

Our findings

Care planning in response to people's health conditions was not sufficient to meet their needs. Care plans did not provide staff with guidance to manage diabetes, although this condition was affecting people living in the home. Diabetes is a metabolic disorder that can cause serious complications. There were no care plans in relation to diabetes to describe to staff how to manage the condition and what action to take if the person became hypo or hyperglycaemic. A hypoglycaemic attack is when a person's blood sugar levels falls too low for their brain to function properly. A hyperglycaemic attack is when sugar levels have risen too high for the person's body to function properly. In both cases immediate action needs to be taken.

A person had recently been admitted to hospital following a fall. In the hours before the fall staff noticed that the person was behaving differently and suspected that the person might have a urinary tract infection (UTI). Staff called a GP but did not record that they increased or monitored fluids in response to the suspected UTI. The notification to the Care Quality Commission (CQC) stated that the person had been regularly monitored during the time period before the fall. However, records showed that monitoring recording had only started after the fall had taken place. Staff did not respond appropriately to the person's needs.

At 3.30 pm on 17 November 2015 we reviewed people's daily notes. They recorded that one person had been found in their room at 12.55pm unresponsive to the presence of the staff member either verbally or visually. The member of staff consulted a nurse employed by the provider who was in the home on the day of the inspection. Advice was given to check the person again in 15 minutes time. However, at 3.30pm there was no record that the person had been checked 15 minutes later or whether the person had recovered. The registered manager later told us that checks had been made, but we could not be certain of this because there were no records in support of this. There was a risk, that this person's needs had not been met.

One person had severe osteoporosis. Osteoporosis is a condition that affects the bones, causing them to become weak and fragile and more likely to break. This meant that support given by staff to help the person mobilise needed to be given in a very specific way. The person's moving and handling care plan did not include information that the person had osteoporosis or give any detail about specific moving and handling requirements in relation to this. The person's relative told us "One of the temporary care staff helped (them) by sort of grabbing (them) around the ribs – (they) are still in pain now. They are all a bit too rough." The provider did not provide care which met this person's individual needs.

Some people demonstrated behaviour which may challenge others. We saw that these people had behavioural monitoring charts in their rooms to record details of these behaviours. However there were no positive behaviour support plans in place, to identify possible triggers or advise staff about strategies to manage the behaviour in the most effective and safest way. There were no care plans in place to address the specific needs of people who demonstrated behaviour which may challenge. There was a risk that staff would not know how to appropriately manage these behaviours to keep both the person and themselves safe.

It was not possible to determine how staff were made aware of people's specific needs and how they were updated about people's changing needs. We were told that a handover meeting was held between each shift changeover, however there were no written records supporting this as it was a verbal handover. There was no information sheet to facilitate this process containing key information about people's specific care needs such as people's illnesses, support required for personal care, continence needs, dietary needs in terms of special diet and consistency of food required. Care staff told us they did not read care plans, although some permanent staff knew about the needs of people they were key worker for which was three or four people. There was an increasing use of agencystaff in the home. However there was no clear documented means of communication to staff about people's specific needs. We spoke with an agency worker on the day of the inspection. They told us they had been present at the verbal handover meeting and had written down that one person required regular monitoring but no other information. There were no care summaries in people's rooms or at the front of care plans. People told us that agency staff were not aware of their specific needs and relatives had expressed concern about the high and increasing use of agency staff. Staff were providing care without key information about people's specific needs.

A diary was used as a communication book for staff. Messages were recorded such as reminding staff to change people's sheets, asking for cover for shifts or checking whether tests had been booked and carried out for people. Messages were ticked when they had been completed. However, there were many messages not ticked and it was not clear whether these actions had been completed. One message involved an important blood test, which when we checked, had not been completed. There was no system in place to monitor communication in the book and check that actions had assigned responsibility and were completed in a timely manner. Staff were not always carrying out requested tasks to meet people's specific care needs.

The provider had not carried out an assessment of needs and preferences for people. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, relating to meeting person-centred care.

The service was responsive to concerns from people and staff. Staff, people and relatives had raised concerns about the planned restructuring and how it would affect them. Meetings with staff, people and relatives had been held to discuss the changes and invite questions. Some people and some staff remained unhappy with the planned changes. . We spoke with one relative who thought the changes were positive. One member of staff we spoke with said "Personally, I think it is something which has to be done although the pay does concern me a bit."

Staff we spoke with thought the registered manager was approachable and said they would raise concerns with her directly about people's care. Staff concerns about the changes had been reported to external bodies, however and not always directly to the registered manager. The complaints policy was displayed on the notice board to ensure people and relatives knew how to complain.

People were supported to take part in social activities. There was an activities co-ordinator on shift on the day of our inspection. Positive records were kept about activities and people's enjoyment of these. One person's care plan contained records that the person had a 'zest to join in' and there was 'evident enjoyment in the company of others.' The activities co-ordinator was enthusiastic and there were a range of activities available for people such as, crafts, singing, jigsaws and games. Other activities provided by external parties included tai chi, holy communion, singing and piano performances and a hairdresser. The house had once been owned by the author Elizabeth Gaskell and people had recently enjoyed a week celebrating the life of Elizabeth Gaskell. This included a visit from school children dressed in Victorian clothes, guest speakers, the ringing of church bells, listening to extracts from her novels and a Victorian high

tea. One gentleman felt that the activities were squewed more towards feminine activities. He told us "I used to carve wood, but I can't do it since my stroke. Sometimes I do get bored; there are activities like knitting, but none for me." The registered manager explained that this had already been recognised and the home planned to recruit male volunteers to support male orientated activities.

Inadequate

Is the service well-led?

Our findings

The provider had a quality monitoring system in place; however these had not been effective in identifying areas for improvement. A care plan audit had been carried out on 6 November 2015. Some actions had been identified but there was no evidence that the actions had been completed. The provider failed to identify the concerns raised in this report, during their audit of care plans. This meant care plans were not an accurate reflection of people's needs and risks. Even though a medicines audit took place on 9 November 2015, the provider had not identified the concerns in relation to medicines management we found during our inspection. The provider visited the home on 9 November 2015 in order to carry out a compliance audit. Actions identified during this audit had also not been addressed. The audit noted the increasing number of agency staff and the operations manager told us that actions had been taken in relation to recruiting more staff but this was not recorded as an action resulting from the provider audit. There were no actions to address the detrimental impact on people's care caused by the high and increasing use of agency staff.

The registered manager submitted monthly reports to the provider. The last report on 9 November 2015 included information about the use of agency staff and the high volume of sickness absence. It was not clear whether the provider had responded to this information or taken any action. The registered manager told us about one member of staff who had been referred to occupational health due to long term sickness; however she felt that the increasing sick leave of her staff team was in relation to unrest amongst staff. The provider had not taken any action to address the unrest and displeasure amongst staff. This led to people being at risk of unsafe and unsatisfactory care. The provider had not taken action to identify and mitigate risks to people.

The lack of effective quality assurance in the home and the failure to identify and mitigate risks to people was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, relating to Good governance.

There was an atmosphere of uncertainty in the home. People were unsettled and distressed about recent changes and significant numbers of staff were leaving the home. Staff and the registered manager told us about the low morale amongst staff and that they were working hard to try and improve it.
In the light of a difficult financial background the provider had proposed a massive restructuring programme affecting staff at all levels. A document had been produced detailing the reasons for the restructuring. This included a revision of the terms of employment for all staff. As a result staff said they were unsure what the future held for them and had not felt included in the process. The reaction from staff has impacted directly on people's care and welfare. This was because low staff morale had resulted in staff leaving or calling in sick at short notice. The increase in the use of agency staff as a result meant that people received care from agency staff who they did not know and who were not informed about their specific needs. The provider had instigated the restructuring programme without due regard to the major impact on the wellbeing of staff. They did not plan for or mitigate for, the response from staff.

As part of the restructuring programme the role of the registered manager would be expanded to include responsibility for budgeting, maintenance and marketing. By taking on additional roles there was a risk that

the registered manager would not have the capacity to effectively manage the home and oversee the actions required to address all of the identified concerns in order to drive service improvements and ensure the safety of people.

The registered manager and the operations manager recognised that the home was going through a difficult time and they were confident things would improve. The registered manager said "I believe it will improve for everyone, but it won't be easy." She also explained that the restructuring was required to ensure that staff were aware of their roles and responsibilities as this was currently a 'grey area.' There would also be opportunities for staff to be recognised for their achievements.

The registered manager told us that the goals of the home were to provide a good standard of care in an environment similar to people's homes where they have choices and the service is personalised to them. Our inspection has demonstrated that these goals were not being achieved in the home. There was a lack of risk assessment and care planning and people did not receive a personalised service because agency staff were not aware of their individual needs. The registered manager acknowledged that the home was struggling to provide this level of service and said that improvements were needed to care plans, systems, policies and training. She told us she had support from the provider to do this in terms of human resources, finance, nursing advice and support from higher management.

Staff told us the registered manager was approachable however this view was not replicated by people who said they hardly saw the registered manager. One person said "The new manager isn't very approachable." Some people were reluctant to give their views about the home. One person said "I don't want to say anything as it will come back to me." The registered manager told us that the location of her office made her feel cut off from the home and she planned to relocate her office to a small room next to the front door. This would make her more central to the home and more visible to people and visitors to the home. The registered manager told us she was signed up to complete a programme 'My Home Life Leadership Support.' The aim of the programme is to promote quality of life and deliver positive change in care homes for older people.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The registered person did not comply with the requirements of the Mental Capacity Act 2005. Regulation 11 (1) (5)

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 way for service users. The registered person did not assess the risks to the health and safety of service users receiving care and treatment, do all that was reasonably practicable to mitigate those risks or ensure the proper and safe management of medicines. Regulation 12 (1) (2) (a) (b) (g)

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 Service users were not protected from abuse and improper treatment. Systems and processes were not established and operated effectively to prevent abuse of service users. Regulation 13 (1) (2)

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 9 HSCA RA Regulations 2014 Person-centred care The registered person did not provide care which was appropriate, met people's needs and reflected their preferences, by carrying out, collaboratively with the relevant person, an assessment of needs and preferences for care and treatment and designing care with a view to achieving service users' preferences and ensuring their needs are met. Regulation 9 (1) (a) (b) (c) (3) (a) (b)

The enforcement action we took:

Warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes were not established and operated effectively to ensure compliance with the requirements. The registered person did not assess, monitor and improve the quality and safety of services provided in the carrying on of the regulated activity. The registered person did not assess, monitor and mitigate the risks relating to health, safety and welfare of services users and others who may be at risk from the carrying on of the regulated activity. Regulation 17 (1) (2) (a) (a) (b)

The enforcement action we took:

Warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were not sufficient numbers of suitably qualified, competent, skilled and experienced persons deployed in order to meet requirements.

Persons employed by the provider did not receive such appropriate support, training, professional development, supervision and appraisal as necessary to enable them to carry out the duties they were employed to perform. Regulation 18 (1) (2) (a)

The enforcement action we took:

Warning notice