Embrace (SW) Limited

Lake & Orchard Care Centre

Inspection report

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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?	Requires Improvement
Is the service well-led?	Inadequate

Overall summary

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 and to pilot a new inspection process being introduced by CQC which looks at the overall quality of the service.

This inspection was unannounced. There were no breaches of the regulations following the last inspection in November 2013. At this inspection we found breaches of Regulations 9, 10, 12, 13 and 22 of the Health and Social Care Act 2008 (Regulations) 2010.

Lake and Orchard Care Centre offers accommodation for up to 99 older people who have a diagnosis of dementia or physical disability requiring nursing as well as

Summary of findings

rehabilitation services. The centre is divided into two units Lake and Orchard. Lake was further divided into three units, Coniston, Buttermere and Waterside, where older people who require nursing input and rehabilitation lived. There were 30 people resident on the day of our inspection.

Orchard was also made up of three units, Russet, Morello and Bramley where older people with a dementia who require nursing care lived. There were 40 people resident on the day of our inspection.

Our information showed that the service had a registered manager but we found at this visit that they no longer worked at this service. The registered provider had not notified the Care Quality Commission. Another manager, who was not registered with CQC, was in charge on the day of the inspection and told us that although they had submitted an application to be registered with CQC they had given notice to end their employment with the provider and therefore would be withdrawing the application. This meant that there was no registered manager working at this service. A registered manager is a person who has registered with the Care Quality Commission to manage the service and has the legal responsibility for meeting the requirements of the law; as does the provider.

There were policies and procedures in place for staff to follow in relation to the Mental Capacity Act (MCA) 2005 assessments and Deprivation of Liberty Safeguards (DoLS) applications. However the principles of the MCA were not always followed by staff. The care records of people who used the service showed that mental capacity assessments had not always been completed and so there was no written evidence that staff had established whether people lacked capacity to make decisions. People who use the service were restricted as they were not able to freely leave the premises. There were key pads at the end of corridors and people in Orchard unit had no access to key codes. The manager told us that they understood how to make an application for deprivation of liberty safeguards to be put in place and said that they would be looking at making applications following the recent Supreme Court judgement in March 2014. This was where it was made clear that people who lived in care homes and who were restricted in this way may be being deprived of their liberty.

There was no effective quality assurance system in place to regularly assess and monitor the service to identify and manage risks to people's health and safety. Some audits had been carried out but it was clear from our findings that issues such as lack of cleanliness and the lack of appropriate risk assessments had not been identified. This meant that there had been a breach of the relevant regulation under the Health and Social Care Act 2008.

Our findings highlighted that the registered provider did not employ sufficient numbers of staff with appropriate skills and experience to meet the diverse and sometimes complex needs of people living at the centre. This had a negative impact on some people who lived at the service. This meant that there had been a breach of the relevant regulation under the Health and Social Care Act 2008.

People's care plans did not always detail the risks to their health when receiving care and so staff had not identified how to minimise or avoid any risks. Staff had not always fully identified risks to people by identifying whether or not they had mental capacity. This meant that there had been a breach of the relevant regulation under the Health and Social Care Act 2008.

Medicines were not managed safely. It was not possible to account for all medicines as they had not been recorded properly when received and not all medicines had been given at the correct times. This meant that there had been a breach of the relevant regulation under the Health and Social Care Act 2008.

We had concerns about the prevention and control of infection at this service due to the lack of cleanliness in all areas of the service. This meant that there had been a breach of the relevant regulation under the Health and Social Care Act 2008.

People living at Lake and Orchard Care Centre had differing views about staff. They told us that their needs were not always met promptly and we could see that people living with a dementia did not lead meaningful and supported lives.

Summary of findings

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

This service was not safe. We found that medicines were not managed effectively.

Orchard was odorous and had some areas that were dirty. There was a risk of infection.

There was not enough staff to provide safe and effective care to people who use the service. The levels of staffing were inconsistent and staff told us they felt they were not always working safely because they did not have sufficient time to deliver care effectively and in a caring way.

Is the service effective?

Requires Improvement

The service was not effective. Care plans were incomplete and did not always reflect people's needs, likes and preferences. When we looked at seven care plans we saw that risks were not always identified and the plans did not instruct staff how they should deliver care safely.

People were supported to eat and drink but staff could not spend time making mealtimes relaxed and calm for people living with dementia because they were too busy.

Staff had not received regular supervision although we were informed by the manager that supervisions were carried out every two months.

Is the service caring?

Requires Improvement

This service was not caring and needed improvement. Despite people telling us that most of the staff were kind we observed a member of staff show a disregard for a person's wellbeing. We did observe other staff being kind and considerate but one person did not respond to a person's need when asked and did not ensure their dignity or treat them with respect.

Staff had not taken account of one person's religious and cultural beliefs.

People were not able to choose what they wanted to happen when they reached the end of their life. Staff, however, had put plans in place to make sure that people received appropriate care at this time.

Is the service responsive?

Requires Improvement

This service was not always responsive. We saw that reviews of people's care had not always taken place which meant that people did not always receive the most appropriate and up to date care.

There were no activities taking place on the day of our inspection and people who used the service and staff told us that activities were not appropriate or in place for some people, particularly those with a dementia.

Summary of findings

The service had a complaints policy and procedure and we saw that complaints had been addressed within the timescales and recorded.

Is the service well-led?

Inadequate

This service was not well-led.

There had not been a manager in place since May 2014 and the present manager had given notice to terminate their contract with the registered provider. This meant there was a lack of stability in the leadership of the service.

We asked the manager to provide us with a range of documents which would demonstrate how the service was managed. We were not given and did not see any evidence of registered provider visits or completed audits. There was no evidence when we inspected the service that action had been taken to improve the service as a result of any internal audits such as infection control and medicines.

Lake & Orchard Care Centre

Detailed findings

Background to this inspection

The inspection team consisted of two inspectors, a pharmacy inspector, a specialist advisor in mental health and two experts 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. The area of their expertise was dementia care. The pharmacy inspector carried out the second day of inspection.

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 also looked at notifications for this service, reviewed any intelligence received by CQC and looked at the risk level for this service. We spoke to other health professionals and commissioners prior to and following the visit. They had some concerns around documentation, infection control and administration of medication. We reviewed all the information that we held about the service.

On July 22 2014 we looked at all areas of the building including individual bedrooms, with people's permission.

We observed how medication was managed and observed a lunchtime period in three dining rooms. We looked at records. This included seven care plans, six staff recruitment files, duty rosters and training records. We spoke with the manager, care staff, domestic staff and the cook, 24 people who used the service person and five visitors on the day of our visit. We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

This report was written during the testing phase of our new approach to regulating adult social care services. After this testing phase, inspection of consent to care and treatment, restraint, and practice under the Mental Capacity Act 2005 (MCA) was moved from the key question 'Is the service safe?' to 'Is the service effective?

The ratings for this location were awarded in October 2014. They can be directly compared with any other service we have rated since then, including in relation to consent, restraint, and the MCA under the 'Effective' section. Our written findings in relation to these topics, however, can be read in the 'Is the service safe' sections of this report.

Inadequate

Is the service safe?

Our findings

This service was not safe. We found that there were breaches of Regulations 12, 13 and 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

When asked most people we spoke with said that they felt safe, however one person said, "I feel partially safe because I don't have a call bell nearby." We activated the call bell of that person with their permission and it was answered by staff within one minute which meant that the staff on duty were alert to people's needs. A visitor told us, "I think they are quite safe although we are not here when they make their way to their bedroom. They are left to their own devices: there is not enough staff." When asked if they felt safe one person told us, "Oh I do, I know when they help me move they aren't going to drop me." One person said, "I don't worry about anything, I'm fine here." A second visitor said, "I can go home and know my mum is safe, I don't sit about worrying about what is going on." As we walked around the home one staff member who had not been introduced to us asked for identification which showed us that staff were proactive in ensuring people were safe.

Our observations identified that people were not always safe. On the day we visited it was 21 degrees centigrade outside but people could not go out. When we asked if the patio doors in one unit could be opened as a means of alleviating the heat staff said, "We can't have them open because there's only a small fence and some of the residents are at risk of wandering, We don't have the staff to have someone in here all the time to make sure that everyone is safe." When we looked around the building we found that the heating system was working in some areas which exacerbated the already unbearable heat within the house. One staff member told us, "I feel sorry for them, it's so hot." We asked the maintenance man to turn off the heating immediately and asked staff to open windows to make sure that people's health and wellbeing was not adversely affected because some people were at risk of overheating due to the high temperature. People's health and safety was being compromised because of the extreme heat within parts of the building.

The Care Quality Commission (CQC) had received 13 concerns in the last twelve months about this service. Five of those had resulted in a safeguarding referral been made to the local authority for investigation. Four of the alerts were relating to physical aggression between people who lived in Orchard unit. None of these were substantiated and went on to be dealt with through local authority case management and review. All of these four incidents occurred in communal areas when staff were present which suggests that staff were not able to deal with situations where people living with a dementia have behaviour that challenges. Another referral related to a person not receiving vital medication which was required to manage their symptoms. The provider had been asked to make improvements to the way they managed medicines following the investigation. Staff had not followed correct procedures for ordering medicines this had resulted in the person suffering further symptoms.

We spoke with staff about their understanding of what it meant to keep people safe. They were aware of what abuse meant and said that they would discuss any concerns with the manager but said that they could not always supervise people at busy times. Staff had already told us that the doors must be kept shut because there were not enough staff to maintain people's safety if they went outside. People who used the service did not have access to outside space when they wished because of a lack of staff time. Most staff had received training in safeguarding vulnerable adults and did recognise the impact of their actions but in order to maintain people's health and safety with the staff available they felt unable to act any differently.

We looked at the staff rotas and spoke with staff and visitors about staffing levels. We found sometimes there were not enough staff to care and supervise people effectively. For instance there was one nurse to cover all three units within Orchard from 4pm until 8pm on the day we visited. We were told by staff that this usually happened from 2pm and that the member of staff had stayed later than usual. The qualified nurse said, "It is difficult to cope and I feel it is unsafe." She said she had to administer medication across all three units and supervise care staff. This was not possible for the majority of the time meaning that people with complex needs were sometimes cared for by staff that were unsupervised.

We were told by the manager that there was one nurse and two carers on both Lake and Orchard units during the night. When we looked at the rotas we could see that there was only one nurse for both Orchard and Lake units on five nights during the week we visited. The manager told us that on the day we inspected the staffing level was what

would be considered normal. There was one nurse and six care assistants working on Orchard unit and one nurse and four care staff working on Lake Unit. There was an additional nurse working between the units. In addition there were kitchen and domestic staff working. They manager said that the levels of staffing changed dependent on people's needs.

When we looked at the staff rotas we saw that staffing was inconsistent and numbers were often below what was required. There were numerous occasions when the staffing fell below the levels described as normal by the manager. For instance on 13 and 14 June 2014 there were four care staff on duty in each unit all day and on the 15 June 2014 there were four care assistants in Orchard and three in Lake. It was clear from our observations during the inspection that staff were rushed and were unable to respond to people's needs in a timely way.

People who used the service told us that what time they got up in a morning was determined by how busy staff were and a member of staff told us that, "People with a dementia don't want to see us rushing around they need love and attention." One person who used the service told us, "I needed some help to go to the toilet and I am waiting for them to come back. It's OK, I can wait", and when one person indicated to us that they needed to go to the toilet we were told by the only staff member available, "I told him he will have to wait as I am on my own." We suggested that this was not acceptable and that the staff member gets someone from another unit to help and she told us, "No as there is only one carer on upstairs." The staff member then went to get someone who was on their break leaving the unit with no staff. This meant that there was insufficient staff available to meet people's immediate needs.

Following our inspection we were told by a visitor to the service that there had been no nurse on duty at night. We asked the manager to check the rotas and they told us that there had been no nursing cover and that this had happened on several occasions during the previous months because it had been impossible to get someone to cover. We asked one member of staff what the impact was when staffing levels were low. They said, "I sometimes have to work up to 16 hours a day because someone has phoned to say they are sick and I have to wait until someone comes: we just have to cope." This meant that the registered provider was not ensuring safe staffing levels and was unable to respond to changes in need. This was a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) 2010.

A pharmacy inspector carried out a second day of inspection on 17 September 2014 and found that the service was not safe because appropriate arrangements for the storage, recording, administration and safe handling of medicines were not in place.

People did not always receive their medicines at the times they needed them or in a safe way. We found that the morning medicine round had not been completed by 11.30 am. This had a knock on effect on the administration of other medicines; for example, one person prescribed a tablet to be taken at midday was not given it until after 2.30pm. It was of concern that the time of administration of medicines was not accurately recorded making it impossible to determine when the next dose could safely be given. This was particularly important for some medication which must have minimum set times between doses in order to avoid unwanted side effects and toxicity.

Most medicines were kept in locked cabinets and trolleys and the keys to these were kept securely; however we found a large quantity of waste medicines in an unlocked office where they could easily be accessed by unauthorised people. We also saw that a prescription had been left unattended on the front desk in the foyer. The foyer was not staffed on the day of our visit. Prescriptions are important confidential documents and should be stored securely at all times.

We found that medicines were not stored at the correct temperatures. Records showed that the room temperature had been consistently too hot. It had been between 26 and 28 degrees centigrade since 1 July 2014 apart from four days when it had been 25 degrees centigrade. The fridge temperature was recorded as been too high for the previous four days. We were told that an air conditioning unit was to be installed in the medication room, but no action had been taken to reduce the storage temperatures in the meantime. Medicines may spoil and/or not work properly if they are not kept at the correct temperature.

Some medicines are only safe to use for a short period of time after opening such as eye drops and we saw that the opening dates had not always been recorded, meaning that it was not possible to tell whether items such as

Is the service safe?

insulin, eye drops and nutritional supplements were still fit for use. This showed that registered nurses were not following the nursing and midwifery council code of practice for safe handling of medication. People living at this service were placed at risk of harm when out of date medicines and other products were used. This was a breach of Regulation 13 of the Health and Social Care Act 2018 (Regulated Activities) regulations 2010.

We observed that aspects of infection control were not consistently applied. In Lake unit there were no odours and the unit was clean and tidy. Orchard was malodorous throughout. People were not always able to wash and dry their hands as there was no soap and paper towel available in some areas. We saw faeces and urine stains on furniture and flooring, dirty floors in bathrooms and toilets and dirty pads left on the floor in one room. This meant that people were not protected from the risks of infection because of a lack of cleanliness throughout the service.

Infection control policies and procedures were in place. Staff told us that they had cleaning rotas but one member of the cleaning staff told us, "I think I could make a real difference to the standard of cleaning, I know we need to do better." When we discussed this with the manager told us that they were recruiting domestic staff as they had vacancies. They felt that lack of staff had caused this problem. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2010.

We were also contacted by the community infection prevention and control nurse following our inspection who told us that they had concerns and would be carrying out an infection control audit of this service which they did in September 2014.They informed us that they had identified a significant number of cleanliness and infection control issues, posing a risk of transmission of infection within the home. They told us that there were poor levels of cleanliness across the service when they visited which meant that people were not protected from the risk of acquiring an infection. We were given a copy of this report which confirmed our original findings which identified that there was a lack of appropriate standards of cleanliness and hygiene at the service and showed no improvements had been made since our original visit.

We checked six staff files and saw that safe recruitment practices had been followed. Criminal record checks had been completed through the Disclosure and Barring service and when there was any comment on the DBS check this had been discussed with the person and the outcome recorded. We saw that staff did not always have a record of their induction although staff told us that they had received an induction. This included working under the supervision of a more experienced member of staff.

We looked at the care records for seven people and noted that they did not include any recent mental capacity assessments for people living with a dementia and lacked the ability to make their own decisions. These show whether or not a person has the capacity to make and communicate decisions about their day to day care as well as other more complex decisions about their healthcare and finances. We saw that two people had capacity assessments in their files but they were not fully completed. We did not see evidence of best interest meetings taking place. These were meetings which involved people who were important to the person, advocates and professionals who met to make a decision for people who lacked capacity. This meant that staff were not always following the principles of the Mental Capacity Act 2005 when planning peoples care.

The provider information return completed by the manager told us that no one at this service was subject to a Deprivation of Liberty safeguard (DoLS) authorisation. This was confirmed by the manager during the inspection. The manager was aware of the recent changes made by the Supreme Court and the changes in procedures and told us they had plans to make applications for DoLS to the local authority.

Requires Improvement

Is the service effective?

Our findings

We looked at staff training records to confirm what the manager had told us in the provider information return. We saw that most of the staff had completed mandatory training in subjects such as fire safety, health and safety, first aid, food hygiene, moving and handling, prevention and control of infection and control and restraint. Staff had also completed training in other subjects such as dementia awareness and palliative care. This meant that staff had completed the training required by the service but this was not planned individually and so may not provide every staff member with the skills they need to do their job. Staff we spoke with told us that they did receive an induction and training but said, "Training is limited as there is a lot of online training" and, "We need more practical training." We could see that there was no assessment of how staff learn best and that most of the training for staff working at this service was carried out on line. The registered provider was using one method of training and not following this up with competency checks of staff to ensure that the training was embedded in practice.

We spoke to staff about the support they received as we had seen from records that staff supervision was not up to date. The registered provider had told us in the provider information return that supervisions were carried out every two months. During our inspection visit we did not see any records to support this. Staff told us that they were supported by the manager but they said they had not had any one to one supervision. The manager confirmed that supervisions had not been kept up to date but this was one area they were aware of. They told us they had plans for them to be reinstated as soon as possible. The staff did tell us that they were part of a supportive team and told us, "We've got a new manager now and she is trying to put things right. I've got faith that it will get better – she is far easier to talk to and is interested when I suggest things."

We looked at how people were supported with their health needs. We looked at six people's care plans and could see that they were not detailed. For example one person had no care plan for their social needs. This person was nursed in bed and therefore was isolated. We saw that information in the care plans was not always completed. One person had a mental health care plan which did not reflect their significant history. We also saw that risks had not always being identified which meant that people may not receive care that met their assessed needs.

People told us they had not been involved in planning their care but had some discussions when they first arrived about their likes and dislikes. This meant that people may not receive the care and support they need because they were not consulted.

Orchard was specifically for people living with dementia and we saw that there was a lack of monitoring of physical health within the care plans of persons living there. For instance one person had a chart in place for hourly comfort rounds but this had not been completed for three hours. We went to see this person and saw that they had a dry mouth with crusting on their lips and their eyes were sticky. This person had become uncomfortable and we saw that when a staff member did give this person a drink they were drinking a lot quickly as if their mouth was dry. We also saw that some people had incomplete life profiles which are particularly important for staff in order that they can get to know and understand the history, likes and preferences of a person living with dementia. This meant that care was not personalised as described in current best practice guidelines such as the National Institute for Health and Care Excellence (NICE) quality standard 30. There was insufficient information within care records for care staff to be able to support people living with a dementia.

There was no evidence in the care plans to suggest that people or their representatives had been involved in writing or contributing to their care plans. This meant that the care plans may not always reflect people's preferences and wishes. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) 2010.

We looked at how people were supported with eating and drinking across both units. We observed the lunch period in Russet, Morello and Coniston dining rooms. Tables were set and had condiments available. There was no menu board in the dining rooms or individual menus on tables and when asked people told us they did not know what was for lunch. Food was served in each dining room and staff were observed offering people choices. People were offered drinks throughout the meal and drinks were available for those who remained in their rooms. This ensured people's hydration needs were attended to during mealtimes.

Requires Improvement

Is the service effective?

People who used the service told us, “Food’s good, always plenty” and another told us, “Food is alright. Two choices, pudding and I like fruit.” A visitor said, “They all seem quite delighted with the food, a bit of a shortage of afternoon tea. Again this is staff, no-one in the kitchen.”

We observed one staff member help someone eat their food without communicating with them whilst another received constant support and reassurance from a staff member. There was a notice in the foyer advising visitors that meal times were protected to; ‘enable residents to enjoy their meals with minimum distraction’. We observed a variation in practice over the lunchtime period when staff were assisting people to eat.

We observed that one dining room was calm with little disruption, but another was very busy with staff coming in to speak with colleagues at least four times about work related matters during the meal which disturbed people who were eating and a third was calmer with no disruption and positive staff interactions. There were some people in smaller areas eating their meal and some in their rooms. Staff appeared very rushed and one told us, “Fortunately people don’t seem to need so much help today; it would really slow us down. We have to be in too many places at once and really can’t spend time with residents.” This meant not all the people were able to have their meals in a calm and unrushed manner.

We also observed teatime in Orchard unit. People had a choice of sandwiches with several choices of filling and cheese on toast. We did observe that one person who staff told us required a soft diet had to wait for their food. Staff seemed genuinely concerned and apologetic when we asked why this was so. They told us, “We have no kitchen assistant and so we have do all that rather than help residents eat. “Historically staff told us that kitchen assistants had helped feed people but this had recently stopped and only care assistants could now do so. This meant the registered provider did not ensure there was sufficient staff available at mealtimes to make sure that people received their food in a timely manner.

We saw that some people had had a risk assessment regarding how and what they eat and how this would impact on them. However, one person’s records showed that they were at risk of malnutrition because of their condition but there was no plan in their care file to prevent any deterioration and instruction for staff on what to do if they did not eat or drink. Another person who was nursed in bed had not had a nutrition risk assessment completed for two months. The fact that they were nursed in bed as well as their physical and mental health meant that they were at high risk of malnutrition and the care plan did not reflect this. The manager had told us in the provider information return that there were 14 people living at this service who were at risk of malnutrition because of their mental or physical health. Staff were not consistent in ensuring that people’s health risks were minimised as not everyone had risk assessments and management plans in place which were regularly reviewed and which reflected their current needs. This was a breach of regulation 9 of the Health and Social Care Act 2008(Regulated Activities) 2010

Requires Improvement

Is the service caring?

Our findings

We observed that staff spoke to people respectfully and people told us, "Staff are very good and very friendly." One person however, told us, "The staff are not kind and caring." We observed that most of the staff cared about people who used the service in the way they spoke and acted towards them. There was a sense of frustration amongst staff that there were not enough of them to provide the level of care that they felt people required. One member of staff told us when asked that they would not bring a member of their own family to live at the service.

We carried out a SOFI observation over lunchtime in a dining room in Orchard unit and saw that there were some positive interactions between staff and the people who used the service. We saw that some staff did engage with people. One staff member encouraged and supported people while another seemed to be focussed on the tasks rather than the person. The atmosphere over lunch was busy and meant that those living with dementia could not always eat in a calm space.

We observed staff interacting with people and this was carried out in a respectful and sensitive way. However, when a relative mentioned to one staff member that they could not find an item belonging to their relative we saw that they showed no interest and walked away saying, "Probably in her wardrobe, you know what they are like." In another incident the same member of staff was asked to assist a person to use the toilet by an inspector. They responded, "I told him he will have to wait as I am on my own." The inspector suggested that they got help from other staff and eventually that is what they did. This meant that this person did not support people in a dignified way. We discussed these incidents with the manager on the day of inspection. They said that they would speak with the person and if they thought it was necessary utilise disciplinary measures. We had been told that two people who worked at the service were dignity champions and saw from records that staff had been trained in dignity, respect and person centred care. We did see other staff knocking on doors which showed respect for person's unfinished sentence and unclear privacy.

We saw that staff had not taken account of a person's religious and cultural beliefs. In the document "This is me" it stated one person's religion, which was non-Christian, and how it was important to them. The staff had not made any efforts to facilitate this person being able to pursue their chosen religion and the person had in fact been taken to a Christian service which the person told us they enjoyed but it held no relevance for them. The person had not been offered foods that were familiar to them and there was no evidence of these been a choice on menus we looked at. The person's family did visit them regularly so they were able to maintain family links.

We saw no evidence of the use of advocates in care plans. Four people had an Enduring Power of Attorney or Lasting Power of Attorney (LPA) in place. This meant that people had someone responsible for finance and care and welfare decisions. There was not always evidence of people having regular reviews and a relative told us, "There has been no review for my mum. I think they just change things as and when they need to." When we looked at records we saw that the monthly evaluations by staff were out of date. NICE dementia guidelines state that people living with dementia should participate in their reviews and there should be evidence of this in care plans. This meant that staff did not take account of relevant guidance and that people were not included in discussions about their changing needs.

We looked at the records for a person who was reaching the end of their life. We could see that they had a specific care plan which demonstrated how staff were to meet their needs and make them comfortable. This care plan was kept in the person's room so that staff could easily access the information. This person's GP had been consulted about any pain relief that may be required

Requires Improvement

Is the service responsive?

Our findings

In the provider information return the manager told us that people were involved in writing their pre admission assessments and this ensured that the correct support was in place which was then reviewed and evaluated monthly. When we checked people's records we could see that the evaluations and reviews had not always been completed for every person. People's care plans did not always reflect people's current needs. For instance one person had been nursed in bed for eight months but the care plan did not reflect this. The daily notes told us what had happened but there was no care plan or management plan to show how staff had managed this. Despite the information in the PIR we could not see clear evidence that people were involved in planning their care.

People's preferences were not always reflected in care plans. One person's care plan did not reflect their mental health history or the potential risks for this person. There was a letter in one person's notes suggesting that they needed to have their blood levels checked for toxicity related to their medication. We could find no entry in the person's records to tell us that this had been done or giving any result. Another person had a mental health condition which required staff to know what to do if they had a relapse. We did not find any instructions for staff in the person's care plan about what to do in this case. We saw a person had a wound and their care plan just stated, "keep wound clean." It did not specify how staff should do so and how often this needed doing. Staff were not responsive to people's on-going needs and people did not always have their needs met in a consistent way. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) 2010.

We saw no planned activities on the day of the inspection and people who used the service, visitors and staff told us that this was not unusual. Staff in Orchard told us, "We need activities, they (persons) sit in their chairs all day; we're not trained; we have an activity person but they spend most of their time in Lake as this is very challenging for them." We were unable to speak with the activity organiser because they were on holiday. NICE guidelines state that there should be, "A range of tailored interventions such as reminiscence therapy, multi-sensory stimulation, animal assisted therapy and exercise available" for people living with dementia.

A visitor commented on the lack of activities saying, "The home does arrange trips but they are infrequent." They did not know that there was an activity organiser at this service. Another visitor said, "They just sit, nothing to stimulate." Referring to their friend they said, "She used to love to cook and was a very good cook. Don't tell me they couldn't make a few biscuits." A third visitor said, "There is a lack of things going on. A lot of them just sit around getting bored and of course they go to sleep"

A person when asked what they did during the day said, "Nothing, wait for the next day to come." When asked what staff had organised they replied, "Nothing", although they acknowledged that the activity organiser collected their paper each day. One person said, "I'd like to go to the pub now but you can't because it's a controlled environment. Staff have so much to do around the clock bless em." One person in Lake said, "Sometimes there are activities and yes we get taken out on trips in the mini bus."

We saw that people were able to maintain links with family and friends as there were several people with visitors on the day of our inspection. One visitor told us, "I have a routine but I have never being told when I couldn't come." Another told us that they visited their relative several times a week and said, "We are confident in the home's ability to look after my father well. They (staff) always ring me if dad is unwell and will get the GP out when necessary."

Inadequate

Is the service well-led?

Our findings

This service was not well led. There was a breach of regulation 10 of the Health and Social care Act 2008 (Regulated Activities) 2010 because the registered provider had not ensured that regular assessment and monitoring of the service had taken place in order to ensure people's health, welfare and safety.

The service had a manager working on the day of our inspection but they told us that they had given one months notice to terminate their employment with the company that day. The previous manager who was still registered for this service had left in May 2014 but we, CQC, had not being notified of this change. On the day of our inspection we met the operations manager who stayed throughout the day to provide support to the manager. The manager told us that the operations manager carried out monthly visits but there was no evidence that these had taken place.

We received positive comments about the manager. Staff told us that the new manager had made some positive changes and had listened to their views. They told us, "I think we can explain why things aren't being done as well as we could do them and I think this manager would listen to us." Another told us when asked about the leadership of the service, "Previously the office door was always closed. Now it's different. The manager will hear what you have to say there and then, even if they have a lot to do. There is a lot that we know we can do better and I think that (manager) is trying to help that happen."

However, people who used the service appeared to have different experiences and one told us, "I have never seen the manager" and one person asked about the manager as we spoke, "Is that one of your lot?" We saw the manager moving around the home but did not observe any interactions with people who used the service only with staff.

There was no evidence of consistent good practice at this service particularly in relation to the care of people living with dementia. There was no evidence to suggest that the service was using NICE guidelines or other relevant guidance in their care of people with a dementia.

There was a whistleblowing policy and procedure in place at this service. The staff told us that they knew how to raise concerns and would feel confident that the new manager would act on them. One member of staff said, "I know I could go to the manager and we all know the regional manager, so I could talk to her. If that wasn't the right thing then I know about CQC and that's where I would go next."

Staff meetings were held at the service. However, the last one for which we saw the minutes was in April 2014. This was just before the previous manager left the service but there was no record of any meetings to notify staff of this event or that a new manager was to start work. The main topics discussed were management of medicines and menus.

We saw that there were policies and procedures covering all aspects of the running of this service. but they had not been updated in the last twelve months which could mean that staff were not aware of changes to current legislation or guidance. Safety checks for gas, water, electricity and equipment had been carried out and were current.

The manager told us in the PIR that audits had been carried out and told us that action plans were in place. During the inspection, we found that medicine audits had not been carried out regularly and though nurses were supposed to carry out a daily ten point checklist but that had not been completed for eleven days prior to our visit in September 2014.The last time it was completed was 6 September 2014.The checks and audits which had taken place had not being used as they were intended, to improve the service. Care plans were out of date, infection control and cleanliness had not improved, medication was not managed safely and supervisions were not completed for staff. There were no current medicine or infection control audits and no audits had been completed for equipment. Staff could not show us any up to date action plans to indicate that improvements were planned or underway. This meant that the provider was not protecting people who used the service and others who may be at risk, against the risks of inappropriate or unsafe care and treatment by means of the effective operation of systems which monitored and assessed the quality of the service. Risks relating to the health and welfare of people who used the service had not been identified and managed. This is a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) 2010.

CQC had been notified of eight complaints since February 2014. When we checked the complaint records we saw that these were all recorded and the response by the manager logged with any actions taken. However, there was no

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analysis or learning from the issues raised. For example, we were aware that some of the complaints related to the cleanliness of the environment and we could see that no improvements had been made following these complaints.

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 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services The registered person did not take proper steps to ensure each service user received care that was appropriate and safe.

The enforcement action we took:
Warning Notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers The registered person did not have effective systems in place to monitor the quality of the service delivery.

The enforcement action we took:
Warning Notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control The registered person did not have effective systems in place to protect people from the risks of acquiring a health care associated infection as appropriate standards of cleanliness and hygiene were not maintained

The enforcement action we took:
Warning Notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines

This section is primarily information for the provider

Enforcement actions

People were not protected against the risks associated with medicines because the provider did not have appropriate arrangements in place for the safe administration and recording of medicines.

The enforcement action we took:
Warning Notice

Regulated activity

Accommodation for persons who require nursing or personal care

Regulation

Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing

The registered person did not have suitable systems in place to ensure there were sufficient numbers of suitably qualified, skilled and experiences persons employed.

The enforcement action we took:
Warning Notice