Larchwood Care Homes (North) Limited

Harmony House

Inspection report

The Bull Ring
Chilvers Colton
Nuneaton
Warwickshire
CV10 7BG

Tel: 02476320532

Date of inspection visit:
07 June 2016
08 June 2016
14 June 2016

Date of publication:
29 July 2016

Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Requires Improvement**
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 7 and 8 June 2016. The visit was unannounced on 7 June 2016 and we informed the provider we would return on 8 June 2016. We gave feedback about concerns we had identified to the registered manager and regional manager on 8 June 2016. An inspector and inspection manager returned, unannounced, on 14 June 2016 to check if immediate actions had been taken in response to concerns identified had been implemented by the registered manager to address issues we identified.

Harmony House provides accommodation, nursing and personal care and support for up to 57 older people living with physical frailty due to older age and complex health conditions. At the time of the inspection 52 people lived at the home. The home has two floors; on the days of our visit, the ground floor offered six residential care beds and 16 nursing care beds. People on the first floor all required nursing care.

The home is required to have a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run. At the time of this inspection the home had a new manager; who had been in post since March 2015 and registered with us in August 2015.

When we inspected the home in March 2015 we identified a breach in the regulation relating to good governance of the home. In addition to the new manager that had started, in January 2016, the provider of the home, Larchwood, had arranged for Healthcare Management Solutions (HCMS) to take over as managing provider of the home from the previous managing provider. At this inspection, we found insufficient improvement had been made by the registered manager and the managing provider to meet the regulation relating to good governance. However, the HCMS regional manager shared a developmental plan with us which showed they had identified some issues that required improvement. We found further areas that required improvement that had not been identified as part of the development plan.

People did not always have their prescribed medicines available to them because staff had not ensured adequate stocks were available. Risks to people had been assessed, however, actions staff should take were not always detailed which meant risks of harm and injury were not minimised. Staff understood their role in protecting people from abuse and what actions to take if they had concerns.

People felt there were not always enough staff available on shift to meet their needs when support was requested. Some people felt staff were positive towards them but this was not consistent and care was not personalised. People and relatives shared concerns with staff and the registered manager. However, whilst they felt listened to, concerns and complaints raised were not always effectively responded to or resolved to people's satisfaction.

Staff worked within the principles of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.

People told us that most staff were kind and had a caring approach but did not always have the time to effectively care for them. Staff did not consistently respect people's dignity when supporting them. Most people enjoyed the varied group activities offered at the home, but a few people felt socially isolated in their bedrooms.

Risks to people's nutritional health had been assessed but these were not effective because actions to minimise identified risks were not completed. For example, when weight loss was identified, these people were not offered extra calories in their meals or as snacks. Drinks were offered to people and support was given when needed, however people did not always have drinks left within their reach. Staff referred people to healthcare professionals when needed, but did not always follow the guidance shared with them.

Audit processes to monitor the quality and safety of the service were not effective in identifying where improvement was needed. This meant that people experienced a number of shortfalls in relation to the service they received.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The overall rating for this service is 'Inadequate' and the service is therefore in 'Special Measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

People did not always have their prescribed medicines available to them because stocks had run out. Sufficient numbers of staff were not available to meet people's needs in a timely way. People were assessed to reduce the risk of harm or injury, however, actions staff should take were not detailed which meant risks to people were not always minimised. Staff were trained to protect people from the risk of abuse and knew how to report concerns.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff training was provided although some people felt staff skills needed further improvement. Staff worked within the principles of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. People were offered food and drink, however this did not always meet their individual needs because extra calories and snacks were offered where people had lost weight or had been identified as at risk of malnutrition. People did not always have drinks accessible to them. People were referred to healthcare professionals when needed.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People told us most staff were kind and had a caring approach but did not always have the time to provide effective care. Some people experienced caring and respectful interactions from staff. However, this was not consistent and people's dignity was not always maintained. People and their relatives were not routinely supported to express their views or be involved in decisions about their care.

Is the service responsive?

Inadequate

The service was not responsive.

People did not always receive care that was personalised to them. Staff did not respond to people or their relative's requests for their care needs to be met at the time of the request but prioritised other tasks. People and their relatives did not always feel concerns raised were responded to or improvement sustained. People's care plans were not detailed to support staff in delivering care in accordance with people's needs and preferences. Social activities were offered to people but some people felt care staff did not have time to spend with them.

Is the service well-led?

Inadequate

The service was not well led.

The provider's vision and values were not shared by all the staff, which resulted in a culture that was task led and not focused on people living at the home. Audit processes to monitor the quality and safety of the service were not always effective in identifying where improvement was needed. This meant that people experienced a number of shortfalls in relation to the service they received.

Care records and risk assessments were not up to date, and did not always accurately describe the care or support people required. A home development plan to address these shortfalls, with timescales for action to be implemented was shared with us.

Harmony House

Detailed findings

Background to this inspection

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

The inspection took place on 7 and 8 June 2016. The visit was unannounced on 7 June 2016 and we told the provider we would return on 8 June 2016. The inspection team consisted of two inspectors on the first day and two inspectors and an expert by experience on the second day. An expert by experience is a person who has personal experiences of using or caring for someone who uses this type of care service. We gave feedback about concerns we had identified during our visit, to the registered manager and regional manager on 8 June 2016. An inspector and inspection manager returned unannounced on 14 June 2016 to check if immediate actions we were told about were being implemented by the registered manager.

The provider had 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 the information we held about the service. This included information shared with us by the local authority and statutory notifications received from the provider. A statutory notification is information about important events which the provider is required to send us by law. Prior to our inspection, we were aware of an investigation into an incident that occurred at the home in April 2016. The investigation is on-going.

A few people living at the home were not able to tell us about how they were cared for due to living with dementia or complex health care conditions. We spent time with them and observed the care and support they received from staff.

We spoke with 20 people who lived at the home and 11 relatives or friends of people. We spoke with seven care staff, two senior carer workers, three nurses, two cooks, two domestic housekeepers, two activities staff, the maintenance staff member, the registered manager and area manager.

We reviewed a range of records, these included care records for six people and 10 people's medicine administration records and weight checks. We reviewed staff training and quality assurance audits and minutes of meetings.

Requires Improvement

Is the service safe?

Our findings

The management of people's medicines was not always effective because staff had not ensured stocks of people's medicines were available to them. A nurse told us, "I am ordering one person's medicine today because they have run out." We identified one person had missed eight doses of their medicine because stock had run out. Another person's eye drops had not been given because staff recorded they could not find them and another person missed two doses of their medicine because staff could not find it. We discussed our concern with the registered manager and regional manager and they told us they had not been aware of any issues with people's medicines. The registered manager told us, "Staff need to make sure they order people's repeat medicines when needed. We will check this happens."

Some people had medicine prescribed to be given as they needed them. For example, paracetamol for pain relief or medicine for anxiety. However, guidance to staff about when medicine should be offered or given to people, was not always available. This meant that staff, such as agency nurses, did not have the information they needed to refer to. There was a risk that this would be administered in an inconsistent way.

A few people self-administered medicines such as inhalers or medicines through a nebuliser to help them breathe. One person told us, "I keep my inhalers next to me and also some nebules for my nebuliser, I know how to administer these and when I need them." This person felt less anxious because they had their medicine close to them when needed. However, we found that where people self-administered their medicines this was not recorded on their MAR or care record. This meant that staff did not have the information they needed to ensure people received these medicines as prescribed and checks were not in place to support people that self-administered their medicines.

This was a breach of Regulation 12 (1) (2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Prior to our inspection we were aware of an incident involving one person, which had occurred at the home during April 2016. Staff told us there had been changes to this person's smoking risk assessment. We looked at the risk assessment that staff had followed in April 2016 and found no effective actions were described to tell staff how to minimise the risk of injury or harm. However, care records identified minor injuries had occurred but we found no risk assessment review had been completed until May 2016.

This was a breach of Regulation 12 (1) (2) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessments to minimise the risks of people falling had been completed, however, actions to reduce the risk of harm or injury were not detailed which meant staff did not have the information to refer to if needed. Most staff on shift were able to tell us how they kept people safe, however some informed us they did not usually work on the floor allocated to them that day, so would need to ask other staff if they were unsure. We observed safe moving and handling practices by staff, for example, two care staff explained to one person that they were going to support them to transfer from their wheelchair into an armchair, and this was

undertaken in a safe way.

Care staff told us if they suspected a person's skin was becoming sore or damaged they would inform the nurse. One staff member said, "Most people have special mattresses on their beds to reduce the risk of getting pressure areas, we also try to re-position people cared for in bed." People had special mattresses on their bed to reduce the risk of their skin becoming sore, however, one staff member told us they were unsure of what setting the air flow should be at and the information was not in the person's care record for staff to refer to. There was a risk that the setting of the air flow might not be correct and this would potentially mean pressure relief was ineffective.

People told us they felt safe at the home because it was secure and staff were there. One person told us, "I prefer living here to on my own because there are staff here." People were protected from the risks of abuse. Staff attended training in how to safeguard people, one staff member said, "I would recognise abuse and report it to the manager. If I felt it was ignored, I'd report to social services or the CQC. There is a poster to tell us what to do." The registered manager informed us that if any concerns were identified to them, they would act on these and refer any allegations of abuse to the local safeguarding team and to CQC.

Staff told us how they would respond to an emergency that might arise, such as a person falling. One staff member said, "I'd get the nurse or the manager and I'd stay with the person and reassure them." Equipment, such as fire evacuation mats, were available to staff to use in the event of a fire. The registered manager informed us that people's personal emergency evacuation plans (PEEPS) were "work in progress" and being reviewed to ensure they contained all the information needed by staff and emergency services.

Most people and their relatives told us they felt there were not always enough staff on shift to provide the care and support they needed. One person said, "I can't fault the staff, but it would be better if there was more of them." Another person told us, "There are not enough staff, so we have to wait for support." One relative said, "It is very hard to locate staff when I need to ask them to help my family member." We found the allocation and number of staff, on the first two days of our visit, was not sufficient to meet people's needs and discussed this with the registered manager and regional manager. The registered manager informed us that on the first day of our visit two care staff, working on the first floor, had left their shift early due to feeling unwell.

On the ground floor, one carer was new and inexperienced with people's needs and another carer told us, "I don't work on this floor and don't know people well." We observed these issues impacted negatively on the needs of people being met. For example, one person told us, "I prefer to get up early, but there were no staff when I wanted to get washed today." The nurse was also unwell and left their shift early, however, another nurse came on shift to replace them. On the second day of our visit, we were told both floors of the home were fully staffed. However, staff told us more of them were needed on the shift to meet people's needs safely and in a timely way. The registered manager explained they used a dependency assessment tool to determine how many staff were needed but told us, "It would be nice to have more staff." The regional manager said, "Staffing has been increased from eight to a total of nine staff to cover both floors; this includes nurses and carers." We discussed staffing levels with the regional manager and they told us, "The registered manager and I will look again at the dependency assessment levels and also how tasks are prioritised by staff."

Requires Improvement

Is the service effective?

Our findings

Some people felt staff had the skills they needed to effectively care for them. One person said, "The staff are rushed, but when they do get to me they do have the skills they need to support me." Another person said, "Some staff are better than others, the nurse on today is good and listens to my concerns and does something." However, some people felt staff skills needed improvement. One person told us, "Staff put a pad under me but do not secure it, so it is not effective." A different person's relative said, "Staff don't put underwear on my family member, so their incontinence pad is not always secure."

Some relatives whose family members had lived at the home for several years felt things had improved. However, relatives informed us they left notes on their family member's bedroom wall to remind staff about care tasks. One relative told us, "I leave a note to remind staff to do things." Another relative told us, "I feel I have to visit often to check things are done and check charts in their bedroom." A further relative told us, "Sometimes the charts say something is done, such as cleaning my family member's nails but when I look at their nails, I can see it either wasn't done or was not done effectively."

Staff told us they felt they had the skills they needed for the job. One carer told us, "Today is my first day and I have been told about training I will be doing." Staff said they felt training had improved since the change of managing provider of the home. One senior carer told us, "We are now having more taught session's rather just online training." One nurse told us, "The registered manager has asked me to be more involved in training the senior carers so they have the skills they need." Nurses told us they felt they had the skills they needed. One nurse said, "We now have proper handover reports, paperwork is more robust such as people's catheter records. Things are slowly getting here and we are working hard at it."

Some staff told us they had completed training on the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS). The Mental Capacity Act 2005 provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards.

One staff member told us, "I always explain to people what is happening, we can't force people to do things." We observed staff worked within the principles of the Act and whilst not all care staff could explain how the MCA impacted on their job roles, we saw they asked people's consent before undertaking care tasks. However, we identified people's care records had not been reviewed to reflect changes in their mental capacity and three people's 'best interests' decisions were undated.

The home had key-coded doors and access out of the home was restricted. Staff confirmed that the locked door was for both security and to prevent people that lived there from leaving the building. Care staff informed us they did not know who had a DoLS but would check with the nurse or registered manager if a

person wished to leave. Nurses told us who had a DoLS and said they would check with the registered manager if they were uncertain. The registered manager understood their responsibilities under the Act and told us, "If a person has mental capacity and wishes to go out, then we will give them the code."

Some people told us the food was good, one person said, "I get a choice and have enough to eat." People eating in the dining room told us their food was hot and appetizing. However other people felt improvement was needed in both the choices of the food and the temperature it was served at to them in their bedroom. One person eating their meal in their bedroom said, "Food is often luke warm or cold, and more choice would be good." Another person said, "Another stew today, it seems like it is stew every day and that's mostly gravy."

We observed the care and support people received from staff during their meal. One staff member described the food to one person whilst supporting them with their meal in their bedroom and checked whether this person liked the food.

On the first two days of our visit, the cooks told us that the menu had been changed as planned food items were not in stock. We saw stocks of food were low and one cook told us, "We have been informed of a reduction in the food budget, we've only ordered basics." A second cook confirmed they had also been given this information by the home's administrator. We discussed this with the regional manager who informed us that there had been an error in the information and they were not aware that cooks had been informed to reduce expenditure. The regional manager told one cook, "Order the food that is needed and to ensure you have enough stock." On the third day of our visit, we checked food stocks and saw these had been replenished. One cook told us, "We have now been told we do not have to restrict food orders and I've got everything in stock that we need to meet people's needs."

Some people were assessed as being at risk of malnutrition and / or dehydration and depended on staff assisting them to meet their nutritional needs and maintain or increase their weight. We looked at seven people's weight records, which showed weight loss but none of these people were offered 'fortified' (extra calories added) meals or high calorie snacks. One cook told us, "We have not been told to fortify anyone's meals or do any high calorie snacks." The registered manager confirmed people that had lost weight were not receiving extra calories. The registered manager and regional manager informed us that action to improve would be implemented and on the third day of our inspection we saw this had taken place.

Staff told us they had set times to offer a choice of hot drinks to people from the 'tea trolley round.' One staff member told us, "The tea trolley can take up to an hour to get around as we need to support a lot of people with their drink and we can't rush them to drink it." Although people were offered drinks at set times, we found they did not have drinks accessible to them. One staff member told us, "There are jugs of water or squash in people's bedrooms," however, we found most people could not access these without staff assistance. On the first day of our visit, we observed a senior carer request a staff member to check people had a drink accessible to them prior to their lunchtime meal being served. However, we found this check was not fully effective as a few people in their bedrooms remained without a drink. We discussed this with the registered manager and they said, "Staff should leave people's drinks within reach, people have jugs of water in their bedroom but staff should make sure beakers are in reach."

People told us if they felt poorly they told staff and felt they would inform their GP if needed. However, one person told us, "My family member recognised I was not well and asked for the GP. Staff should have realised I wasn't well from my behaviours." One nurse told us, "People have different GPs at various surgeries in the local area, so we contact whichever one if needed for people." We found referrals were made to healthcare professionals such as speech and language therapists, and information sheets were available

to staff. However, staff did not always check the information or follow the guidance. Some people had limited verbal communication and had a percutaneous endoscopic gastrostomy (PEG) and may not have been able to remind staff that they were 'nil by mouth' and to follow the guidance given by healthcare professionals. PEG is an endoscopic medical procedure in which a tube (PEG tube) is passed into a patient's stomach through the abdominal wall, most commonly to provide a means of feeding. One person told us, "I have a PEG for my food and drink that nurses do for me. I'm 'nil by mouth 'and there's the sign, (pointing out a sign displayed in their bedroom), but staff still come and offer me hot drinks."

Requires Improvement

Is the service caring?

Our findings

Some people made positive comments to us about the staff. One person said, "I would give them ten out of ten." Another person told us, "The staff are good most of the time, I asked one girl (staff) to trim my finger nails and she's done one hand but had to go to do something now. I hope she comes back." We spoke with this person on the second day of our visit and they said the staff member had returned to them, which showed us the staff member cared in remembering to return to complete this person's request.

We observed some kind and friendly interactions between staff and people living in the home. We observed activities staff members supporting people to join in group sing-alongs and people were smiling and laughing. One person told us, "One of the staff helped me to the lounge last week so that I could attend the Church service, I appreciated that." One staff member took the opportunity to discuss current affairs prompted by the television news whilst supporting one person with their meal, creating a friendly and relaxed atmosphere.

Most people and relatives felt staff had a caring approach but did not always have the time to spend with them. One staff member told us, "We do our best but if we had more time, we could be more caring and take our time with people rather than rushing." One person told us, "Most staff are caring but some can be sharp." One staff member was dismissive of our request on behalf of one person requiring support. This staff member informed us they had only arrived at 2pm for the shift and didn't know anything about this person's request and they were busy. We discussed this with the registered manager who told us they would address this approach.

Most people living at the home could not recall being involved in decisions about their care. One person said, "I'm not involved in planning and making decisions about my care." Some relatives informed us they had been involved in care reviews, but felt when suggestions or requests were made, they did not always receive feedback. For example, one person told us they had suggested a wheelchair would be useful for them and one relative had suggested their family member might benefit from physiotherapy; however, they had not received feedback from the registered manager following their suggestions. This meant peoples' and relatives' views were listened to but not always acted upon.

One person told us, "Staff are very respectful toward me." We observed most staff respected people's privacy and dignity. Two staff knocked on one person's open bedroom door before entering and closed the door before supporting the person with personal care. However, we observed times when staff did not show respect and walked into people's bedrooms without knocking or calling the person's name. We received mixed responses from relatives about how staff promoted and maintained people's dignity and we saw there was an inconsistent approach by staff resulting in people having mixed experiences.

Staff told us they were trained to support people with their medicines and we observed that people were supported in a person centred way to take their medicines. We saw one staff member discreetly asked a person if they needed any medicine to help relieve constipation in order to uphold their privacy and dignity.

Inadequate

Is the service responsive?

Our findings

Most people told us they had to wait for staff to respond to their needs. Across both floors of the home and on both days of our visit, (7 and 8 June 2016), we observed people did not receive personalised care that was responsive to their needs at the time requests were made. One person said, "I spend ages waiting for staff to help me wash and get me up. Today, I wanted to get up before lunchtime, but staff have now told me it's too late and I'll have to wait until after lunch. It gets me down at times." Another person told us, "Staff have a good excuse for everything, saying they are busy or equipment is being used somewhere else so I'll have to wait." We found the home had sufficient equipment, such as hoists, but staff were not always available to respond to people's needs.

We observed one person pressed their call bell at 9.45am to request support to wash and get up. A staff member responded at 9.50am, and informed this person they were busy but would return. Staff returned to support this person with personal care needs at 10.23am. One relative informed us, "At 2pm, I requested staff wash and change my relative and help them into bed for a rest, as that is what they want. It's now 3.45pm and they have still not come back, my relative is wet and sore. It's not that they don't care here, it's just they haven't got the time. This is not a one off, my family member likes to be supported to wash and dress in the morning but on a recent visit, staff came at five past three in the afternoon." This person told their family member, "I'm all wet," we observed they waited two hours for staff to respond to their needs. On a separate floor of the home, we observed another person waited from 2.15pm until 3pm to be assisted to the toilet. We discussed this with staff and one staff member informed us, "I am making someone's bed and need to wait for another staff member, they are busy doing other things."

One person told us, "I would like a bath, but staff said I can't. I smell and I don't like it." Another person said, "I do generally get a shower once a week, but it's not when I want but when they tell me there are enough staff." Some people told us staff had said it was not possible for them to have a bath or shower because staff had informed them the hoist did not fit under the bath and they did not have equipment to shower people. We found this was not accurate and the hoist could be used to support people to access the bath and an accessible shower room was available. We found staff did not respond to people's requests for a bath or shower and people were given inaccurate information as to why they could not have a bath or shower.

Most people were cared for in their bedrooms and, on each day of our visit, we identified people that had no call bell cord accessible to them to enable them to gain staff support if needed. We asked staff about call bell cords being left out of reach of people and were told staff must have forgotten to given them to people. One person told us, "If they forget to give me the call bell, I shout staff." We gave this person their call bed that was out of their reach behind their bed. We saw a few people used communal lounges but had no accessible call bell cord to them. One person in the lounge told us, "Staff are not always about, I can shout or just wait, but that can be a long time."

One person told us, "I don't feel involved in my care, it's just the same thing every day." Care plans seen were not personalised. Although people's care plans briefly described most people's needs, the information was not detailed and did not always inform staff how to meet needs in a way the person preferred. We found

little information about people's likes, dislikes, routine or preferences which meant staff did not have the information to refer to if needed. The area manager informed us of plans for improvement which would be implemented before the end of August 2016.

The registered manager informed us that 'resident and relative' meetings took place as a way of consulting and seeking feedback from people, we saw meeting date information was displayed in the reception but may not have been accessible to people living at the home. One person told us, "I don't know when they are held but I wouldn't bother going anyway. My relation has raised issues with the manager for me about things that need to be improved, but nothing has been done. They just say 'they'll look into it.'" Another person said, "I've never been invited to any meeting." One relative told us, "I have heard of relative meetings, but I haven't attended." Meeting notes from March and April 2016 showed none of the people living at the home attended the meeting and few relatives attended. In the March 2016 meeting, issues around poor care practices, such as drinks not being accessible and staff not responding to people's needs at the time when requests were made were identified to the registered manager. Whilst relatives reported some improvement at the April 2016 meeting, we identified the same poor practice issues during our visit which meant the registered manager had not ensured improvement in care practices were sustained.

Some people and their relatives informed us that concerns about staff responsiveness had been raised. One person told us, "Last week, I was cross at having to wait an hour for staff to help me and told one nurse and they said 'We are short staffed and run off our feet.'" A few people said when issues had been raised they had been dealt with. One person told us, "My relatives asked if I could move to a ground floor bedroom as I found the home atmosphere better down stairs. It got sorted out for me." However, whilst people and relatives told us they felt they could raise concerns with staff and the registered manager, most people told us they felt issues improved only for a short time or were not addressed at all.

Complaints were not always used to drive improvement. The registered manager told us they had received nine complaints this year, some of which identified issues of poor care practices. Relatives spoken with felt complaints were not always satisfactorily resolved. One relative said, "I raised an issue about cleanliness and it was dealt with but the same issue re-occurs again." Another relative told us, "A complaint I made has not been resolved." We looked at one complaint about poor care practices and found the registered manager's response had not addressed the issues identified to them. The registered manager informed us that they investigated complaints and spoke with staff to remind them of their job role, however we found the registered manager's action had not been effective because improvements were not sustained.

This was a breach of Regulation 9 (1) (a) (b) (c) (2) (3) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During our last inspection, in March 2015, we identified improvement was required in opportunities offered to people about how they spent their time. At this inspection, the registered manager informed us two activities staff had been recruited to offer people activities and trips out. We found improvement had been made to group activities offered and during our visit observed people take part in a sing-a-long and enjoy a live performance from musicians. One person said, "I really enjoy this, it's lovely." Another person told us, "Things we can do has improved a lot, there are two girls (staff) who arrange all this, and it's good to have things to do." However, a few people cared for in their bedrooms told us they felt isolated, one person asked us, "Can you come back and visit me, staff don't have the time to talk with me." One activities staff member told us, "We try to provide someone to one time with people in their bedrooms, but it can be a challenge to fit everyone in as much as they would like. Although we offer the group activities to everyone, we know some people either don't want to come downstairs or are unable to move from their bed." This meant some people enjoyed the activities and social interaction offered, however there were a few people whose

individual needs for companionship to prevent social isolation were not always met.

Inadequate

Is the service well-led?

Our findings

When we inspected the home in March 2015 we identified a breach in the regulation relating to good governance of the home. Some changes had taken place at the home since our last inspection. A new manager had started in May 2015 and became registered with us in August 2015. In January 2016, the provider of the home, Larchwood, arranged for Healthcare Management Solutions (HCMS) to take over as managing provider of the home from the previous managing provider. At this inspection, we found insufficient improvement had been made by the registered manager and the managing provider to meet the regulation relating to good governance. The HCMS regional manager shared a developmental plan with us, this showed that they and the registered manager had identified some issues that required improvement and had timescales in place for implementation. However, we found further issues and some concerns that had not been identified as part of the development plan. For example, medicine checks had not identified some people had run out before repeat medicines were received. Audits of people's care records had not identified when action was required to review risk assessment so risks were managed safely and staff had the information they needed. Checks on the deployment of staff, to ensure people's needs were met were not effective.

Ineffective and inconsistent systems and processes were in place to monitor the quality and safety of the services.

The medicines audit of February 2016 identified areas for improvement but the audit action plan had not been completed. An informal medicines audit dated May 2016 identified issues and concerns to the registered manager, such as no action had been taken about one person's missing medicine that was reported during April 2016. We asked the registered manager what action they had taken about issues identified in the audit and they told us, "I am reminding staff about the importance of following the medicines policy and getting things right." We identified further issues with the safe management of medicines that the provider's audits had failed to identify.

Care record audits had not identified that where risks of harm or injury to people had been identified, assessments did not describe the actions staff needed to take to minimise the risks. Accidents and incidents were recorded by staff and the information was used by the registered manager to complete a monthly analysis to look for any themes. However, the analysis did not always look for opportunities to reduce the risk of reoccurrence of falls. For example, the registered manager told us a person had to have experienced two falls before a review took place. People's relatives were not always informed of falls and we asked the registered manager if this was in agreement with relatives. The registered manager informed us people's relatives had not been consulted as to whether they wished to be informed or not, we found this approach was not transparent to keep relatives informed about their family member's wellbeing.

The registered manager informed us that infection control audits, planned for every three months, had not been completed. The most recent infection control audit, dated October 2015, had scored 78% and the home had rated itself 'inadequate' in infection control standards. Actions required for improvement had been identified and some had been implemented, however others had not. For example, the first floor

lounge kitchenette units were broken and the broken panel kick board meant effective cleaning could not take place. This and other maintenance décor issues identified had no timescale for improvement to be implemented.

Despite a number of people and relatives having raised concerns about the length of time staff took to answer call bells, staff response times in answering people's call bells and responding to their care need were not effectively monitored. The registered manager informed us these checks were informal and call bell response audits were not completed.

Staff completed people's weight checks but we found these checks were not a part of the registered manager's audits, which meant important information was not passed to the kitchen staff about people's dietary needs. This was despite a number of people having been identified as experiencing weight loss. We discussed this with the registered manager and they told us that action would be taken to include this in their 'nutritional' check to ensure they identified people with a recorded weight loss and would inform kitchen staff when extra calorific snacks were required for people.

Quality monitoring checks undertaken by the regional manager had not always identified where improvement was needed in the home. For example, in March 2016 the regional manager found that the home was compliant in most areas and only needed minor improvement in some areas was needed. The registered manager told us their nutritional checks had not identified some of the issues we found, such as where people had experienced weight loss, they were not having extra calorie snacks made available to them.

This was a continued breach of Regulation 17 (1) (2) (a) (b) (e) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

On the first day of this inspection, we saw that the provider was not displaying their CQC rating in the home; from our March 2015 inspection. It is a regulation, which came into force on 1 April 2015, that says providers must 'conspicuously' and 'legibly' display their CQC rating at their premises and on their website. We discussed this with the registered manager and they told us, "We have the inspection report displayed but not a rating poster. I will do it today." On the second day of our visit, we saw a poster was displayed to show the rating of the home.

Staff told us they felt the registered manager was approachable and would listen to them. However, one staff member told us, "The manager is nice and will listen but sometimes they cannot always resolve issues to improve things, like they know we are rushed, but they can't put on extra staff." Another staff member said, "We have staff meetings and one to one supervision which is good, but at the end of the day, sometimes the manager's hands are tied. For example, if a carer phones in sick, they try to get cover from the staff but we need our days off and staff don't always want to cover shifts, so that means the shift is short staffed."

The registered manager informed us that agency staff were used when needed and said, "I try to cover shifts with our own staff when possible for continuity of people's care, but will use agency if they are available which is not always if it is late notice." The registered manager informed us that during May 2016, 175 hours were covered by agency nurses and 31 hours by agency carers. We discussed recruitment and the high turnover of staff; with 54 new staff in the past 12 months with the registered manager. They informed us that staff had left for varied reasons and they were currently recruiting and said, "Since HCMS took over, staff pay has been reviewed and some incentives introduced that recognise the value of staff. For example, 'Staff member of the month' where their hard work is recognised. I think current recruitment efforts will improve

staffing and reduce the previous high turnover."

Staff gave us mixed feedback about the culture of the home. Some staff felt there was a positive culture and staff worked well together. Some staff told us they felt some of their colleagues lacked motivation and this impacted on the shift and how people's care needs were met. We discussed this with the registered manager and they informed us that a few staff had not successfully completed their probationary period. The registered manager added that checks on staff took place as a part of their daily walk around the home. However, we found these were not always effective in addressing poor care practices or ensuring improvements were sustained.

Satisfaction surveys had been sent to people and their relatives in February 2016 and analysis identified areas for improvement. For example, the availability of drinks and snacks had been identified as requiring improvement, the registered manager had responded by recording an 'improved snack trolley' had been introduced. However, people told us they felt improvement had not taken place and was still needed. On the first day of our visit, biscuits were the only snack offered to people and there was nothing available for people requiring a soft diet. Actions for improvement following feedback from people had not been effective.

The home's health and safety audit completed in May 2016, recorded 'fail' with a score of 83%. We found some actions, such as improving fire safety, had been implemented and where other actions for improvement were identified a timescale for action was recorded, for example checks of the first floor window restrictors were planned to be included later in the 2016 audit.

On 8 June 2016, we gave feedback from our visit to the registered manager and regional manager, they informed us action would be taken to respond to concerns we identified to them, such as to ensure where people had lost weight, they were offered snacks and their meals had extra calories added to them. The registered manager and regional manager agreed other improvements were needed and shared timescales with us for implementing action. This included a full review and update of people's care plans to Larchwood care records. The regional manager said, "All care plans and risk assessments will be totally updated, reviewed and transferred to the new care file paperwork by the end of August 2016."

Due to concerns we identified during our visit on 7 and 8 June, we returned to the home on 14 June and asked the registered manager to show us what action they had implemented to make immediate improvement. A daily medicines audit checklist had been implemented to identify any issues such as out of stock medicines and recorded action taken to ensure people had their medicines available to them. One to one supervision meetings with staff had commenced to discuss areas of responsibility and address any poor care practices. The registered manager confirmed to us that there was no restriction placed on the cooks ordering food supplies that were needed and one cook on shift confirmed this to us. People were receiving extra calories in their meals and high calorie snacks when needed. This meant that the registered manager and area manager had responded to concerns identified to them by us and had taken urgent action to address issues and implement improvement, with further improvement planned for.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care Regulation 9 (1) (a) (b) (c) (2) (3) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The care and treatment of service users was not person centred care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Regulation 12 (1) (2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The management of medicines was not safe. Regulation 12 (1) (2) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Care and treatment was not always provided in a safe way for service users.

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 17 HSCA RA Regulations 2014 Good governance
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 (1) (2) (a) (b) (e) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Systems and processes to assess, monitor and improve the services were not effective.

The enforcement action we took:

Warning Notice