Galleon Care Homes Limited

Lindsay Hall Nursing Home

Inspection report

128 Dorset Road
Bexhill On Sea
East Sussex
TN40 2HT

Tel: 01424219532
Website: www.titleworth.com

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

We inspected Lindsay Hall Nursing Home on 5, 6 and 7 July 2016. This was an unannounced inspection

Lindsay Hall provides accommodation and nursing care for up to 38 people living with differing stages of dementia who have nursing needs, such as diabetes and strokes. There were 26 people living at the home on the days of our inspections.

Lindsay Hall Nursing Home is owned by Galleon Care Homes Limited and who have two other homes in the South East. Accommodation was provided over three floors with a passenger lift that provided level access to all parts of the home. People spoke well of the home and visiting relatives confirmed they felt confident leaving their loved ones in the care of Lindsay Hall Nursing Home.

There was no registered manager in post. A manager was in post and was in the process of registering with the CQC. 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 a comprehensive inspection in March 2015 the overall rating for this service was Inadequate. At this time we took enforcement action. Seven breaches of Regulation of the Health and Social Care Act 2008 (Regulated Activities) 2014 were identified. The inspection in March 2015 found significant risks to people due to the poor management of medicines and people not receiving appropriate person centred care. Where people's health needs had changed considerably, care plans had not been updated. Staff did not have the most up to date information about people's health. This meant there was a risk that people's health could deteriorate and go unnoticed. Risk assessments did not reflect people's changing needs in respect of wounds and pressure damage. Accidents and incidents had not been recorded appropriately and steps had not been taken by the staff to minimise the risk of similar events happening in the future. Risks associated with the cleanliness of the environment and equipment had been not been identified and managed effectively. People had not been protected against unsafe treatment by the quality assurance systems. We also found that training had not been delivered where identified as needed and administrative processes to support training, staff supervision and appraisal were inaccurate and incomplete.

Following the inspection, we received an action plan which set out what actions were to be taken to achieve compliance by June 2015. During our inspection in August 2015, we looked to see if improvements had been made. The inspection found that improvements had been made and breaches in regulation had been met. However the improvements were not fully embedded in practice and they need further time to be fully established in to everyday care delivery.

Due to a high number of concerns raised about the safety of people, the meal service and staffing levels we brought forward the scheduled inspection to the 5, 6 and 7July 2016, so we could ensure that people were

safe.

This inspection found that people's safety was being compromised in a number of areas. Care plans did not reflect people's assessed level of care needs and care delivery was not person specific or holistic. We found that people with specific health problems such as pressure ulcers and wounds were not up to date and did not have sufficient guidance in place for staff to deliver safe treatment. The lack of suitably qualified and experienced staff impacted on the care delivery and staff were under pressure to deliver care in a timely fashion. Shortcuts in care delivery were identified. We also found the provider was not meeting the requirements of the Mental Capacity Act (MCA) 2005. Mental capacity assessments were not completed in line with legal requirements. Staff were not following the principles of the MCA. We found there were restrictions imposed on people that did not consider their ability to make individual decisions for themselves, as required under the MCA Code of Practice.

The delivery of care suited staff routine rather than individual choice. Care plans lacked sufficient information on people's likes and dislikes. Information in respect of people's lifestyle choices was not readily available for staff. The lack of meaningful activities impacted negatively on people's well-being.

People, staff and visitors were not always complimentary about the meal service at Lindsay Hall Nursing Home. They thought the closing of the kitchen and the meals coming from the sister home had caused delays, cold food and missed meals. The dining experience was not a social and enjoyable experience for people. People were not always supported to eat and drink enough to meet their needs.

Quality assurance systems were in place but had not identified the shortfalls in care delivery and record keeping. We were told that incidents and accidents were recorded but six months of completed accident records were not available for viewing and the accident and incident audit was not up to date. We could not be assured that accidents and incidents were consistently investigated with a robust action plan to prevent a re-occurrence.

People's medicines were stored safely and in line with legal regulations. However people did not always receive their medicines on time and we found that some people's essential medicine was out of stock for six days. There were missing signatures for medicines. These had not been followed up to ensure that people received their prescribed medicines. We also found poor recording of topical creams, dietary supplements and 'as required' medication.

People and visitors we spoke with were complimentary about the caring nature of some of the staff. But said that the constant changes to staff, use of agency staff and staff leaving had impacted on how the home was run. Many people were supported with little verbal interaction, and many spent time isolated in their rooms.

Feedback had been sought from people, relatives and staff in 2015 but had not been undertaken since changes to the running of the home were implemented and the new management had been introduced. 'Residents' and staff meetings were held on a regular basis which provided a forum for people to raise concerns and discuss ideas. However an action plan for ideas suggested and concerns had not been shared with people and visitors.

Staff told us they thought that communication systems needed to be improved and they required more support to deliver good care, they felt that the lack of permanent staff and high staff turnover had raised issues. Their comments included "We work well but need to build up the staff team, we can't do everything."

People had access to appropriate healthcare professionals. Staff told us how they would contact the GP if

they had concerns about people's health. However care plans did not include all the information about people's health related needs.

People were protected, as far as possible, by a safe recruitment system. Each personnel file had a completed application form listing their work history as wells as their skills and qualifications. Nurses employed by Lindsay Hall Nursing Home and bank nurses all had registration with the nursing midwifery council (NMC), which was up to date.

The overall rating for this provider is 'Inadequate'. This means that it has been placed into 'Special measures' by CQC. The purpose of special measures is to:

• Ensure that providers found to be providing inadequate care significantly improve.
• Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.

Services placed in special measures will be inspected again within six months. The service will be kept under review and if needed could be escalated to urgent enforcement action.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

Lindsay Hall Nursing Home was not safe. Risk assessments, whilst in place were not up to date. The management of people's individual safety and skin integrity was poor and placed people at risk.

People were placed at risk from equipment which was not suitable for their needs and we observed poor moving and handling techniques.

There was not always enough suitably qualified and experienced staff to meet people's needs. People's needs were not taken into account when determining staffing deployment.

The management and administration of medicines was not always safe.

Staff had received training in how to safeguard people from abuse but were not confident about how to respond to allegations of abuse. Staff recruitment practices were safe.

Is the service effective?

Inadequate

Lindsay Hall Nursing Home was not effective. Meal times were observed to be a solitary and inefficient service. Senior staff had no oversight of what people ate and drank. No guidance was available on how much people should be eating and drinking to remain healthy.

Staff had received training to carry out their roles effectively. This was not always put into practice by staff because safe care delivery was not consistent throughout the service.

Not all staff received on-going professional development through regular supervisions, and the lack of effective induction processes for agency and new staff was a particular concern.

Staff had some understanding of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. However, the use of on-going mental capacity assessments for people who had limited capacity were not in place.

Is the service caring?

Inadequate

Lindsay Hall Nursing Home was not caring.

Care mainly focused on getting the job done and did not take account of people's individual preferences or respect their dignity. People who remained in their bedroom received very little attention.

Staff were not always seen to interact positively with people throughout our inspection. We saw staff undertake tasks and care without any interaction. However we also saw that some staff were very kind and thoughtful and when possible gave reassurance to the people they supported.

Is the service responsive?

Inadequate

Lindsay Hall Nursing Home was not responsive. Care plans did not always show the most up-to-date information on people's needs, preferences and risks to their care.

Staff told us that people were able to make everyday choices, but we did not see this happening during our visit. There were not enough meaningful activities for people to participate in as groups or individually to meet their social and welfare needs; so some people living at the home felt isolated.

Whilst a complaints policy was in place we were not assured that complaints were handled appropriately. Not all visitors felt their complaint or concern had been resolved appropriately.

Is the service well-led?

Inadequate

Lindsay Hall Nursing Home was not well led. There was no registered manager in post. People were put at risk because systems for monitoring quality were not effective.

Management hand not ensured that the delivery of care was person focused or ensured that people not were left for long periods of time, with no interaction or mental stimulation.

The home had a vision and values statement, however staff were not clear on the home's direction.

People spoke positively of the care staff, but commented that staffing levels and the high use of agency staff had impacted on the running of the home and the care delivery. Staff and visitors had an awareness of the management team but felt communication could be improved.

Lindsay Hall Nursing Home

Detailed findings

Background to this inspection

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

The inspection took place on the 5, 6 and 7 July 2016. This visit was unannounced, which meant the provider and staff did not know we were coming.

Three inspectors undertook this inspection.

Before our inspection we reviewed the information we held about the home. We considered information which had been shared with us by the local authority and looked at safeguarding alerts that had been made and notifications which had been submitted. A notification is information about important events which the provider is required to tell us about by law. Before the inspection we spoke with the Local Authority and Clinical Commissioning Group (CCG) to ask them about their experiences of the service provided to people.

We observed care in the communal areas and over the three floors of the home. We spoke with people and staff, and observed how people were supported during their lunch. We spent time looking at records, four staff files and other records relating to the management of the home, such as complaints and accident / incident recording and audit documentation. We looked at ten care plans and risk assessments along with other relevant documentation to support our findings. We also 'pathway tracked' eight people. This is when we looked at people's care documentation in depth and obtained their views on how they found living at the home. It is an important part of our inspection, as it allowed us to capture information about a sample of people receiving care. Some people were unable to speak with us. Therefore we used other methods to help us understand their experiences. We used the Short Observational Framework for Inspection (SOFI) during the morning of the 5 July 2016 and the afternoon of the 6 July 2016. SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We spoke with 11 people living at the service, four visiting relatives, ten care staff, (which included agency staff) the chef, a housekeeper, two registered nurses, the provider, the area manager and the manager.

Inadequate

Is the service safe?

Our findings

People told us they felt safe living at Lindsay Hall Nursing Home. One person told us, "I know I'm safe, I get everything I need." Another person said, "I have no complaints really just a few niggles." One relative told us, "I have had concerns about staffing levels at meal times and the amount of agency staff." Another relative said, "It's all very worrying at present, too many agency staff, that's when mistakes happen. We found there were shortfalls which compromised people's safety and placed people at risk from unsafe care.

Peoples' risk assessments were not all up to date and some lacked sufficient information and guidance to keep people safe. Care plans contained risk assessments specific to health needs such as mobility, continence care, falls, nutrition, pressure damage and a person's overall dependency. They looked at the identified risk and included a plan of action to promote safe care. However not everyone's health, safety and wellbeing had been assessed and protected. For example, the management of one person's pressure ulcer was inaccurate and poorly documented. The care staff had completed daily notes that referred to the person's pressure ulcer but the organisation's policy for wound management had not been followed. There were no wound care plans, description of wound or photographs of wounds for staff to monitor improvement or deterioration. The management team were not aware of this additional wound until we asked for the wound documents.

Risk associated with the use of pressure relieving equipment and the use of bedrails had not always been assessed and used appropriately. For example, six pressure relieving mattresses were set at the wrong setting for individual people. If pressure mattresses are set incorrectly people are placed at additional risk of pressure damage. This included a mattress which was on a setting for a person who weighed 140 kgs. The person weighed only 56 kgs. Risks associated with the use of bed rails with pressure relieving mattresses had not been assessed or recorded to ensure that they complied with safety guidelines. For example the space between the mattress and the top of the bed rails for one person was less than that recommended by The Health and Safety Executive. People were therefore potentially at risk from falling from bed. These were discussed with the management team who told us they would check them immediately.

Good skin care involves good management of continence and regular change of position. There was guidance for people to receive two or four hourly position changes. During the inspection, we observed people remaining in the same position for long periods of time, both in communal areas and in their bedrooms. Two people had been sitting in one position for six hours. During this time their incontinence pads had not been checked or changed. The charts to record position changes showed us that people had not been moved as their care plan specified. Staff told us, "I haven't had the time, it's not an excuse, its reality." We informed the agency nurse who took immediate action. We looked at these two people's care plans for continence management which stated that two to four hour checking of incontinence aids should be undertaken and barrier creams applied. Staff had not followed guidance in the person's care plans to ensure they managed people's skin integrity safely with regular checking and movement of position.

One person living with behaviours that may challenge themselves or others had a mental health care plan which detailed they did not accept that they required care. However, there was no specific behaviour

management plan, no record of outcome, of referral to the Mental Health Team (MHT) or whether the GP had been involved. We saw two separate incidents during our inspection where staff experienced difficulties in managing this person's behaviours that challenged. Neither were managed in a way that ensured the safety of the person or staff.

Whilst the provider had arrangements in place for the management of medicines, we found the administration and recording of medicines were potentially unsafe. This placed people at risk of not receiving their prescribed medicines. One person's essential medication was out of stock for six days and staff had not put in place an action plan to monitor the health of the person whilst they had not received their prescribed medicine. For example monitor for breathing difficulties and reduced urine output.

Morning medicines were prescribed to be given at 8am, we observed these medicines were still being administered at 12 midday. This meant some medicines were not being given with food as prescribed. It also impacted on those people who were prescribed to have medicines on a four hourly regime for maximum benefit such as pain relief. We found a large number of staff signature omissions (identified as gaps) in medication administration records (MAR). For example one person over a six day period had 16 signature gaps. These gaps had not been identified by the nurse administering medicine on the next shift, and had not been followed up to determine whether it was a missed signature or a missed dose. There was no explanation recorded on the MAR as to why the medicines had not been administered. Staff followed the home's medicine policy with regard to medicines given 'as required' (PRN), such as paracetamol. However records had not always been completed with details of why they had been given. We also noted that there was a lack of directives as to when PRN medicines should be administered. For example pain charts.

Topical creams were not consistently signed as being administered as prescribed. On discussion we were told that the care staff member who delivers personal care should sign that the cream had been applied. We saw that creams prescribed for a specific person were in use in another person's room. This was also a cross infection risk.

The recording of injuries such as skin tears were not up to date and some were not recorded immediately, as the organisational policy stated they should be. During our inspection one person was found to have skin tears on their arm. A care staff member confirmed that they had found them at 8 am when they had taken breakfast to the person. They had not informed the nurse and no documentation completed at that time. A dressing was applied at 3pm by the agency nurse who assured us an accident record would be completed.

People were not protected from avoidable harm due to inappropriate moving and handling techniques. We saw two care staff move a person who had slipped in their chair by means of using a 'drag' lift. A 'drag' lift (underarm lift) is any method of lifting people where staff place a hand or arm under the person's armpit. Use of this lift can result to damage to the spine, shoulders, wrist and knees of the staff and, for the person lifted there is the potential of injury to the shoulder and soft tissues around the armpit. We also observed one person moved in bed by staff pulling them forward so they could eat their meal.

Not all areas of the home were clean and hygienic. The sluice room on the garden floor was odorous and the yellow bag used for soiled pads and clinical waste was open and hanging off the bin without a lid. The floor of the sluice room was unclean and not impermeable to spills. There were also specific rooms that had unpleasant odours that were attended to by the housekeeper when identified. During the inspection, there was an incontinence accident in the dining room involving a chair and the floor. There was a 20 minute delay in cleaning the chair and the floor. Staff continued to move people to the dining table area where the accident had occurred and served people their meal. The floor was then cleaned with a strong disinfectant whilst people were still eating.

There were people who had significant weight loss and their care plans and risk assessments had not been updated to reflect this. The manager informed us that an urgent weight loss plan should have been started. However this had not happened for three specific people. For example, one person had lost 18 kgs since 04 September 2015 to 19 June 2016, their weight was now 34.8 kgs. There was no care plan to guide staff to ensure the person's needs were met. The person's risk assessment had not been updated and there was no evidence that this weight loss had been referred to the GP or the dietetic team. Another person had lost 11 kgs since January 2016 and there was no supporting evidence that staff had taken appropriate action to ensure their health needs were met.

All of the above issues demonstrate that people were not protected against the risks of receiving care or treatment that is inappropriate or unsafe and were a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were 26 people living in Lindsay Hall, this included two people that were currently in hospital. Staffing comprised of six care staff on the day shift in addition to two registered nurses. The manager was supernumery to the staffing levels. Three waking staff provided support at night with one nurse. At the time of our inspection, we were told staffing levels had been increased in the morning to seven care staff. However one staff member was on induction and therefore was not supposed to be working unsupervised or delivering care. Due to the staff deployment this was unavoidable and a senior care staff member said, "There's just the two of us, we've just finished washing people, and she (new care staff) is on induction, she shouldn't even be doing that."

A high percentage of agency staff had been used regularly in the past six months due to a sudden turnover of staff. During the inspection 80% of staff were agency, which included trained staff. We looked at the staffing rota and saw that on many days there was just one permanent staff member supported by agency staff. Most days the nurses on during the day were agency staff. There was little continuity of nurses and one nurse said she wouldn't be going back after this initial shift. Therefore there was no positive leadership and the nurses were unsure of the normal running of the home. This had not ensured that there was consistent care delivery, also people who live with dementia respond more positively to people they recognise. One staff member said, "It's been a real problem, the agency staff are really good but they don't know people and everything takes twice as long."

Staff were busy throughout the day and care was not delivered in a timely manner. Personal care to assist people up for the day was still being undertaken at midday on to of two of the three days and this was not always people's individual preference. This also meant that people were not receiving timely continence care which impacted on people's skin integrity. One staff member said, "Its busy today and we haven't done the turns as it been full on." Another staff member said, "I have worked here before so I do know residents a bit but it doesn't always run smooth because of lack of leadership."

Over three days we observed the midday and evening meal service. There were insufficient staff deployed to give the support people required. Meals were left in front of people and some people had not eaten before their meal became cold; they were then removed. Staff had not followed care directives, such as regular turns and changes of position due to the staff deployment and time restraints.

Personal emergency evacuation plans (PEEP's) were in place but lack of appropriate induction for agency staff placed people at risk from failed emergency evacuations. The agency nurses and an agency health care assistant confirmed that they had not received an induction and fire procedures had not been explained to them before starting work. The provider had not ensured that there were sufficient, experienced and qualified staff to meet peoples' needs and this was a breach of Regulation 18 of the Health and Social Care

Act 2008 (Regulated Activities) Regulations 2014.

Safeguarding policies and procedures were in place and were up to date and appropriate. However when we asked if the concerns staff shared with us in respect of staffing issues, not being able to deliver safe and appropriate care and the problems with the meal service had been referred to safeguarding, they told us they hadn't because it wasn't physical abuse. So whilst staff had received training in safeguarding adults at risk, further embedding of the learning from the training is needed. This was an area that requires improvement.

People were protected, as far as possible, by a safe recruitment system. Staff told us they had an interview and before they started work, that the provider obtained references and carried out a criminal records check. We checked three staff records and saw that these were in place. Each file had a completed application form listing their work history as wells as their skills and qualifications. Nurses employed by the provider of Lindsay Hall Nursing Home and bank/agency nurses all had registration with the nursing midwifery council (NMC) which was up to date.

Inadequate

Is the service effective?

Our findings

People spoke positively about the home. Comments included, "I'm looked after." "The carers are very good." However, we found staff and management at Lindsay Hall Nursing Home did not consistently provide care that was effective.

Staff were not always working within the principles of the Mental Capacity Act 2005 (MCA). Staff told us most people would be able to consent to basic care and treatment, such as washing and dressing. The MCA says that assessment of capacity must be decision specific. It must also be recorded how the decision of capacity was reached. We found that the reference to people's mental capacity did not record the steps taken to reach a decision about a person's capacity. We identified that certain decisions about where people spent their time had not been asked, considered or referred for a best interest meeting. During our inspection we noted that some people remained in their rooms. We asked why and were told that was what was 'normal'. One person who had been in the home for a year had still had not visited the garden. Their relative told us, "I have asked but it's never the right time, (name) loves the fresh air and gardens." Another visitor said, "I have to visit daily so I know (name) is got up and taken downstairs as (name) like's company, staff don't ask (name) because of the illness." Staff were unable to tell us about how certain decisions were made such as, consenting to photographs of wounds. One person was able to tell us clearly how they wished to spend their time but the documentation stated that that they did not have the mental capacity to make that choice. Staff said, "They will only change their minds." There was no consideration given for those whose mental capacity may fluctuate daily. We spent time with one person who told us that staff never asked her if she would like to get up, "I think it's easier for everyone if I stay in bed." There was no supporting documentation that explained the reasons why the person was on bed rest and whether any other option had been considered. There were other people who remained on bed rest without any rationale documented. This told us mental capacity assessments whilst undertaken were not decision specific and were not recorded in line with legal requirements.

In March 2014, changes were made to the Deprivation Liberty Safeguards and what may constitute a deprivation of liberty. These safeguards protect the rights of people by ensuring that any restrictions to their freedom and liberty have been authorised by the local authority, to protect the person from harm. Our information informed us that two DoLS application had been made, however the management team were not clear on if any other applications had been made. Everyone at Lindsay Hall could be seen as needing a DoLS as there were key pads on most doors and lifts. We saw people restricted from moving by bed rails, tables placed in front of their chairs, poor positioning in recliner chairs and people remaining on bed rest without a clear rationale in place.

There were no individual mental capacity assessments for people living at Lindsay Hall Nursing Home on how their freedom may be restricted or what least restrictive practice could be implemented. This is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Since the last inspection the meal delivery at Lindsay Hall had changed. The kitchen had closed and all the meals were prepared and cooked at the sister home Highbeech 200 yards down the road. The feedback

about the quality of food, the timing of meals and the actual delivery of food was varied and not all positive. Families were very concerned about the fact that food was often cold by the time it was served, the choice was limited and the quality was not good. One relative said her husband had often been forgotten at tea time and that on numerous occasions when the food arrived it was cold. She said "I had to ask staff to reheat it so he ate the first course at 1:30 pm instead of 12:30 pm and then I had to ask for a pudding at 3:25 pm and they hadn't got one for him so he had yoghurt." She also told us, "I worry if I wasn't here what would happen. " During our inspection we observed three midday meals and one supper service.

The main dining area and lounge was on the middle floor (ground) however there were two tables and three chairs available which meant that not everyone would be able to sit at a table to eat their meal if they wished to. On the first day of the inspection, two people had been sat at a table all morning and they remained there for lunch. No-one sitting in the lounge area or in their bedrooms were given the opportunity to choose where they had their lunch. No-one on the lower floor and garden floor were offered the choice of going to the main dining area. The meal service on the second and third days of the inspection were more organised.

People were seated at dining tables which were uninviting as they had not been set for a meal, for example no condiments, glasses or napkins for people. There was no visual stimulus that would have promoted it as being a mealtime. People were not told what the meal was and there were no menus displayed or available in the home. Staff were not aware of the choices or what the meals were. One staff member said, "We know when it arrives, but the pureed can be difficult to name."

Meals arrived in the home from the sister home ready for serving in heatable trollies. On two occasions the trollies were not plugged in to keep food hot once they arrived and therefore not everyone had a hot meal. For example, on the first day of the inspection the trolley arrived on the garden floor at 12:40 and the care staff were still undertaking personal care. At 12:57 the senior care staff member arrived on the floor and said, ""Oh no, I've got more to do yet. I'll plug it in to keep it warm." The care staff started to serve meals at 1:30 pm and then started to assist people. This meant that food was cool by the time the meal service finished at 2:30 pm. Two people received barely warm food which had started to congeal. One staff member said, "I know it isn't right, we should have staggered it better."

On two separate occasions we saw that people were given a meal that was not of the correct consistency. We intervened when a care staff member assisted one person with their meal as the person had been assessed as requiring a soft diet. They acknowledged the meal consistency was incorrect for that person. There was not an alternative available and the person was given a pudding. On the third day of the inspection people were served omelettes as their main meal and some were burnt. One person said, "I don't really like all the black bits, I have to pick it out and it puts me off." This person informed us they would like a ham sandwich. We informed the nurse who said "I will get her a pudding." Another person who was eating omelette and chips had thrown the chips in to their bin, "Too hard to eat as I don't have any teeth. The person's care plan stated, "I need a semi soft diet as I find it hard to chew." We saw a lot of food wastage. The staff had various ideas of why, which included, "Meals too close together, sometimes breakfast is late so people aren't hungry at lunch, then it puts out their routines," "It's cold and then people don't want it," and "It's too much on a plate sometimes so they are put off."

Food returned uneaten or partially eaten was not monitored or recorded. Staff said they would notice if a pattern was occurring, however due to dependency on agency staff, this information would be inconsistent. Some people had food records and these were inconsistently completed. Some food charts were blank and therefore it was difficult to assess whether people were receiving adequate nutrition to maintain their health. Records for fluids were not all completed in full and did not assure us that people were receiving

adequate fluids to maintain their health. We saw during the inspection that drinks were left with people who needed prompting or assistance and then removed not drunk or recorded as refused.

There were people who had been assessed as needing a thickener in their drinks as they had a swallowing problem. On five separate occasions we found drinks for two specific people that were lumpy and not of the syrup consistency advised by the speech and language therapist (SaLT). These drinks had not been drunk, but the fluid chart was completed saying that the person had drunk 150mls fluid (each drink). This meant that the records were not correct and staff did not have an accurate overview of people's hydration status. We identified this to the staff and manager on the 5 July 2016 but still found the same problems with thickened fluids on the 6 July and 7 July 2016.

Two people were assisted in bed by staff still in a reclined position which meant that they were at risk from choking. We saw both good and poor assistance given by staff. For example, one care staff member (who was on their induction) was assisting a person lying in bed with their meal, by leaning over the raised bed rails. There no verbal interaction or eye contact and the person ate very little. We also saw good practice from a senior care staff member who had lowered the bed and bed rails and sat by the persons' side to assist them in a professional way.

We talked to people and their visitors about the meal service. People told us, "Not bad food, enough for me." The relative of one person said, "Meals! It's an on-going problem, the meals are often late, the food is cold and sometimes there has not been enough food for everyone." They also told us that breakfast was sometimes still being served at 11 am. This was not people's personal choice and meant that people had not had food for over 15 hours. This could impact negatively on people's health and well-being. For example, diabetics and people who need food with their medicines. The kitchen at Lindsay Hall was supposed to have some basic foods, fruit and spare meals, however the stocks were very low on the 5 July 2016 and there was no fresh fruit available during the inspection. There was a variety of cereals, biscuits and bread available, however staff did not use this facility when people had not eaten their meal.

Discussion with the cook told us that they had a list of people dietary needs and preferences. This list was kept in the main kitchen at the sister home. Dietary requirements were included on the handover sheet but not all staff we spoke with had a handover sheet. This meant that new/agency staff could not be sure of people's up to date dietary requirements. We asked how often the printed handover sheet was updated with people's identified fluid and food intake requirements and received no definitive answer. We were therefore not assured that people's nutritional needs were known and met on a day to day basis.

The pureed meals were presented well and displayed on a plate that identified the colours and differing textures, such as meat or vegetables, however staff mixed it together before assisting people with their meal. This meant the differing tastes were unidentifiable for people. Staff informed us that the consistency of the masheable meat was not 'right', but this was not reported back to management or the cook. Despite this statement from staff the meal was still served to people. The provider had not ensured that people received suitable and nutritious food and hydration which is adequate to sustain life and good health and was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us that they had completed training to make sure they had the skills and knowledge to provide the support individuals needed. Some staff told us they were behind in some areas and this was already known to the organisation. Whilst training was available it was not effective in all cases. We observed poor practice in moving people, assisting people with their food and in delivering person centred care. There was also a lack of understanding shown by staff in supporting people who lived with dementia. This was observed by the lack of interaction when supporting them and not managing some behaviours effectively.

We looked at training records. The organisation had identified that training needed to be improved. It was difficult to track training as there had been a high number of staff leavers and new staff joining the team. The agency staff told us that they had received essential training but we were not able to track competency checks to their care delivery. Training records indicated that fundamental training for all staff was up to date. For example, MCA, safeguarding, health and safety. Service specific training, such as end of life care, dementia, wound care and nutrition had not been undertaken or updated to ensure best practice was followed by all staff.

Staff supervision was not up to date for all staff. Supervision helps staff identify gaps in their knowledge, which was supported if necessary by additional training. Staff said, "Supervision is a bit hit and miss but it has been organised." Staff records of supervision confirmed that staff supervision had fallen behind for certain staff, but was now being undertaken. Staff told us they had felt unsupported due to staff changes and lack of leadership. This was reflected in the unsafe practices we observed. We were told that new staff received an induction programme which lasted a month and they received on-going training support. We were also told that newly appointed staff shadowed other experienced members of staff until they and the service felt they were competent in their role. However this was not being followed as we met new staff who were working independently without supervision and support. Staff said that staff changes and high use of agency staff had impacted on their training and professional development. One staff member said, "I want to do my diploma in health and social care, but we (the home) are not in the right place at present."

The provider had not ensured that staff had received appropriate training, professional development and staff supervision to meet the needs of the people they cared for and this was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People did receive effective on-going healthcare support from external health professionals. People commented they regularly saw the GP, chiropodist and optician and visiting relatives felt staff were effective in responding to people's changing needs. Staff had referred people to the tissue viability nurse (TVN) and speech and language therapist as required. It was however identified during our inspection that referral to external health professionals was not always done in a timely manner. We have received concerns from the TVN that a recent grade 4 pressure ulcer had not been referred to them as required. This is now under a safeguarding investigation.

Inadequate

Is the service caring?

Our findings

There was inconsistency in how people were cared for, supported and listened to and this had an effect on people's individual needs and wellbeing. Staff did not always focus on people's comfort, and therefore there was a risk of people receiving inappropriate care, treatment or support. We observed people who found it difficult to initiate contact who were given very little time and attention throughout the day. People spoke positively of some care staff, but a visitor expressed some concern about lack of communication between staff and the people who lived at Lindsay Hall. Comments included, "I visit every day and sometimes I do not recognise any staff at all," and "I see staff busy, too busy and they are too busy to help people when they call out, I worry that people might not get the care they need." We were also told "Very nice staff, they are kind, and "The care staff are really good."

Staff were task focused and did not always treat everyone with respect, kindness and compassion or maintain people's dignity. We undertook a SOFI which identified that verbal interaction was minimal and staff lacked empathy with the people they supported. We saw examples where people were isolated and the only time people saw staff was when a 'task' was undertaken. Staff said, "We don't have time, it's just too busy." There was a lack of engagement between staff and people and the environment and atmosphere was unstimulating. Staff talked over people and referred to them in the third person. One member of staff said, "Who still needs feeding?" in the middle of the dining room and another member of staff replied, "X (name) needs feeding." A care staff told another care staff "Take X (name) to their bedroom as they have wet themselves." This was said in a communal area in front of people and visitors. This was not respectful or dignified. There was very little meaningful interaction seen. One agency care staff member was asked to remain in the lounge area to 'keep an eye on people'. The staff member stood with arms folded and did not attempt to engage with people.

People were not always treated with dignity and respect. We met one person on the garden floor who told us they loved music and ballroom dancing. There was no television or radio in their room for company or to engage their interest. This person was sitting in a chair facing the doorway and the corridor wall. Their back was to the window and they had just a glass on their table which was over their chair. We asked staff why this person was placed facing the doorway and bare wall, they told us "It's because we do an hourly check to ensure they are safe, staff can glance in and see that without entering the room." The placement of the person was for the staff benefit and not the person's. We spoke with a member of the management team who assured us that this situation would be attended to. We visited the person again the next day and saw that the person was enjoying their music and looking out of the window. We also spoke with one person in their room who was sitting in front of a television with loud music and dancers. They told us this wasn't their preference. Together we found a television programme they wanted to watch.

Staff told us they respected people's privacy. Staff however did not always knock on bedroom doors and wait for a response before they entered. We saw one care staff member complete personal care in one room and then enter another room to wash their hands before leaving to serve food. No verbal exchange with the person in that room took place had taken place. We saw staff approach and assist people with food and drinks wearing plastic gloves, which could be frightening for some people who may not recognise the feel

and texture of plastic due to living with dementia. The reasons for staff wearing gloves were not clear as this was not to prevent cross infection. People's room care folders and some notes were left on the table on the garden floor, which meant that any visitor could access them. Staff had not ensured that people's confidential information was protected.

People's preferences for personal care were recorded for each person but not always followed due to staff being rushed. Documentation on when people received oral hygiene, bath or a shower recorded that often people would not receive a bath or a shower in 14 days. The manager informed us, "Care staff should be recording in people's daily notes when a bath or shower is offered and why oral hygiene was not given." The sample of daily notes and personal care check list we looked at were not consistently completed. Visitors shared concerns that baths and showers were not being offered. Care staff commented that most people received a bed bath but could not confirm why people were not offered a regular bath or shower. One staff member said it was because the bath on the garden floor had a hoist that had not been serviced. We checked with management and they confirmed it had been serviced but the sticker with the date had not been updated. The shower/bath on the middle floor was not being used as it was used to store equipment. This was discussed with the management team. Due to these factors, we could not be assured that people's personal hygiene needs were being met.

The communal areas within Lindsay Hall had been designed to be dementia friendly and homely. However these areas were not being used to their full potential and people were not encouraged to use them. For example the garden floor had been decorated to resemble a garden with chairs and a dining table. However this was unused until the last day of the inspection when one person sat by themselves with no interaction offered. The main lounge on the middle floor was divided into three areas with a dining room in the middle. Whilst it was light and airy, the communal area was lacking in atmosphere; three people sat in silence whilst another sat at one end of their own. There was a lack of accessible sensory equipment for people to prompt memories or encourage mental stimulation. This meant the environment was not a caring and stimulating for people who were living with dementia. People were isolated, despite being with other people. One person told us that they didn't know people's names despite sitting next to them every day. The management team were aware there was work to be undertaken and discussed their future plans for the service with us.

People's independence was not always promoted. For example we observed in the lounge that people spent a considerable amount of time without staff being present. There were people who could request attention, however these people had no access to a call bell to summon assistance. We asked one person how they called for staff, they said, "I wait till I see someone."

People were not consistently treated with dignity and respect and they were not encouraged to be independent or to live a life of their choice. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Despite the above concerns, we did see some staff interacting with people in a kind and compassionate way. They talked about commitment to their job, integrity and wanting to make a difference.

Visitors told us they could enjoy a laugh with staff. They said staff worked hard and that it was a shame that staff had left.

Inadequate

Is the service responsive?

Our findings

Whilst some visitors told us they were happy with the standard of care provided and that it met their individual needs, our observations identified that staff were not always responsive to peoples' individual needs.

Communication and social well-being was an area which we identified as a concern. This was because a large amount of people were isolated in their bedrooms, and in the lounge areas, with little interaction from staff. During our inspection we noted at times there were no staff in communal areas and people were left with the television on in the background. There was no rationale given by staff or any evidence this was people's choice. One person said, "I don't watch it because it's not what I want to watch." There were also people whose only opportunity of respite from lying in their bed was meal times when they were sat up and assisted with their meal. Staff performed tasks but they did not use this one to one time to chat or offer reassurance. The SOFI identified that there was little empathy shown by staff to people and very little positive conversation.

Care plans reflected some people's specific need for social interaction for example, "Likes company" but these were not being met consistently. We were told by staff "Oh they all like company, they all do, but we have a job to do, and that comes first." We visited five people regularly throughout our inspection and saw they received little social interaction from staff, apart from being given drinks and their meals. We observed staff waking one person for their lunch meal and they soon dozed off again without eating. We looked at the person's room care plan. It did not contain any information of their hobbies and interest. We spoke to the staff member who was assisting them and they said they didn't know the person and felt "Daft just chatting about nothing."

The activity co-ordinator was not available due to sick leave and a care staff member had not been allocated to take over the planned activities. We looked at the activity sheet displayed in the home. It demonstrated that most mornings were dedicated to one to one sessions with up to five people a day and specific afternoon group activities, such as pet pals visits, bathing the ducklings and people's birthday parties. None of these took place over the three days of the inspection. Whilst the activities and interests care plans in individual care files mentioned life histories and preferences, they did not contain any specific identified social need. There was no reference to one to one sessions undertaken, how the sessions went, whether it was beneficial and if an alternative activity might be tried.

Activities promoted were not fully reflective of people's individual interests and hobbies. One person told us that trips out would be good but it was not clear from talking to staff if outings were offered or planned. One staff member said "They visit the other home sometimes down the road but not many go." A visitor told us "The staff are lovely but don't think of taking them in to the garden, I expect they are too busy."

On the Garden floor people had high nursing needs and were on bed rest or remained in their room. We noted that apart from when care was being delivered, staff were rarely seen on this floor as they were assisting elsewhere. The communal area was not used until the third day of the inspection and then it was

only used for one person. However the person was left alone for long periods of time with nothing available to watch or interact with. During this time there was a series of incidents concerning this person, for example throwing the beaker of juice on to the floor, and knocking their table over. Staff told us it "Was for attention." Instead of using diversional tactics, music or sensory equipment, the person was moved back to their room.

We visited people in their bedrooms throughout the home and observed some people lying in bed with nothing to visually engage with or listen to. They spent most of the time asleep and were disengaged. The room documentation contained no guidance as to people's preferences for music, books or television and because a high number of staff were agency, they did not have the knowledge of people to ensure that they had what they needed.

People's care plans included risk assessments for skin damage, incontinence, falls, personal safety and mobility and nutrition. However some people's care plans lacked details on how to manage and provide specific care for their individual needs. One persons' care plan stated "needs currently being met in bed due to grade 4 pressure sore," (dated 29/02/16).Only two months of reviews were documented, (March and April 2016) which stated DoLS applied for due to refusals of personal care, and medicines. Documentation stated "All medicines were stopped and referred back to GP for further management." During our inspection this person was receiving covert medicine (Covert' is the term used when medicines are administered in a disguised format), was up and mobilising and their pressure wound had healed. Their care plan was out of date and confusing. The lack of accurate information meant staff would not be able to respond to people's individual needs, and placed them at risk from inappropriate care and treatment.

People's continence needs were not always managed appropriately. One person's continence plan had guidance in regard to catheter care. A separate catheter care record was undated and simply stated "removed, test urine monthly" written on it. A hand written sheet dated 13 May 2016 explained the need for the person to have monthly urine checks. The document also stated "reassess for pads to see if they are help to skin". There was no evidence these actions had taken, the outcome and there was no further review. Staff therefore would not have a clear understanding of the person's individual care and treatment needs.

Peoples' individual preferences for personal care were not always being met. For example, a person's care plan stated 'needs a daily bath' but the personal preferences for personal care compiled by the family stated 'prefers a shower'.

The evidence above demonstrates that delivery of care in Lindsay Hall at this time was seen as task based rather than responsive to individual needs. This meant that people had not received person centred care that reflected their individual needs and preferences. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A complaints procedure was in place and displayed in the reception area of the home. However, this was not displayed elsewhere in the home or provided to people in an accessible format such as large print or pictorial. We received differing views on the complaint response, which were discussed with the provider. One visitor told us "I have been to the office but I'm not sure I have been taken seriously." Another visitor said, "I am confident that I can raise any concerns or grumble and the team ensure it's dealt with." There had been a number of complaints received in the past few months and documentation confirmed complaints were investigated and feedback was given to the complainant. However one visitor said, "It got better, they wrote to me but now it's worse than before." We were therefore not assured that the providers' complaint procedure was fully established and operated effectively. This was an area that requires improvement.

People were supported to maintain relationships with people who were important to them. We observed people visiting throughout the day. Visitors told us they were always welcome at the home. They told us they were able to visit whenever they wished.

We saw photographs that showed people enjoying visits from outside entertainers and visitors. We also saw that people's birthdays were celebrated. One person told us that staff had provided them with a special light so that they can continue to do their hobby, "I like my curtains drawn because I stay in bed and the sun affects my vision, staff got me this light, it's really helpful."

We were told that satisfaction surveys had been sent out in the latter part of 2015, and was in the process of collating them. However there had been a large amount of changes, including management and meal delivery. We were told further surveys would be sent out when changes were settled. One visitor said, "I have been asked to complete a survey but I think it was last year, but I give feedback all the time."

Inadequate

Is the service well-led?

Our findings

The feedback from people, staff and visitors about the leadership in the home was varied. Comments from visitors included, "New manager, so lots of changes," "a lot of agency staff, staff have left over the past few months and the home feels unstable," and "I feel the use of such large amounts of agency staff has really affected the atmosphere, the care and my fear is however nice they are, the staff don't always know the residents well enough." Staff said, "It's a bit of a struggle, because so many old staff have left, there always an element of panic, because of the amount of agency, but the manager has said new staff are being recruited." Nurses from the agency felt unsupported when they came in, "I was just expected to get on with it, I didn't have an induction and I feel unsafe."

There was no registered manager in post. The registered managers' post had been vacant for two years. A manager had been recruited and was in the process of submitting an application with CQC to be the registered manager of Lindsay Hall.

Organisational quality assurance systems were in place, however they were not all fully completed and had not identified the shortfalls we found. Therefore the quality assurance systems were not effective. We found gaps in audits from when the last manager had left and when the new manager started their role. Six months of accident records were not available for cross referencing with people's care plans and the accident audits were not up to date. Therefore there was no evidence of learning put in place for prevention of reoccurring accidents and incidents. One person had had a head injury and the records were incomplete about the actions taken, apart from a record of attendance from the ambulance crew and actions they had taken. There was no evidence of an accident form having been completed or an overview of steps taken by staff to prevent accidents in future.

The provider's systems for audit had not identified a wide range of areas. These included people's safety being potentially at risk as some care plans were lacking in specific information, which had the potential to cause harm to the individual. Also care plans we looked at, had not been updated since April 2016 We identified throughout the inspection that many people were unstimulated and isolated at times and that staff did not actively engage with them due to time constraints and lack of understanding of person centred care. We also found that people's nutritional needs were not being managed effectively to enjoy the meal time experience or monitored to ensure that people had enough to eat and drink. The provider's care plan audits had not identified that people's specific health needs were not accurately reflected in their care plans, for example the management of wound care, dementia and continence. People's records were not always accurate and placed people at risk from inappropriate care. People therefore had not been protected against unsafe treatment by the quality assurance systems in place and this was a breach of Regulation 17 of the Health and Social Care Act 2014.

The culture and values of the home were not embedded into every day care practice. Staff told us that they felt unsupported and that the management team were not always approachable and visible. Agency staff said that they felt their careers were at risk because of the lack of communication and induction into the home. One agency nurse said, "I have never felt so uncomfortable and useless. I have not been told how the

shifts run and it's my first day. Medicines are a nightmare because they take so long because we are both agency nurse today and we don't know people." This was immediately fedback to the manager. The manager was surprised that the night registered nurse had not undertaken the induction at handover. This was to be investigated and appropriate support for agency staff be put in place. We later saw the manager undertake an agency care worker's induction.

Staff we spoke with did not yet have an understanding of the vision of the home. From observing staff interactions with people it was clear the vision of the home was not yet fully embedded into practice as care was task based rather than person centred. We saw poor practices which were undertaken by a small percentage of staff but not challenged by other staff. This told us that the culture of the home had still to change to ensure person centred care was delivered. Staff also told us that over 22 staff had left the service under the new management structure and they felt stressed because of all the changes. The management team confirmed that staffing over the past six months had been a challenge.

Communication and leadership needed to be improved within the home. People and visitors had an awareness of the management team but felt that staff turnover and use of agency had unsettled the running of the home. Due to staff deployment and high use of agency staff we saw that poor practice was accepted by staff. We saw shortcuts in care delivery such as not moving people in a safe way and not supporting them with adequately with meals and drinks. These shortcuts were noted to be due to time constraints and staff deployment. People therefore did not always receive the care they wanted and required. One visitor said, "Sometimes there's only one member of the staff team that was not agency and I worry that the information I get is not accurate." Staff and visitors had an awareness of the management team and felt that "Time will tell if the changes were successful, it can't be an easy job." We spoke with staff about how information was shared. They told us they were given updates but felt they "Were too quick and didn't really tell them much." They were not informed of the status of wounds, blood sugar irregularities and which people had not been drinking and eating enough. The management had identified this as an area that required improvement and were dealing with this through meetings with staff, new handover sheets and supervision. However feedback from new and agency staff had confirmed these were not always being implemented.

During the inspection we raised concerns that the management overview of the service was not up to date or accurate. We found that the manager was not aware of two people's wounds, of people's substantial weight loss, and of the lack of inductions for agency staff. This was acknowledged and on the third day of inspection the manager spent time working with staff on shift.

The area manager told us one of the organisational core values was to have an open and transparent service. Friends and relatives meetings were planned and surveys were to be conducted to encourage people to be involved and raise ideas that could be implemented into practice. People and their visitors told us that they would like to be involved and welcomed the opportunity to share their views. One visitor said, "I have been worried because there seemed to be a lot of changes, but things seem to be going forward, I hope they get things sorted."

Staff meetings had been held regularly over the past six months, and we were assured that regular meetings would be held whilst changes to the home and management structure continued. The manager said, "There is a lot to change, such as the culture, but I have confidence that we will get there. There is a strong organisational team that are working with us to improve the service."

There were clear lines of responsibility and accountability within the management structure. The service had notified the Care Quality Commission (CQC) of all significant events which had occurred in line with their legal obligations.

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 The provider had not ensured that service users received person centred care that reflected their individual needs and preferences.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The provider had not ensured that service users were treated with dignity and had their privacy protected.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent Where people did not have the capacity to consent, the registered person had not acted in accordance with legal requirements.

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 The provider had not ensured the safety of service users by assessing the risks to the health and safety of service users of receiving the care or treatment and doing all that was reasonably practicable to mitigate any such risks.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs The provider had not ensured that the nutritional and hydration needs of service users were met.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not ensured that service users were protected from unsafe care and treatment by the quality assurance systems in place and had not maintained accurate, complete and contemporaneous records in respect of each service user.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had not ensured that there were sufficient numbers of suitably qualified, competent, skilled and experienced persons deployed in the service to meet service user's needs. Staff had not received appropriate training, professional development and supervision.