# The Fremantle Trust

# Lent Rise House

## Inspection report

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## Ratings

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|---|---|
| Overall rating for this service | Requires Improvement |

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|---|---|
| Is the service safe? | Requires Improvement |
| Is the service effective? | Requires Improvement |
| Is the service caring? | Good |
| Is the service responsive? | Requires Improvement |
| Is the service well-led? | Requires Improvement |

# Summary of findings

## Overall summary

Lent Rise House is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. We regulate both the premises and the care provided, and both were looked at during this inspection.

Lent Rise House can accommodate 60 people within four units, each of which has separate adapted facilities. The service cares for adults, including people living with dementia. The premises are modern and purpose-built. People live in their own bedrooms and have access to communal facilities such as a dining and lounge areas. At the time of our inspection, 44 people used the service.

Our inspection took place on 17 May and 18 May 2018 and was unannounced. This was a comprehensive inspection. Our prior inspection was completed on 31 January and 1 February 2018. It was a focused inspection to establish whether the service had made sufficient improvements after our inspection in December 2017. We found that the service had not improved and there were continued breaches of seven regulations. The service remained rated inadequate overall and therefore in 'special measures'. We took no further enforcement action after this inspection, but the service was not permitted to accept admissions and was required to submit weekly action plans.

The overall rating for this service is now requires improvement. This service has been in 'special measures'. Services that are in 'special measures' are kept under review and inspected again within six months. We expect services to make significant improvements within this timeframe. During this inspection, the service demonstrated to us that improvements have been made and is no longer rated as inadequate overall or in any of the key questions. Therefore, this service is now out of 'special measures'.

The provider is required to have a registered manager as part of their conditions of registration. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. At the time of our inspection, there was a manager registered with us.

People were better protected against abuse and neglect. Staff had received more training in how to protect people against harm and reporting of incidents had increased. People's medicines were managed in a safer way, with increased monitoring by nurses and management. Recruitment checks of new staff were improved, which ensured only fit and proper persons were employed. We made a recommendation about infection prevention and compliance.

People's risk assessments were more detailed and contained increased relevant information. Extensive staff training was completed to ensure people were care for by workers with sufficient knowledge and skills. The assessment and management of people at risk of malnutrition had improved significantly. We made a recommendation about the service's environment for people living with dementia.

People and relatives told us staff were caring and compassionate. They said there were improvements since our prior inspection. People and relatives were more involved in the care planning and review process. People's dignity and privacy was maintained.

Some care remained task-focused instead of person-centred. At times, there was a lack of engagement with people by staff. During routine care, staff effectively communicated with people and included them in the process. People and relatives had an improved opportunity to have a say in how the service operated. They felt there was more information from the management team and provider. People's end of life preferences were assessed and respected. We made a recommendation about the Accessible Information Standard.

The governance of the service had improved. Additional time is required to demonstrate sustained monitoring and improvement of the care safety and quality. A better management structure was implemented. This fostered better scrutiny of care practices. A range of existing and new audit tools were used more routinely to examine strengths at the service and any areas for improvement. The workplace culture had improved for staff, and they were progressively filling vacant posts. The service worked closely with community partners to improve the safety and quality of people's care.

The service has achieved compliance with all breaches of the regulations from our previous two inspections. Further improvement is required in a number of areas.

## 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 always safe.

People were better protected from abuse or neglect.

People's care risks were better managed, which reduced the incidence of avoidable injuries.

People's medicines were safely managed.

More robust recruitment practices were implemented.

Infection prevention and control required further improvement.

### Is the service effective?

**Requires Improvement**

The service was not always effective.

Improvements were required to ensure a suitable environment for people with dementia.

Staff had completed additional training and refresher courses to ensure they were knowledgeable and skilled to care for people.

People's access to health and social care professionals was improved to ensure they lived healthy lifestyles.

People received satisfactory nutrition and hydration. The assessment and management of people's malnutrition risks had significantly improved.

The service was compliant with the Mental Capacity Act 2005 and associated codes of practice.

### Is the service caring?

**Good**

The service was caring.

People and relatives told us staff were kind and friendly.

The service involved people and relatives in care planning and reviews.

Staff ensured people's privacy and upheld their dignity.

There was increased support from staff to maintain and improve people's independence.

## Is the service responsive?

**Requires Improvement**

The service was not always responsive.

Some aspects of people's care remained task-focused and not person-centred.

Further improvements were required to meet the communication needs of people with sensory or cognitive impairments.

Improvements in the management of complaints were in place.

People's end of life care preferences were documented and respected.

## Is the service well-led?

**Requires Improvement**

The service was not always well-led.

The service had increased monitoring of the care quality, however further time was required to demonstrate sustained improvement.

The safety and quality of people's care had improved from the use of audit results and an ongoing improvement plan.

A more robust management team was implemented, which had stabilised the governance of the service.

The service had improved reporting of incidents, and ensured an open and transparent approach when things went wrong.

Information from community partners was used to drive improvement in the safety and quality of care.

Staff reported the workplace culture had improved and felt more included in the management of the service.

# Lent Rise 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.

Our inspection took place on 17 May and 18 May 2018 and was unannounced.

Our inspection was completed by an inspection manager, two adult social care inspectors, a dietitian, a registered nurse and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We used information the provider sent us in the Provider Information Return. 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 notifications and any other information we had received since the last inspection. A notification is information about important events which the service is required to send us by law.

We also requested and reviewed feedback from the safeguarding team, local authority, clinical commissioning group, commissioners, and Nursing and Midwifery Council. We checked records held by Companies House, the Information Commissioner's Office, and requested information held by the local fire inspectorate and the district council environmental health office.

We spoke with 10 people who used the service and seven relatives who visited during our inspection.

We spoke with the provider's regional director and human resources business partner, the service's registered manager and three duty managers. We spoke with six registered nurses and 10 care workers about people's support and treatment. We also spoke with the kitchen staff, the cleaners, the activities coordinator and the staff trainer.

We looked at 11 people's care records and multiple additional individual risk assessments, five staff

personnel files, training records, audits and other records about the management of the service. After the inspection, we asked the provider to send us further documents and we received and reviewed this information. This evidence was included as part of our inspection.

Requires Improvement

# Is the service safe?

## Our findings

At our July 2016 inspection, we found a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014. This was because medicines were not managed safely. The provider was required to submit an action plan. At our December 2017 inspection, there was a continued breach of Regulation 12. This was because people did not receive safe care and treatment. We imposed urgent conditions on the provider's registration which included no new admissions to the service, and a weekly action plan. At our inspection in January and February 2018, there was a continued breach of Regulation 12 as people's care and treatment was still not safe. No further enforcement was imposed by us, and the service continued to submit weekly action plans. At this inspection, we consider the service has made satisfactory changes to ensure safer care and treatment of people. The service is now compliant with the requirements of Regulation 12. However, some changes are ongoing and require evidence of sustained improvement.

Medicines were managed safely. The provider had reviewed and updated the medicine policy and nationally recognised guidance was available for staff to follow. Medicines were stored appropriately and storage temperatures were monitored and recorded twice daily. Medicines were administered by nurses who told us they refreshed their knowledge and skills in line with current guidelines. We saw records of competency assessments undertaken to check the skills of the nurses in managing medicines. We were told these were kept under review by the management team. At a previous inspection issues were found in ordering of medicines to ensure people always received their medicines in a timely manner. At this inspection we found there had been improvements in this area. However, there had been two occasions when people had not received their medicines for up to five days due to the ordering process not functioning smoothly. This had been investigated and as a result, meetings had been held between the service, the pharmacy and the GP surgery to prevent further instances occurring.

People were supported to take their medicines in a kind and caring manner. They were asked if they were ready and time was taken to allow them to take them at their own pace. When people were prescribed medicines to be taken when necessary (PRN), a protocol was available for everyone to assist and guide staff in when to administer those medicines. Some people received their medicines covertly (mixed with food or drink to disguise them). When this was the case it had been instigated following an assessment of their mental capacity and in their best interests. Relevant people such as their family, staff who knew them well and health professionals had been involved in making this decision on their behalf. The registered manager had introduced a procedure for ensuring all medicines were signed for and audited following each medicine round. This had reduced the number of errors and staff told us it had made them more aware of following procedure.

Risks to people's health and well-being were assessed. These included risks associated with mobility, falls, skin integrity, nutrition and specific health conditions such as Parkinson's disease. Identified risks were incorporated into people's care plans which provided guidance for staff on minimising and monitoring risks. For example, in one person's care plan it was noted they would need additional time to process information and respond due to a condition they lived with. Staff could tell us about people's risks and how they were

assessed, reviewed and minimised. They confirmed when people's condition changed the risk assessments were reviewed and the care plan amended accordingly.

Accidents and incidents were reported and investigated appropriately. The registered manager had introduced a system whereby lessons could be learnt from these and staff told us they were discussed and reflected on during team meetings and one to one sessions. We saw the content of these meetings were recorded and actions taken were recorded. Where necessary, the registered manager had complied with their duty of candour. During these meetings any relevant alerts relating to medicines or healthcare products were also communicated to staff.

Staff were practised and familiar with actions to take in an emergency. In accordance with the requirements following a visit from the fire inspectorate officer a new fire control panel had been installed. Other recommendations had also been complied with such as relocation of the sprinkler valve key. Fire drills had taken place including practice evacuations. Staff had been given the opportunity to provide feedback on the drills and reflect on what went well and where improvements could be made. As a result, they had been able to identify gaps in knowledge and experience. They had taken steps to provide further training and the opportunity to undertake alternative roles in an emergency to increase staff confidence. The provider had a set of contingency plans which provided guidance on actions to take in such events as poor weather preventing staff attending the service, loss of utilities and fire.

At our December 2017 inspection, there was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) 2014. This was because people were not safeguarded from abuse and neglect. We used our urgent enforcement powers to impose conditions on the provider's registration and required weekly improvement plans to be submitted. At our inspection in January and February 2018, there was a continued breach of Regulation 13 as systems were insufficient to protect people from abuse. We did not use further enforcement, but monitored the service closely to ensure people's safety. At this inspection, we considered the service has made satisfactory changes to ensure people are protected from abuse and neglect. The service is now compliant with the requirements of Regulation 13.

Improvements were implemented by the service to reduce the risk of abuse and neglect of people. Staff were aware of the importance of safeguarding and protecting people from harm. A nurse explained how safeguarding would often be talked about at handover meetings and told us any concerns were reported immediately to the management team. They felt confident appropriate action was taken to alert the local authority and investigate any concerns raised. They described reporting such things as bruising, medicine errors and poor practise. Records confirmed any such events had been appropriately documented and considered. We saw the registered manager had taken steps to ascertain the root cause of concerns and had taken steps and measures to help prevent further instances in the future. For example, staff had received refresher training in moving and handling following a person being bruised because of poor handling technique. Information on safeguarding was readily available and signposted around the service for staff to refer to. This included contact details for the local authority, us, the registered manager and the provider's governance manager. Staff were familiar with the provider's whistleblowing policy and said they would have no hesitation to report poor practice.

People and relatives commented that the service was safe. Their feedback included, "(I) feel very safe. (I) haven't experienced any discrimination. (I) have no concerns", "Oh yes, (I) feel quite safe", "I feel safe. Staff are polite and friendly", "Quite safe, yes. Mum is well looked after and they understand her foibles", "Yes, I have no concerns about (the person's) safety or how she is treated. I come in three to four times a week", "Nan loves it here. (I) have no concerns about her safety" and "I feel much better about (the person's) safety and relieved that I can go home and know she is well looked after."

At our December 2017 inspection, there was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) 2014. This was because staff recruitment practises were unsatisfactory. At our inspection in January and February 2018, there was a continued breach of Regulation 19 as fit and proper persons were still not employed. At this inspection, we consider the service has made satisfactory changes to ensure people are protected from abuse and neglect. The service is now compliant with the requirements of Regulation 19.

Improvements were made to ensure fit and proper persons were employed. Staff had been recruited safely, appropriate checks had been completed before staff commenced working at the service. For example, a disclosure and barring check was carried out and references were sought from previous employers. Staff files contained records as required by the Regulation and associated Schedule.

There were sufficient numbers of staff to provide safe care to people. During the inspection we saw call bells were answered promptly. Staff worked in a calm, efficient manner and reported they thought there were enough of them to give good care always. The registered manager had introduced a dependency tool to assess people's needs and provide an indication of the number of staff required. This was kept under monthly review and had resulted in an increase of staffing levels to help ensure people's safety. Although the service continued to use agency staff, a good effort was made to ensure continuity. Positive steps were made across the entire service to recruit to vacant staff posts. The management team acknowledged some setbacks, but continued to recruit and interview applicants in a positive manner.

People and relatives provided positive feedback about the staffing levels. Comments included, "Staff are consistent…there is someone available if needed", "Whenever I'm here (visiting), it's adequate", "There are good carers here", "There is a definite improvement. Staff are more stable and their understanding of dementia has been improved", "There has been a difference over the last two months. Staff are more regular" and "There has been a complete turnaround. Care is really good".

Maintenance was undertaken promptly. The maintenance team conducted regular and appropriate checks to help ensure safety throughout the service. We saw staff reported any deficiencies promptly and we were informed that action to make repairs was taken promptly. Contracts were in place with suitably qualified professionals to monitor such equipment as the fire safety system and lifting equipment. A schedule was held to ensure the management team were aware of when inspections and tests of equipment were due.

The district council had visited the service to check food hygiene practices. The kitchen food safety rating had increased to five (the maximum score) since our prior inspection. The service was generally clean. Staff were observed to wash their hands after personal care, before serving food and wore appropriate personal protective clothing when assisting people. More access to alcohol hand gel dispensers was required and we provided this feedback to the management team. Housekeeping staff deployed increased and we observed them completing their routine daily tasks in a thorough manner. Records were kept of all cleaning undertaken. Some new chairs and furniture had been obtained to replace those with wear and tear. There were several areas that required more attention to deep cleaning. We provided this feedback to the management team and they were receptive of our feedback. The service was not fully following the code of infection prevention and control from the Department of Health. For example, there were no internal staff appointed as infection control champions and internal audits of infection control required improvement.

We recommend that the service reviews the Department of Health's infection prevention and control code.

Requires Improvement

# Is the service effective?

## Our findings

We have not inspected this key question since July 2016. We reviewed and refined our assessment framework, which was published in October 2017. Therefore, there are some key lines of enquiry (KLoEs) which are included as part of this inspection and were not covered in our prior inspections.

Improvements were required to ensure the service's environment was suitable for people with dementia. The same coloured paint covered all walls with no change in colour to denote a different area. We did not see any use of reminiscence boards on walls. A staff member stated the service was using sensory activities such as toys for people with dementia. We did not see any use of these items during the inspection. The inspection team noted on multiple occasions throughout the service, especially in communal lounge rooms, that televisions were playing loud pop-style music. This made it difficult to hold conversations with people, as they were unable to hear what was being said. The registered manager told us the service had used a nationally-recognised tool to complete an audit of the environment. The management team were receptive of our feedback about the environment for people living with dementia. The registered manager showed us textiles that were recently purchased to use with people who were living with dementia.

We recommend that the service reviews national best practice guidance regarding dementia-friendly environments in adult social care settings.

At our prior two inspections, and during our monitoring between the inspections, concerns were raised about people's nutrition and hydration. We received evidence that once aware of the issues, the service had worked with the clinical commissioning group (CCG) and healthcare professionals to improve these areas of people's care.

Nursing staff and a duty manager had a good awareness of the people's high nutrition risk and the care plans with appropriate actions to implement. There was awareness, accommodation and communication between management, nursing and catering staff regarding people's individual dietary needs and preferences. Food and fluid charts were completed for everyone who used the service. This would routinely be only for people with high risks, to avoid unnecessary monitoring and recording. However, the management explained this was in place to ensure all people's nutrition and hydration needs were met and would be scaled back during further reviews.

People's weights were measured weekly for all people with high risk of malnutrition and monthly for other people. In a few cases there were some concerning weight fluctuations both up and down, for example 5kg in one week. However, this was a result of using two different sets of scales and a set of uncalibrated scales. People's most recent weight records did not show this and the chair scales were repaired and recalibrated. The malnutrition universal screening tool (MUST) was widely correctly used throughout the units. Extensive staff training about MUST had occurred. Our findings corresponded with a prior dietetic audit on MUST use at the service. Correct care planning in response to high scores was evidenced.

On one unit, most people with high risks gained weight. On another unit, several people with progressive

illnesses continued to lose weight despite multiple nutrition interventions. There was evidence from staff, catering and our observation that nutrition care planning was appropriate. The importance of food fortification (high calorie meals) and supplemental drinks required reinforcement. Food fortification and supplemental drinks were not provided every day when different staff were on duty. There were also no written recipes or guidance for this in the kitchen. The special diet board in the kitchen had not been updated in line with the information in people's care plans.

There was a six-week menu cycle in place which changed between summer and winter. However, this was not followed at the time of inspection due to food not being ordered in time. The chef told us the service planned to restart the menu cycle two days after our inspection. The documented menu cycle was varied and nutritionally balanced. Some people felt they did not have enough choice at lunch time and that sandwich fillings were limited. If people disliked the two main lunch choices there was a range of other options available from the kitchen but these were not always effectively communicated to people and staff in the units. Some people told us they did not have input into the choice of the menu, although the chef told us that he had asked people what they liked and disliked and included a variety of meals based on people's feedback.

Improvement in the texture modified (for example soft and pureed) meals was required. People who received texture modified diets were appropriately assessed by speech and language therapists (SALT). However only the terms "puree "and "soft" were used by the service's staff, and this was not in accordance with the current terminology for modified diets. Clear written documentation about texture modification was removed from the kitchen and not replaced. Meals did not always contain appropriately modified and presented protein foods, vegetables (as permitted by the SALT) and potato. A prescribed powder was used correctly used to thicken drinks, as specified by the CCG and guidance was provided to the service's staff from the SALTs.

People's and relatives' opinions of the food were divided. Comments included, "Food is fine. They bring drinks round on a regular basis and biscuits", "No improvement in food. It's unimaginative (and I) don't get much choice. Drinks are brought round often", "Quite happy with the food. Not much choice but quite OK", "It's alright. Don't know about choices but it is certainly something I could eat", "Food is pretty bad. It's a bit better at weekends. Soup is like water" and "(The person) would say that it's not good, but it is well-balanced and they (people) are given choice. It has improved a lot."

People and relatives told us their experiences of assessments, care planning and outcomes. One person said, "Don't know about a care plan. Can't remember the (assessment)" and another stated, "I don't honestly know." However, relatives said, "We worked on her (the person's) care plan just a month ago", "Improving. Care plans are now much more dementia friendly (and) moving ahead positively" and "The (person's) new chair has made such a difference to her and me, much improving her involvement. Where they (staff) used to put her to bed for long periods she can now sit in comfort and enjoy the atmosphere."

We looked at a variety of people's care plans specific to their medical diagnoses. There were detailed records in place for the management of two people identified to have pressure ulcers on their feet. The nurse in charge of one unit gave a detailed account of pressure ulcers. She stated they were present on the side of the person's foot and heel and had developed about a month ago. She stated the person was high risk and had a poor diet with a reduced appetite. The person was being turned every two hours. Records showed a care plan was written to manage the pressure ulcers. This included measurements and photographs. Updated photographs were taken and documented. A referral to the tissue viability nurse was made and an e-mail response stating to continue with current treatment was recorded in the care plan.

There was evidence of care plans to support staff with people's behaviour that challenged. More detail was required in some to ensure the care plan was in line with evidence-based guidelines. One person's plan stated they shouted "help, help" repeatedly. The plan stated the person could be in pain and staff should assess for pain and provide distraction should when the person became distressed. The care plan lacked detailed about how the staff could interact with the person by using specific words, voice tones, and space or positioning. The care plan did not contain specific references to behaviours that may occur because of deterioration in the person's mental health, for example hallucinations, withdrawal, agitation and how to report and assess these behaviours.

Another person had a care plan in place containing strategies for when they refused tablets. The strategies included staff coming back later with tablets, ascertaining why they were being refused. This care plan contained a good level of detail about the client's behaviour in response to medicines administration. Additionally, the person had a detailed care plan for the use of covert administration of medicines containing a medical assessment, discussion with the person's family and review of the procedure.

Six staff we spoke with stated that they felt communication had improved and that they spoke with each other in a respectful way. Changes in people's conditions were handed over verbally and discussed at the daily 11am meeting. There was some inconsistency about how changes were communicated between staff with multiple methods, of communication in circulation. There was written documentation for the 11am meeting and the night meeting, bedside care plans, and a book which are used to document changes. One care worker stated any changes in a person's condition were updated at handover. She said they have a book in the unit and that the carer or nurse writes in the book. She said staff know to read the book "…from time to time." Another care worker stated he used the care plan and the daily report to update his knowledge on changes. He wasn't aware of the book. A nurse showed us a list they used for the handovers to convey changes in people's conditions. The list contained sufficient details to ensure important information was shared between each shift and different teams.

People and relatives said staff were knowledgeable and competent. Comments included, "They (staff) are well-trained have good attitudes. (I) feel well matched", "Most of the staff seem quite competent. We know each other", "You just get used to someone (a staff member) and then they change", "They're (staff members) alright. Seem nice people", "Certainly very competent on this wing", "(I) think they are very skilled. All get on well together now. There were problems with (one unit). It was going downhill" and "(Staff are) 100%."

Training records were held on a spreadsheet that was updated by the duty manager. At our inspection, it was not possible to determine the number of staff who had completed training in particular topics. However, there was evidence the staff received training when we received the spreadsheet after the inspection. We excluded staff who were on long term leave or who had recently commenced in post. Staff said that they had attended a lot of training over last few months and the nurses were pleased with the support they were given. The duty manager said staff attend corporate induction and are then shadowed on shifts by experienced staff until they are deemed competent to work without direct supervision.

A focus of staff training was in moving and handling. This was because of injuries and unexplained harm which occurred prior to our last two inspections. An update of the training was required every 3 years. According to the records, only six staff members were due manual handling training in 2018. This was because dedicated trainers had spent considerable time re-training staff and ensuring their practical skills through competency checks. Therefore, the percentage of 80 staff that had up-to-date training was approximately 92%. Another topic the service had concentrated re-training staff in was food hygiene and safety. Management staff had completed advanced courses and other staff completed standard-level food

safety hygiene. Only 12 out of 80 staff had not completed the training. All staff had completed safeguarding training. Some subjects had a higher percentage of staff whose training had lapsed. For example, there were staff whose basic life support and fire safety was not current. The duty manager told us about the service's plans to address this and presented evidence of future training bookings.

Cleaning staff were offered dementia training for the first time and told us they were satisfied they had the opportunity to attend. They felt they understood more about people's behaviour and could act in a different way when people's dementia affected their behaviour. Staff had not commenced performance appraisals but were receiving one-to-one sessions with their line managers. Two nurses said they were very happy with the support. One nurse stated she had received individual supervision to administer medications on a night shift. A care worker we asked stated he had training in fire safety, infection control and manual handling recently. More fire drills had taken place, and the duty manager explained additional drills were planned for the night shift staff. This was an improvement since our last inspection.

People had appropriate access to a range of health and social care professionals to ensure a healthy lifestyle. Comments included, "If I need to see anyone, the care workers will arrange it. When I have had a hospital appointment they have arranged transport", "They will call the GP if needed. I have seen the chiropodist who comes in", "I saw the GP two weeks ago for a general check. I also have my own beautician who looks after my feet. She comes in often", "People (healthcare professionals) in and out all the time", "When she (the person) has needed a doctor they (staff) have been very quick to react. Everything is explained. She has seen a chiropodist who comes in", "They (staff) take action when needed. Things are dealt with efficiently", "They (staff) called a doctor in a couple of weeks ago because she (the person) had a cough. They keep my mother informed."

Referrals were made to appropriate specialist teams. People at risk of pressure ulcers were referred to the tissue viability teams who responded, and care plans were devised by nursing staff regarding their advice. People were referred to the podiatrist, including a person with diabetes. Care documentation contained evidence that relatives and GPs were consulted about people's healthcare status.

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

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met.

Where possible, people's verbal consent was obtained by staff for routine actions, such as asking to enter a bedroom or approaching them to assess observations. There was evidence of mental capacity assessments for people who lacked capacity to make certain decisions and subsequent best interest decision meetings with a multidisciplinary team. At the time of our inspection, people who required DoLS authorisations or renewals were awaiting best interest assessors to visit the person and complete an assessment. The registered manager explained that some people previously subject to DoLS authorisations did not require renewals as they were not deprived of their liberty. There was a list of DoLS applications pending

maintained by the management team.

Good

# Is the service caring?

## Our findings

We have not inspected this key question since July 2016. We reviewed and refined our assessment framework, which was published in October 2017. Therefore, there are some key lines of enquiry (KLoEs) which are included as part of this inspection and were not covered in our prior inspections.

People and relatives provided feedback about how they were treated by staff, whether staff try to get to know them and how quickly the service recognises and meets their needs. There were positive comments from both people and their relatives. This included, "They have got used to me. Communication (with me) is good. They do meet my needs", "We (people who used the service) are treated like ladies…", "Marvellous people (staff). (They) really work hard to keep us occupied. (Staff) speak to me by name", "Staff treat us with great respect. I feel welcome. I am greeted by name and they (staff) meet her (the person's) needs", "I have seen an improvement over last few months in the attitude and nature of carers", "They (staff) love her (the person); always having a laugh and always keep us informed of what's going on" and "(There is) much more interaction than before."

People were supported in a caring, compassionate and kind manner. We observed interactions between people and staff that were gentle and understanding. For example, staff spoke respectfully, touched them gently to indicate their presence and demonstrated kindness in their approach. A visitor to the service was very complimentary of the care and praised the attitude of the staff. They told us, "They are all so kind…all of them." They went on to tell us how they felt the service had deteriorated for a while but said, "It's much better now. They seem to be back on track." We saw how staff made visitors welcome and they were offered a meal to have while with the person they were visiting.

Staff provided information to people about their care in a manner that reflected their understanding. For example, we saw a nurse explaining to someone how it was important for them to take their medicines to keep them feeling well. We also saw staff speak slowly and get close to people to help ensure they heard them. Care plans indicated how to communicate well with people. For example, one person used a writing board and another required additional time to process questions and respond. We observed staff using methods of communication to suit people's individual needs.

People and relatives commented that the service ensured privacy was upheld and dignity was respected. There were no restrictions on visiting people. One person said, "I do need help with dressing and washing. They (staff) close the doors and curtains. There is no restriction on visitors. Another person stated, "Not a concern; Staff are quite polite and helpful. They will knock before coming in (to the bedroom). They help me with washing and dressing." A further person said, "(I am) quite satisfied with privacy and dignity." A relative commented, "Everything is done well. If the (bedroom) door is closed, they (staff) will knock." Privacy and dignity were respected, staff knocked on doors before entering and ensured people were aware of their presence. We observed people were assisted to protect their dignity when they found this difficult. For example, a person was discreetly covered when they were unable to do this for themselves. People were spoken to with respect and addressed as they wished.

After our prior two inspections, the service's staff had worked to maintain and increase people's independence. People's and relatives' comments included, "I can make a cup of tea or a sandwich if I want, and make decisions of what I want to wear. There are only a few things I need help with. I don't need support to get up and go for a walk around", "I can manage most things myself. I have this frame (mobility aid) which gives me some stability, so can get around the home. I am going out today to wild life park", "I'm very independent; I'm here to help other people" and "She (the person), likes to think she can manage most things herself and does quite well." One person we observed had a new modified chair with attachable meal tray, and sat in a communal lounge. They could independently eat their meal since the provision of equipment. Staff and a relative provided praise to the person and recognised the improvement in the person's independence in eating.

Care plans provided guidance for staff in encouraging independence. They indicated areas in which people remained independent and those where they needed assistance. People's personal preferences and routines were recorded and staff we spoke with could provide examples of how people liked things done. We observed them using this knowledge when they supported people.

Requires Improvement

# Is the service responsive?

## Our findings

We have not inspected this key question since July 2016. We reviewed and refined our assessment framework, which was published in October 2017. Therefore, there are some key lines of enquiry (KLoEs) which are included as part of this inspection and were not covered in our prior inspections.

At our December 2017 inspection, there was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) 2014. This was because the care and treatment of people did not meet their needs and did not reflect their preferences. At our inspection in January and February 2018, there was a continued breach of Regulation 9, as care remained task-focused instead of person-centred. In our prior two inspection reports, this breach was detailed under key question "well-led". We have moved the breach of Regulation 9 to this key question, in accordance with our current KLoEs. At this inspection, the service has made progress towards a person-centred care model. Therefore, the service is now compliant with the provisions of Regulation 9. However, there was some evidence that task-based care practices by staff continued. Changes to how people received personalised care were ongoing, and require further improvement over time.

There was mixed feedback from people and relatives about whether care was personalised and responsive to their needs. Comments included, "In my opinion, it is not person-centred care. You rarely see anyone (staff) unless you call them." A relative said, "Seems OK. Staff are quite good with us." Other comments included, "Staff are very quick to advise me of any issues. I am kept well informed" and "There was a stage where we might have looked for an alternative place, but they (the service) are working hard to make things better for the residents."

Interactions we observed between people and staff were positive. However, although there were some spontaneous interactions unrelated to care, there was an overall lack of this from some staff who provided care and treatment. Some staff were reluctant to approach, speak and engage with people. People sat for long periods of time unengaged, falling asleep in front of the TV or with little in the way of stimulation. Staff were seen to sit next to people but not engage with them unless they were assisting with a task or needed the person to do something. The registered manager suggested this was due to the service's historical culture, which the provider was actively addressing.

The inspection team observed two lunch time periods in all dining rooms, some communal lounges and some people's bedrooms. People were served food from a list which we were told contained the choice they had made earlier. No further choice was offered at the beginning of lunch. People were however asked what they would prefer to drink and provided with what they requested.

On the first day of our inspection, several people struggled to eat the meat dish served, pushed it away and said it was hard. Two members of staff tried the meat and confirmed it was not edible. At this point an alternative of an omelette was provided for those who requested it. However, there seemed to be little in the way of other alternatives to offer. We saw that tables had been dressed in linen cloths. Vases of fresh flowers decorated each table. However, no condiments were available and we observed only one person was offered salt and pepper to accompany their meal. Assistance to eat their meal was provided to people when

required. We noted one staff member began assisting a person as soon as their plate of food was served. However, when another person required their assistance to cut their food and the staff member went to help them, the person they were assisting began eating on their own. This indicated the staff member was focussed on the task of ensuring the person was fed, rather than observing their preference of eating without assistance.

On the second day of the inspection we saw tables had again been dressed and condiments were available along with other sauces on each table. People who had chosen to eat in their own room were supported to do so and staff ensured they were in good positions to eat and had everything they needed to hand.

All providers of NHS care or other publicly-funded adult social care must meet the Accessible Information Standard (AIS). This applies to people who use a service and have information or communication needs because of a disability, impairment or sensory loss. There are five steps to AIS: identify; record; flag; share; and meet. During our inspection, we gathered evidence about these five steps by examining documentation, talking to staff and people who used the service.

People's communication needs were assessed and where they required, alternative means of communication were considered and applied. For example, one person with poor hearing used a speaker to make communication easier while for another, staff wrote things down so they could understand clearly. Care plans provided guidance for staff on how best to communicate with people such as, "(The person) finds it easier to respond to a closed question when being asked something." The registered manager told us how they were preparing a list of useful words and pictures in another language. This was to help a person who due to their deteriorating condition was reverting to their native language.

To meet the AIS requirements for people who lived with dementia at Lent Rise House, additional work was required. Orientation boards to assist people with dementia to recognise their surroundings were absent from walls and communal areas. Existing signage displayed in the dining rooms was too small and high on the walls, which hampered people's view of them. There was no signage displayed on the walls of the corridors and communal areas for the time, date and year and place. The service lacked pictorial or symbol-based signage to toilets and communal areas so people would not know which way to turn when leaving a room.

We recommend that the service reviews signage throughout the premises in line with the requirements set out by the Accessible Information Standard.

Since our last inspections, there was an increase in group social activities. An activities coordinator had joined the staff team. There was a list of activities and promotional materials about upcoming and past events throughout the building. On one day of our inspection, people went on a community outing. The number of people who could attend was limited by the amount of transport availability. The activities coordinator was enthusiastic and tried to offer a wide variety of social entertainment. The service was decorated with pictures of the royal family, bunting and was preparing for a garden party to celebrate the upcoming royal wedding. A relative had brought multiple bunches of flowers to the service and these were placed across communal area, which provided a pleasant fragrance and became a talking point. People were also supported to practice religious and spiritual beliefs if they wished. Staff told us members of different faiths visited regularly, and whatever denominations people belonged to they would seek involvement if the person wished. They also told us how they ensured appropriate end of life practices were followed if a person had previously identified their specific faith.

We asked people and relatives if they knew how to raise a concern or complaint, their experiences of raising

concerns or complaints and whether they had access to the complaints policy and procedure. There was mixed feedback and understanding of the process for raising complaints. However, some people and relatives had voiced their concerns. Comments included, "Not ever complained. I don't know (the) complaints procedure (but) would speak to a senior (staff member)", "I wouldn't know (the complaints procedure). If I have any complaints I would speak to my family. No (complaints) I can recall", "I wouldn't complain to staff. I would speak with someone from outside", "If I had a complaint I would speak to someone. (I am) not aware of a procedure", "I have complained on her (the person's) behalf about the food and didn't like the fact that she had been kept in bed for 6 months. (I) complained to the management", "I have complained in the past…nothing serious. They (the service) will listen and act as needed", "Nan has always been treated well. We were quite shocked when they had to (manage issues with staff)" and "If I have a concern it is sorted out immediately…unlike a few months ago."

We reviewed complaints, concerns and compliments received by the service. Since the management team commenced recording these in February 2018 a total of four complaints and 25 compliments had been received. Complaints were taken seriously and each was considered and responded to appropriately. Better documentation was in place with regards to complaints management. Compliments were also passed on to staff either individually if that was appropriate or as a team when they were more generally applied.

Although we asked people and relatives about how the service assessed and managed the end of life preferences, not everyone wanted to discuss the issue and we respected their choice. One person said, "(I have) not made any decisions." Another person told us, "(I) don't want to think about it. Relatives said, "It (end of life) has been discussed. She (the person) has a 'do not resuscitate' order in place" and "(I'm) not a great believer in end of life decisions." People were given the opportunity to discuss their wishes for end of life care. Staff told us this discussion would take place when a person's condition began to deteriorate. We saw in people's care plans there were records indicating where a person wished to be cared for at the end of their life and who they would wish to have with them. It also documented who should be contacted and at what point. The nursing staff told us they made all staff aware of people's wishes so that they could be followed when the time came. Procedures were in place to request anticipatory medicines when a person was identified as nearing the end of their life. These are medicines that are used to manage people's symptoms during the final days of life and help people to remain pain free. They contribute to the person having a dignified death.

Requires Improvement

# Is the service well-led?

## Our findings

At our December 2017 inspection, there was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009. This was because the provider had failed to notify us of certain events without delay. At our inspection in January and February 2018, there was a continued breach of Regulation 18 as we did not receive the required notifications, or where we did, they were submitted with delays. Prior to this inspection, we checked our records of notifications received since our previous inspection. The management team were notifying us of events in line with the regulations. At this inspection, we considered the service has made satisfactory changes to ensure events were notified to us without delay and is now compliant with the requirements of Regulation 18. At the service, a folder containing all notifications sent to us was maintained by the management team and the records were appropriately organised so that further information about events could be promptly and easily sourced when required.

At our December 2017 inspection, there was a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the service had failed to act in an open and transparent way when notifiable safety incidents occurred. At our inspection in January and February 2018, there was a continued breach of Regulation 20. Prior to this inspection, we checked our records of notifications received since our previous inspection. There was one instance of a notifiable safety incident. At the service, we checked whether the management had completed the steps required by the duty of candour regulation. The registered manager provided evidence that an investigation of the incident had occurred, that the 'relevant person' was verbally notified and that a written letter of apology was sent. We considered the service has made satisfactory changes to ensure they were open and transparent when safety incidents happened, and is now compliant with the requirements of Regulation 20.

At our December 2017 inspection, there was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014. This was because there was inadequate management of the safety and quality of people's care. We used our urgent enforcement powers to impose conditions on the provider's registration and required weekly improvement plans to be submitted. At our inspection in January and February 2018, there was a continued breach of Regulation 17 as systems were not used effectively to ensure the good governance of the service. We did not use any further enforcement but monitored the service closely for improvements. At this inspection, we considered the service has made satisfactory changes to ensure the good governance of people's care and treatment. The service is now compliant with the requirements of Regulation 17.

More robust methods of monitoring the safety and quality of care were introduced. Some improvements were still required. Other systems and processes put in place were more recent and required more time and results to measure and evaluate their effectiveness in monitoring the service.

The issues regarding medicines management were resolved, with only ad hoc incidents occurring. Various checks and cross-checks of medicines management were in place and worked effectively. This included nurses peer-reviewing other nurses' administration records for accuracy and any omissions, duty manager audits of medicines administration records and recording of all medicines incidents detected. Medicines

incidents were reviewed by management team members, and steps put in place to reduce recurrence. There was evidence of some out of stock medicines due to the ordering process, but this problem had significantly reduced since our last inspection.

Checks of the quality and detail of "health and social care plans" had increased. A tool was used to check each person's care folder. When we checked six random folders with a staff member, the form was absent in one folder, not completed in a second folder, partially completed in two folders and fully filled in for the remaining two folders. The form was a simplistic 'tick-list' style document, set out month-by-month. Staff ticked and initialled the form when they had checked a person's folder during the month. The form itself contained no space to record missing care documents or those that required updates and did not ensure that staff acted to remedy any issues with care documentation. We pointed this out to the registered manager who was aware of this and planned to discuss this with the provider.

Two infection prevention and control audits were completed since our last inspection. However, these were completed by a member of the clinical commissioning group (CCG) and not by staff from the service itself. In the January 2018 audit report, there were reference to non-compliance with staff training, handwashing and alcohol hand gel dispensers. A second review of the infection prevention and control at the service took place in May 2018. An e-mail from the auditor to the registered manager stated, "The recommendation(s) from my previous visit have all been addressed…Make sure that the suggestions for the (infection prevention and control) policy are being incorporated, even though they were quite minor issues…I am happy that your infection control processes are in place." The service was aware that they had not completed their own infection control audits, and had reasonably used the results from the CCG to make appropriate changes. After our inspection, the registered manager submitted to us an infection control audit completed by the service. The result was broad compliance, with four minor actions required.

The service continued to use the electronic "manager's workbook" to record performance. This was a tool populated with various key performance indicators such as safeguarding, complaints, compliments, incidents and accidents, safety checks and finances. This provided a monthly score and risk rating for the service. The results were also used by the provider to compare the service's performance with similar services of the provider. The level of compliance in the "manager's workbook" had steadily increased since January 2018, showing improvements had occurred in the areas measured. The provider also commenced a "themed service visit", the topics of which were our key questions (safe, effective, caring, responsive and well-led) and associated lines of enquiry. The audit and report were completed by a member of staff from the provider's head office. A "themed visit" of key question safe was completed on 1 May 2018. The service had achieved a score of 85%,  and several action points were noted. Due dates and responsible staff were not documented in the report. The registered manager told us the remaining "themed service visit" areas would be completed throughout the remainder of the year.

Following our prior two inspections, we required the provider to submit weekly reports of actions taken to improve safety and quality. These were submitted within time most weeks and contained relevant information about how the management and service worked towards addressing the highest risks at the service. Areas for improvement in the action plan included moving and handling safety, management oversight of care, staff communication, staff training, medicines management and risks of malnutrition. The action plan was updated regularly with target dates, responsible staff members and progress made. The action plan also had new items added when the service had identified further areas for improvement. For example, in May 2018 wound management, recruitment, key workers and staff emotional wellbeing were added. The action plan was distributed to external stakeholders such as the CCG, safeguarding team, commissioners and local authority. The progress of the improvements in the action plan were discussed at weekly meetings within the service and with the external stakeholders.

After our last inspection, a significant change in the management structure was implemented by the provider. A permanent manager was appointed and subsequently registered with us. This meant the provider had complied with their condition of registration for the Lent Rise House to have a registered manager in post. Duty managers were in place to oversee the four units between 7am and 10pm, seven days a week. This provided the opportunity for nurses in charge of units to raise any issues with the duty manager, who could then assist with resolving problems. The oversight of the service by the duty managers also meant increased monitoring of the care quality people received. The duty managers were directly responsible to the registered manager and had oversight of one floor each. A further three duty managers were recruited, and one had commenced in post and completing their induction during our inspection. Senior nurses were posted on each unit to provide continuity in the clinical care of people, and oversee the support provided by care workers. A regional director supported the registered manager and visited the service regularly. Other staff from the provider's head office also visited the service regularly to provide support, complete audits, convene meetings, ask people's and relative's feedback and speak with staff. The management structure and support had stabilised the service, decreased the fragmentation of care and staff and boosted the morale of Lent Rise House.

People and relatives had noticed the difference. Comments included, "I would say it (the service) is run for us. I don't know the manager but (see) seems to work quite well. It seems to have improved lately. Staff are working better together", "Staff seem to get on well together", "(The) changes (are) good. Everyone (staff) is working well together. No had any problems", "(I) have noticed an improvement over the last couple of months. There seems to be more staff", "The (registered) manager seems very nice. They have a very good (administrator) who is aware of everything", "New management has been so different to previous. Staff are happier. They have appointed (staff member) as a senior, who is amazing with the residents", "Management and care is more cohesive -everyone seems to be working well together" and "The (registered) manager has got a real 'hands on' approach. (She) won't let anything go unattended. It's (issues) jumped on immediately, much more…than before."

There was better communication from the service and provider with people, relatives and others who were involved with Lent Rise House. Comments included, "We get to join in", "(I) have definitely been asked for input. Overall, mum is treated very well", "I do go to the residents' meetings to be (the person's) voice", "Yes, (I) frequently have discussions (with staff) about how things are going", "I think there has been a definite change for the better", "I have given feedback on the food…I'm much happier. A happy chappie." There was evidence of consultation with people and relatives, through verbal and written communications. This included meetings in 2018 after our prior inspection. The meeting records showed the service and provider were honest and open, discussing failings and methods that were put in place to improve the safety of people and quality of care. The registered manager told us of further planned meetings with both people who used the service and relatives.

The service was required to have a statement of purpose (SoP). A SoP documents key information such as the aims and objectives of the service, contact details, information about the registered manager and provider and the legal status of the service. The provider submitted the SoP to us within 28 days after a change was made (as required by the regulation). We found the SoP for the service was appropriate and up-to-date. The SoP and provider's website set out a clear and credible strategy to achieve good care for people. For example, service objectives included that people be respected as individuals, be open and honest, and foster continued learning. The registered manager and regional director could explain the service's and provider's care-related goals, the progress made towards them and plans.

Staff consistently told us that morale had improved and professional relationships between workers and management were stronger. Many staff explained the change in culture had occurred when the

management of Lent Rise House was in a stable state. One staff member said, "In the last three months there has been a massive difference in the staff at Lent Rise. Staff are happier and there is a different atmosphere in the home." Another long-serving staff member said the culture had improved a lot and having four staff working on the unit was much better. They felt they didn't need to rush people and were allowed more time to speak with people. The staff member said, "Everything is better. Communication is better and nurses and the management listen to us. The home is cleaner and more activities are happening." A nurse told us the new management were, "Very good and understanding". They also commented that the staff at Lent Rise House are more positive and treated her as "one of the team". Other comments included, "Things are on the up, with happier staff not under so much pressure", "I am really happy working here now", "(Since December), I have seen a lot of change in that time", "There is always room for improvement but people (staff) feel valued and listened to" and "(The registered manager) has taken charge in a kind and caring way." Regular staff meetings, both informal and formal, were held. These included night staff so that important information was available to all members of the team. Specific meetings were also commenced with the cleaners and other ancillary staff. Staff told us they felt more comfortable approaching management to raise any issues, concerns and to ask questions.

The service had worked closely with community partners such as the CCG, local authority, health and social care professionals, GP surgery and pharmacy to improve the care at Lent Rise House. This had resulted in improvements to care, joined up working and better communication with the external stakeholders. The service had consistently shared their findings with the community partners and reached out for assistance when required.