Lawford House Residential Care Home

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Inspection report

Lawford House
Walford Road
Ross-on-Wye
Herefordshire
HR9 5PQ

Tel: 01989566811

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Lawford House is located in Ross-on-Wye, Herefordshire. The service provides personal care for up to 15 older people. On the day of our inspection, there were ten people living in the home.

The inspection took place on 11 April 2017 and was unannounced.

There was no registered manager at this service, and there had been no registered manager in post since March 2015. However, a manager had been appointed and was in the process of registering with the Care Quality Commission. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered providers and registered managers 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 our previous inspection on 18 and 22 November 2016, we found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These were in relation to staffing, safeguarding service users from abuse or improper treatment, person-centred care, dignity and respect, meeting hydration and nutrition needs, and good governance. As a result, we asked the provider to complete an action plan to detail the steps they would take to improve the quality of care provided to people. The home remained in special measures, meaning significant improvements were required, or enforcement action would be taken.

People and relatives expressed concern over staffing levels and deployment of staff. The physical environment was not conducive to people's safety. Staff did not always sign to confirm they had given people their medicine , so it was not always possible to know people had received their medicines safely and as prescribed.

Health professionals had not always been consulted when people were in need of medical attention. People's dignity was not always maintained, and terminology used was not always respectful.

People's preferences and interests were not always taken into account, or known by staff. Where people had expressed interest in a particular hobby, this had not always been pursued by staff.

There was no registered manager in post. The registered providers had not taken action when risks and concerns were brought to their attention. Staff felt unsupported in their roles by the providers, and the manager was not given guidance or direction.

Staff had received training which was relevant to their roles and had enhanced their understanding of people's needs. Staff understood the legislation underpinning their daily practice, and what this meant for the people they cared for.

People enjoyed a variety of food and were given choices in what they wanted to eat and drink. People's

weight was monitored and action taken where concerns were identified.

People's individual communication needs and styles were known by staff. People's independence was promoted as much as possible.

People could enjoy group outings and more in-house entertainment was provided. People's and relatives' views were sought, and there was a system for capturing and acting on complaints.

The overall rating for this service is 'Requires Improvement.' However, we are placing the service in special measures. We do this when services have been rated 'Inadequate' in any key question over two consecutive comprehensive inspections. The 'Inadequate' rating does not need to be in the same question for each of these inspections for us to place services in special measures.

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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 is not consistently safe.

People and relatives expressed concerns over people's needs not always being met. People's physical environment was not always conducive to their personal safety. People's medicines were not always signed for, meaning it was unclear whether they had been given.

Is the service effective?

Requires Improvement

The service is not consistently effective.

People did not always have access to health professionals when necessary.

People enjoyed the variety and quantity of food provided and their choices and preferences were catered for. Staff received training which was relevant to the needs of the people they cared for.

Is the service caring?

Requires Improvement

The service is not consistently caring.

People's dignity and respect was not always maintained. Terminology used when speaking with people was not always respectful.

People's individual communication needs and styles were known by staff. People were supported to maintain their religious beliefs.

Is the service responsive?

Requires Improvement

The service is not consistently responsive.

People's preferences were not always responded to, or known.

People's care plans were reviewed to ensure they were reflective of people's current needs. There was a system in place for responding to complaints, as well as gathering feedback and

suggestions.

Is the service well-led?

Inadequate

The service is not well-led.

There was no registered manager in post. The providers had not taken action when shortfalls in the service were brought to their attention, which adversely affected the care people received. Staff, relatives and health professionals expressed concern over the provider's management of the home. Staff and the manager were not supported in their roles.

Lawford House Residential 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 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.

We made an unannounced inspection on 11 April 2017. The inspection team consisted of two Inspectors and one 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. They had knowledge and experience of care for older people.

We asked the local authority if they had any information to share with us about the care provided by the service. Due to ongoing concerns regarding the care people receive, a local authority action plan was in place with the provider.

We spoke with five people who use the service and two relatives. We spoke with manager, the providers, and four members of staff. We also spoke with two healthcare professionals. We looked at two care records, which included risk assessments, capacity assessments and healthcare information. We looked at the medication administration records, two staff pre-employment checks and quality assurance audits.

Requires Improvement

Is the service safe?

Our findings

At our previous inspection, we found the provider was in breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations. This was because people were not always protected from harm or abuse, and incidents had not always been reported to the police, local authority or the Care Quality Commission. The providers' action plan told us that a safeguarding policy was now in place, and that all staff and the manager knew how and when to report concerns.

At this inspection, we found improvements had been made. There had been no safeguarding concerns raised in the last six months. We spoke with the manager, who told us they were in the process of arranging additional safeguarding training for all staff. Staff we spoke with knew about the different types of abuse, and told us they would feel confident recognising this and reporting it to the manager. The manager told us they would report any matters of concern and that their priority was protecting people living at Lawford House. We saw that following a previous incident of financial abuse in the home, the manager now carried out finance audits and ensured people's money was stored securely on their behalf. A safeguarding policy was in place, as per the action plan, and staff were aware of its contents.

At our previous inspection, we also found the provider was in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations. This was because staffing levels were not determined by the needs of the people living at the home and staff regularly worked significantly over their contacted hours, resulting in potentially unsafe practice. We also found on our previous inspection that staffing levels were not sufficient to meet the needs of people living at Lawford House. The providers' action plan told us two additional senior carers would be appointed, and that any changes to the staff rota would have to be authorised by the manager.

At this inspection, we found that some improvements had been made. The manager had introduced a dependency tool to assess staffing levels. They told us the current staffing levels were adequate for the people currently living at the home, but would need to increase if and when more people moved in.

Previously, the provider had not permitted the use of agency staff, which meant all shifts were covered by the existing staff team. At this inspection, the manager told us they booked agency staff when required. They told us, "I book agency and then let the providers know what I have done. I make it clear to them I have had to do that to ensure people's safety." Staff we spoke with told us the use of agency staff was the biggest difference to staffing levels. One member of staff told us, "I'd say one of the biggest improvements is that agency staff are used now to cover shifts."

We spoke with people about the staffing levels and whether they felt there were enough staff to meet their needs. Two people we spoke with mentioned that because staff were so busy, some of their personal care needs had to "fit around" staff availability. One person told us, "I had a bath this morning, at quarter past six. I have to have help. They're so busy here; we have to fit in with them." We discussed this with the manager, who told us there were no set times for things like baths and showers and that there was flexibility in staff's approach. The manager told us they would observe and monitor this to see whether this was an

issue. One person we spoke with told us they were worried that agency staff would cover the night shift that evening and that they were concerned about who it would be. Staff and the manager told us that as much as possible, regular agency staff were used to provide consistency for people.

A relative we spoke with expressed concern over staffing levels and deployment of staff, and the resulting effect. They told us, "People are left for long periods in the lounge with no member of staff present, which is unsafe." Although this was not reflected in our observations, the relative told us, "There are staff in the lounge today and that is because you are here." The relative gave further examples of the concerns they had about staffing levels and the impact this had on their relative's personal care. They told us, " [person] is unshaven again today, I just lose the will to live. I came up Saturday and there was stubble all over [person's] chin. I've put a shaver and cream in the room and showed the staff how to clean it. I don't know what to do. If I go away for a week, I don't know what I'll find when I come back". The relative told us about their concerns regarding a lack of regular baths and showers and the resulting effect on their relative's skin health. This person did not have capacity in relation to their personal care needs, and so relied on staff to attend to their personal care needs. The person's risk assessment stated the person was at risk of pressure sores. We discussed these concerns with the manager, who told us that staffing levels were still, "a work in progress". Although the provider had started a recruitment drive since our last inspection, not all vacancies had been filled.

When we spoke with people about what being safe meant to them, one person expressed concern over the safety of their personal belongings. They told us, "I've got a wheelchair but the other day, I saw someone else in it. There's me trying to hobble about on my frame, and someone else is in my wheelchair." This person's risk assessment documented the difficulties they had with their mobility. We shared this concern with the manager, who was aware of the problem and had taken steps to prevent it from happening again. This person also expressed concern over not always receiving the help they needed with their mobility. They told us, "It's a long way to (the bathroom) and I can't do it. The girls (staff) are sat there saying, "Come on, you can do it", but you know yourself what you can do."

Staff told us that whilst they felt people were safe in most respects, they had concerns over the physical environment of the home for people. One member of staff told us, "Since doing the dementia course, I have realised this is not a dementia-friendly environment. For example, the toilets are not a good colour for people with dementia, and people are struggling to use them because they can't see them properly." During the course of our inspection, we expressed concern over lighting in some communal areas, including bathrooms. One part of the home was particularly dark. People had to use this area to access a bathroom and to get to one person's bedroom. Staff told us although no one had fallen there, it was a concern as several people did have mobility problems and impaired sight. A health professional we spoke with also expressed a similar concern. We spoke with the manager, who agreed the lighting did need addressing and told us they had raised the issue with the providers who had said action would be taken, within an unspecified time-scale.

We looked at how people received their medicines. We looked at the medication administration records (MARs) and saw there was a total of five gaps in two people's records for prescribed cream for their skin infections over a period of twelve days. Because the medicine in question was a prescribed cream, we could not check whether this cream had been given. We brought this to the attention of the manager, who told us they would look into it and ensure that staff signed the MARs when medicine had been given. Staff and the manager told us the creams would have been given to the people concerned but when we asked how they could be certain of this, they told us that people always had their medicines. This response did not tell us what checks were in place to ensure medicines were given safely, and as prescribed. We saw that people were supported to take their medicines. One person was offered help with using their inhaler, but they

refused this and that was respected by staff. Medication reviews had taken place recently for each person living at Lawford House to ensure people's medicine reflected their current health needs.

Requires Improvement

Is the service effective?

Our findings

At our previous inspection, we found the provider was in breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations. This was because people did not have choice with the food and drinks they were provided; people were sometimes served food which was stale and past its use by date.

The provider was asked to complete an action plan, which told us a "daily nutritious menu" would be available to every person living at Lawford House.

At this inspection, we found that people's views on what they would like to eat had been taken into consideration. We saw people enjoyed their breakfast, as well as their lunch, with choices available at both meals. One person told us about their breakfast, "It was lovely, I ate it all. Look at that, I had a bit of everything this morning." Another person told us, "I had boiled egg and bread and butter- that is what I asked for. One day, I said I fancied fried egg on fried bread and I had it. It was bloomin' lovely." A relative we spoke with told us, "The food is very nice, there's always plenty of veg. It's served beautifully, never just flung on the plate."

The manager had introduced cleaning schedules for the kitchen and a stock rotation system to reduce the risk of out of date food being kept and served to people. The manager told us, "Mealtimes and the kitchen have been my priority. Staff now visibly offer people a choice of meals, rather than make that decision for them." This was reflected in our observations during the lunchtime meal.

We looked at the access people had to healthcare professionals, as required. During our inspection, we noticed that two people had ill-fitting dentures. We spoke with one person's relative, who told us, "[person's] bottom teeth have been missing since Saturday. I've put Fixodent in the office but they can't have used it or else [person] wouldn't have been able to take them out." The relative told us they were aware of difficulties in taking the person to the dentist, but were concerned that not more had been done about the person's teeth. We spoke with staff about this, with one member of staff telling us, "[person's] teeth don't fit them properly now because they have lost weight. They need to see the dentist." However, although this was recognised, the matter had not been resolved for the people concerned. We discussed this with the manager, who arranged dental appointments for both people.

People's weights were monitored on a weekly basis to ensure a healthy weight was maintained. Where there were concerns about a person's weight loss, referrals had been made to GPs and their medical guidance followed. One person had been referred to the Speech and Language Therapy team about their weight loss. The manager told us they would follow the referral up as no assessment had been carried out as yet.

We spoke with staff about the ongoing training, development and support they received. Staff we spoke with were particularly pleased with recent dementia training they had received. One member of staff told us, "The dementia course is great. I never really knew before about the best ways to communicate with people before, or about the different types of dementia. I understand so much more now." Another member of staff

told us, "The dementia course is the most useful training I've done." Since our previous inspection, a senior carer had been appointed to carry out in-house training regarding moving and handling and to carry out observations of staff's practice. They told us they had no concerns about staff's ability in this area from the observations they had carried out. We spoke with a healthcare professional, who told us they had seen improvements in some areas of staff knowledge and competency, such as catheter care and leg ulcer care. Staff told us they received monthly one-to-one meetings from the manager to discuss their roles, receive guidance and be given feedback. One member of staff told us, "All my support comes from the manager. The providers don't get involved."

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 to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the provider was working within the principles of the MCA.

We looked at how the MCA was being implemented. Staff had a good understanding of the Act, particularly in relation to people's capacity to make specific decisions, and people's right to make choices. For example, one person had been prescribed a meal supplement, which they did not want to take. Staff understood about the ability of the person to make this decision for themselves and the need to respect the choice made, even if it did not appear to be in the person's interests. Staff told us about best interest decisions which were in place for people. One example was about an influenza vaccination, and we saw that the correct process had been followed to protect the person's rights and ensure the decision made was in the person's best interest. Where appropriate, the manager had ensured people access to an Independent Mental Capacity Advocate (IMCA). An IMCA is someone who helps people with communication difficulties make their views known and represents people when decisions are being made about them.

At the time of our inspection, every person living at Lawford House had been assessed in respect of their individual care and support needs, and the manager had ensured DoL applications had been submitted accordingly. We reviewed a sample of these applications and saw that each application was specific to individuals' requirements. Where conditions were in place, these were adhered to. Staff we spoke with knew how many DoLS were in place, and what these restrictions meant for people.

Requires Improvement

Is the service caring?

Our findings

At our previous inspection, we found the provider was in breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations. This was because people's dignity was not always maintained. The providers' action plan told us staff would have weekly supervisions to discuss matters such as dignity and respect, and observations would be carried out routinely to ensure staff were treating people with dignity and respect.

At this inspection, we found that although the manager had discussed dignity and respect with staff in, and outside of, supervisions, people were not consistently treated in a dignified way. At our previous inspection, some personal care tasks were carried out in communal areas, which placed people in undignified situations. At this inspection, we found that screens were used to maintain people's dignity where people requested their personal care to take place in a communal area. However, language and terminology used was not always appropriate. For example, after a person had finished their lunch, a member of staff told the person they were a, "good boy." Staff also discussed being pleased their shifts were nearly over in front of people as they ate their lunch, which was not respectful. A relative we spoke with told us their relative did not always get the help they needed at mealtimes to maintain their dignity. This was reflected in our observations. We spoke with the manager about these concerns, who told us they would continue to address these matters in supervisions and staff meetings, as well as addressing any issues they saw during their observations. The manager agreed that what we had observed at lunchtime was not respectful, and contradicted the guidance they had provided to staff in this area.

Although attempts had been made by the manager to address the issues around dignity and respect, this had not been consistently put into practice by the staff. From our observations and what people told us, we could not be assured that adequate improvement had been made.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations.

We spoke with people and relatives about the care people received. One person told us, "I don't have any trouble with them (staff)." Another person told us, "They (staff) all try their best for us." A relative we spoke with told us, "The staff are very good. [Person] likes the staff." Another relative told us there was a homely environment, which their relative liked. We saw that staff spent time speaking with people about things of enjoyment to them.

Staff we spoke with understood people's individual needs and preferences, including communication needs. Staff told us that one person liked to have things written down for them as they sometimes found this easier than communicating verbally. A relative we spoke with told us staff made an extra effort to communicate with their relative because of their hearing and vision difficulties. Staff told us people had told them they did not want male agency staff used, so every effort was made to ensure that people's preferences were catered for in that regard. People we spoke with confirmed they did not want male agency staff and that they usually had female agency carers.

People were supported to maintain their religious beliefs and faiths, as much as possible. A local church visited the home monthly to offer Holy Communion for people. One person told us they were hoping to be taken to church soon by staff, which staff confirmed was being arranged.

People told us staff helped them to maintain their independence. For example, one person told us, "I need help with bathing, but I like to choose my own clothes." Other people told us they as much of their own personal care as possible, with staff helping with the things people were unable to do themselves.

Requires Improvement

Is the service responsive?

Our findings

At our previous inspection, we found the provider was in breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations. This was because people were not able to pursue their individual hobbies and interests. Although people had been asked for their views on their care, people's requests had not been acted on. We asked the provider to complete an action plan. The action plan stated that an activities board would be implemented for people, and activities would be "tailored around the needs and wants of the residents."

At this inspection, we found people had recently enjoyed river walks and a theatre group visit. Forthcoming social opportunities were displayed, and included a canal boat trip, an Easter egg hunt and an Easter party, with an external music based entertainer coming in to perform for people. We saw that where people had made requests, some had mostly been responded to. For example, one person had requested a shopping trip, which staff had arranged. The person had enjoyed this and asked for staff to take them again, which was being arranged. However, one person told us they had asked for large print books, which they were still waiting for. This person chose to spend their time in their bedroom, and told us the books helped them not to feel lonely. The person told us, "I like to read a nice book. I like mysteries with a few murders thrown in. One girl (staff member) found about three, but I read them in no time. No more books have appeared since." We brought this to the attention of the manager, who told us they would get in touch with the local library that day.

A relative we spoke with told us their relative had expressed interest in being taken to the pub, which had not happened as yet. Another relative told us, "The girls (staff) are very good with [person], but I can't say the activities are person-centred. The staff have listed [person's] interests as tennis and football, but [person] hates these." Staff spoke to the person during our inspection about the possibility of planting strawberries in the garden. The person's relative told us the person had never enjoyed gardening. We saw the person did not express an interest in this when suggested to them.

On the day of our inspection, we saw staff supported people with knitting, and with an Easter card making activity. However, one person showed us the card-making kit in front of them and said, "These were plonked down on the desk, I don't know what it is." We saw that staff asked one person what colour ribbon they wanted, but the person themselves did not make the card. At our previous inspection, people had requested a take-away, which had not been arranged for them. At this inspection, no take-aways had been bought for people. People told us they would enjoy eating fish and chips "from the paper."

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

A health professional we spoke with told us there had been improvements in respect of people's care plans and ensuring these were followed. The example given was regarding a medical condition and how the care plan had been updated to reflect one person's needs, and how to meet those. The health professional told us there had also been improvements in communication, such as staff raising concerns, or responding to

changes in people's health and wellbeing. We saw that everyone's care plan had recently been updated, with the involvement of people and relatives, where possible.

At our previous inspection, we found the provider was in breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations. This was because there was not a visible or accessible complaints procedure for people or relatives. At this inspection, we found people and relatives had been informed of the complaints procedure, and this information was displayed for people. At the time of our inspection, no formal complaints had been received. Residents' meetings were held in order to capture any feedback, suggestions or dissatisfaction. Although one had not been held recently, the manager told us they would arrange one. We also saw there was a feedback post-box for visitors, which the manager checked on a daily basis.

Inadequate

Is the service well-led?

Our findings

At our previous inspection, there had been no registered manager in post since March 2015. There was still no registered manager in post at the time of our inspection. However, a new manager had started in February 2017 and had begun the registration process. As there was no registered manager in post, the registered providers were solely responsible for the management of the home and ensuring compliance with the regulations underpinning their practice. By not having a registered manager in post, the providers had breached their registration conditions.

At our previous two inspections over the course of 12 months, we found the provider was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations. This was because the providers had not taken action where the manager's quality assurance checks had identified concerns, nor had the providers identified the concerns and we brought to their attention during the course of our inspection.

The provider was asked to complete an action plan which described the actions they would take to meet the regulation. The provider's action plan told us that a registered manager would be appointed, and that the providers would support the manager by means of supervisions, as well as monthly meetings. The providers also told us there would be an assessment of the home's décor, repairs and any health and safety issues.

At this inspection, we found there were continued maintenance issues within the home. The manager had highlighted these to the provider, but action had not been taken as a result. We spoke with the providers, who recognised there was outstanding work which needed doing. Some of this work had been outstanding for a period of 12 months. Staff we spoke with expressed concern over the maintenance of the home, such as inadequate lighting in certain areas, and the difficulties this caused people. One member of staff told us, "The garden needs improving; it is not safe for people. The surfaces are uneven and people can only use part of it." Staff also told us that people's bedrooms were not personalised, which was reflected in our observations. One staff member told us, "The bedrooms need colour. They are currently all painted white and are too clinical and not individual."

We looked at health and safety concerns, and found that water checks over a period of two weeks stated the water temperature in the bathrooms was up to 56 degrees centigrade, with 23 temperatures recorded as 50 degrees during the same period. The Health and Safety Executive's (HSE) guidance for residential homes is that water above 44 degrees poses a scalding risk to people. The manager told us they had informed the providers of the issue. We discussed this concern with the providers. Neither provider were aware of this risk, with one telling us, " [manager] deals with all that. I'll be honest, I haven't got a clue" (about any water temperature issue). The provider told they would address the issue as matter of urgency. The manager looked into this matter, and told us it was a recording and reporting error, which they would correct. Although action was taken to ensure correct temperatures were recorded, we expressed concern to the providers that they had been unaware and that no action had been taken since the issue was first raised at the beginning of the month.

We spoke with the providers about the support they provided to the manager and staff, including the manager's supervisions, as per the action plan. The providers told us three formal supervisions had taken place since the manager had started, with all three being recorded. However, when we spoke with the manager, they told us that no formal supervisions had taken place, only informal conversations; we could find no record of any supervisions having taken place. We spoke with the manager about the support they felt they needed, and whether they received this. The manager told us about supervisions, "It would be useful to be given some guidance and direction as this is my first managers job and I am still learning. I would like supervisions with someone knowledgeable. It would also be good to have some formal feedback and be told things like, 'you're doing a really good job' so that I know I am valued. I also need to know the providers are 100% on board." The manager told us they regularly worked up to 60 hours per week, and did not feel they could take annual leave at this point due to their workload and concern over the management and running of the home in their absence. The manager told us, "I am working hard but I am not stressed. I am working hard to get it right." The providers told us they recognised how much work the manager had done, and continued to do.

The providers told us they regularly spoke with staff and attended staff meetings. The providers told us feedback from staff was positive about the running of the home. However, all staff we spoke with voiced concern over a lack of involvement by the providers. One member of staff told us, "They need to support [manager] more, it's not right. I don't know how they know whether [manager] is doing a good job by speaking on the phone. This is why we've had so many managers, and we worry that this one will leave as well." Another member of staff told us, "They (providers) just don't make the effort. They don't do enough, and they don't spend money where it is needed. We hardly see them, and they never ask us for our opinions or suggestions. I've been here for [time worked] at they have attended one or two of our meetings". Another member of staff told us the only contact they had with the providers was when they answered the telephone to them. We spoke with the manager, who told us the providers did not regularly attend staff meetings, and they were aware of staff's dissatisfaction with the providers' management of the home. A health professional we spoke with told us, "There is a certain culture, and certain practices at the home, which have been allowed to continue for so long. That's not the staff's fault, it's because the providers have never challenged this, nor are they even aware." This was reflected in our observations throughout the day, such as in relation to dignity and respect.

The providers told us about the quality checks and audits they carried out. The provider told us they audited care plans. We asked the provider what they looked at as part of the care plan audit. They told us, "handovers, medication, daily logs and generally just checking people are leading a happy life." However, this information was not recorded in people's care plans, and we could find no evidence of these audits being carried out. Where audits had been carried out, these had not always identified shortfalls. For example, gaps were found in the medication administration records, which had not been addressed.

The provider had failed to have oversight and understanding of the issues we had highlighted on the previous inspection and on this inspection. This meant that the people living at Lawford House continued to be at risk of not having their needs met effectively. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our previous inspection, we found the providers were in breach of Regulation 18 of the Care Quality Commission (Registrations) Regulations 2009. This was because although the provider told us they were aware of their legal obligation to notify the Care Quality Commission of safeguarding incidents, they had not done so. Since the previous inspection, no statutory notifications had been received. We spoke with the manager, who told us no incidents had occurred, but they would ensure all relevant notifications were submitted, as required. We spoke with the local authority, who confirmed they were not aware of any

incidents which should have been reported.

People knew who the new manager was. One person said about the manager when they were in the room, "[manager] is one of us – they help out." A staff member we spoke with told us, "[Manager] is involved with the residents more and interacts quite a lot; they know who [manager] is."

Staff and relatives were positive about the new manager and the improvements and changes they had implemented. One member of staff told us, "Things are much better under [manager]. There's been a lot of changes, but we can see they were needed." Another member of staff told us, "There is now so much more choice for people. [Manager] takes action." A relative we spoke with told us the manager kept them informed as to any concerns with their relative and they had noticed some areas of improvement within the home. The manager had taken steps to gather the views of, and feedback from, people and relatives. For example, a cheese and wine evening had recently taken place. The manager told us that in order for improvements to be made, they needed the support of the providers. They told us, "I have asked for a meeting with them because I need to know they are 100 % on board." They told us they did not currently feel they had the full support and backing of the providers. We spoke with the providers, who told us the manager was fully supported in their role.