Lister House Limited

Lister House Nursing Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

The inspection of Lister House Nursing Home took place over two days, 22 and 23 May 2017. Both days were unannounced. At our last inspection in March 2016, we rated the home as requires improvement. . There was one breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 for good governance. On this inspection we looked to see if improvements had been made.

Lister House Nursing Home provides accommodation and nursing care for up to 31 people. On the days we inspected there were 31 people in the home, one of whom was receiving respite care.

There was a registered manager in post and they were available on the second day of the inspection. 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.

People told us they felt safe and we saw evidence of appropriate interventions when safeguarding concerns were raised. However, we found risks were poorly managed with a lack of suitable assessments, unclear and contradictory instruction for staff and limited personalised assessments. This was especially in regards to moving and handling as we observed numerous poor procedures with staff lacking confidence in their knowledge and judgements. Specific equipment had not been provided for individuals where required.

Staffing levels were not always appropriate for people's level of need. Some people required one to one support which staff were not always able to give and many people remained in their rooms. It was not clear if this was their choice as there were no records to indicate this.

Medication was administered, stored and recorded appropriately.

Staff's knowledge of person-centred care appeared lacking and they did not appreciate the significance of a Deprivation of Liberty Safeguard (DoLS). Mental capacity assessments were in place for most people unable to make decisions but these were not evident for every decision. People were not always supported to have maximum choice and control of their lives and staff did not always support them in the least restrictive way possible; the policies and systems in the service did not always support this practice.

People were supported to eat and drink and we saw appropriate records kept of their intake. However, due to the staff pressures and the number of people requiring assistance people had to wait for some time before receiving their meals.

External health and social care support was accessed as needed.

We observed staff interactions to be mixed. Some staff were very caring and attentive but others displayed

brusqueness and irritation at times. We saw some people were ignored and staff did not actively engage with people.

Privacy and dignity was not always respected as some people had to wait for support to access the toilet and their needs were not kept confidential as staff shouted to each other requesting assistance.

Care records were mostly person-centred but did not always reflect people's current needs and were complex to navigate. One care worker admitted to not reading them which meant care tasks could be missed.

Activities were arranged but not everyone engaged in them and there was little evidence of one-to-one interaction, especially for people in their rooms.

Complaints were handled promptly and effectively with apologies given where required.

Although some people expressed their satisfaction at living in the home, we found the atmosphere strained and tense at times, as staff struggled to meet people's needs. There was limited evidence of senior leadership.

There was limited evidence of quality assurance which focused on individual concerns rather than overall practice issues. We found breaches of regulations in relation to dignity and respect, safe care and treatment, good governance and staffing. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

We observed poor moving and handling practice on both days of the inspection and there was a lack of appropriate risk assessment for staff to follow.

People and visitors told us they felt safe and we saw appropriate recording and actions for safeguarding concerns.

Medicines were managed safely. We observed staff were under pressure both days due to the needs of people in the home.

Is the service effective?

Requires Improvement

The service was not always effective.

People had to wait long periods for their meals as staff were under pressure to support with eating.

Staff's understanding of mental capacity was vague and although they had undertaken training it was not evident in their day to day practice. They were not supported with regular supervision.

People had access to external health and social care services as required.

Is the service caring?

Inadequate

The service was not caring.

People had mixed opinions of the way in which staff interacted with them. This was mirrored in our observations.

People's privacy and dignity was not always respected.

We observed some explanations being given to people and consent being sought but not consistently.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People had access to activities but these were limited in time and accessibility.

Care records showed evidence of people's individual needs, although information was contradictory.

Complaints were handed well with investigations and apologies as necessary.

Is the service well-led?

Inadequate

The service was not well led.

Although some people spoke positively of the home, we saw many others were ignored or spoken to harshly.

There was a lack of clear leadership as the nursing staff ensured care tasks were completed but there was limited overall scrutiny of care practice. The registered provider did not fully co-operate with the inspection process making it difficult to access records.

Audits were in place but not robust enough to identify significant concerns or change wider practice issues.

Lister House Nursing Home

Detailed findings

Background to this inspection

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

This inspection took place on 22 and 23 May 2017 and was unannounced on both days. The inspection team consisted of two adult social inspectors on the first day 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. The expert by experience had specialist knowledge of care for people living with dementia and physical frailty. On the second day the team comprised two adult social care inspectors.

We had received a Provider Information Return (PIR) before this inspection. 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 checked information held by the local authority safeguarding and commissioning teams in addition to other partner agencies and intelligence received by the Care Quality Commission.

We spoke with seven people using the service and five of their visitors. In addition we spoke with six staff including three care workers, one nurse, the registered manager and the registered provider.

We looked at 10 care records including risk assessments, six staff records including all training records, minutes of resident and staff meetings, complaints, safeguarding records, accident logs, medicine administration records and quality assurance documentation.

Inadequate

Is the service safe?

Our findings

At the last inspection we rated this key question as requires improvement. At this inspection we found concerns and have rated the key question as inadequate.

All the people we spoke with told us they felt safe at Lister House. One person we spoke with told us, "It's an instinct you have, I know I am safe. I have never found it hard to talk to anyone".
Another person said, "I feel safe here because of the nurses, company and there are people to look after me, I wasn't getting fed at home. I made up my mind in two weeks that I wanted to stay here." A further person told us, "The doors are always locked and if I feel scared of any resident, I am reassured by the staff." People said they would speak to any staff member if they had any concerns.

This view was echoed by visitors to the home. One visitor told us "People are safe because I feel as if staff are caring for the resident, that's why I feel they are safe" and another said, "There are two permanent nurses here and they keep me well informed. They make sure any issues are dealt with and that staff are kept on their toes."

Staff were able to identify the signs of possible abuse whether through physical marks or a change in a person's behaviour and were confident in reporting this. We saw evidence of appropriate reporting to the local authority and the Care Quality Commission with subsequent investigation and actions taken recorded. Instructions were issued to staff where there was specific learning or a reinforcement of good practice needed such as regular body checks for any marks or bruising.

One person who had bruising to their face told us they had had a fall and 'it hurt when I went'. We observed this person try to get up numerous times during the day but staff were quick to intervene and encourage them to sit as the risk of harm was high. On some occasions they did try to distract the person by giving them small jobs to do such as sorting the DVDs. Another person who had also had a recent fall causing significant bruising to their face was in bed asleep with a crash mat at the side of the bed. One visitor we spoke with told us, "My relative has an alarmed mat and they put a foam mattress on the floor by their bed at night to limit risk of falls."

Staff told us they had participated in regular fire drills and we saw evidence of this. We asked the registered provider, for evidence of personal emergency evacuations plans (PEEPs) and they showed us a list of room occupancy. We later discussed this with the registered manager who advised the colour-coding on the list of occupants represented the number of staff needed to support a person but there was no other information. It was however, up to date as we saw a new admission for respite had been added. There were individual risk assessments for people in their electronic care records indicating the level of support needed.

Risk assessments were misleading and contained contradictory information. One person was recorded as needing a handling belt with two care workers but could need a hoist if tired. There was no information regarding the sling type or method for staff to follow, and it was recorded 'staff should assess before each movement.' This meant staff were constantly making decisions about the safe method of transfer without

any indication as to when to hoist or use the handling belt. This ambiguity was reflected in the practice we observed.

In a further risk assessment it was recorded '[name] is unsteady on their feet and is at risk of falling.' However, we observed this person was unable to stand and staff we spoke with confirmed this. They told us the person always used a hoist but the risk assessment only said to use this if the person had fallen. The risk assessment had been reviewed on 3 May 2017 but did not reflect the current level of need. The corresponding care plan for mobility said 'Two staff will be needed to assist [name]. Use a handling belt to assist [name] rising from a chair.' We discussed this further with the nurse who said each day was different but this was not mentioned anywhere in the documentation.

We observed poor moving and handling practice on more than one occasion where staff seemed unsure of how to safely transfer people. We saw one person have a handling belt placed around them to support them with standing and one care worker supported them under their arm rather than holding the belt, which risked injury to the person or themselves. We observed a care worker put their hands under a person's armpits to steady them on standing which could have caused harm. No brakes had been applied to the wheelchair before the person had stood up creating a further potential hazard.

One person had requested assistance to go to the toilet which was provided after a few minutes but they were hoisted using a net sling which was not safely used as the person's bottom was hanging out of it. We asked the care worker if the person had been assessed for this sling and they said, "I'm not 100% sure to be honest. That's the nurse's job. We are trying to do what's safe. Some days [name] will stand but they're having a bad day today." Once in the wheelchair the other care worker tried to put the person's feet on the footplates but the wheelchair rolled as again the brakes had not been applied. During this procedure the hoist had to be stopped twice as the material got stuck.

We observed another person being hoisted with the same sling just used for someone else. We asked the care worker which was the first person's sling and were told they did not have one. They said, "There are no individual slings." This was repeated by another staff member. The registered manager advised us only people with long term physical disabilities had their own assessed slings. This is both an infection risk and a moving and handling concern as all people using the hoist need to be assessed individually for slings to ensure the appropriate size and type is used. These examples are breaches of Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as people's safety was not being ensured due to poor moving and handling practice and the use of inadequately assessed equipment.

One person we noted had had 15 falls in the space of three weeks, resulting in minor bruising on some occasions. When looking at their risk assessments we could not see evidence of guidance for staff or any analysis of the events to help limit the likelihood of future harm. Staff told us there was an unwritten agreement to keep the person under 24 hour scrutiny but this was not always possible. There was some confusion in the person's care records as to whether they were using bed rails but we established with the nurse they were not in use as this would have posed a considerable hazard. The care plan indicated bed rails were in use but a risk assessment completed a week later indicated they were not, and we observed a crash mat was in place. We noted these records had been amended on the second day of the inspection by the registered manager.

There was evidence of risk assessments in place for weight, falls and pressure areas. These had people's specific scores which indicated the level of risk based on different factors but there were few corresponding risk reduction measures recorded. Most of those we saw were generic such as avoiding trips by removing hazards or correct footwear to be worn. In one person's risk assessment it was recorded they were

'unpredictable' in relation to getting up frequently (and we observed this) but the only guidance for staff when supporting the person to have a shower was to 'ensure the brakes were on' the shower chair as 'they can hit to try to get up.' To minimise the risk of falls for this person it said a falls mat must be in place and they were to wear their glasses. We did not see this person wearing any glasses over either day we were there. In a different person's care record it said 'to ensure the brakes of the shower chair were off' to prevent it having to be moved. This meant staff had incorrect guidance.

Accidents and incidents were recorded on the electronic system but with varying levels of information. One record referred to a recent fall which had resulted in significant bruising to the person's face but the only action suggested was 'It may be an idea to think about employing an extra member of staff between 20:00 and 22:00 as this is when staff are busy with supper.' It was not clear who had added this. In a previous incident the person had sustained a skin tear as they had tried to put their leg through their bed rails. These were immediately taken out of use and we saw a crash mat in place.

We saw equipment had been serviced as required under the Lifting Operations and Lifting Equipment Regulations (LOLER) regulations.

All the people we spoke with told us they received their medicines when they should and had access to pain relief when they needed it. We observed medication being administered and had no concerns as the nurse was diligent, checking the medication before giving it to the person and then remained with them ensuring they had taken it. Records showed people's health conditions and identified if they had any allergies. People were only given PRN (as required) when appropriate and we saw protocols in place to ensure staff followed these correct guidelines. However, we pointed out to the registered manager there should be separate PRN protocols for each medication as triggers for as required medication may differ. The nurse was very keen to ensure the use of sedative medication only when needed explaining the increased risk of falls if it was prescribed during the day.

Two people were on covert medication and we saw the pharmacist had been involved in this decision via a telephone call. Details of the method of administration was recorded. However, we informed the registered manager there needed to be more detailed evidence of best interest decision making in line with the National Institute for Clinical Excellence (NICE) guidelines. The treatment room was the correct temperature, as was the fridge, and we saw these were regularly checked. All the medication was stored correctly and was within date. We checked random samples of medication against the records and found no discrepancies. All liquid medication had been dated on opening to ensure it was not used past its expiry date. If people were receiving topical medication this was noted on a specific chart, and the cream stored in the treatment room if this was medicated for staff to access when required. Controlled drugs were stored correctly and stock checks tallied. Records showed staff responsible for medication had had their competency checked.

Most people we spoke with told us there were enough staff on during the day. One person said, "There are always staff willing to come". People felt call bells were answered promptly although this could exceed 10 minutes on occasion. One person did tell us, "I do sometimes have to wait a long time for example to be taken to the toilet and that staff sometimes say to me, 'Can't you see I am busy?'" Another person said, "They have no time to talk but if I call them they come."

On each day of the inspection there were six care staff on duty, three assigned to each floor although they did interchange as required. Two of these were senior care staff and there was a nurse on duty each day. There were four staff on duty at night. We found in the auditing file a monthly analysis of staffing needs based on people's dependency scores. A person's level of need had been rated as low, medium or high and the associated number of staffing hours were then allocated to determine the number of staff needed in the

home to meet people's needs safely. The registered manager advised us there was no issue if staffing needed to be increased and they had been operating at the above levels for two months. They did not use agency staff and all care staff were 'on call' one day a week so if anyone rang in sick they would cover the shift.

One care worker said "It is impossible for staff to do everything they're supposed to do in the time they have. I refuse to rush people though." This view was echoed by another member of staff who said, "There are not enough staff to meet people's needs. There are a mix of ages here and their needs are complex." They continued, "I go home feeling I haven't done my job properly because we know people have had to wait to be supported – we can't be in two places at once, we do our best." A further staff member told us they were conscious of the number of people who needed close monitoring due to their high risk of falls. We asked the registered manager if they monitored the call bell response times but they told us only thorough their observations within the home. There was no data from the system to use to assess this. We saw many times when staff were under pressure during both days and people had to wait for attention. This is a breach of Regulation 18 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as people's needs were not met in a timely manner and staff were under pressure.

Staff files contained the appropriate checks including Disclosure and Barring Checks. The Disclosure and Barring Service (DBS) helps employers make safer recruitment decisions and reduces the risk of unsuitable people from working with vulnerable groups. References were provided and probation periods completed. The registered manager said they were continually trying to recruit staff and they liked staff to have NVQ2 and a minimum of a year's experience.

Requires Improvement

Is the service effective?

Our findings

Most people felt staff were competent in their role. One person told us, "Some staff can be a bit 'sharp' at times." Another person told us, "If they are new, I talk them through it." One person we spoke with told us, "I am a very independent person and have looked after myself into my old age but I am amazed how I have accepted being here." This person's visitor told us they felt this was down to the staff who had helped the person adapt and settle down.

One care worker we spoke with told us "I had a thorough induction with a lot of training which was good. I am working on my National Vocational Qualification (NVQ)." They also said they had received practical training in relation to moving and handling including the experience of being in a sling which helped them understand the experience for people. This was echoed by another care worker. However, they told us they had not received any supervision, only an appraisal. Appraisals reflected both employee and employer views of performance, and identified areas for development.

When we spoke with the registered provider in the absence of the registered manager on the first day, they advised us training and supervision records were kept by the registered manager and they could not access these. The registered manager advised us all staff had three monthly supervisions but we were shown no evidence to support this despite requesting it on more than one occasion. Most training was delivered face to face by an external trainer.

One visitor told us they were very impressed with the way staff approached one person they visited who has sight difficulties. They told us "Staff always introduce themselves and tell [name] who they are." This showed staff had some insight into supporting people with visual impairment. We saw staff had access to a wide range of courses which included mental capacity and deprivation of liberty safeguards, nutrition, infection, person-centred care, equality and diversity, moving and handling, health and safety, palliative care, falls and dementia awareness. There was no evidence the impact of such training was regularly assessed as our observations saw some poor care practice. This is a breach of Regulation 18 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as there was a lack of oversight in regards to the effectiveness of training and staff were not receiving regular supervision.

All the people we spoke with told us they could make everyday choices such as what time to get up in the morning and that staff respected their choices. Four people we spoke with told us staff ask for their consent before providing care and two told us they did not always happen.

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. We found urgent and standard authorisations had been requested for people where necessary and one person was subject to a DoLS at the time of the inspection.

We asked staff their understanding of capacity and found it was vague. One care worker said, "Oh we've got one of those. [Name] has a DoLS. It's all about their people's rights, they can't be infringed. They have to be given their own choices where possible." They were not able to distinguish between obtaining consent or the requirements of a DoLS.

Capacity assessments were available for people where they were deemed unable to make a specific decision. We also saw a corresponding cognition care plan which indicated the level of decision-making a person was able to achieve. However, in one record it was noted "[Name] can make basic choices' and then continued 'can hold a conversation about when asked what they like to do.' There was a best interest checklist but no evidence of who had been consulted in making the decision.

All the people we spoke with told us staff contacted the doctor if needed and three people told us they had seen a chiropodist or dentist recently. Visitors also stressed the home was quick to seek extra healthcare support when needed. Records evidenced input from external health and social care professionals such as GPs, dietician or chiropodist. The registered manager had developed positive links with the local speech and language therapy team who provided weekly visits to the home and provided advice on the safest methods of nutrition according to people's needs.

Five people we spoke with told us the home was clean but one person said it sometimes smelt of urine. This view was reiterated by visitors to the home. One visitor was keen to tell us, "They always change their bed." Another visitor told us the home is clean "apart from the carpets". This visitor felt they could have more appropriate flooring to avoid urine smells lingering. All the inspection team noted the odour at different parts of each day although we observed domestic staff cleaning throughout the day.

The bedrooms we saw were personalised although not many were en-suite and some were quite cramped. One bedroom we saw was shared and roomy, being set out well for two people. The downstairs corridors were painted in light colours but doors were not distinguishable by different colours and signage was poor. There was an enclosed courtyard which was used by smokers so this was not accessible to all people in the home. Apart from the clock in the lounge, there were no dementia friendly resources which meant people had little to do. We noted the bathrooms and shower rooms were used as storage areas for equipment for significant parts of each day, and some rooms for use by staff only, such as the sluice were left unlocked.

Most of the people we spoke with told us the food at Lister House was good and there was plenty of choice. One person said, "The food is very good here especially for someone who can really eat. There are good choices; it's amazing." Another person told us, "Food is great, not too rich and not too bland. You have to be careful when you get older."

One person felt specialist diet choices were limited but another said they were always offered an alternative. Another person told us, "The food is cooked well and presented nicely on a tray and it's nice and hot. I like my food to be hot." This person also told us they preferred their cup of tea after they have eaten and staff complied with this. Another person had always had a glass of sherry before lunch and this was honoured as well.

We observed lunch and people seemed to enjoy their food. Many of the people we observed cleared their plate. There were plate guards to enable people to eat independently, and some people were encouraged to use a spoon to promote independence. Other people were supported by care staff at an appropriate pace. There was a pictorial menu but this was positioned in a narrow corridor and not accessible for everyone in the home. People's specific dietary needs were recorded in their care plans such as requiring specific food appropriate to their culture or health condition. People's nutritional and fluid intake was recorded although not always very detailed. Totals were accrued which meant it was easier for staff to ascertain people had had sufficient during the day.

All the people we spoke with told us there was enough to drink and they had access to plenty of water. We observed drinks being offered to people at regular intervals and juice and jugs of water were available in bedrooms. People were offered a choice including whether to have sugar if having a hot drink.

We observed some people had to wait for their lunch. One person who wanted to have their lunch in the patio/conservatory area waited 25 minutes to be served. Another person who wheeled themselves into the dining room waited 15 minutes to be served. People who were in their own rooms had to wait even longer. One person waited over 50 minutes. When we asked care staff about this, one confirmed lunch was late. They said, "People who can eat without support have either gone downstairs or were being given theirs on a tray. But those who need support have not had this yet. It's been mad today." This comment was made at 13:35 and lunch had been served from 12:45. Another care worker said 18 people in the home required support to eat, 10 were upstairs and 8 downstairs. This meant staff were under considerable pressure to support people in a timely and safe manner. This is a breach of Regulation 18 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as staff were not able to support people effectively as people had to wait for their meals for a considerable length of time.

We saw the staff handover sheet which comprised one line about each person, mostly 'settled' or 'sleepy'. This provided very little guidance for staff on how the person had been or what significant events had happened. However, the electronic system allowed for messages to be viewed by senior staff of where there had been specific concerns and we saw the registered manager responded to these.

Inadequate

Is the service caring?

Our findings

People's views of care staff was mixed. All spoke very highly of the nursing staff but had differing opinions about the care staff. One person told us, "I couldn't be put in a place with better care" and another said "All the staff are very kind I find." Another person we spoke with identified one member of staff and told us "They are a lovely person. If you get an awkward one (resident) they sit with them and talk to them."

Most visitors spoke positively of the staff. One told us, "I am delighted with Lister House because of the level of care and number of staff around. Staff spend time sitting and talking to the person I visit. They do not talk down to them; they are very gentle, caring and welcoming." Another visitor said "Staff are very nice and helpful; you can talk to them." However, one visitor felt it was not until a person was nearing the end of life that staff's caring became more evident.

However other people said, "Most staff listen to you and you can have a laugh with them but some just come do what you ask and go" and "Some staff you can have a joke with and they are caring. You can talk to them and they have time for you but some are too busy for you." People told us it varied on the staff member as to whether they felt respected as they felt some were task focused. One person told us when asked if staff treated them with respect, "Sometimes they do, some staff are nice but they don't understand and say I am always causing trouble." Staff were overheard by the inspection team at different intervals having conversations between themselves while supporting people with care tasks.

We overheard a commotion in one person's room and went in. A care worker had been trying to apply a dressing to the person's hand and the person was being very loud and swearing. We calmed the person down and saw the person was able to respond to patient talking. When we asked the care worker what had just happened, they just laughed and said "What can I do?" We had not heard the care worker try and explain what they were doing or make efforts to engage with the person.

There were varied views of whether privacy was respected. Three people told us they felt it was respected but two others said it depended on the care staff delivering care. People said most staff knocked on their room door before entering but we noted doors were mostly open during the day so staff could see people. There was no indication this was people's choice. Screens were used in shared rooms when people were being supported with personal care.

One person told us, "They go out and leave me while I am on the toilet and never rush me".
However, another person said, "They do not treat me nicely when I have an accident (of urine). They get irritated." A further person said, "They don't listen to old people."

During the church service being held in the lounge on the first day we observed a care worker about to hoist one person out of a wheelchair into a chair. This meant considerable disruption to the ongoing service and the person's dignity was not respected. We asked them if they could wait until the end but they ignored this and hoisted the person in front of everyone in the lounge. After doing this the care worker then went on their break showing they had put their needs before the person or other people in the lounge including visitors.

We observed on one occasion a care worker discreetly ask a person "Do you want to go to the toilet before you get in your chair?" which was then followed by a loud comment, "Come on then, I don't want to get you settled in your chair and then you're jumping up and down to go." A bit later the same care worker asked one person if they wanted the CD changing. The person said 'yes' but the care worker then left the room without changing it. One minute later a different care worker came into the lounge and asked the person if they wanted to watch a film or listen to some music. The person requested a film and was assisted in making a choice by being shown some DVDs. The film was on for five minutes before it was replaced without discussion by the original care worker who had decided to put on a CD of their own choosing. This showed a complete lack of regard for other people in the room and their preferences.

On another occasion one person was being hoisted and a screen was placed around them which proved to be more of a hazard for staff to work with as it got in the way of the hoist and drew attention rather than distracted people.

One person in the lounge called out they needed the toilet very loudly but staff turned away. A care worker was in the lounge administering tea and biscuits who acknowledged this request and said, "I'm gonna get someone to help you" but then continued giving out the tea. They told us they had buzzed for help but no one came to assist for over 10 minutes. When another care worker came into the room, the initial care worker announced very loudly "[Name] needs the toilet." Upon their intervention care staff used no equipment despite the person struggling to weight bear. Once the person had arrived at the room one care worker said, "Right [name], we're gonna hoist you. I don't want you to fight OK?" This person was spoken to later quite sternly by staff with one care worker saying "You'll have to wait a minute" after they had repeatedly asked for the toilet.

We observed one person hold out their hand to a care worker who looked at it and then looked away. We spoke with the care worker suggesting the person may need some attention and they then went over to talk to them. Staff spent much of the time in the lounge 'supervising' people rather than interacting. One care worker told us, "We are not allowed to leave the lounge unattended and it is one person's responsibility to be in the lounge. We take turns." This was endorsed by the registered manager but we observed periods of each day when the lounge had no staff in there. These examples all illustrate breach of Regulation 10 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as people were not always treated with dignity or respect.

People felt their independence was promoted. One person told us how staff encouraged them to self-care as far as possible and another told us, "They cut the food up for me so I can feed myself. They take me shopping for clothes and give me compliments and encouragement when I am choosing new clothes. Then they take me for a coffee; it makes me feel better." One visitor told us, "They get my relative to sort their own laundry and to sort the CDs in the lounge. They give them little tasks like that."

We observed interactions between staff and people; some of these were task based and others were caring and person-centred. During lunch we saw one staff member supporting two different people to eat but they did not always explain what they were doing nor engage with the people very much at all. This staff member was focused on the task of feeding rather than the person. During the serving of lunch people were not always acknowledged by care staff and had aprons put on them without being asked if they wanted one.

By contrast, another staff member helped someone who did not want to eat but they encouraged the person gently to try and take the time (the person was very slow to eat) and patiently helped the person eat almost all their dinner and some pudding. This staff member explained what they were doing, was very encouraging, patient and caring. The chef brought many of the meals in and was very friendly with people.

Another person had their lunch on the patio/conservatory area and staff had good banter with that person. The nurse observed one person enter the lounge and requested care staff support them to find a clean jumper.

Similarly, we observed interactions in the lounge and some staff completed required tasks with very little contact. Other staff took time to talk to, reassure and respond to people, their body language was open, they had good eye contact and got down to the person's level. It was evident not all staff knew how to engage with people who had communication issues due to physical disability or dementia or were familiar with the principles of person-centred care.

All the people we spoke with told us their personal preferences regarding gender of care worker was respected. One person told us, "I always have a woman carer but when I want someone to accompany me places I ask for a certain male member of staff and he comes with me."

There was a large screen in the reception area of the home where staff entered key electronic information about care delivery. This was in full view of any visitors and had the potential to compromise confidentiality.

Requires Improvement

Is the service responsive?

Our findings

People's experience of activities was varied. Some were not aware of any, others were not interested but others participated. People told us they could opt out if they wished. We saw a schedule on the wall which appeared to reflect regular commitments such as a church service, reminiscing and music, quiz, motivation exercise and the 'music man'. One person did say they would like bingo but did acknowledge they went on outings every week. Another person told us they had been supported to continue with knitting and crochet. A further person said, "All I have seen is films - that's about it."

Visitors felt there was not enough for people to do and one told us, "There could be more activities based here rather than at Sherrington." This was the other care home supported by the registered manager and provider. The registered manager advised us Lister House had access to the same activities. They were aware people could go out as long as it was booked in advance. They also told us one of the senior care workers was putting together memory boxes for each person at Lister House.

There were photographs on display in the entrance area but these were portraits rather than people engaged in activities. We observed a church service in the lounge during the first day and old films were played on the TV during the morning and music during the afternoon. There were lots of music CDs and films available. Some people also went out during our time in the home to the local shops with a care worker.

Some people we spoke with told us they received support to keep in contact with relatives and friends but others told us they did not. One person told us, "They are always bringing the phone to me." This person's visitor confirmed that the person received a lot of phone calls.

One care worker felt there was not enough for people to do as activities "are usually only for one hour a day." We observed a lot of people remained in their rooms all day, some through choice but others who were not able to verbalise, also were in their rooms. We observed very little one to one interaction unless in the communal area.

People told us they had the choice of when to have a bath or shower, or to receive visitors.

Care records contained key information about people including their photograph and family contacts. We saw care plans in place for medication, mobility, diet, personal care, falls, continence, infection, cognition, the use of bed rails and sleeping. Each care plan had the individual need outlined, the objective that was being sought and what action was required to ensure this was met.

We looked at a number of care records and found discrepancies in information. One person's diet record said "has a varied normal diet but can have softer options. Can feed with supervision and sometimes requires assistance." But then in the actions said "If full feeding is required to be fed in a dignified manner." Again, the direction for staff was limited as to how they knew which consistency of food was appropriate. No direction was evident in care records if people were resistant to receiving care. In another record it was

recorded the person often tried to leave the home as they thought it was an airport and staff were to be vigilant when call bells rang as they may have left via the front door which was unlocked.

One care worker told us care needs were reviewed monthly including people's preferences. This view was repeated by the registered manager who said nurses took the lead in reviewing records, but if needs changed then records would be amended in the interim period as well. The registered manager told us they assessed them regularly to check they remained person-centred in their approach. However, we found not all records reflected people's current needs.

One care worker admitted they did not have time to read care plans. They told us, "I don't understand or like computers to update the system." This meant some care interactions were not being recorded as required.

Not everyone we spoke with knew how to complain, however the people who did explained they had complained and the matters dealt with, resulting in change. People who had complained had confidence in making further complaints if needed. All the visitors we spoke with knew how to make a complaint. One incident was referred to and the visitor told us, "I was very impressed with how this was handled, the staff member came in and apologised." Another visitor had raised concerns about tidiness and poor diet but they felt the issues were tackled appropriately. The complaints procedure was available in the reception area of the home.

We looked at the complaints file and saw evidence of three complaints since the start of 2017. Two of these had regarded poor care practice in relation to respecting a person's privacy and confidentiality and had been addressed with the staff members concerned to the satisfaction of the each complainant. Another complaint had been referred appropriately as a safeguarding concern and the investigation was ongoing at the time of inspection.

Inadequate

Is the service well-led?

Our findings

People living at Lister House told us the atmosphere was "Friendly; we are all friends here," "Perfect; everyone is very friendly here," "Couldn't be any better; helpful in every way" and "You have your own room, are given the choice to sit in the lounge. It's home from home."

Not everyone we spoke with was aware of who the registered manager was. Those who were said they felt they could talk with them, that they were approachable and would listen. One person told us, "The manager comes to see me. I can talk to [them] or the nurse about any concerns." Another person who was not aware of who the manager was said, "I wouldn't be slow at finding the boss but I have no complaints."

This lack of awareness was evident from the visitors to the home. One visitor told us, "I have been here every afternoon for many hours for the past three weeks and only seen the manager three times." Another said, "I see the manager during normal working hours and if I phone and leave a message they always phone back. I do not see the manager at weekends or evenings." Two visitors said they could talk to the manager about their relative's care. Upon our arrival at the home on the first day the nurse in charge was not aware the registered manager or deputy were not working as they had to contact the registered provider in our presence to find out.

We asked people if they felt the home was well managed. One person told us Lister House was well managed because "It's first class here, because everything and everyone helps you. I've not met anyone who's said "no". They will always say I will see to that for you." Another person said "I am happy living here, I love it." Visitors also endorsed this view. One visitor said, "It's well managed because if there is an issue I know it will be fed down to staff. I know the manager does not like things to slide. There are two very good nurses here who are very particular and resident oriented. They are not afraid to say what needs to be done."

One care worker said "We support each other in the team. We couldn't ask for two better nurses. They're really good. I love it here. I love my job." We observed both nurses on each day giving clear direction to staff and directing interventions where necessary. Another care worker also spoke highly of the nurses, "I feel [name] is very supportive. They join in to help care staff whenever they can. They work alongside us." We asked the registered manager if they received the support they needed to fulfil their role and said "I work well with the provider and they are very supportive. They challenge me but I feel it is their role to do this."

However, when asked staff about the support of the registered manager and provider, one care worker told us "I would never go to them with any issues. The home is seen like a production line. They do not speak to staff or residents. Most staff are scared of them due to the response they get." They also said "The registered manager is never here as they are always in the other home." Another care worker told us, "Managers hear what is said to them and then sweep it under the carpet. It doesn't make any difference."

When we requested access to the records for the premises to ensure safety checks had been carried out the registered provider advised us they were not available at Lister House but were stored in their neighbouring

care home. They told us if we needed to see them we would have to visit this home. We requested them again on the second day and were told the same information. When we visited the other home we found the records were all integrated with those of the other home and were difficult to navigate. This was mirrored in relation to other documentation such as the supervision and training matrices, and audits which were in the registered manager's locked office and to which the registered provider said they had no access. This demonstrated the obstructive nature of the registered provider to meeting the requirements of the inspection.

The latest staff audit had been completed in April 2017 but responses were limited. Comments similar to the previous year were found such as 'training helped them to do their job better' but other comments prevailed regarding staff not feeling appreciated or part of a team. In 2016 just over 50% of staff said they felt supported and recognised for what they did. There was no action given as to how the registered manager had intended to improve this and the few returned surveys we saw indicated this was still an issue.

When we spoke with the registered manager about this they said "There's been no issues here for the past 12 months. The team is more positive this year. We've moved away from traditions and routines and I'm getting carers to think for themselves. They are taking ownership of their role." We did not observe this in practice as staff needed leadership and guidance and not all were confident in performing their duties.

We found serious breaches of care in regards to dignity and respect, safe care and treatment and staffing which all indicate issues with poor leadership and governance. This is a continued breach of Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as there was lack of overall monitoring and oversight in terms of care intervention.

Two people and one visitor we spoke with had attended resident meetings and had filled in a questionnaire about the quality of care delivery in the home. Discussions at these meetings had included choice of food, cultural needs, care delivery and activities. Comments had included people saying how much they appreciated holy communion being brought to them in the home. However, one person had raised a concern regarding the time staff took to attend to them and this led to continence issues. This same person had also said they had been denied food at night as staff told them 'it was locked away'. These comments had resulted in an action plan which included supervision for all staff regarding continence care, support and the importance of answering call bells in a timely manner.

The registered manager had sent out the annual satisfaction survey to people and was in the process of analysing the results. This had been difficult the previous year as the surveys were not separated according to which home they referred to so the information was of limited value. This had been amended for this year and most returned surveys we saw spoke positively of the activities, personal care provision, the environment and staffing. There was also a question for people to indicate if any improvements could be made. Two people had indicated meals could be hotter on arrival and these were from people based in their rooms. We could not see evidence of any immediate action having been taken and our observations did not indicate this has been resolved.

We asked the registered manager what they felt the values of the home were. They told us "To provide person-centred care for people. It's their home and we support them to make choices and decisions, whether in the short or long term." In our discussions with the registered manager it was evident they knew people well and were able to explain recent significant events in their lives at Lister House. They were in the process of analysing the fall pattern of one person just before we interviewed them and were assessing how much fluid the person was receiving as they knew poor fluid intake could contribute to increased likelihood of falls.

Three people we spoke with would recommend Lister House, two would not and one was uncertain. The recommendations were because "It's a place as if you feel you can rely on what is being done. The food is good and the care, helpful, friendly staff" and "I did recommend it to a lady at the hospital. It's nice, cosy and you can get around and then come back to your room. They look after you." One visitor we spoke with said they would also recommend the home because "It is one of the better ones; there will be issues but they will be dealt with. The staff have been very good." However, one person said, "I hate the place, it's not appropriate for me. There are lots of people with coughs in the lounge; I don't go in there unless there is an activity I like."

We saw evidence of staff meetings which had most recently focused on person-centred care. Minutes of a meeting held in May 2017 for night staff, with similar issues recorded for day staff, stated "Staff need to know what people would choose for themselves, not do what is right for them. Residents do not need to fit the routine, the workload plan needs to reflect their needs and choices." This showed the registered manager was keen to promote a person-focused culture.

We asked the registered manager what they felt the key risks to the service were and they told us "Managing falls and people with dementia as we need to move away from more physical conditions and look at cognition." They told us the deputy manager was supporting them in preparing a course about managing behaviour that challenges to ensure staff had the knowledge to support effectively. We also asked them what they felt had been achieved and they said "a changed culture, medication is better and we have a strong nursing team."

There were a series of audits listed in the quality assurance file as completed by the registered manager including compliments, complaints, safeguarding, accidents and incidents, dependency needs, nutritional and hydration intake, weights, activities, infections and pressure care. No compliments were evident in the file and neither was there any analysis regarding possible safeguarding concern trends despite there being a sheet to log these. Following an in-depth infection control audit in October 2016 we saw actions had been completed to improve the environment although no infection control lead had been appointed. Fluid records were audited on a minimum of a weekly basis and we saw evidence of instructions to staff where closer monitoring was required of specific individuals. This was echoed for weight management where requests for external input were made as necessary.

Medication audits were ad hoc but reviewed most areas such as controlled drugs, medication administration records, stock levels and cream charts. There was no specific format which made it difficult to determine trends or action points. However, where concerns were noted such as missing signatures there was evidence of action taken with the nursing staff to reduce the likelihood of future errors.

We saw a memo dated December 2016 from the registered manager to all nursing staff saying all people should receive regular body checks to assess for any skin damage. There was also evidence in the file of direct observations being carried out by the registered manager on a monthly basis. They had observed lunchtimes and moving and handling practice since January 2017 on five different occasions. For the latest on 5 May 2017 it was noted "Some improvement since the last observation: still chaotic!" in reference to practice during lunchtime. There was no indication as to what support staff had been given by the registered manager; it was only recorded they had asked staff to consider how they could be more organised. No suggestions were evident in other records. Where there had been issues observed with moving and handling it was recorded the registered manager had given direction.

Accidents were audited according to date, time, action taken, injury sustained and whether the person needed hospital admission. Although a total of accidents per month was recorded it was not always clear

what action had been taken to identify any trends or causation. Nine out of the 14 accidents recorded for April 2017 did not indicate whether the falls were witnessed. The previous monthly analysis had the same issue. We saw a handwritten sheet in the January and February information which linked any falls to specific people and showed the time of fall. However, there was little further scrutiny of what action had been taken for these people.