Runwood Homes Limited

The Lawns

Inspection report

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Warwick
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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?	**Requires improvement**

Overall summary

This inspection took place on 17 & 21 December 2015 and was unannounced.

The Lawns is a purpose built residential home which provides care to older people including some people who are living with dementia. The Lawns is registered to provide care for 76 people. At the time of our inspection there were 57 people living at the home.

At our last inspection in September 2014 we identified breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. We found there were insufficient staff to provide the care and support people required and we could not be sure people received their medicines as prescribed. The provider sent us an action plan telling us the improvements they were going to make. At this inspection we found some improvements had been made. The provider recognised further improvements were still required and were taking steps to ensure people received a quality service.

The service had not had a registered manager since October 2015. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered

Summary of findings

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.

A registered manager from one of the provider's other homes was temporarily managing this service. A new manager had been appointed and was due to take up their post in January 2016 and make an application to be registered with us.

Staff knew how to keep people safe from the risk of abuse. People told us they felt safe living at The Lawns and relatives we spoke with agreed their family members were safe. However, a staff member told us about a safeguarding incident that had not been referred to us or the appropriate authority. Following our inspection the provider notified the local authority and had commenced an investigation into the incident.

People, relatives and staff told us they felt at certain times in the day staff could not always support people in a timely manner. The deployment of staff required further improvements and closer management to ensure people's needs were consistently met throughout the day.

Care plans were sufficiently detailed to support staff in delivering care in accordance with people's preferences, although some required updating. There were occasions when delivery of care did not support people's needs. For example, people were not always transferred safely by staff who had the knowledge and experience.

Staff received training in areas considered essential to meet people's needs. The manager had identified staff required further training in areas specific to the needs of people living in the home. A programme of training had commenced to make sure staff continued to support people's individual needs effectively.

People told us staff were respectful and kind towards them and relatives confirmed this. When staff provided support to people, they were caring and kind. Staff protected people's privacy and dignity when providing care and asked people for their consent before care was given.

Staff understood they needed to respect people's choices and decisions. Assessments had been made and reviewed to determine people's capacity to make certain decisions. Where people did not have capacity, specific decisions were taken in 'their best interest'. Relatives told us they were kept informed when certain care decisions were required and that their views were taken into account.

The provider was meeting the requirements set out in the Deprivation of Liberty Safeguards (DoLS). At the time of this inspection, five applications had been made under DoLS for people's freedoms and liberties to be restricted. The manager had contacted the local authority and was in the process of reviewing people's support to ensure people's freedom was not unnecessarily restricted.

Family and friends were able to visit when they wished and staff encouraged relatives to maintain a role in providing care to their family members.

Some people we spoke with told us there were limited opportunities to promote their physical and mental wellbeing. Activities were available and provided to people living in the home, however it was recognised further improvements were required so staff had more time to spend talking with people. There had been no activities co-ordinator at the home for several weeks and the provider agreed this had impacted on the quality of social stimulation some people received.

People were supported to maintain their health and were referred to health professionals where appropriate.

The manager had identified and was improving processes and systems to make sure regular checks were completed to identify and improve the quality of service people received. The manager's quality checks fed into an overall action plan to ensure improvements were made in the quality of service people received.

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

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was not consistently safe.

People told us they felt safe and staff understood their responsibility to report any observed or suspected abuse. Staff told us they were busy at certain times of the day so there were some delays in meeting people's needs. Staff supported people who had been identified at risk and it was not always clear if some people received their medicines when prescribed.

Requires improvement

Is the service effective?
The service was not consistently effective.

People and relatives were involved in making decisions about their care. Where people did not have capacity to make decisions, support was sought from family members and healthcare professionals in line with legal requirements and safeguards. People received support from a staff team that did not always put their training and knowledge into practice. People were offered meals and drinks that met their dietary needs.

Requires improvement

Is the service caring?
The service was not consistently caring.

Staff provided care in a kind and sensitive manner, however there were periods of time when people had limited interactions with staff, or staff were not available or attentive to people's caring needs. People told us when staff spent time with them, staff were patient, caring and understanding.

Requires improvement

Is the service responsive?
The service was not consistently responsive.

People's care records were reviewed, but they did not always reflect the levels of care and support people required. This meant staff were not always responsive in meeting people's needs. The manager responded to people's informal concerns and written complaints which were resolved to people's satisfaction. The system that recorded complaints required improvements to demonstrate the actions taken.

Requires improvement

Is the service well-led?
The service was not consistently well led.

There was a lack of clarity around the management of the home from the provider and the roles of staff within the home. Further managerial changes made staff and people anxious and uncertain regarding the future leadership of the home. Some systems and checks required better organisation to ensure people had consistently positive experiences in the home.

Requires improvement

The Lawns

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.

This inspection took place on 17 December 2015 and was unannounced. On 17 December 2015 the inspection was carried out by four inspectors 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. One inspector returned on 21 December 2015 to speak with more people and staff about their experiences of living and working at the home.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. What the provider had identified as required improvement was supported by what we found during our inspection.

We reviewed the information we held about the service. We looked at information received from relatives, whistle blowing concerns and other agencies involved in people's care. We also looked at the statutory notifications the manager had sent us. A statutory notification is information about important events which the provider is required to send to us by law. We also spoke with the local authority before this inspection but they did not share any information with us that we were not already aware of.

We spent time observing care in the lounge and communal areas. We also used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experiences of people who could not talk with us.

We spoke with 20 people who lived at The Lawns, one visitor, a relative, three visiting health care professionals and a representative from a GP surgery. We spoke with three care team leaders and seven care staff. (in the report we refer to these as staff). We spoke with the deputy director of care services, a dementia services manager, a regional care director, the manager and deputy manager. We looked at eight people's care records and other documentation related to people's care including quality assurance checks, management of medicines, complaints and incident and accident records.

Requires improvement

Is the service safe?

Our findings

At our last inspection in September 2014, we found people did not always receive their medicines on time and there were no clear guidelines for staff to administer 'as and when required' medicines. We also found staff did not always respond in a timely manner when people called for assistance. We asked the provider to send us an action plan outlining how they would make improvements. At this inspection we found some improvements had been made and the provider assured us further improvements would be made to ensure people received safe care and support.

People told us they felt safe living at The Lawns and the majority of time staff responded to their care and support needs. This was because at certain times of the day they had to wait for assistance, but not for long. One person said, "I use my call bell. I don't wait long, about five or 10 minutes." People we spoke with had mixed views about levels of care staff at the home and whether it supported their physical and emotional wellbeing. Comments people made were, "The best time to ring the bell is when the day shift just come on. They respond quickly", "They could do with more help in the morning, they are pushed" and "For what they have to do, there is enough staff."

Care staff felt staffing levels met people's needs but said mornings and lunchtimes put additional pressures on them. Staff said there was a high number of agency staff which meant they had to spend time explaining and showing them how to support people safely so people sometimes had to wait for support. We observed staffing levels on both days of our visit to see if there were sufficient staff to keep people safe and to meet their support needs. From our observations and from what people and staff told us, staff were able to meet people's needs.

People told us they received their medicines when required. People received their medicines from experienced staff who had completed medication training and whose competency had been assessed to ensure they continued to give people their medicines safely.

We looked at examples of people's medicine administration records (MAR). We found some gaps in the recording of the administration of prescribed medicines and medicines stocks did not always correspond with what had been given. Speaking with staff and from our observations of records, we could not be assured people had received their medicines as prescribed. One concern was records showed a person had not received prescribed paracetamol for mild pain relief since 24 November 2015. It recorded 'manager notified' but there was no other action taken. Care staff were not sure whether this person continued to have this medicine or not. This medicine was not a medicine to manage a diagnosed health condition, however it showed the safe management of medicines was not always effective.

We spoke with the manager and deputy manager about this who told us they had already recognised medicines management needed improvement and planned to address this. They told us they had taken over the management of medicines which involved booking medicines into the home. They said they would make a thorough check of incoming and outgoing medicines so any medicines stocks carried over would be counted correctly and any shortfalls, identified. Following our visit we received a notification from the provider where upon booking in people's medicines, an error was identified for one person's medicines prescribed by a GP. This gave us assurance that the improvements to the medicines management system would make sure people received their medicines safely.

We asked people if they felt safe living at the home. Everyone we spoke with said they felt safe and said staff looked after them to ensure they remained safe. One person told us about a recent incident and said the help they received made them safe. Another person said, "I feel safe here, I like my room and I can see all along the hallway from here which I like."

We asked staff how they made sure people who lived at the home were safe and protected. All staff had a clear understanding of the different kinds of potential abuse, and told us they had received training on how to protect people from abuse or harm. They were aware of their role and responsibilities in relation to protecting people and what action they would take if they suspected abuse had happened within the home. One staff member said, "I would get the member of staff away from the person and find out what was going on." We asked staff what they would do if they found unexplained marks or bruises on people. One staff member said, "We would body map it, photograph it and keep an eye on it." We saw one person's

Requires improvement

Is the service safe?

care plan contained body maps and photographs of bruises that were sustained during a hospital visit. This showed us staff knew how to make sure people were protected from harm.

The provider had a policy and procedure about safeguarding and this linked in with the local authority's protection of adult's procedure. The manager told us what action they would take if they suspected abuse. From the information we looked at prior to the visit, we were aware that the provider had reported safeguarding concerns to the local authority and the CQC appropriately. However, one staff member raised a potential safeguarding incident to us that happened early December 2015. We spoke with the manager about this. They told us statements had been requested, however they had not notified the local authority or us. They said they were waiting for the information before making the referral. On the second day of our visit, the deputy director of care confirmed it had been referred to safeguarding and they were investigating whether the provider's own safeguarding policies and procedures had been correctly followed.

Risk assessments and care records identified where people were potentially at risk and actions were identified to manage or reduce potential risks. Staff spoken with understood the risks associated with people's individual care needs. For example, staff knew how to support people who were at risk of falling, or their skin becoming sore. Speaking with staff showed us they knew when and how to reposition people who were at risk of sore skin, to help maintain the person's skin integrity. Where people were at risk of falling, risk assessments had been reviewed and additional support and equipment identified. This meant staff were consistent in how they supported people so any emerging risks were minimised and people remained safe.

The provider had plans to ensure people were kept safe in the event of an emergency or unforeseen situations. Fire emergency equipment was checked regularly and staff knew what action to take in emergency situations. There were records of what support each person required to keep them safe if the building had to be evacuated and this was accessible to the emergency services.

Requires improvement

Is the service effective?

Our findings

People told us they were pleased with the support they received from staff and they felt most staff had the skills and experience to care for them. People said staff employed by the provider knew about their care needs more than agency staff. One person said, "I always have two staff to help me. The regular staff know what they are doing. The agency staff don't."

The manager and staff told us an induction supported new staff in the home. The manager said the provider's induction period was two days, but the manager extended the induction so staff had time to work alongside more experienced staff. They said, "This is a big home and some people have complex needs so staff need more time, it's important." The manager said there was no pressure for staff to work on their own until they felt confident to do so. Staff said they welcomed this as it helped them become more confident and understanding of people needs.

Staff told us they received training to meet people's health and safety needs and they had received some training specific to the needs of people, such as caring for people living with dementia. The manager used a training schedule to make sure staff received refresher training and this showed not all staff had received training updates. We saw one example where staff did not put their training into practice. Two staff supported a person to transfer using a hoist. When the person's sling was not available, they used the nearest sling without checking it was the right size and correct type of sling to ensure the person was transferred safely. We spoke with the manager about this who told us they had identified this and had prioritised staff training in moving and handling. They also said they prioritised staff training in fire safety and first aid so staff knew how to keep people safe in emergency situations.

We checked whether the service was working within the principles of the Mental Capacity Act 2005 (MCA), and whether any conditions on authorisations to deprive a person of their liberty were being met. 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.

Mental capacity assessments were completed for people who lacked capacity to make certain decisions. Capacity assessments for individual decisions involved the person, their family and appropriate healthcare professionals. We found staff followed the principles of the Act when providing people with support and respected the right of people with capacity to make decisions about their care and treatment. Staff understood the need to support people to make their own choices and staff received training in the Mental Capacity Act 2005 (MCA). People we spoke with told us staff recognised they wanted to remain independent, which included making their own day to day decisions. Staff gave us examples of how they sought consent and how they made sure people had consented before any care was provided.

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).The manager understood their responsibilities under the legislation. They identified five people who could have some restrictions on their liberty and had submitted the appropriate applications to the authorising authority which were approved.

We observed lunchtime and saw menus were on tables with a pictorial presentation of the choices on offer. A staff member also showed people plated meals so they could see what the meals actually looked like. People who required help received assistance from staff and people's meals were prepared to meet their dietary needs. People had mixed views about the quality and choice of food. Comments people made were, "The food is very nice", "The food… you have to take it or leave it" and "The chicken was insipid."

People were offered a variety of drinks during our visit and at mealtimes and staff understood the importance of keeping people hydrated. People who had risks associated with poor fluid and food intake had 'food and fluid' charts completed to monitor their daily intake. These records supported people at risk, and staff told us they used these to check people remained hydrated and nourished. Staff

Requires improvement

Is the service effective?

said where people were identified at risk, people were weighed weekly and if their weight caused concern, support from dieticians or other health professionals was requested. One person we spoke with said they were prone to water infections and said staff made sure they remained hydrated and had access to fluids throughout the day and night.

People told us they saw other healthcare professionals when required. During our visit we spoke with two district nurses and a healthcare professional at a GP surgery close to the home. They told us they had previously had serious concerns around how some medical conditions had been managed, particularly around skin care and wound management. However, they said staff were good at seeking and following advice and nobody living at the home had any pressure areas or skin breakdown at the time of our visit.

Requires improvement

Is the service caring?

Our findings

People were complimentary about the staff who they described as 'kind' and 'caring' and who supported them, despite being busy. People told us they received the support they needed and people said staff were patient and attentive. One person told us, "I want to stay here, I love it…They (staff) are great. I can't say one more than another, they're all good." Other comments people made were, "It's lovely. People are very welcoming and staff are very helpful" and "They're caring, they really are." One person we spoke with took more time to complete certain tasks and appreciated the time staff spent with them. They said, "I think they're all capable, the staff that is. I'm not the most patient, but it's me – I'm frustrated with myself." They told us staff understood their abilities and gave them the time they needed without them feeling rushed.

From speaking with people and relatives, staff were kind, considerate and caring when they carried out their duties. During our visit we saw friendly interactions with people. Staff spoke respectfully and explained what they were doing as they supported people to move around, or if people were upset or agitated. Staff helped keep people calm and relaxed. We saw one staff member asked people questions at lunchtime which were personalised and people responded well and enthusiastically. We looked at a care record for a person living with dementia. The daily records painted a picture that this person became distressed because they kept forgetting their family had been to visit and thought their family had forgotten about them. To help this person, staff put a notepad in their room for the family to sign so the person had something to refer to. One entry 12 December 2015 read, 'Spoke about notepad and [person] thinks it's a great way of reminding [person] when family have visited'. One staff member told us they visited the home on their days off so they could sit and talk with people as they did not have spare time when they working their shift.

Although staff were kind and caring we saw examples where people did not always receive support from staff because time constraints made it difficult for staff to meet people's needs. For example, we were speaking with one person when a staff member approached us with a hot drinks trolley. The staff member did not acknowledge the person by name, nor offer a choice of drinks. A mug of tea was placed on the table without anything being said.

Another person was disorientated and anxious to 'go home'. They were continually addressed by a staff member who used the person's wrong name. This person showed us their name plate on their bedroom door and said, "This is me." The staff member saw the name plate, and still used their incorrect name.

At lunchtime we saw a person was sat separately to eat their lunch. There was no over chair table available and the person had to use a side table. This made it difficult and the awkward position meant the person dropped some food on the floor. Their facial expressions showed they felt worried and anxious. We saw some people did not have parsley sauce with their meal and care staff did not offer it. Catering staff asked if people had been offered the sauce and people said 'no', Staff then said "Do you want some…oh, it's too late now" so people did not receive any. This showed a lapse in caring attitudes and consideration by some staff to meet people's needs.

All the staff told us they cared for people but said the high number of agency staff meant some staff were more, "Task based." Staff said they were able to meet people's needs but wanted to spend more time with people but said it was not always possible. Staff said some agency staff did not know people well enough to engage them in conversations or care for them in the way they preferred. This was supported by people we spoke with. One relative said, "It's not very homely." They explained this was because certain things were not done. They said, "It is the little things, but they are important. One day I came and [person] had no socks on and [person] was mithered by it. I helped get their socks on." They also said they brought some flowers in and staff, "Stuck them in a vase without unwrapping the cellophane." They told us the flowers, "Died because staff hadn't put enough water in."

Most of the people we spoke with were able to express their views and opinions so we asked them if they were involved in their care decisions. Some of the people we spoke with had not been involved in how their care plans were designed around their needs. One person said, "I have never seen it" and another said, "My daughter checks my care plan." The manager said care plans were reviewed monthly and plans were being made to include people in making those care decisions.

People told us they were supported with their personal appearance where required and staff respected their privacy and dignity. One person said, "They've all treated

Requires improvement

Is the service caring?

me with respect and that's important." People wore age appropriate clothes and looked individual in how they were dressed. On the morning of our visit we met two people who told us they had just had a shower. One person said, "Oh that was a lovely shower, I told them to mind my hair didn't get wet." We saw staff listened to this person and did what they asked. People's rooms had an en-suite shower and we were told they could have a bath if they preferred. People looked well cared for and people's personal rooms were kept clean and tidy. People said staff helped promote their independence and supported them to do things for themselves, such as washing, dressing and making their own day to day choices. Staff recognised this was important and one staff member told us, "You can't take away their independence. Some like to help themselves, it is about knowing their needs."

Staff respected people's privacy and dignity. They understood people's need for personal space and privacy. Some people we spoke with chose to leave doors open and said they enjoyed seeing what was going on from the comfort of their room. When people required assistance with their personal care, it was managed discreetly and behind a closed door. People's bedrooms were individually furnished. For example, people furnished their rooms with personal items such as furniture, pictures, photographs and other personal memorabilia.

We spoke with the manager and asked them how they were confident staff respected people's choices and supported people in a caring and dignified way. They told us they were regularly on the floor observing staff and they used this time to see how staff conducted themselves with people and relatives. They said, "I stand and listen at doors and around corners and I haven't had any concerns." The manager said they were planning to work over night so they could see how night staff supported and cared for people.

People were supported to maintain relationships with those closest to them. We saw visitors were able to eat with their family member's. One relative told us they came most days and joined their relative for lunch. We saw staff made the visitor feel very welcomed. A relative said they could see their family member in their room or they could use other parts of the home, for example lounge areas or quiet areas in the home. They said they were able to make themselves drinks and they felt comfortable asking staff for anything they or their family members needed. The manager told us relatives and visitors had been invited to join their family members for Christmas lunch at the home.

Requires improvement

Is the service responsive?

Our findings

People told us they were generally happy with the support they received from staff and were complimentary about the staff who provided their care and support. However, people told us staff were not consistently responsive because they were not always able to support them at times they preferred. One person we spoke with said, "Occasionally, there's cut-backs; you just have to wait a bit longer. But they're good, they don't lose their patience." Another person said staff were not always responsive because, "They're in so much of a hurry, they've so much to do." People said if they rang their call bells for help there were occasional delays but staff did attend to their needs. One person told us if staff could not help them immediately, they would explain that they would come back and provide the support they required as soon as possible.

We considered whether the service was responsive to people's equality and diversity needs when receiving support from care staff. On the day of our visit there were two male care staff and three female care staff on the first floor. The majority of people living at the home were female and we asked some of them what they thought about having personal care delivered by male care staff, or, if they had a choice. People we spoke with said they did not mind and some were complimentary about the help they received from male care staff. One person said, "The men, they're just as good as the ladies" and another said, "I've got used to the men giving me personal care. I just accept it. They're good." Staff told us if people wanted support from staff of the same or different gender then this was acted upon where possible. People said representatives from different religions visited the home each month to provide guidance and meet people's individual spiritual needs.

People gave us mixed opinions about the quality of activities within the home. We found that activities were more group orientated rather than about the individual and promoting people to follow their own hobbies and interests. Some people enjoyed visits by outside entertainers or people from the local community. For example, a local school choir sang carols which people enjoyed. During our visit a singer entertained people and people enjoyed this by singing along with some staff. Most people said they were not always kept physically and mentally stimulated and were not always encouraged to pursue their own hobbies and interests. One person said, "I've got used to just sitting here." Another person shared this view by saying, "I sit here all day. To tell you the truth, I've lost interest in things….they had schoolchildren the other day, singing carols, that was nice." An activities co-coordinator put together a programme of activities but they had been off work for a period of time, so this had lapsed. Time constraints on staff meant they did not always engage with people on a one to one basis. Some people who spent time in their room did not always receive one to one time with staff and were therefore at potential risk of social isolation.

Throughout the day there were missed opportunities to involve those people who wanted to be engaged. For example, in the middle lounge on the first floor, a staff member decorated a Christmas tree but did not engage with people around them. This would have been an ideal opportunity to ask them for their input; choose what to put on the tree and where to put it.

It was clear that some of the people had formed supportive friendships with each other. One person said, "We make our own fun." People had mixed opinions about their involvement in their care decisions and any reviews that were completed. Some people said they had not been involved in their care decisions and seemed content to accept the care provided for them. Others were involved in their care decisions but everyone felt able to voice any concerns with their care and were confident staff would listen and support their requests. A relative told us they felt involved in care decisions and if there were any important changes these were communicated with them.

We looked at eight care records and they described people's needs and abilities and how staff should support them. Care records had information about people, their backgrounds and families and how they lived their lives before moving to The Lawns. The manager told us they were introducing a one sheet profile of people called 'This is me, this is what I like'. This was being put in each person's room. The manager said, "This is mainly for the staff. When you are assisting with personal care, you can have a conversation with them. Little ways of making it more person-centred." This was a work in progress and the dementia services manager was completing these for everyone in the home. Care plans contained good information about people's personal preferences, for example how they liked to dress. Care plans were clear as

Requires improvement

Is the service responsive?

to what people could do for themselves and what they needed prompting or assistance with. There was a strong emphasis on people remaining independent, especially with personal care as they wished to be. Staff said this was important because it gave people control over what they wanted to do for themselves. Staff said they referred to care records and found daily 'handover' provided them with useful and relevant information to help meet people's needs. Staff said this was important, especially if they had been off or were working in other areas of the home.

People told us they would talk to staff if they had a concern or complaint although not everyone knew who the manager was. In the communal areas we saw the provider's complaints policy was accessible to people which informed them how to make a complaint. Records showed that two written complaints had been responded to in accordance with the provider's policy, since the temporary manager took over. Prior to this, there were no records available which meant it was difficult to see if previous complaints were investigated thoroughly and resolved to people's satisfaction.

Requires improvement

Is the service well-led?

Our findings

At the previous two inspections we identified the provider was not meeting their legal requirements and not meeting the regulations associated with the Health and Social Care Act 2008. We returned to check the provider had made improvements and to look at the overall quality of the service to provide a rating under the Care Act 2014. Although we could see some improvements had been made, the provider had not taken steps to fully meet their obligations to comply with the regulations.

This home should have a registered manager in post. At the time of this inspection there was no registered manager in post. The registered manager left The Lawns in October 2015 and the home was being managed temporarily by another manager from within the provider's organisation. The manager had been asked to take over the management of the home as an interim measure due to "longstanding issues." This home has been through significant managerial change over the last 12 months and reopened this year following a refurbishment. Not only had the management of the home been inconsistent, people and staff have been moved to and from this location because this and other homes within the provider's organisation were being temporarily closed and reopened following refurbishment.

During this period the lack of consistent management and leadership from the provider has had a destabilising effect on the home. The deputy director of care, regional care director and manager at the home acknowledged the home had been through a difficult time. They told us a lot of work lay ahead to improve the delivery of service and to convince people, relatives and staff that improvements would be made and sustained. The deputy director of care said, "We have a new manager starting in January 2016. We know this is another management change. They are already working for us (Runwood) and they are committed to improving this home for as long as it takes. We are in this for the long term."

The result of inconsistent management had affected relationships with some health care providers and professionals which need to be re-established to benefit people living at the home. For example, we spoke with a health care professional who provided us with evidence of the support they had offered to the home. Their offers of assistance included pharmacist support with monthly medication, supporting staff with people needing multiple medications, educating staff with minor illness management and educating staff with early recognition of illness so early intervention care could be provided. The healthcare professional told us they had made numerous attempts to contact previous managers with no success. They said, "We thought about not supporting the home going forward, but it is for the good of the people." We shared this with the manager who told us they were not aware of the support that had been offered because there had no handover when they took up their temporary position. We discussed this with the new manager who will manage the service from January 2016 and they agreed they would follow this up and establish those vital links. Another consistent message from other health care professionals was there were no staff available to escort them or be available to handover important information during visits. One district nurse said, "The problem is with this building, it is quite large and they have people with high dependency. We can't find staff to talk to them" and "I have been in the home and actually rang up and asked where staff are to help. I will go and look for somebody and I can't find anybody." We spoke with the manager about this and we were assured this would be resolved when the additional care team leader was in post. As a temporary measure, a handover book informed staff when healthcare professionals arrived which prompted them to review their notes.

We spoke with the manager who told us the home had numerous areas for improvement and had not always been managed effectively. They told us this had a negative impact on staff morale and some staff had left. They said staffing was their biggest issue. They told us, "I am desperate to get staff, but they need to be right." The manager said some staff had previously been recruited who were not suitable, and particularly described problems with staff not arriving for shifts in good time. The manager said, "We need our own staff here on time to support the agency ones." The manager described the detrimental effect on staff morale because of the negative messages they received and explained, "Staff have had the stuffing knocked out of them, staff told me that previous managers consistently told them they were not doing enough." The manager said, "I have watched good ones leave."

The manager told us they used 200 – 250 hours agency staff per week and wanted to get their own consistent staff

Requires improvement

Is the service well-led?

team. The manager found some of the agency staff did not always exhibit the standards they wanted to promote. They said, "Let's try and get the best agency in" and had recently changed the company providing their agency staff to ensure they had staff who promoted high standards in their work. The manager said it was difficult to recruit because of the current reputation of the home, which was supported by people and other health care professionals. The high staff turnover and agency staff made it difficult to effectively manage and plan staffing rotas so people received continuity of care from staff who knew them well, were suitably trained and experienced to care for them.

We found systems that identified what staffing levels should be were not always effective. Staffing levels were based on people's dependencies using a dependency tool to calculate their care needs in time. Where dependency levels had increased or decreased, there were no records to explain why. We checked one person's care records and spoke with them. From what this person told us and what was recorded in their daily notes, their assessment as medium dependency was not correct and should have been high. A more detailed analysis of people's needs should capture the emotional and physical impact of people, such as those living with dementia which would give a more realistic assessment score. This may not affect staffing levels but would indicate where people needed 'activities' or 'engagement' time such as staff being able to sit and hold hands, listen, engage and reassure people. Staff said at key times of the day it was more difficult to meet people's needs, such as mornings and lunchtimes. In response to this, the deputy director of care and regional care director confirmed with immediate effect, additional staffing would be allocated to these specific times of the day. This also included reorganisation of shift patterns long term and an additional care team leader on the first floor to manage the shift and staff deployment more effectively. These measures would make sure people received help and support when needed.

There was a lack of proactive management and leadership of the shifts which meant staff were not always effectively deployed to meet and support people's needs. Staff said it was not clear what their roles and responsibilities were on each shift. One staff member said they were responsible for personal care only, but we saw they supported people at breakfast time. Staff and senior staff told us an additional care team leader on the first floor would help manage the shift more effectively. One care team leader told us it was difficult to cover two units and said at times, "I do not know what is going on in the other unit for up to two hours or so." They said an extra care team manager on the first floor would help with medicines, GP visits and would help with the deployment of staff to where ensure people were regularly checked to maintain their safety.

Audits showed incidents and accidents had been recorded and where appropriate, people received the support they needed. The manager told us they analysed incidents for any emerging patterns and took measures to reduce the potential of further incidents. The manager told us their analysis meant necessary measures could be taken to keep people safe. However, we found some incidents had not been investigated thoroughly. One incident involved a person who had fallen out of a hoist and received hospital treatment. We could see no learning had taken place to ensure this did not happen again. During our visit, we found a similar incident could have occurred without our intervention. We asked a staff member what size sling a person they were transferring with a hoist required. It is essential that the correct size sling is used to prevent people being put at risk of falls. The staff member said, "Small, medium, large?" We asked if the sling was correctly sized and they were unable to tell us. We spoke with another staff member about the effectiveness and availability of the equipment they used to transfer people safely. They said, "There are maintenance contracts for the hoists and slings, but we need more slings. We don't have any spares. People only have one each at the moment. If one person's sling is wet, we have to use another person's, which could be the wrong size." A lack of ownership and oversight in checking availability of equipment, had potential to place people at increased risk of harm.

People we spoke with were unable to tell us who the manager was and some did not know who to voice their concerns to. One person said, "I couldn't tell you who the manager is, I've no idea." We looked at complaints and concerns raised by people and relatives and found the system that monitored and recorded complaints was inadequate. The only records of complaints available to us were two complaints received following the temporary managers appointment. This showed us the system was not effective because records of complaints were not available so it was difficult to see what actions or learning was taken to prevent further similar complaints reoccurring.

Requires improvement

Is the service well-led?

The system that checked staff training was not consistently managed so some staff had not received refresher training to make sure they continued to support people safely. There was no effective system that sought views of people and relatives. For example, a number people told us they did not enjoy their meals but there was no consistent approach to hear their views and for people to feedback about the service they received. One person said, "I haven't been to a resident's meeting and I haven't had any informal chats with the manager to say what I think."

This is a breach of Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked the manager what they felt the service was getting right. They responded, "The care quality is very good here," but accepted that "In every area there is room for a lot of improvement."

We asked the manager whether they felt supported and they said they did. They said their manager visited today three days a week (also during our visit) and they said, "[Operations manager] is actually staying overnight to do a night visit." Since the temporary manager moved to this service in October 2015, they had identified and prioritised the main issues facing the service and begun putting systems in place to improve the quality and safety of care provided in the home.

We saw systems were being implemented to monitor the quality of service. We looked at examples of completed audits. For example health and safety, infection control and fire safety. Actions from each audit were collated to form 'one action plan' that the manager said made it easier to identify what actions were outstanding. The manager recognised medication required improvements and they and the deputy manager, were taking responsibility for this. They said this would help them to be confident people had the medicines they required and if not, swift action could be taken so people had the prescribed medicines they needed.

People's personal and sensitive information was managed appropriately and kept confidential. Records were kept securely in the staff office on each floor so that only those staff who needed to, could access those records. Staff updated people's records every day, to make sure that all staff knew when people's needs changed although some required further improvement to ensure they remained accurate so people continued to receive the right levels of support.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance Systems or processes are not robust, established and operated effectively to ensure risks to people are reduced and to provide a good quality service to people. Regulation 17(1)(2)(a)(b)(e).