Anchor Carehomes Limited

Lightbowne Hall

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

Summary of findings

Overall summary

This inspection took place over two days on 14 and 16 November 2016. The first day was unannounced, which meant the service did not know in advance we were coming. The second day was by arrangement.

Lightbowne Hall is a large three storey detached property in Manchester. The home provides residential care for up to 52 people. At the time of the inspection there were 50 people living in the home. The home has large communal areas on each floor with separate dining areas. Each floor also has a quiet lounge. The kitchen and laundry facilities are on the ground floor of the building and there is a hairdresser's on the first floor. All floors are accessible by a lift and stairs. The service provider had transferred in 2015 from Ideal Care homes to Anchor Care homes.

At the comprehensive inspection of Lightbowne Hall on 16 July and 4 August 2015 we identified seven breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (HSCA). We issued the provider with seven requirements stating they must take action to address these breaches. We shared our concerns with the local authority safeguarding team.

Following that inspection, the provider wrote to us to say what they would do to meet legal requirements in relation to these breaches. This inspection was undertaken to check that they had followed their plan, and to confirm that they now met all of the legal requirements.

During this inspection we found that some improvements had been made. However, they were not sufficient enough to meet the requirements of the regulations.

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."

At the time of the inspection, the service had a manager registered with the Care Quality Commission (CQC). A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The registered manager was on annual leave at the time of the inspection. There were arrangements in place to cover the management of the service including an area manager and support from the deputy managers.

People's medicines were not managed safely. For example, we found one person had recently been discharged from hospital with a new medication supply that would last for ten days, therefore the service was required to order more medication with the local pharmacy. We noted this did not happen in a timely manner and resulted in the person missing five doses of their medicines.

We found accident records at the home were comprehensive and evidence showed people were monitored effectively following an accident. However, we found one incident had not been responded to in a timely manner, resulting in a person not receiving medical attention for two days.

Audits on the home's quality were not accurate which meant systems to improve the quality of provision at the home were not always effective. We found the home in breach of the regulation in relation to good governance as there were not effective systems in place to monitor the quality of the service. Surveys were completed but the information was not collated and used to improve the provision of care at the home.

At the last inspection we found there were not sufficient levels of staff of staff on duty. At this inspection we found staffing levels had increased and people we spoke with confirmed staffing levels were adequate.

During this inspection, we found that the provider had made some improvements to safe care and treatment. Risks to people's health and well-being were identified and a plan was in place to manage those risks appropriately. Staff had access to this information and they were able to reduce the recurrence of the identified risk. Risk assessments were reviewed regularly when there was a change in people's needs.

Care plans were based on the needs identified within the assessment, however we found three care plans did not have a dementia specific care plan in place, and therefore it did not reflect the current needs of these three people.

People had access to activities, however we received mixed feedback with regards to the activities provided. People were not always protected from social isolation. The range of activities available were not always appropriate or stimulating for people.

At the last inspection we found individual plans to support people in an emergency had been formulated on their admission to the home but had not been reviewed since. At this inspection we found people had a personal evacuation plan that reflected their current level of mobility. However, we found the service was not undertaking regular fire drills, to ensure staff were fully prepared in an emergency, such as a fire.

We found staff were recruited safely. Suitable checks were made to ensure people recruited were of good character and had appropriate experience and qualifications.

We reviewed the information and support available to ensure people received adequate nutrition and hydration. We found records were held as required to support people at risk of not receiving enough nutrition and hydration. We found advice given by specialist teams including GPs and dieticians were followed. Records in relation to monitoring people's intake of food and fluids were completed when required.

Staff had received appropriate training, supervision, and appraisals to support them in their roles. Staff, with the support of their line manager, identified their professional needs and development and took action to achieve them, although we noted supervisions did not happen as often as stated in the provider's policy.

People told us they knew how to complain if they were unhappy and records showed the service responded appropriately to complaints they had received. One relative commented that the service did not respond appropriately to their complaint; the area manager arranged a meeting with this person shortly after to discuss their complaint.

We found that the home was properly maintained to ensure people's safety was not compromised, however we found two carpets within the home that were heavily stained and threadbare. These carpets had been identified during a number of home audits, but had not yet been replaced.

Staff sought consent to care from people they supported. Staff were aware of the principles of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) and how to support people effectively, however we found some of the staff were not aware of the people living at the home who were subject to a DoLS.

The environment had some adaptations for people living with dementia.

Staff maintained people's dignity, and respected their privacy. Care records were kept confidentially.

Staff expressed confidence in the management team and in each other. There were regular staff meetings where staff could contribute their views.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Medicines were not managed safely.

There was sufficient staff to meet people's daily needs. However staff did not have time to also arrange regular activities for people to be involved with.

Staff had received training in safeguarding adults and knew the correct action to take should they witness or suspect abuse. A system was in place to recruit suitable staff.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff received training and support from the provider, to enable them to develop their skills and knowledge. However, we found a small number of staff were not aware who was subject to a DoLS living at the home.

Staff received supervisions, although not as often as stated in the providers policy.

People received the support they needed to help ensure their health and nutritional needs were met.

Is the service caring?

Requires Improvement

Some aspects of the service were caring.

People were not supported to be involved in their care planning.

People we spoke with told us the staff were very nice and were trusted by the people who lived in the home.

Staff were discreet when talking about people's needs.

Is the service responsive?

Requires Improvement

The service was not always responsive.

We saw few activities taking place during the inspection. People and staff told us there were not enough activities taking place.

Care plans were complete and were regularly reviewed. However, they lacked detail in areas such as how to effectively support people living with dementia.

People told us they knew how to complain if they were unhappy and records showed the service responded appropriately to complaints they had received. However, one person did not feel complaints were responded to correctly.

Is the service well-led?

Inadequate

The service was not well led.

Systems in place to monitor and improve the quality of the service were not effective.

Monthly audits of medicines had been conducted, but had not been sufficiently robust to identify some of the issues raised during the inspection, or to prevent a person going without their prescribed medicine.

The registered manager was well liked and considered approachable by people, their relatives and staff.

Lightbowne Hall

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 14 and 16 November 2016 and was unannounced on the first day. The inspection team included two adult social care 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. On the second day of the inspection one inspector from the inspection team were on site.

We sought feedback prior to the inspection from the local authority commissioning as well as the local Healthwatch board.

Before the inspection we gathered and reviewed information we held about the registered provider. This included information from previous inspections and notifications (about events and incidents in the home) sent to us by the provider. On this occasion we did not ask the registered provider to complete a Provider Information Return (PIR) before the inspection. The PIR is a form that asks the provider to give some information about the service, what the service does well and improvements they plan to make.

During the inspection we spoke with 10 staff, including the two area managers and deputy manager (referred to as the management team), six care assistants and the chef. We spoke with eleven people who lived in the home and four visitors.

We observed how staff and people living in the home interacted and we used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. We observed support provided; in the communal areas including the dining room and lounges during lunch, during the medication round and when people were in their own room. We looked in the kitchen, laundry and staff office and in all other areas of the home.

We reviewed six people's care files and looked at care monitoring records for personal care, body maps used to monitor injuries and accident records. We reviewed medication records, risk assessments and management information used to monitor and improve service provision. We also looked at meeting minutes and four personnel files.

Inadequate

Is the service safe?

Our findings

All the people we spoke with in the home said they felt safe. People told us, "I feel I am in a safe place; I am not worried." "I feel safer here, I was always falling at home before." "I feel I am in safe hands here, very much so. They are all very good, no complaints."

At our previous inspection on 16 July and 4 August 2015 we identified that there were insufficient staffing levels to look after people safely. At this inspection we found staffing levels had improved and the area manager confirmed the staffing levels were increased immediately after the last inspection.

On the first day of inspection we arrived at the home at 7.45am. The staffing levels during the night had increased since our last inspection by two waking night staff. Discussions with the night staff on duty confirmed there were sufficient staffing levels during the night support for people. One staff member commented, "The staffing levels have improved."

We saw that people were attended to within acceptable timescales. The atmosphere on all floors during the two days of inspection was calm and pleasant. We heard no one calling or shouting for help. Call bells, when activated, were attended to promptly and staff did not appear hurried or under pressure when undertaking their duties.

The area manager provided the inspection team with a completed assessments tool that calculated people's dependency levels. Although people's dependencies were assessed and recorded, the area manager acknowledged there was no tool used to calculate safe staffing levels within the home. The area manager confirmed a new staffing dependency tool would soon be introduced within the home that would better capture the staffing levels required.

We asked people if they thought there were enough staff to meet their needs. People living at Lightbowne Hall told us there were enough staff and said they were not kept waiting when they needed any assistance. One person commented, "It is alright here, of course there is no place like home. At night, bells are answered quite quickly." Another person commented, "They don't seem to be too busy." Staff acknowledged the improvements made to staffing levels and told us, "We have enough staff now, but weekends can be difficult to cover if people go off sick;" and "We have enough staff at the moment, but more staff would be nice of course."

During our last inspection we found a number of discrepancies in the safe management of medicines. For example, medicines prescribed 'as required' had no medicines care plans to inform staff about the circumstances they should be administered. We saw creams and lotions were not being signed as administered according to the instructions. For example, one person's cream which should have been applied twice daily was not signed for as being applied on four days out of the previous ten days. This meant that people were not always receiving their medications as prescribed by their GP.

At this inspection we looked at a sample of medicine administration records (MARs) and found charts had

been completed correctly with no gaps noted. However, during our sampling of medicines records we found discrepancies of two people's medicines. We found six named medicines did not tally up correctly. We noted from the MARs that weekly stock checks had been carried out, but this did not pick up on the discrepancies we found.

Records were not always kept up to date in relation to the medicines people required. For example, one person had recently been discharged from hospital with a new medication supply that would last for ten days. Discharge instructions instructed staff to administer this medicine twice daily for fourteen days, with a further increase in the medicine strength after this time, therefore the service was required to order more tablets with the local pharmacy. We noted this did not happen in a timely manner and resulted in the person missing five doses of their medicines. This incident had not been followed up correctly by the provider, and resulted in the person not receiving their medicines as required and then not receiving the increased dosage within the correct timescales. Not receiving the correct dosage of medicines as prescribed by the hospital professional as well as some missed medicines could have a detrimental impact on the health and well-being of a person.

We looked at how medicines were monitored and checked by management to make sure they were being handled properly and that systems were safe. We found that the deputy managers completed a monthly audit of medicine checks. However these audits did not record what action was taken when medication discrepancies were found, nor had they identified all the issues that we found during the inspection.

Medicines were not managed safely. The provider did not ensure medicines were available in sufficient quantities to keep people safe. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The medicines recording file contained individual photographs of people and information about allergies and how people liked to take their medicines, was recorded. Systems were also in place to record fridge temperature checks; medication returns and any medication errors. We saw there were 'when required' (PRN) protocols in place to help guide staff as to when they should administer these medicines.

We saw medicines classified as controlled drugs were stored and recorded correctly, and a weekly stock check was carried out. Controlled drugs are drugs which by their nature require special storage and recording.

We checked the safeguarding records in place at Lightbowne Hall. We noted that a tracking tool had been developed to provide an overview of safeguarding and care concerns that had been received; we noted these records had been placed in a folder for reference. Examination of individual safeguarding records confirmed the provider had taken appropriate action in response to incidents. During discussions with the deputy manager they were in the process of conducting a full disciplinary investigation, due to an allegation made towards a staff members conduct. We will review this safeguarding outcome once this has been investigated.

Staff told us that they had completed training on safeguarding adults from abuse, and that they completed refresher training every twelve months. Staff were able to describe different types of abuse, and the action they would take if they became aware of an actual or potential incident of abuse. Staff told us that they would report any concerns to the registered manager or a senior member of staff and were also confident about using the whistle blowing procedure. They were certain they would be listened to and that appropriate action would be taken.

We reviewed records to ascertain how the home managed accidents and incidents. We saw records were comprehensive and included time sensitive reviews. These included timely checks to ensure there were no after effects from the accident. However, we found one incident had not been followed up appropriately. We found one person had been observed by staff to be limping and appeared to be in a considerable amount of pain. This person was supported by care staff to the hospital, to undergo an X-ray. However this person was unable to have an X-ray due to correct paperwork from the person's GP not being received by the hospital.

This person did not have capacity and was unable to make any decisions regarding their care and treatment. This person returned back to Lightbowne Hall and did not receive any medical treatment. Two days later the person had still not been examined and we saw recorded in their daily notes by a care worker that they were still in pain and were observed to be limping. An ambulance was called by the care staff, and the person attended hospital and a fracture to their lower limb was confirmed. We viewed this person's records and found no specific monitoring records had been completed by staff during the two day period immediately after the incident occurred. We discussed this with the management team during our inspection, they had not been aware there had been a delay in this person receiving medical treatment.

Identified risks were not monitored or reviewed to ensure people were kept safe. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Risk assessments had been completed for any areas that were considered to be of concern. We saw risk assessments for malnutrition, skin integrity, medication, mobility and the risk of falls. Staff told us that risk assessments were reviewed every 12 months or following any incidents. The risk assessments we saw in care plans had been reviewed on a regular basis to ensure they remained relevant and up to date.

At the last inspection in July and August 2015, we found fire drills had not been completed monthly for day and night staff. Records had shown that only two fire drills had been undertaken in 2015. Both records indicated the drill had been poor and identified further training for staff was required.

At this inspection we found the service had made little improvement in this area. We viewed the fire safety records which confirmed there had been three fire drills since our last inspection for day staff only. At the last inspection we found a fire risk assessment had not been completed for some time. At this inspection we found a fire risk assessment was now in place at the service. However, we found inconsistencies with the completion of fire safety checks, for example gaps in emergency lighting checks. The management team informed us that, the maintenance man had recently changed paperwork since the home had been taken over by a new provider, and this was a possibility why the records were not accurate.

The provider did not have clear systems and guidance on how to support people in the event of an emergency. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last inspection we found the Personal Emergency Evacuation Plans (PEEPS) had been completed when people became residents at the home, and had not been updated since. Not all records included information about how people could mobilise. There were also a number of records for people who no longer lived in the home. At this inspection we found an update file containing people's PEEPS had been completed in detail. A contingency plan had also been implemented that provided details of how the home would continue to deliver the service in the event of an emergency.

Through discussion with staff and examination of records we received confirmation that there were satisfactory recruitment and selection procedures in place.

During the inspection we looked at the records of four newly recruited staff to check that the recruitment procedure was effective and safe. Recruitment procedures were in place and being followed to ensure only suitable staff were employed by the service. Prospective staff completed application forms and the information provided included a full employment history. Pre-employment checks had been carried out. These included Disclosure and Barring Scheme checks, health clearance, proof of identity documents, including the right to work in the UK, and two references, including one from the previous employer.

At the last inspection we found areas of the home were not clean. For example, bedrooms were dirty and we saw evidence of faecal handprints and clinical waste in en-suite bathrooms, both increasing the risk and potential spread of infection. Furthermore there was one domestic staff during our inspection and schedules were not used to monitor and manage the cleanliness of the home.

At this inspection we noted the rota stated there were two domestic staff on duty on our first day of inspection. When we asked for further information about these staff we were told by whom that one person had not yet started their employment. The rota did not accurately reflect the number of domestic staff on duty that day. Although the rota had an additional shift for domestic hours, this shift had not been covered for a number of weeks. During our two day inspection we found a number of areas around the home had not been vacuumed and cleaned, and there was a lack of direction as to who was responsible for these cleaning tasks. Comments from two relatives included, "The cleanliness of this home could be better; you don't see many cleaners." Another relative commented, "I always have to clean my [person's name] room when I arrive; the cleaning could be better."

We discussed this shortfall with the area manager during our inspection, who confirmed the service had recently recruited two domestic staff and they were just waiting on their DBS checks to come through. After the inspection the area manager informed us that the service now had additional hours for a domestic worker to be on rota seven days a week and a new domestic worker was due to start at the service the following week.

We found areas of the home were not clean, and cleaning schedules were not fit for purpose. This was a breach of Regulation 15 (1) (a) and (e) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service had a whistleblowing policy that was available to staff. Whistleblowing is when a person tells someone they have concerns about the service they work for. We had received one whistleblowing concern prior to our inspection concerning the cleanliness of the home. After our findings during this inspection we found areas of the home were not clean.

We looked at service certificates to check that the premises were being maintained in a safe condition. There were current maintenance certificates in place for the electrical installation, the passenger lift, mobility and bath hoists, gas equipment and fire extinguishers.

Requires Improvement

Is the service effective?

Our findings

People spoke positively of the staff working at the home. A person told us, "The staff are good here; if I need a doctor they will always get me one." "An optician visits the home; I am happy with that."

We spoke to six members of staff during the inspection who confirmed they had access to a range of induction, mandatory and other training relevant to their roles and responsibilities. Examination of training records confirmed that staff had completed key training in subjects such as first aid; moving and handling; fire safety; food hygiene; safeguarding; medication; control of substances hazardous to health; infection control; dementia; and health and safety.

Additional training courses such as national vocational qualifications / diploma in health and social care; record keeping; falls and nutrition and dignity training had also been completed by the majority of staff.

New staff were required to complete the Care Certificate. The Care Certificate is a set of standards that social care and health workers adhere to in their daily working life. It is the new minimum standards that should be covered as part of induction training of new care workers.

During our last inspection a number of staff told us they had not received supervision from the registered manager for up to 12 months but we did see evidence of a number of supervisions within the personnel files we looked in. The supervision policy stated staff should receive this support every six to eight weeks. At this inspection we looked at the supervision records and found the majority of staff were now having a supervision at least every six to ten weeks.

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 MCA.

The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The Care Quality Commission (CQC) is required by law to monitor the operation of Deprivation of Liberty Safeguards (DoLS). Discussion with the area manager showed they had a clear understanding of the principles of the MCA and DoLS, and we saw that if it was considered that people were being deprived of their liberty, the correct authorisations had been applied for. The area manager maintained a record of people subject to a DoLS.

We saw that there were policies in place relating to the MCA and DoLS. Where people did not have the capacity to make decisions about their care, meetings were held with people, their relatives, and health and social care professionals to help ensure that any decisions were made in the best interests of people using

the service.

Staff we spoke with confirmed they understood the meaning of mental capacity. However, some of the staff were unsure of who was subject to a DoLS authorisation. The area manager explained this would be covered at the forthcoming team meeting.

We looked in people's care files for information around consent. The care plan included consents for photographs, outings, medication and the sharing of information. There were forms in care plans that recorded people's consent to their care provision. In one care plan we found a relative had signed this consent form on the person's behalf because they acted as the person's Power of Attorney (POA). A POA is someone who is granted the legal right to make decisions, within the scope of their authority (health and welfare decisions and / or decisions about finances), on a person's behalf. However, we saw that not all consent forms had been completed and some consent forms had been signed by a relative when there was no evidence they were the person's POA. The area manager assured us that they would check with all relatives who had POA and record this information in the person's care plan.

The building was a large and purpose built for people living with dementia. Rooms were spacious and furniture and fixtures were all in a good condition. However, during the inspection we found the carpets in the hallway on the ground and first floor was in need of replacing. These carpets were heavily stained and the threads on the carpets had worn and potentially could cause a tripping hazard. The provider's health and safety audits in July 2016 had also identified the carpets that needed replacing. We discussed this potential hazard with the area manager who confirmed new flooring had been agreed and would soon be installed.

At the last inspection we found there was not appropriate signage to support people to find their way round the home. There were some laminated pictures of toilets and baths on the ground floor doors and better signage was needed for people living with dementia. At this inspection we found the service had improved in this area. We found appropriate signage was now available with people having photos, or other distinctive indicators in place that would help people recognise their bedrooms. The service now had pictorial signage in place confirming the day, month and season of the year. However, during the inspection we found these helpful pictorial reminders had not always been changed.

Prior to the inspection we received concerns about the standard of the food being provided at the home. During this inspection people we spoke with told us they liked the food provided. We asked people what they thought of the food at Lightbowne Hall. One person told us, "The food is okay", a second person said, "I have no issues with the food here", and third person commented, "The food's not bad; if there is something you don't like they will change it for you."

A four week rolling menu plan was in operation, which offered people a choice of meals and was reviewed periodically. People were offered a range of options at breakfast, the main meal was served at lunchtime and a lighter meal was served late in the afternoon. One of the inspection team ate lunch with the people using the service. They found there were choices on the menu and said the meal they had was acceptable. We spoke with the cook about the dietary needs of the people living at Lightbowne Hall and found they were aware of which people had specific needs, such as diabetes. They were knowledgeable about how to prepare foods for those with swallowing problems or who needed to gain weight. The cook also knew the food preferences of each person and we saw this was documented by the home. The kitchen area was clean and tidy and we saw the service had been awarded five stars out of a possible five during their most recent food hygiene inspection in October 2015.

We observed lunchtime meal experience on each floor over the two day inspection and found staff practice varied. During our ground floor observation on the first day of our inspection we observed one person slumped sideways in an armchair in the lounge area near to the dining room. They were asleep next to the food placed in front of them. Some but not all of the meal had been eaten. We observed staff assisting other people in this area while this person was sleeping, walking past on a number of occasions. We observed that staff offered no support to the person, encouraged to finish their meal and they were not assisted to be seated more comfortably.

On the second day of our inspection we observed the lunch time experience on the first and second floor of the home. We saw people were offered drinks and a choice of meal, and offered an alternative if they did not want the choice on offer. We noted that staff were available to offer encouragement and support to people requiring assistance and that staff were attentive to the needs of people using the service. We saw good interactions between people and staff at lunch time. People were encouraged to eat their meals themselves however those people requiring support were assisted by staff. Staff were seen chatting with people they supported and we found the atmosphere at lunchtime was calm. We discussed our observations with the management team who told us they would continue to review the meal time experience for people.

We looked at how people were protected from poor nutrition and supported with eating and drinking. Where people were at risk of poor nutrition, they had been referred to a dietician and appropriate food supplements were prescribed and offered. Regular checks were made on people's weight, either monthly or weekly depending on the assessed risk.

We saw from observation and from support plans that the people who used the service had complex health needs which required input from a range of healthcare professionals. In the six support plans we looked at we noted individuals had been seen by a range of health care professionals, including GPs, opticians, dentists, a physiotherapist, chiropodists and other specialist healthcare professionals. Visits were recorded in the daily records for each person and upcoming appointments were recorded in their care files.

Requires Improvement

Is the service caring?

Our findings

We asked people who lived in the home and their relatives about the relationships they had with staff. One person told us, "Girls [care staff] are very good, very considerate to me." Another person commented, "Staff are very good, all of them. They are patient, and kind. They help me to use the stand aid and make me feel it is not a nuisance. I am treated with respect." A relative told us, "The staff are caring; they are always approachable."

At the last inspection in October and August 2015 we found people and their relatives (with the person's permission) were not involved in planning their care. At this inspection we looked at six people's care files and spoke to people and their families about their care planning. People and their relatives we spoke with told us they had not been involved or consulted when it came to planning their care. In the provider's action plan following our last inspection, the provider told us they were focusing on working with people and their relatives during the planning of people's care, however we found no evidence people were being involved in the planning of their care.

We saw that all care files contained a section for people's final wishes record. This allowed the person chance to express what they wanted to happen in their final days. In the six files we viewed we noted this section had not been completed.

People or the relatives were not involved in planning their care. This was a breach of Regulation 9 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 which relates to person-centred care.

We saw care workers were provided with information about the personal history of the person they were supporting. The information included which members of their family and friends knew them best, the person's interests and hobbies as well as their work and family history. Care workers were able to understand the interests and experiences of the person they were supporting.

People's privacy and dignity were respected. We observed that people were clean and were supported to maintain their personal hygiene needs. People were supported to go to the bathroom when they wanted.

We saw staff were discreet when discussing people's personal care needs with them and ensured that personal support was provided in private. The staff we spoke with explained how they maintained people's privacy and dignity, One staff member said, "I always treat the people with dignity and respect; if I saw a member of staff not doing this I would report it straight away." We observed staff knocking on people's bedroom doors and waiting before entering. On the second day of our inspection we were informed by the management team of allegations made against a staff member being verbally abusive towards a person living at the home and another staff member. The management team took immediate action.

We spoke with two care workers about people who used the service. Both care workers knew detailed information about people's life histories, their families, their past employment and their favourite activities.

This showed us that staff knew the people using the service well as individuals.

People's wishes for their end of life care were recorded. For example, some people had a do not attempt resuscitation (DNAR) order document in place and an advanced care plan (a plan of their wishes at the end of life). We saw that the person concerned and their family were involved in this decision.

None of the people receiving personal care services at the time of our visit had specific needs or preferences arising from their religious or cultural background. The provider's assessment process would identify these needs if necessary. Equality and diversity training was included in the provider's basic training programme.

Requires Improvement

Is the service responsive?

Our findings

At the last inspection we spoke with people about how they spent their days. People told us there was not much to do.

At this inspection we found activities had not significantly improved. We were told by the management team the service did not have an appointed activities co-ordinator. Instead, care workers were responsible for providing games and activities when they could. We asked staff whether they felt they had enough time to provide activities and stimulation for people. One staff member told us, "We do try our best to keep people actively stimulated but we just don't have time." Another staff member commented, "There doesn't seem to be any direction on who is meant to do what with the activities. For instance today we have a singer in, nobody knew he was even booked."

An activities timetable was located in all dining rooms, however we noted the activities that were planned, did not take place. On the second day of our inspection we noted on the ground floor, bingo was planned for the afternoon, however a singer turned up. The staff on duty were not aware this had been booked and were observed rushing to arrange the room so people could listen to the singer. We found the activities that had been recorded did not always take place due to a lack of direction of who was meant to be taking the lead from the staff team. Many of the activities recorded did not take into account people's interests such as going out for walks. We also noted that some people's capabilities were limited due to living with dementia and this also had not been taken into account when organising activities, for example two staff members commented that bingo, and arts and crafts were not suitable for people living on the ground and first floor due to people capabilities, however this had been recorded on the timetable. The activities timetable was not always followed and updated correctly; this was not helpful for people living with dementia as this could cause further confusion.

We asked the people living at Lightbowne Hall what they thought about the daily activities. One person said "There isn't much going on really, I do get fed up times." Another person commented, "We have the odd entertainer that comes in, but in general it could be better." A person's relative commented, "You will see jigsaws out on tables, but they never do anything with them, I should know I visit here often enough." We also saw these jigsaws placed on small tables on the first floor of the home. All the jigsaws consisted of 1000 and 2000 pieces and we considered that these were not appropriate activities for people living with dementia, nor were the tables large enough to accommodate these jigsaws.

Shortly after the inspection the area manager provided the inspection team with records that captured what activities people had participated in. We found the activities on this record did not record how long the activity took place. Some activities being recorded included watching TV, having quiet time and sitting in their bedroom.

People's social needs were not being met. There were not enough activities in place to stimulate people, staff were engaged in care tasks and had little time to provide activities for people.

We concluded this was a breach of Regulation 9, (Person-centred care); of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last inspection we found four of the care files we viewed did not correctly capture how pressure areas were managed. For example, we found when assessments or professionals had recommended people were moved regularly to reduce the risk of pressure sores it had not always happened. At this inspection we found the service was now using new care and found records of care provided were regularly maintained. For example, we saw records of pressure relief were regularly updated. These records indicated people received support with pressure relief to reduce the risk of developing pressure sores as frequently as their care plans directed. Other records, including records of close observations, food and fluid intake and behavioural monitoring charts were also regularly updated during the inspection. This meant that people's support plans contained information which staff used in order to be responsive to their needs.

People's preferences in relation to their care, support with personal care and food preferences had been recorded. However we saw there were inconsistencies with the care plan not covering people's essential needs. For example, we found no care plans that included personalised details of the support people required for aspects such as living with dementia and epilepsy. This meant that the correct level of support required by people was not assessed and documented so that care staff would understand how to meet their needs. We discussed this area with the care and dementia advisor for the provider, who acknowledged this observation and confirmed this would be reviewed to ensure people's assessed needs had been fully captured to guide staff. We will check this at our next inspection.

We asked care workers how they knew what people's care needs were. One care worker said that they would find out by getting to know the person and following the care plan for that person; another care worker said that the managers would inform the staff during meetings if people's care plans had been updated.

We saw complaints posters outlining the procedures to follow when making a complaint were available on notice boards around the home. There was also a copy in the resident information booklet. Audits were undertaken by the registered manager of the complaints received by the home. We found there had been a significant increase of complaints since our last inspection. We viewed the complaints records which confirmed 23 complaints had been received since our last inspection.

The management team acknowledged the service had received a high volume of complaints but were confident that these complaints had been responded to correctly and future complaints would reduce. Many of the complaints we viewed were about the cleanliness of the home and the food on offer. We reviewed the complaints and saw that these had been investigated and actions taken where required. We saw the provider's procedure had been followed where formal complaints had been received, such as issuing responses within agreed timescales. One person's relative commented during the inspection that they raised a complaint previously about the food at the service, but never received a response. The area manager commented that they was not aware of this complaint and immediately arranged a meeting with the relative to discuss their concerns.

Inadequate

Is the service well-led?

Our findings

Since the last inspection there has been a change in the management of the service with a new registered manager appointment. The registered manager had been in post for approximately 12 months. At the time of our inspection the registered manager was on annual leave. Staff we spoke with told us morale has improved since the change in manager. Comments from staff included, "The manager is extremely supportive and always available if you have concerns." Another staff member said, "I think the manager has not had it easy with many of the old staff leaving, but I feel this is for the better and I can see a positive change."

At the last inspection we found the information held within the home and associated audits did not correlate. Information was contradictory and did not identify risks and issues as effectively as they could As a consequence, actions to improve things may not be identified. At this inspection we saw a number of systems and audits had been introduced to allow the registered manager to effectively monitor the quality and safety of the service. There were a wide range of audits and checks carried out including, infection control, the environment, medicines, accidents and catering. We saw that audits had been completed regularly, however areas of improvement that had been identified were not always actioned. For example, monthly medicines audits picked up on similar discrepancies we also identified during our inspection, but no action had been devised to remedy these issues. We also viewed a number of health and safety audits that did not pick up on the expected levels of fire drills, and no action had yet been taken in respect of the threadbare stained carpets for a number of months.

The area manager carried out monthly 'compliance visit record checks' and a report was drawn up with the findings, with what action was needed to rectify any issues that had been identified. We looked at the most recent compliance visit, which was in November 2016. The compliance visit check identified similar medicines errors we have found during our inspection and devised an action plan for the registered manager to follow. However, the compliance visit check failed to discover the lack of fire drills for day and night staff. This potentially placed people at risk of harm.
We saw a number of surveys and questionnaires were completed by people with an interest in the home. This included care surveys, staff satisfaction surveys and food and menu surveys. We found the surveys were not monitored and action plans were not developed from them. Surveys are a tool for improvement and should be used as such. If actions are not identified from the feedback provided then the feedback has not served its purpose.

At the last inspection we identified the infection control audits had not identified areas of concern seen on the inspection, such as the home's clinical waste located outside the home was not secure, and a container appeared broken and was easily accessible in a store that was not padlocked. At this inspection we found monthly infection control audits were now being completed; we noted many of the actions on the audits related to the poor cleanliness of the home. We found the provider has still not addressed this area, and one domestic staff member on rota for the whole building was not sufficient.

Over the past two inspections of this service we have found several breaches of the regulations since 2015.

We found the same or similar breaches in regulations where the provider had failed to act on these to improve the care and support people received. We have not seen sustained improvements to the service due to the lack of reliable and effective governance systems in place.

We concluded this was a breach of Regulation 17, (Good governance); of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During the inspection we spoke to the area manager who informed us the new provider, had now introduced an audit tool called 'excellence' that followed the same key lines of questions used by the Commission. The audits had only been introduced in November 2016 and the registered manager was expected to answer a number of questions each month; this information would then be generated into an action plan for the management team to follow and give a percentage score of compliance. We will view the effectiveness of this audit during our next inspection.

The provider used a floor management file which included the records to complete for each person in the home. Included in the file were all the extra care monitoring records, the accident reports, topical cream records and daily logs. We found this information was recorded throughout the day by the care staff, ensuring this was a live record of tasks that had been completed.

We saw a staff meeting took place monthly and there was another scheduled for December 2016. We saw that the registered manager had encouraged staff to share best practice and their experience of things working well to drive change within the home.

We looked at the resident meeting minutes from February, March, May, June and September 2016. We found at the last meeting people had asked for 'chippy tea' to be added to the menu on Fridays. Discussions with staff and people confirmed this had not yet been done. The management team confirmed the service had incorporated fish and chips on the home's menu, and there was possibly confusion with staff and people wanting this food to be bought in from the local fish and chip shop. The management team confirmed this would be discussed at the next resident meeting to clarify if they were happy with what had been provided on the menu.

The management team understood their responsibilities with the Care Quality Commission and had reported significant information and events, such as notifications of deaths, serious injuries and any safeguarding issues.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The registered provider had not involved people or their relatives (with the person's permission) in planning their care. And. The registered provider did not have a robust programme of activities for people both inside and outside the home.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The registered provider had not ensured areas of the home were not clean, and cleaning schedules were not fit for purpose.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered provider did not ensure medicines were available in sufficient quantities to keep people safe. The registered provider failed to monitor or review risks that had been identified to ensure people are kept safe. The registered provider did not have clear systems and guidance on how to support people in the event of an emergency.

The enforcement action we took:

Warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered provider had not ensured appropriate systems were not in place to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users.

The enforcement action we took:

Warning notice