Barchester Healthcare Homes Limited

Lanercost House - Carlyle Suite

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This unannounced inspection took place on 4, 12 & 26 February 2016. We last inspected Lanercost House - Carlyle Suite on 07 January 2014. At that inspection we found the service met all the regulations that we reviewed.

Lanercost House - Carlyle Suite is a nursing home for up to 15 older people. The service provides care and support for people living with dementia. The home is purpose built and has 15 single rooms with full en-suite shower facilities, which are accessible for people using a wheelchair. On the ground floor are therapy rooms including a kitchen and a sensory room. There are secure garden and patio areas, which are accessible from many of the bedrooms and from the communal areas.

The service did not have a registered manager in post at the time of inspection. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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 and associated Regulations about how the service is run. Since the inspection a manager has been appointed. A nurse with experience of the Carlyle Suite has been put in place as the interim Head of Carlyle unit until a permanent appointment can be made.

At the inspection there were 15 people living in the home. Some people's ability to communicate was limited due to their illness. Those we did speak with told us that they felt safe living there, that staff were "kind" and treated them well. The majority of relatives we spoke with told us that they were happy with the care and support provided. However a number of relatives told us they were concerned that staff had been under pressure recently and that it was difficult to know who was in charge.

We found a number of breaches related to the safe care and treatment of people, medicines management, staff support and supervision, infection control and in providing effective leadership. We were particularly concerned about the risk posed to people from choking. We took urgent action to ensure that the home put measures in place so that people were protected, as far as possible, from being exposed to avoidable harm or risk to harm.

We found that people's safety was being compromised in a number of areas. This included: how care plans and risk assessments were written and updated; how medicines were administered and recorded; making sure that high risk areas such as bathrooms and kitchen areas were locked; and having staff on duty who were up to date and knowledgeable of people's current needs.

We found that some areas of the home's environment required attention. We found chairs and carpets that were not clean. The home was malodorous. The areas we highlighted on the first day of our inspection were attended to quickly. On the second day of our inspection the provider had the home deep cleaned by professional cleaners. The bedrooms we identified as needing attention had been repainted and new carpets were ordered and had been delivered.

We found that there were not always sufficient staff on duty to meet people's needs; to supervise people and spend time on a one to one basis with socialising and offering meaningful activities. While the home had very good facilities downstairs, including a sensory room, craft room and an adapted kitchen, the use of these were dependent on staff availability. Over the three days we visited we did not see anyone using these facilities or being taken out of the home by staff. We also found that there was little in the way of equipment or adapted environment for people living with dementia to be engaged with on the top floor, where people spent most of their time.

We saw that staff were attending to the basic care needs of people. However, staff did not always keep up with the other tasks that were assigned to them, such as updating people's notes and domestic duties of keeping the kitchen clean and tidy. We found that people's needs were not consistently reviewed and re-assessed. This meant care plans and risk assessments did not identify all the health and social care needs of people. Some plans we saw lacked sufficient details for staff about how they should care for people.

Staff lacked supervision and guidance from senior staff. Staff supervisions and team meetings had not been completed for several months. However we did find that the introduction of new staff was well managed and new staff reported that the induction period and training had been very thorough.

People had a choice of meals and drinks, which they told us were good and that they enjoyed them. People who needed support to eat and drink received this in a supportive and discreet manner. The way nutritional intake and weight was monitored for people who were losing weight was inconsistent. Although the home did seek expert advice when required, from a dietician and from a person's GP.

Communication in the service was inconsistent between staff and between shift changes. This meant that staff were not always up to date with the support people needed. This placed vulnerable people at risk of receiving unsafe care and treatment.

Staff had received training relevant to their roles. The provider had effective systems when new staff were recruited and all staff had appropriate security checks before starting work.

People were able to see their friends and families as they wanted. There were no restrictions on when people could visit the home.

The service followed the requirements of the Mental Capacity Act 2005 Code of practice and Deprivation of Liberty Safeguards. This helped to protect the rights of people who were not able to make important decisions themselves.

We saw caring and positive interactions from staff. Staff were aware of people's preferences about their care and daily lives and respected their wishes, wherever possible.

We saw that staff were skilled at engaging with people who could challenge the service. We spoke with mental healthcare professionals working with the home and they told us that staff were good at taking up offers of training and following their advice.

The provider had systems to measure the quality of the service. However due to the lack of clear leadership these had not been maintained, and where audits had been completed the actions arising from them had not been followed through. This had resulted in repeated issues being identified in a number of internal audits with no improvement.

The service had not had consistent leadership for sometime. Over the past eighteen months two managers had been appointed but left for various reasons. The Carlyle Suite would also normally have a Head of Unit but this post had also been vacant for a year. We saw that many of the issues we found on inspection stemmed from the lack of leadership and clear direction.

The overall rating for this provider is 'Inadequate'. This means that it has been placed into 'Special measures' by CQC. The purpose of special measures is to:
• Ensure that providers found to be providing inadequate care significantly improve
• Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.
• Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.

Where we have found breaches of a higher level of risk we will ensure that appropriate enforcement action is taken. We are currently following our enforcement policy and will report on the outcome once any action has been completed.

You can see what action we told the provider to take at the back of the full version of the 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.

Staffing levels did not meet all the assessed needs of the people in the home.

Medication was not safely managed within the home.

Risks in the home were not well managed and measures to ensure the environment was safe were not consistently followed by staff.

We found the service had neglected people's needs and significantly disregarded their need for specialist dementia care and treatment, with a view to choking and the risk of harm.

Infection control measures in the home were not robust and people living and working in the home were put at risk of infection.

Staff were recruited appropriately and relevant checks on their background were carried out.

Is the service effective?

Inadequate

The service was not effective.

Nursing and care staff working in the home had not received regular supervision, support or leadership to make sure they were competent to provide the support people needed.

Care plans and risk assessments did not identify all the health needs of people.

The service had facilities which could be used for the benefit of people living in the service, but these were not being used fully due to a lack of adequate staffing levels.

People's rights were protected because the requirements of the Mental Capacity Act 2005 Code of practice and Deprivation of

Liberty Safeguards were followed when decisions were made about the support provided to people who were not able to make important decisions themselves.

Is the service caring?

Good

This service was caring.

People told us that they felt well cared for and we saw that the staff treated people in a kind and respectful way and that their independence, privacy and dignity were protected and promoted.

Staff demonstrated good knowledge about the personal details of people they were supporting, for example on their backgrounds, their likes and dislikes.

Information was available on how to access advocacy services for people who needed someone to speak up on their behalf.

Is the service responsive?

Inadequate

The service was not always responsive.

Care plans and records showed that people were being seen by appropriate professionals in order to meet their physical and mental health needs. Although this was not always done in a timely manner.

Assessments and care plans were not in enough detail and were not always updated when a person's need changed.

There were some activities and entertainments offered to people. However people's ability to engage in the local community was limited. As was the provision of meaningful activities that were designed to meet the needs of people living with dementia.

Is the service well-led?

Inadequate

The home was not well-led.

There was no registered manager in post at the time of our inspection.

Relatives and professionals commented on the lack of leadership

and the issues that this caused.

Staff told us they did not feel supported and listened to.

Quality assurance systems were insufficient to identify areas of concern. Where areas of concern had been identified systems were not robust enough to improve the quality of the service provided.

Lanercost House - Carlyle Suite

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.

The inspection took place on the 4, 12 & 26 February 2016 and was unannounced.

The inspection was carried out by an adult social care inspector and a specialist professional advisor in dementia care.

During our inspection we spoke with six people who lived in the home, both in communal areas and privately in their bedrooms. We spoke with four relatives, two nurses, eight care staff, two domestic staff and the activity coordinator. We spoke with the interim Head of Unit (HoU) and a regional director for Barchester.

We observed the care and support staff provided to people in the communal areas of the home and during the lunch time meals. We looked at the care plans and records for four people and tracked their care in detail. We looked at records that related to how the home was being managed.

Before our inspection we reviewed the information we held about the service. We contacted the local authority, social workers and healthcare professionals who came into contact with the home to get their views.

The service had 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. We planned the inspection using this information.

Inadequate

Is the service safe?

Our findings

There were a number of people whose ability to communicate was limited due to their illness. However, we saw that these people were at ease around staff and responded favourably to staff approaching them. Some people told us that they felt "safe" living at the home. One person told us, "I love these staff, all of them, they are lovely I tell them things and they do it. I love them."

For those people who had limited verbal communication, many of their relatives told us that they were happy with the care received by their relative. A relative we spoke with said, "The staff are all very good and I feel [relative] is safe here." Another relative said, "It's a great relief to have them here."

Two relatives we spoke with said that while they "rated" the staff, there wasn't enough of them and this, they felt, had become worse recently. They both reported feeling the need to come in to "check" on things and to make sure their relative was getting the care they needed.

We looked at how the service was managing and reducing risks to people. We found that risks were not always identified and managed in order to protect those people using the service. For example, staff told us that the main bathroom should be kept locked at all times due to high risk of items that were hazardous to people with reduced understanding and capacity. We were told by staff that one person had nearly choked several weeks prior due to ingesting an item in a bathroom. On the inspection we found that the main bathroom was unlocked and told staff immediately. There were paper towels, toilet tissue and a bottle of bubble bath in the bathroom. These are all high risk items for people at risk of choking or drinking potential hazardous substances. We found on the second and third day of the inspection visit that the bathroom was locked. However, the kitchen door, which staff also said should always be locked due to the risks posed to people, was found to be open at times across the three days of the inspection, and this was when staff where not in the immediate vicinity to supervise this area.

We found that three people had recently exhibited behaviours that put them at risk of choking. We found that care plans and risk assessments where not up to date and accurate to reflect the increased level of risk. The plans were not in sufficient detail to instruct staff on how to keep people safe. Staff knowledge, across all grades, about the risks of choking was inconsistent, with some staff having no knowledge at all about the risk. We found on the inspection that the nurse in charge was not aware of one person's recent incident in December 2015, whereby an emergency doctor was called out as they had been found eating a bar of soap. We also found that the domestic on duty had no knowledge of the risk to three people from eating toilet/tissue paper and plastic products and was restocking all three bedrooms and communal toilets and bathrooms with these items.

We asked the nurse in charge for the home's environmental risk assessment and was told by them that they were aware the home did not have one. They went on to say that they had a fire risk assessment. We would expect for a specialist service for people who had an impaired cognitive state that the environment would be made safe by means of through risk assessments.

We found that the registered provider had not protected people as they had not done all that was reasonably practical to mitigate risk. This was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We had received information from adult social care and health professionals prior to our inspection that at times there were not sufficient staff available to support people. We spoke with staff most of who thought there were insufficient staff to carry out all the tasks required.

We looked at the rota for Lanercost Carlyle Suite. This showed that four care staff and one nurse were on a day shift and one nurse and two care staff on a night shift. When we asked the nurses on duty they said that these levels did not allow them to do all the care, treatment and paperwork tasks or allow them to supervise and oversee care staff. They reported that when the unit first opened there had been two Registered Nurse's on duty, and that care needs and not changed since then. Nurses reported that all their time was taken up carrying out the medication rounds and dealing with enquires on the telephone. One nurse told us, "We are trapped in the office". Another nurse told us that she felt like she was "running to catch up" from the moment she came to work to when she left and often didn't "have time for drinks."

The interim Head of Unit (HoU) who had been in post since December 2015 was allocated two shifts per week in the unit. However she was also the only nurse on shift on these two days. There were no supernumerary hours for the running of the unit. Both the Interim HoU and the Deputy, who was overseeing this service and the adjoining 82 bed nursing home, Lanercost House, said that they did not know all the nursing and medical needs of those they were caring for. They went on to say that they had little time to get fully familiar with them. A previous interim HoU told us she had stepped down as there was no time to carry out the role effectively and she was concerned about completing all the nursing tasks without the responsibility of running the unit.

We asked both nurses on duty on different inspection days the dependency levels of people. Both nurses gave the same dependency levels stating that all 15 people required staff assistance with personal care. Only three people required one staff member, eight people needed a minimum of two care staff, this could occasionally be three staff, and three people required three care staff to safely deliver care. We judged that with the level of staffing frequently set at one nurse and four care workers people's needs could not be attended to in a timely manner given these high dependency levels.

The nursing and care staff also told us that people's needs could be extremely variable and that this was the nature of the service and of people's illnesses. Due to people's behaviour that could challenge the service we were told that at least one staff member should be in the lounge/dining room. This was so that people could be kept in line of vision, (taking the available staff down to three on duty). However, we saw a number of people had a tendency to walk up and down the corridors and were therefore out of sight. We were told on the inspection that the previous night one person had fallen in the corridor and this was unwitnessed. Staff also reported that sometimes people had to wait to be given personal care.

In light of the inspection findings the provider reassessed all people on the unit to work out how many staff were required to meet the needs of people currently in the home. Barchester's regional manager stated that the organisation's staffing dependency tool would be used by the nurses on the unit and whatever staffing levels were determined would be put in place. This tool had been in place for some time. We will check on whether these levels are sufficient to meet people's needs at the next inspection.

We found that the registered provider had not protected people against the risk of unsafe care by the means of ensuring adequate staffing levels. This was in breach of Regulation 18 of the Health and Social Care Act

2008 (Regulated Activities) Regulations 2014.

We looked at how the service managed the prevention and control of infections. We saw that during personal care tasks staff were using appropriate disposable aprons and gloves. Staff reported having had training in infection control and in the safe handling of food.

However, we found a number of areas of the home were unhygienic and dirty. There was a general lingering malodour in the home. We saw that some bedrooms had stained carpets with the odour being stronger in these rooms.

The kitchen used for making snacks and drinks for people in the home and for staff to use was dirty. The floor was dirty with food and drink spillages and worktops were chipped and not sealed properly, making them difficult to clean. The two fridges were also dirty we found food spills and staining inside. We were told one fridge was just for staff use. In this fridge we found an opened packet of corned beef with a yogurt resting on top, both had juice spilt over them. On the shelf above we saw several jugs of juice for residents and a jug of milkshake without a lid on. These all pose infection risks to people living and working in the home.

In a bathroom we saw that towels were being stored on an open shelf with a toilet and bath in close proximity. We also saw that the pedal bin was broken and this meant that a hand had to be used to lift the lid. On the radiator we saw a used incontinence pad in an untied plastic bag and personal worn clothing was found on the floor. These all posed an infection control and cross contamination risk.

We spoke with the nurse on duty and they were not aware who the infection control lead was for the service. A named lead is good practice as set out in the Health and Social Care Act 2008: Code of Practice for health and adult social care on the prevention and control of infections and related guidance.

We pointed these issues out to the organisation's Director and by day two of inspection many of these areas had been attended to. For example new work surfaces had been fitted and a deep clean of the home had taken place. We saw rolls of new carpet in the entrance awaiting fitting. The company's regional manager had already placed an order for new chairs prior to our inspection.

We found that the registered provider had not protected people against the risk of infections. This was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at how the service managed medicines. We observed medicines being handled and talked to staff about how they carried out medicine rounds. We looked at the medicines in stock, records and care plans in detail for five people. We found gaps in the recordings of whether a person had received their medication; these records are called Medicine Administration Records (MARs). We spoke with a nurse about this, who told us they were feeling under pressure and that they were often distracted when carrying out the medicines round. This they said, meant the medication round took longer to complete and took them away from other duties.

We checked whether nurses had received competency checks to ensure that their practice was up to date and that they were carrying out medicines management safely. We found that these checks had not been done for several months. The interim HoU said that since she started the role, December 2015, she had not been given any time to do these management checks.

The interim HoU told us she didn't know the ordering procedure for the unit and was not sure which nurse

carried out this role. The interim HoU stated that in December 2015 she had found an over ordering of stock and this had led to medicine not being stored in a locked drug cupboard. We found over ordering was still happening on our inspection, but there was now room for these to be stored correctly. The Interim HoU had ordered a new larger medicines trolley and had organised and audited unused medicines.

We found the administration of medicines was not carried out safely. For example, a person had been prescribed, by their GP, a powder to thicken drinks to prevent choking and for swallowing difficulties. There was no care plan in place and we could find no information about the consistency of drinks prescribed for this person. This could result in the person receiving drinks that were not of the required consistency and this could lead to possible choking, aspiration onto the lungs resulting in chest infections and pneumonia.

Another person's antibiotic medicines were found unfinished by the nurse on duty. The nurse could find no recording on the MAR chart about whether this medicine had been discontinued or refused and did not know why this was left over as the course should have been completed several days before.

We found that the registered provider had not protected people against the risks associated with the unsafe use and management of medicines. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at how people were protected from abuse and avoidable harm. The staff we spoke with knew how to protect people who used the service from bullying, harassment and avoidable harm. Staff told us that they had received training that made sure they had the correct knowledge and skills to be able to protect vulnerable people. The training records we saw confirmed this. We spoke with three members of staff individually. They were able to explain how to identify and report different kinds of abuse.

However, we found that where people had been identified and assessed as at risk of choking they had not been protected from this risk by staff applying agreed control measures. The environment was not made safe for people who had an impaired cognitive state. When people had been exposed to this risk the service had not identified this as a form of abuse. Care and treatment must be provided in a way that does not significantly disregard the needs of a service user. We found the service had neglected people's needs and significantly disregarded their need for specialist dementia care and treatment, with a view to choking and the risk of harm.

We found that the registered provider had not ensured that care or treatment must not be provided in a way that significantly disregards the needs of the service user for care or treatment. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw records that showed that the equipment in the home was serviced and maintained regularly to ensure that it was safe to use. The training given to staff and the regular maintenance of equipment ensured that people who lived in the home were protected against the unsafe use of equipment.

We reviewed recruitment procedures in the service. All potential candidates were interviewed by senior staff. If they were successful criminal records checks were carried out and references would be sought. We saw evidence that all of the current staff in the service had up to date employment checks including whether they had a criminal record. All this information helped to ensure only suitable people were employed to care for.

Inadequate

Is the service effective?

Our findings

We asked people if they thought staff were trained and had the right skills to meet their needs.

One person told us, "Staff ask me what I want doing". We asked people what they thought about the food provided in the home. One person commented, "Very good, I like it. The food is excellent, it's always been good."

We asked relatives the same question. Most relatives we spoke with were very happy with the care and treatment received by their relatives. They told us, "I don't think he could get better care anywhere." Another relative said, "It's very individual care. He is well looked after and the health side is also good, with the GP called out when it's needed."

Despite these positive views, some relatives were not as confident about their relatives needs being met and visited the home daily to check their relatives care needs had been attended to.

We asked staff about formal supervision where staff sit down to discuss, in confidence, their job role, their practice, safeguarding matters, training needs and any personal issues they might have. We were told by all staff that formal staff supervisions were not up to date. Some staff said they did not know who their supervisor was. The records we looked at demonstrated, that supervisions had not taken place for a number of months. Staff also reported not having had any recent team debriefs at the end of a shift or group supervisions. They said that when these had taken place they had been very helpful in reflecting on practice, developing team work and improving individual practice. Staff said that at times some shifts could be stressful and that they did not feel they were getting the support and recognition from senior staff or the organisation. Support of this nature is recognised as good practice when working with people who may challenge the service.

We found that the registered provider had not taken appropriate steps to ensure that staff received appropriate support, supervision and appraisal as is necessary to carry out the duties they are employed to perform. This was in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at the arrangements in place to support staff to develop the skills they needed to effectively meet people's needs. We checked training records for the staff and saw that they had received training in various aspects of health and social care including moving and handling, medication and the management of diabetes. All the staff had vocational qualifications in health and social care. The provider had a training officer based in the service and this person monitored the training of staff and sent reminders to staff for training updates.

We spoke with six care staff who all reported that the training was good and wide ranging. We spoke with a new member of staff who commented on how good and thorough her induction training had been, and this had included a lengthy period of shadowing other more experienced staff before working as part of the full

staff compliment.

We spoke to visiting mental health professionals who said that the home was good at taking up offers of training and that staff were good at following advice of how to work with people whose behaviour my challenge the service.

During the inspection staff told us that they had a procedure to perform that they were unsure whether they were qualified and competent to do. This had concerned them as the procedure had caused some distress due to a person's dementia. The procedure was suspended, while the service sought advice from adult social care and from the Gp. The Gp subsequently gave permission for this procedure to go ahead. When we spoke with staff about this they told us they had been unsure about who to raise their concerns and doubts to about whether they required training for this. The care plan for this procedure had been rewritten on 12/2/16 following the Gp granting permission. However when we checked this new plan it was not in sufficient detail to instruct staff on how, when, how often and by whom this should be carried out. There was no accompanying risk assessment about the challenges and risks of harm that this may cause to the person who lacked capacity. The Head of Unit agreed that the care plan was not in sufficient detail to allow this procedure to be performed in a manner that caused the least distress and in setting out the detail of how it should be performed. We found that staff lacked the competence in setting up care plans and in assessing risk. The provider told so that the care plan had been rewritten again on 26/2/2016.

We found that the registered provider had not ensured that person's providing care and treatment to people had the qualifications, competence, skills and experience to do so safely. There had been no support systems in place so that staff could be encouraged to seek help when they felt they were being asked to do something that they are not prepared or trained for. This was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw that the nursing staff were given access to training to keep their professional qualifications and skills up to date through advanced training in areas such as, catheter care, pain management and skin pressure care. However, the nurses we spoke with said that they had not had time to do these recently due to the home being short of qualified nurses.

We found that people's needs were not consistently re-assessed. This meant that care plans and risk assessments did not fully identify all the health needs of people. Some plans we saw also lacked sufficient detail of how staff should care for people. For example, the nutritional plan for weight loss and maintenance for one person was not up to date and was not in enough detail for staff to follow and give the care that was needed. This person was recorded in their care plan as requiring a 'soft diet' and to have 'high calorific foods to maintain weight'. However, the care plan lacked details of the consistency and type of thickener to be used in this persons' drinks. The care plan did not set out in detail how staff should be providing a higher calorific diet. Staff knowledge, when asked, was inconsistent, some described how they were doing it themselves while others said it was carried out in the main kitchen before it was sent over to the unit. We saw this person was not receiving the correct thickener in their drinks and records showed that they had lost weight over the last few months. We raised this with the nurse in charge at the inspection so that they could rectify this immediately.

We looked at how information was handed over from shift to shift within the service. We saw that 'handovers' were not robust and did not always contain relevant information to ensure that people were cared for consistently. This was particularly evident when appointments needed chasing up and following up on visits from health professionals.

We saw from the written records that when necessary the service regularly involved other health and social care professionals in people's care. This included GPs and other associated healthcare professionals. We asked health professionals how well the home was meeting people's needs. We received positive feedback about staff in the home contacting them promptly and appropriately and following the advice given. However, we found that the follow-up and chasing up for requests for these appointments was poor. The systems for staff communication and hand over at shift change were not robust enough to ensure that important information about people's needs was passed onto the next shift. For example we saw a recording in a diary about a GP appointment request and this took three days before staff noticed it had not taken place. In the meantime the person had not received the necessary treatment for their condition and had been in discomfort.

We found that there was a lack of direction for staff within the unit to ensure that they were following care plans. This had led to us finding a number of concerns in the delivery of people's care and treatment. For example we found this in the detail of people's care plans and reassessments and in putting the care plans into practice. For example, one person's care plan stated that they were at very high risk of pressure damage to their skin. However we observed this person sat in the lounge for three hours without the use of a pressure relieving cushion or any attempts by staff to get the person to stand or move their position. We also saw that for people who needed equipment to safely move them, their care plans and risk assessments were not in enough detail in describing the type of equipment, such as which hoist, the size of slings and loops, that staff must use.

We found that the registered person had not taken appropriate steps and made arrangements to ensure that care and treatment is provided in a safe way and assessments were carried out in good time to respond to people's changing needs. This was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Lanercost House - Carlyle Suite is a specialist service for people with dementia whose illness presents in ways that can challenge the service. The building was built with the needs of this group of people in mind. However, we found that the design of the building was not in line with current national good practice for people living with dementia. The home is two storey and the living and bedrooms were all upstairs. There was only one communal space for people to use, with no quiet areas or areas for people to see relatives in private. This meant that bedrooms were used for this and that if people were distressed they were often taken to their bedroom. This is not good practice as it may give negative connotations to what should be a safe welcoming space.

We saw that people were walking up and down corridors and the layout meant that these corridors came to a 'dead end'. There was no attempt to make these areas welcoming and interesting. The corridors contained a miss-match of odd chairs and we saw people slumped awkwardly in some of them asleep. Some of these chairs were unsuitable for people to send any length of time in, for example some were dining room chairs. We did not see any pieces of specialist equipment that people could engage with in a meaningful way on their own. For example, books, rummage boxes, or dementia mittens.

The registered provider was not providing people with meaningful activities and an environment in relation to the specialist needs of people living with dementia. This was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the registered provider had not ensured that the premises was fit for purpose and took into account national best practice.

We looked at how staff supported people to take adequate nutrition and hydration. We noted that each person in the home had a nutritional needs assessment. However, the way nutritional intake and weight was

monitored for people who were loosing weight was inconsistent. For example, we saw that the records of people's diet and weight was not always done and this made it difficult to tell if food and fluid intake were to an appropriate level.

We observed the lunchtime meal and saw that people received individual support in a discreet and patient manner, with equipment available to be able people to eat as independently as possible.

We saw that each person had been assessed as to what capacity they had to make certain decisions. When necessary the staff, in conjunction with relatives and health and social care professionals, used this information to ensure that decisions were made in people's best interests. We saw that the service worked closely with professionals from the local authority to ensure that people's rights were upheld.

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

We found that the focus of the service was on promoting people's rights and respecting the decisions they made. Where people were not able to make important decisions about their care we saw that appropriate people had been included in making decisions in the individual's best interests. We saw clear records that showed the principles of the MCA had been followed. People's care records showed how they had been supported to be included in any decisions as far as they were able. Where people needed any restrictions on their liberty in order to maintain their safety we saw that DoLS authorisations had been agreed by the relevant supervisory body.

We spoke with a visiting professional from the mental health team and they reported that staff had a good understanding of the principles of the MCA and were good at working in ways that protected people's rights. Where people's illness meant they could at times challenge the service we saw that staff used least restrictive ways of working with people and all interventions were carefully planned and agreed with the local mental health team.

Good

Is the service caring?

Our findings

We asked people if they felt well cared for at Lanercost House - Carlyle Suite. People told us that the staff were caring and looked after them. One person said, "It's lovely here, I get asked about how I am". Another person said that she loved all the staff and that they were always kind to her saying, "I love these girls, they ask me how I am and they say thank you, and how are you and what can we get you? And that's how I like it." A relative we spoke with said, "My husband never wears the same clothes two days running. The staff are good and paying attention to detail with things like clothing."

We observed staff caring for people in a relaxed, warm and friendly manner. It was notable that staff were knowledgeable of people's personal history and families were good. When spoken with by staff people became animated and enjoyed staff contact. Staff took time to speak with people who used the service. We observed staff sitting talking to people and engaging in lively conversations about their families, social events and sharing memories. We noted that staff took opportunities to engage with as many people while carrying out care tasks and personal care. For example by bending down to ask if a person would like more tea, by touching a person's hand to ask if they were ok, and by popping in and out of bedrooms to check if people needed assistance.

We looked at how the service supported people to express their views and be actively involved in making decisions about their care and support. We saw that people were able to access advocacy services if they required support to make their feelings known. Staff we spoke with were aware of the need for these services and ensured people were informed of their rights relating to this.

Both people who used the service and their relatives were able to attend 'resident and relative' meetings if they wished to express their views in a more formal manner. One relative said they couldn't remember when the last one was and it was some time ago, staff also confirmed this.

People's privacy and dignity was upheld. We observed that staff took care to ensure people's doors were closed when they were receiving personal care. Staff we spoke with knew that maintaining people's privacy and dignity was important. When we looked at people's care plans we noted there were references to maintaining people's privacy and dignity throughout.

The care plans we saw were clear on ensuring that support was given to the right level and did not undermine people's independence. Staff told us they were clear on trying to promote a service that was person-centred. We saw that people were given time and were able to follow their own routines of getting up in the mornings and where to eat their meals. Staff said that they could od this as currently people had different routines. This meant for example, that they could support some people to get up early while other people chose to have a lie-in.

There were policies in place relating to privacy and dignity as well as training for the staff in this area. There were also policies in place that ensured staff addressed the needs of a diverse range of people in an equitable way. Staff received training on equality. This meant that the service ensured that people were not

discriminated against.

We saw that staff were trained how to provide appropriate end of life care for people who chose to remain in the home towards the end of their lives. The training included information on how best to support people with nutrition, hydration and medication to ensure they were as comfortable as possible.

Inadequate

Is the service responsive?

Our findings

We asked people about the care and treatment they received in the home. We asked about how responsive and flexible the home was to either their changing needs or to concerns or complaints.

Some people who lived in the home had difficulties responding to more complex questions. So we observed how they responded to staff and checked records to see how they spent their time. We asked their relatives and professionals working with them for their opinions.

We again received mixed views on the care and treatment that related to how people were given opportunities to engage in their local community and to how people spent their time. Relatives we spoke with said that the staff were good at treating people as individuals. They said they had been asked them for information about their relative's life history and interests.

People were able to maintain the relationships that were important to them. The people we spoke with said they could see their families and friends at any time they wanted to. Visitors we spoke with told us that there were no restrictions on when they could visit their relatives in the home. One relative told us, "I was asked to write a life history so that staff knew him better. I think that's nice. And now they do chat to him about family and his past job."

We observed that staff treated people in a way that was person-centred. People's routines were flexible and we saw people making choices to have a lie-in or to eat their meals where they chose. We also saw that staff made an effort to ensure that people were dressed in a way of peoples choosing and this reflected their individual taste.

We looked at the written records of care for people who used the service. The service had gathered information about people in order to ensure that care plans were person centred. For example information about people's likes and dislikes was used to formulate care plans relating to people's daily routine and their nutrition.

The home undertook a pre-admission assessment of people's needs as part of the admission to the home. This covered key areas of care and areas to monitor to ensure people's health needs were monitored. This was part of Barchester's set policies and procedures for admission. For example, this included an assessment of the risk of a person falling and set out the timescales for this assessment to be done by staff.

However, we found that not all these key areas had been assessed in the timeframes stated, and some had not been assessed at all as part of the admission procedure. We found that when a risk had been identified for a person, this did not lead to a plan for managing this risk or need. For two people we asked to see the dis-charge summary from their previous placement. Staff could not find these and they were not sure where to find them. After a number of days these could still not be found.

Assessments and care plans were not in enough detail and were not updated when a person's need

changed. The paperwork staff were using was inconsistent and the recording of risk and details that staff should follow to deliver peoples care was in different places through a person's file. This had led to staff not knowing all the care and health needs of each person. For example, one person's moving and handling care plan and assessment did not match. One record stated the use of a hoist and in other records the use of a stand aid was advised. Where hoists were used the details of how to use this safely with a person lacked detail of the equipment to be used and how this should be done in a way that causes the least distress to the person.

We saw for another person, who was identified as being at high risk of developing pressure sores, that their care plan lacked detail of how to manage this risk and need. We observed this person sat in the lounge for three hours in a chair that did not have a pressure reliving cushion on it. Staff did not attempt to move this person or get them to stand and sit down again. These are all measures and recommended practice for a person with a high risk of developing pressure sores. This level of detail was not in the person's care plan.

We found that risk assessments and care plans were not being carried out or being reviewed by staff with the skills, competence and experience to do so. This also led to staff failing to complete appropriate risk assessments and in taking steps to update peoples care plans when their needs had changed.

We found that the registered provider had not ensured that people received care and treatment that was appropriate in meeting their needs and reflected their preferences. This was in breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at how people were spending their time in the home and how the home was meeting people's social, cultural and recreational needs. We observed that there was little in the way of meaningful activities arranged to meet people's needs, or for them to engage in. The home employed an activity co coordinator for 16 hours per week. When we spoke with this person they said that they came up with their own ideas of what activities to do and that they had not received any training on appropriate activities for people living with dementia. We saw that the one activity coordinator for the home was, for part of the morning, carrying out care tasks.

One relative said to us that staff tried their best to spend individual time with their relative but this was often difficult as staff were busy doing care tasks. Another relative said, "Staff don't seem to have the time these days to do things with people. Although they are good at doing hand massages and my relative likes having her nails done." We did see the activities co-coordinator doing a craft activity for valentine's day and she spent time sitting and chatting to people. People who were involved responded well to this and clearly enjoyed the attention.

The activities recorded for many people was receiving personal care such as a bath, shower or sitting in the lounge with other people. The organisations Director told us that the home was due to have training in all aspects of dementia care, including appropriate activities for people living with dementia to engage people in.

While the home had very good facilities downstairs, an adapted kitchen and a sensory room, the use of these was dependent on staff availability. Over the three days we visited we did not see anyone using these facilities or being taken out of the home by staff. People were not supported to engage with the local community. Staff reported that they relied mostly on relatives to take people out. Staff said on occasions people were taken out by them but this was rare.

This is a breach Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered provider did not make sure that people were supported to be involved in their community as much or as little as they wish. The provider was not making sure that people were not left unnecessarily isolated.

We also found that there was little in the way of equipment or adapted environment for people living with dementia to be engaged with on the top floor where people spent most of their time. We did not see that people's life history work had been used to develop things like scrapbooks, picture books or flash cards to help stimulate and engage people.

We observed a number of people spending long periods either alone in their bedrooms or sitting in the same chair for two to three hours with no activities apart from the television. We judged that for many people their quality of life was poor due to a lack of support to engage in meaningful activities and to have contact with other people. This meant that people were at risk of being socially isolated and lacked stimulation. The home did not respond well to this aspect of people's well-being.

We found that the registered provider had not made suitable arrangements to ensure that people's psychological, emotional, social and cultural were met by the home. People were not provided with appropriate opportunities or meaningful activities based on person-centred care that met their needs and reflects their personal preferences. This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered provider had a procedure in place to receive and respond to complaints. We saw that a copy of the complaints procedure was displayed in the entrance to the home. This gave people the opportunity to raise concerns with a senior person in the organisation who was not directly responsible for managing the home. Some relatives said they had a good relationship with the key nurse and staff working with their relative. They said they would raise any concerns with this link person. Some relatives raised concerns about not being clear on who was running the unit. But they did say they felt able to speak to any staff on duty if they had an issue.

Inadequate

Is the service well-led?

Our findings

Overall we gained mixed views about people's experience of the quality of the service people received. Relatives told us they were not sure who was in charge, and they were concerned that there was no manager in post, and that this had been the case for some time.

Professionals who worked with the home also reported concerns to us about the lack of leadership. They told us, "The place feels disorganised. Not all staff know the needs of people, it depends on who's on duty as to the response you get." Another person said, "I don't know who's running the service now. I know they haven't got a manager and are trying to recruit one." They added, "It's been going on for some time now and it's difficult to know who to speak to when you need an update."

At the inspection we found a lack of governance and leadership at Lanercost House - Carlyle Suite. The service did not have a registered manager in post at the time of inspection and there was no permanent HoU for Lanercost House - Carlyle suite. The Deputy for Lanercost House Nursing Home, a 82 bed nursing home in the same grounds as Lanercost House- Carlyle Suite was overseeing both registered locations. A nurse from the Lanercost House Nursing Home had been seconded to the Carlyle Suite in December 2015 as an Interim HoU for two days per week. However this was as the duty nurse on shift. This nurse was given no supernumerary hours to manage Lanercost House - Carlyle Suite.

The interim HoU told the inspector that two days on shift was not enough time to effectively manage the service, and this was made more difficult by the service not having a registered manager. She said, she had frequently reported to seniors in the organisation that she did not have enough hours to effectively manage the service. This had not resulted in more hours and she had been told that a new manager was being advertised.

Staff reported issues with the lack of leadership. Some staff told us they did not feel supported and listened to by the organisation. One staff member said, "When we had a permanent Head of Unit there was someone to praise you and there was also someone to pull you up when you were doing things wrong. The unit used to be run like a tight ship."

Staff reported that the rotas were disorganised and not set up in a way that was fair to staff and that they were changed frequently. One member of staff said they were worried that new staff lacked direction and said, "New staff are not always doing things the way they should." Other staff reported not having time to update records. Overall staff reported that morale was low and stress levels were high.

We were told by the organisations Director that the recruitment of both a manager and a HoU had been on-going for some time as the organisation was keen to get managers with the skills and experience. Since the inspection we have been informed that a manager had now been recruited and was in post. We have also been told that an experienced nurse, who knew the unit well, had taken up the post of temporary HoU until the post was filled. This nurse had been given supernumerary hours to undertake the running of the unit.

We were told that the home had a detailed quality assurance (QA) system for monitoring all aspects of quality in the home. This was a formal system in place for all Barchester Healthcare services. However, we found that this lack of leadership meant that audits were not being carried out in a way that identified issues with the quality of the service. When issues had been identified this did not always lead to an improvement to the service.

In particular we found this to be the case with auditing of care plans and risk assessments. We found that Barchester documents and care planning systems were not being consistently applied by staff. For example we found that some people's risk assessment for choking on inanimate objects was recorded in the nutrition health plan while other people had a separate risk assessment that was not linked to a care plan. This meant that there was no consistent recording and assessment of this very high risk behaviour. Additionally we found that care plans lacked sufficient detail to give staff instructions on how to keep people safe. Some care plans were not update when people's needs changed. These issues had not been picked up by the auditing systems of the organisation.

We found that record keeping was poor and that the care planning system provided by the organisation were not followed by staff in the home. We saw that staff were not following the step by step instructions as set out by the Barchester's organisation's care plan booklet. We found numerous examples where staff had left out sections of the care plan and risk assessments that were blank and not complete. This had led to staff setting up care plans that did not meet people's needs. We also noted that staff were writing in the care plan section information that was a daily record. And writing in daily notes information on how to deliver a change to someone's personal care that had not been transferred into a care plan.

We found that checks on the environment were not taking place and this meant that the home was not always made safe for people who had an impaired cognitive state. This was because systems were not in place to effectively identify and assess risk to the health, safety and welfare of the people who use the service. For example the cleaning staff did not have a schedule of duties that identified people who were at risk from products that should be kept out of their reach due to their impaired cognitive state.

When we looked at the auditing systems to check that supervisions were carried out on a regular basis we found that a lack of regular supervision had been identified over several months by the services' systems but this had failed to resolve the problem.

During the inspection we identified failings in a number of areas. These included the safe management of medications, meeting people's choices, managing risks to people, identifying and managing safeguarding and other incidents. These issues had not been picked up by the auditing systems of the organisation.

We found that the registered provider failed to establish and operate effective systems and process to ensure that the requirements of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 at the location Lanercost House - Carlyle Suite could be met. This meant that people were not protected from receiving unsafe care and treatment due to being exposed to avoidable harm or risk to harm.

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 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 9 HSCA RA Regulations 2014 Person-centred care
Treatment of disease, disorder or injury	The registered provider had not ensured that people received care and treatment that was appropriate in meeting their needs and reflected their preferences. The registered provider had not made suitable arrangements to ensure that people's psychological, emotional, social and cultural needs were met by the home. People were not provided with appropriate opportunities or meaningful activities based on person-centred care that met their needs and reflects their personal preferences.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect
Treatment of disease, disorder or injury	The registered provider did not make sure that people were supported to be involved in their community as much or as little as they wish. The provider was not making sure that people were not left unnecessarily isolated.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment
Treatment of disease, disorder or injury	The registered provider had not ensured that that the premises were fit for the purposes of providing an environment that was suitable for

the needs of people living with dementia.

The environment was not properly maintained and was not being cleaned to a hygienic standard.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing People were not protected against the risk of unsafe care by the means of ensuring adequate staffing levels. Appropriate steps had not been taken to ensure that staff received appropriate support, supervision and appraisal as is necessary to carry out the duties they are employed to perform.