Aegis Residential Care Homes Limited

Ladydale Care Home

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

Summary of findings

Overall summary

We carried out unannounced inspections of this service on 23 June and 14 July 2016. At these inspections, we identified a number of Regulatory breaches and we told the provider that immediate improvements were needed to ensure people consistently received care that was safe, effective, caring, responsive and well-led. The service was rated as 'inadequate' and was placed into '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.

We undertook this unannounced comprehensive inspection on 23 September 2016 to check that the required immediate improvements had been made. You can read the report from our previous inspections, by selecting the 'all reports' link for Ladydale Care Home on our website at www.cqc.org.uk.

At this inspection, we found the required improvements had not been made. The breaches of Regulations we identified at our two previous inspections were still present and we identified an additional new Regulatory breach. The service was again rated as 'inadequate'. As a result of this, the service will remain in special measures.

The service is registered to provide accommodation and personal care for up to 54 people. People who use the service may have a physical disability, a learning disability and/or mental health needs, such as dementia. At the time of our inspection 43 people were using the service. Two of these people were residing in hospital, one of whom was being treated for a serious injury they sustained whilst living at Ladydale Care Home.

The home had a registered manager. However, they had recently left the service. 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 and associated Regulations about how the service is run. An interim manager was in place during the registered manager's absence and a new home manager had been recruited and was due to start working at Ladydale.

At this inspection, we found that the provider did not have effective systems in place to assess, monitor and improve the quality of care. This meant that poor care was not being identified and rectified by the registered manager or provider.

Risks to people's health, safety and wellbeing were not consistently identified, managed and reviewed and people did not always receive their planned care. Medicines were not managed safely.

Safety incidents were not analysed and responded to effectively, which meant the risk of further incidents was not always reduced. There were not enough suitably skilled staff available to keep people safe and meet people's individual care needs.

People were not protected from the risk of abuse because suspected abuse was not always identified or reported as required.

The requirements of the Mental Capacity Act 2005 were not always followed to ensure people decisions about care were being made in people's best interests when they were unable to make these decisions for themselves. We identified a person who was being potentially unlawfully deprived of their liberty.

We found staff did not always have the knowledge and skills required to meet people's individual care needs and keep people safe. People's health was not effectively monitored and managed to promote their health and wellbeing. Prompt referrals to health and social care professionals were not always made in response to changes in people's needs or behaviours.

Effective systems were not in place to ensure people's end of life care needs and preferences were met.

People's care plans were not always accurate and up to date which meant staff didn't always have the information they needed to provide safe and consistent care.

People and their relatives were not always involved in planning and reviewing their care. This meant we could not be assured that people's care preferences were being regularly identified and met.

Effective systems were not in place to ensure concerns about the quality of care were reported, investigated and managed to improve people's care experiences.

There was a programme of social and leisure based activities on offer to people. However, we found some people were not supported to engage in activities that were meaningful to them when they wanted or needed this intervention.

The provider did not always notify us of reportable incidents and events as required.

People spoke fondly about the staff and at times, we observed some positive interactions between staff and people. However, we found that people's dignity was not always promoted and the choices people made

were not always respected.

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. Risks to people's health and wellbeing were not consistently identified, managed and reviewed. Medicines were not managed safely.

People were not consistently protected from the risk of abuse as suspected abuse was not reported as required.

Staff were not always available to keep people safe and meet peoples care needs in a prompt manner.

Is the service effective?

Inadequate

The service was not effective. People's health needs were not effectively monitored and managed and, prompt referrals to health care professionals were not always made when people's needs changed. Staff did not always have the knowledge and skills needed to meet people's needs effectively.

The requirements of the Mental Capacity Act 2005 were not always followed. This meant we could not be assured that decisions were made in people's best interests when they could not make decisions for themselves.

The requirements of the Deprivation of Liberty Safeguards (DoLS) were not always followed and people were potentially being unlawfully deprived of their liberty.

Is the service caring?

Inadequate

The service was not caring. People were not always supported to receive care and support in a dignified and caring manner. People's right to privacy was not always promoted.

People were involved in making some choices about their care, but the choices people made were not always respected by the staff.

Systems were not in place to enable people to receive effective, consistent and person centred end of life care.

Is the service responsive?

Inadequate

The service was not responsive. People and their representatives were not always involved in the planning and review of their care. Care plans did not always contain the accurate and up to date information staff needed to meet people's individual care needs and preferences.

An effective complaints system was not in place to respond to people's concerns regarding the quality of care.

Is the service well-led?

Inadequate

The service was not well led. The provider did not have effective systems in place to consistently assess, monitor and improve the quality of care.

Effective systems were not in place to monitor safety incidents, so action was not always taken to reduce the risk of further harm occurring.

The provider did not always notify us of reportable incidents and events that occurred at the service.

Ladydale Care Home

Detailed findings

Background to this inspection

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

We undertook an unannounced inspection of Ladydale Care Home on 23 September 2016. This inspection was completed to identify if improvements had been made and sustained since our last inspections that took place on 23 June 2016 and 14 July 2016. We inspected the service against the five questions we ask about services: is the service safe, effective, caring, responsive and well-led? Our inspection team consisted of two inspectors.

We checked the information we held about the service and provider. This included the notifications that the provider had sent to us about incidents at the service and information we had received from the public. We used this information to formulate our inspection plan. We also used the action plan the provider sent to us following our last inspection provider's to inform our inspection. In addition to this we liaised with representatives from the local authority to discuss the concerns they had with quality and safety at this service.

We spoke with 10 people who used the service, three visitors, eight members of care staff from day and night shifts, the deputy manager and an interim home manager. We did this to gain people's views about the care and to check that standards of care were being met.

We spent time observing how people received care and support in communal areas and we looked at the care records of 11 people to see if their records were accurate and up to date. We also looked at records relating to the management of the service. These included audits, incident forms, staff rotas and training records.

Following our inspection we shared our findings and concerns with the local authority. We did this because we continued to have significant concerns about people's health, safety and wellbeing.

Inadequate

Is the service safe?

Our findings

At our last two inspections, we found that improvements were needed to ensure that risks to people's safety and welfare were consistently assessed, monitored and managed. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, we found the required improvements had not been made and people continued to receive or be at risk of receiving unsafe care.

A relative shared concerns with us about the number of falls their relation had suffered at Ladydale. They told us they felt their relation's falls, "Could have been avoided". We found that effective and prompt action was still not taken to identify and manage people's risk of falling. For example, since our last inspection, one person's care records showed that they had fallen on two occasions. Another person had fallen on three occasions in the 14 days leading up to this inspection. None of these falls that the two people had suffered had triggered any reviews of their risk of falling again. This meant no action was taken to protect them from the risk of further falls and sustaining injuries associated with falling. Another person's care records showed that care staff had identified and recorded a significant falls risk, however no action had been taken to address this specific risk and the person's care records showed they had fallen on at least three further occasions where this hazard may have been present.

We found that risks to people's safety as a result of people's behaviours were still not effectively managed to promote people's safety. One person's care plan for their behaviours that challenged had been reviewed by staff as being up to date in August 2016. This review stated that staff should 'continue to ask [the person] to be nice to other residents'. However, this person's care records showed that this advice was ineffective in promoting people's safety. The person's care records showed they had displayed significant behaviours that posed a risk to people's safety and wellbeing on at least nine occasions since this review. On at least six of the nine occasions their behaviours in the form of verbal aggression had been directed towards other people who used the service. This showed the plans in place to protect people from the risks associated with this person's behaviours were ineffective. Again, none of these incidents had triggered a review of the person's care plan so that changes could be made in response to these incidents.

Where risks to people's safety had been recognised and planned for, we found that care was still not always delivered in accordance with their agreed care plan. For example, staff told us and a person's care records showed that staff needed to provide activities and hobbies that the person enjoyed to help manage their risk of aggression to other people. The care plan also stated that staff needed to 'distract' the person when they became verbally aggressive towards other people. During our inspection, we witnessed this person being verbally aggressive to another person who used the service. The person was not being engaged in activities or hobbies at the time of the incident or during our observations throughout the day. Staff were also not present during the incident, so they were unable to follow the care plan and 'distract' the person. This meant this person's care plan was not followed which posed a risk to the person and the other people who used the service.

Although we saw some improvements in the way medicines were administered, we found that effective

systems were still not in place to ensure people's medicines were managed safely. At this inspection we continued to see that medicines with short shelf lives were not always labelled with an opening date to ensure that staff knew when these medicines were safe to administer. This meant there was a risk that people may have received medicines that were unsafe and ineffective.

Accurate records continued to not be maintained to ensure the provider could account for all the medicines at the home. We found inaccuracies in the numbers of stock recorded on people's medicines administration records and the actual numbers of medicines in stock. For example, we could not identify if one person had received the medicines they needed to prevent dizzy spells as prescribed because the numbers of medicines in stock did not match the number of medicines recorded on their medicines records. These inaccuracies meant people who used the service could not always be assured that they had received their medicines as prescribed.

Some people needed medicines to be administered on an 'as required' basis dependent upon their presentation and symptoms. Protocols were now in place to help guide staff as to when these medicines should be administered for each individual. However, improvements were needed to ensure these protocols contained adequate detail to enable staff to administer these medicines in a consistent manner. For example, staff confirmed that one person who used the service could not always tell them they were in pain. This person's protocol for their as required pain relief contained no details outlining how this person presented when they were in pain so that staff could administer pain relief when required.

At our last two inspections, we found that effective systems were not in place to ensure equipment was safe to use. At this inspection, we saw that equipment at the home was now being effectively maintained to ensure it was safe for use. However, we noticed some safety concerns with the home environment. For example, there was loose tape on the dining room carpet which presented as a potential trip hazard to people who used, worked at or visited the service. This concern had not been identified and acted upon through the provider's quality assurance checks.

The above evidence demonstrates that effective systems were not in place to ensure people consistently received their care in a safe manner. This was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last two inspections, we found that people were not consistently protected from the risk of abuse or avoidable harm. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, we found the required improvements had not been made and people continued to be at risk of abuse and avoidable harm.

Some people told us they didn't always feel safe and settled at Ladydale. One person told us, "[Another person who used the service] bosses me around a bit. I told the big boss and she told me to take no notice". This person described the other person as being 'sharp' with them at times. Care records showed no action had been taken to address this person's concerns and the person confirmed that they just tried to ignore the times when they were 'bossed' about like the staff had advised. We saw one person who used the service verbally abuse another person who used the service when no staff were present to diffuse the incident. Later in the day, the victim of this verbal abuse asked an inspector if they could ask the perpetrator of the abuse to move from the corridor so they could pass. This person told us they didn't like to talk to this person and we observed they looked afraid of them.

Some staff still lacked an understanding of their responsibility in identifying, recording and reporting suspected abuse. We found at least nine entries in one person's care records that demonstrated they had

been verbally abusive/aggressive toward other people who used the service. None of the nine incidents had been discussed with or reported to the local safeguarding team in accordance with local and national guidance. Some of the incidents had not been reported to the management team as incidents, so the management team were not always aware of the alleged verbal abuse that had occurred. We informed the local authorities safeguarding team about the alleged abuse after our inspection. However, the records relating to the incidents did not contain the names of the alleged victims of the verbal abuse as this had not been recorded by staff. This meant effective systems were not in place to record and report alleged abuse. Some people were the victims of sustained alleged abuse as a result of this. This was a continued breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last two inspections, we found that staff were not always available to keep people safe or meet people's care needs and preferences. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, we found the required improvements had not been made and people were still not receiving prompt and effective care and support when they needed it.

Some people continued to tell us that they did not always receive their care and support in a timely manner. One person said, "Staff are busy and I have to wait a while" and "We could do with a few more staff". Another person told us how they frequently had to wait to be supported to use the toilet.

Staff in the new wing of the home told us their staffing numbers had increased in the morning, but remained reduced in the afternoon. A staff member told us, "It's very difficult to manage in the afternoon". We saw that people experienced delays in receiving their care in the afternoon when the staffing numbers were reduced to two. For example, in the afternoon when only one staff member was visible in the communal area on the new wing, we heard one person ask staff to assist them to access the toilet. The staff member said they could not assist them at that time as they were leaving the room to support another person with their personal care needs. The person who needed the toilet stated, "I need to go now or it will be too late". This person continued to express they needed to go to the toilet by stating, "Oh I'll have to go" and "I need to go". However, no staff were present in the communal area to hear the person's continued requests for assistance. This person was supported to access the toilet 30 minutes after their initial request.

In the main building, we also saw that people experienced delays in receiving the care they requested and needed. For example, one person's visitor asked staff if they could assist their friend to access the toilet. We observed staff support this person to access the toilet 25 minutes after the first request. We also witnessed an incident where one person who used the service was verbally aggressive towards another person. Staff were not present in the communal area at the time this incident occurred.

The interim manager told us they had identified the need for more staff in the afternoon/evening and they were in the process of recruiting new staff in order to fill staffing gaps. Records of a quality assurance check completed by the interim manager 15 days before our inspection also confirmed the need for increased staffing levels at this time. However, no immediate action had been taken to increase staffing numbers to meet this identified gap. This meant the need to increase staffing numbers was not being immediately addressed to promote people's health, safety and wellbeing.

We also saw that staff were not effectively deployed to ensure people's needs were met in line with their agreed plans of care. For example, we saw one person who used the service support another person who used the service to eat their lunch time meal because staff were not present to provide the support that this person's care plan stated they needed.

The above evidence shows that staff were not always available to promote people's safety and ensure people's needs were consistently met in a timely manner. This was a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service effective?

Our findings

At our last two inspections, we found that people's health needs were not effectively monitored and managed to promote people's wellbeing. This was an additional breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, we found the required improvements had not been made and people's health needs continued to not be effectively monitored and managed.

We found that people's weights were still not always being effectively monitored or managed to promote their health and wellbeing. For example, one person's care records showed they had unexpectedly lost over 10% of their body weight between May 2016 and July 2016. The National Institute for Health and Care Excellence (NICE) Nutritional Support in Adults guidance 2006 (reviewed in 2014) states that nutritional support should be considered in the event of unintentional weight loss of over 10% in a three to six month period. A referral to a GP was not made for a further 31 days after their July weight was recorded, during which time the person had continued to lose more weight. This showed that prompt action was still not taken in response to unexplained weight loss.

We saw that people's risk of dehydration was being monitored more effectively. However, we saw that people continued not to always get the support they needed when they required it to eat a balanced diet. We observed one person struggling to eat their hot meal over a 55 minute period. This person's care plan stated they needed support from staff to eat, but staff did not support this person until 55 minutes after their hot meal was placed in front of them. Staff were supporting other people during this time. This meant the person waited a significant amount of time before they received the support they required and in this time, their hot meal would have become cold.

We found that prompt referrals to health and social care professionals were still not always made in response to peoples' changing needs. For example, a person who had suffered two recent falls had not been referred to their GP for advice, despite this being a recent and significant change in their presentation. This showed professional advice was not always sought promptly when people's needs changed.

The above evidence shows that people's health needs were not effectively monitored and managed to promote people's wellbeing. This was an additional and continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last two inspections, we found that the staff did not always have the knowledge and skills to meet people's needs effectively and safely. This was an additional breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, we found the required improvements had not been made and people remained at risk of receiving unsuitable or unsafe care as a result of this.

A relative shared concerns with us that people's behaviours that challenged were not managed effectively by the staff. They said, "There is a lack of understanding about what people with dementia need. If the

owners take people with dementia, the staff should have better training". Some staff told us they had recently participated in dementia training. However some staff told us and training records showed that some staff had not yet completed dementia training. Staff told us they were struggling to manage one person's behaviours that challenged that were associated with their dementia. One staff member said, "We are struggling" and "We are not 100 percent sure how to manage [the person]". Staff told us and the person's care records showed that staff were managing their behaviours that challenged in different ways which meant the person was receiving inconsistent care. This showed the staff did not all have the knowledge and skills required to provide safe, effective and consistent care.

Training records continued to show that some care staff had still not received up to date safeguarding training. We also saw that incidents of suspected abuse were not being consistently identified and reported in accordance with local and national guidance. This showed that staff did not always have the knowledge and skills they needed to ensure people's safety and wellbeing and service users were at risk of harm because of this.

This was an additional and continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last two inspections, we found that the requirements of the Mental Capacity Act 2005 (MCA) were not always followed or met. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, we found the required improvements had not been made.

The 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 make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. Although staff were able to tell us the basic principles of the Act, care records showed these principles were not consistently followed.

Staff told us they were currently nursing a person in bed as this was in the person's best interests. This decision had been made by the staff despite the person's representatives informing staff and us that they disagreed with this decision. Staff told us this person did not have the capacity to make important decisions about their health and wellbeing due to their inability to retain information. The person's care plan recorded that family were aware of their care preferences, however, the family had not been involved in this decision. There was no recorded evidence to show that a best interest decision involving healthcare professionals and this person's representatives had taken place to ensure this was indeed in the person's best interests.

This was a continued breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last two inspections, we found that people were at times being deprived of their liberty in an unlawful manner. This was an additional breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. 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 Mental Capacity Act 2005. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). At this inspection, we found that DoLS applications were now being made. However, improvements were still needed to ensure all the restrictions placed on people were planned for and lawful.

Staff told us and care records showed that one person's behaviours that challenged were at times being managed by threatening to or actively removing the person from communal areas without their permission. This restrictive practice had not been included in the person's DoLS application and this person was therefore at times being potentially deprived of their liberty in an unlawful manner.

This was an additional and continued breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service caring?

Our findings

At our 23 June 2016 inspection, we found that people's right to be treated with dignity was not consistently promoted. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, we found that the required improvements had not been made.

Although people who could tell us about their care spoke positively about the staff and the care they received, our observations and feedback from some people who visited the service showed a consistent caring approach was not always provided by staff. One relative said their relation was, "Not given the dignity they deserve" and, "More care and attention is needed". We observed some positive interactions between staff and people. For example, a staff member who assisted one person to eat chatted and encouraged the person throughout. However, we also observed negative care interactions at meal times. For example, a person who waited 55 minutes to receive assistance to eat was supported by a staff member who did not engage in any conversation with them.

Most people told us and we saw that they were given choices about some parts of their day to day care. For example, one person said, "I get up (out of bed) when I want to get up". However, we saw the choices some people made were not always respected by the staff. For example, we saw one person change their mind about where they wanted to sit at lunchtime. The person initially chose to eat in the lounge area, but later got up and moved to the dining area. Staff then redirected this person to their chair in the lounge. The person responded to this by saying, "Why do I have to go there? I'm all on my own". No reassurance or explanation was given to the person and the staff did not respect their wish to move to the dining area. We saw staff offer another person a drink of juice with their lunch time meal. The person responded by saying, "Are we not having a cup of tea?". The staff member replied, "Not now, after dinner" rather than offering and providing the person with a cup of tea at their request. This meant people's right to make choices about their day to day care was not consistently promoted.

Although some people told us their right to privacy was respected, we saw that staff did not always promote or respect people's right to privacy. During a meal time we saw staff administer two people's eye drops at the dinner table in front of other people who used the service. Some of these people were eating their meals at the time. Neither person was offered to have their medicines administered in a private area. This meant staff had not considered the needs of the people who were receiving their eye medicines in a communal area or the needs of the people who were eating their meals at the time.

We observed multiple examples of undignified language being used by the staff. For example, we heard one staff member say to another staff member, "Shall we toilet her" in a communal area where people were present. We heard another staff member say, "Good girl" to a person with a learning disability. This person was an adult, not a child. Therefore this language was not age appropriate.

One relative stressed they felt the staff tried their best to care for people under challenging circumstances. This relative felt strongly that the poor care experiences they shared with us were due to the overall care approach of the provider rather than individual staff members. They said, "It's not the staff's fault, it's the

owners. They need to be accountable". We identified concerns with the way poor care experiences were identified and managed at the service. For example, we shared a poor care interaction we had observed with the interim manager. This incident involved a person who approached a staff member at a meal time and said, "Am I going to get something?". The staff member replied, "You will have nothing if you keep on Mrs" to which the person responded by saying, "Oh alright". When we told the interim manager about this they did not immediately state that this was an inappropriate manner to speak to the person. Instead they asked if we felt the staff member said this to the person 'in jest'. This comment from the interim manager suggested it may be acceptable to speak to a person in this manner if it was said in jest. However, speaking to the person in this manner did not promote their dignity.

The above evidence shows that people did not always receive their care in a manner that promoted and maintained their dignity. This was a continued breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection, staff told us they were providing a person with end of life care. Therefore we looked at how end of life care was provided at Ladydale. End of life care is the care and support people receive during the last phase of their life. We found that systems were not in place to ensure people received effective and consistent end of life care that met people's individual care preferences. No end of life care plan was in place to provide staff with the information they needed to support the person in a safe and consistent manner. Because no care plan was in place, staff gave us different accounts of how they supported this person with their end of life care needs. For example, when we asked a staff member how often this person needed support to change their position in bed. They replied, "Hourly turns, or is it two?". They then consulted the reposition charts in the person's room and said, "Some people say hourly, but it looks like it's every two hours". The interim manager confirmed that this person should be supported to change position every two hours. However, this person's care records showed they did not always receive this support as frequently as required. Records showed at least one occasion where this person did not receive this support for a period of three hours and 50 minutes. This meant the person was not receiving effective and consistent end of life care.

We observed some caring interactions between staff and this person. However, no care preferences were recorded to show staff how to meet this person's end of life care preferences. The person's care records stated, 'Family are aware of wishes in the event of [person's] death'. Therefore the person's individual care preferences had not been recorded and shared with the staff to enable them to provide person centred end of life care. This meant we could not be assured that this person was receiving end of life care that matched their care preferences.

The above evidence shows that systems were not in place to ensure people received end of life care in accordance with their needs and preferences. This was a new breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service responsive?

Our findings

At our 23 June 2016 inspection, we found that effective systems were not in place to manage people's complaints about their care. This was a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, we found the required improvements had not been made.

Although people told us they could make complaints about their care. We found care concerns and complaints were not always acted upon to improve people's care experiences. For example, the person who told us, "[Another person who used the service] bosses me around a bit" did not have their care concerns acted upon as they were told by staff to, "Take no notice". This concern had not been recorded by staff and the issue remained unresolved and the person told us they continued to be subjected to negative care experiences at Ladydale.

During the three weeks leading up to this inspection, we received three complaints from three separate people about the quality of care at Ladydale. This meant three people had needed to escalate their complaints to us as they did not feel the provider had acted upon their concerns. The care records for two of the people who had allegedly received poor care experiences showed that their relatives had raised concerns about their care to staff. However, these concerns had not been appropriately recorded or acted upon by the staff or provider. This meant the issues raised had not been effectively investigated and managed to improve these people's care experiences. This showed an effective complaints procedure was still not in place. This was a continued breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff did not always know how to meet people's needs as the information in people's care plans was not always referred to so that the correct care could be delivered. We asked a temporary staff member where people's care records were located. This staff member did not know and had to ask another staff member where they were located. This meant staff did not always know where important information about people's care needs and preferences were kept. We observed that one person did not receive the support their care plan stated they needed at lunch time from this staff member.

A relative told us they didn't feel their relation's care plan was being followed. They said, "They put a care plan together, but they didn't implement it". We found that care records did not always show that people's care plans were being followed. For example, one person's care plan stated they should be encouraged to engage in meaningful activity during the night if they were alert and awake. This person's daily care records did not show that this plan was being consistently followed when they were awake at night. Incidents involving this person at night, such as this person being found in other people's bedrooms also suggested they were not always suitably engaged in meaningful activity at night time. This meant the provider could not demonstrate that this person's care plan was being consistently followed to meet the person's needs.

Information in people's care records was not always kept up to date. For example, one person's care records stated they needed to have their position changed every two hours due to a pressure ulcer. We could not

find evidence to show this person was receiving this care, so we asked a senior member of care staff to confirm the care this person needed. They said, "They no longer have a pressure sore. The records are not up to date as I've been on leave for two weeks". This same person was visited on a regular basis by a district nurse. The nursing records suggested this person needed to wear specialist pressure relieving boots to protect their heels from skin damage. This information had not been incorporated into the person's care plan. We asked three members of staff when this person should wear their boots. The first said, "Boots were needed, but I'm not sure if they need them now". The second said, "The boots are for night in bed" and the third staff member said, "I think the boots are to wear at night, I'm not sure about days". This showed staff did not know how to meet this person's skin care needs as accurate and up to date care records were not maintained.

People and their relatives told us they were not always involved in the planning or review of their care. One relative said, "They've not asked us what we think [person who used the service] needs right now. We've been told what they need". Because of the lack of involvement of people and their relatives in the care planning process, care records did not always contain the level of detail required to inform staff about how people wished to receive their care and support. For example, some people couldn't always verbally tell staff how they wanted to receive their care because of their health conditions. Care plans did not always detail how people would like to be cared for at the end of their life. This meant there was a risk that people would receive inconsistent care that didn't meet their care preferences, because people's care preferences were not always recorded in their care records.

There was a planned programme for leisure and social based activity provision at the service. Some people told us they were enabled to participate in social and leisure based activities that were meaningful to them. However, some people did not get the support they needed to address their activity needs. One person told us, "I can't go out on my own anymore, so I don't go out very often now. I just stay here and go out in the garden". This person told us they would like to go out more often so they could go shopping. We saw and people told us that when the activities coordinator was unavailable, systems were not in place to enable people's activity needs to be met. A recent residents meeting had recorded that in the activity coordinator's absence activities with another member of staff had not been successful. People felt that one of the reasons this had been unsuccessful was because the staff had little time to complete this role, because of their care duties.

During this inspection, we saw that the activities coordinator assisted one person to access the community. Other people who used the service had no activity provision other than a singing session in the new wing of the home which a small number of people in that part of the home participated in. We saw no evidence of activity provision in the main building where most of the people who used the service spent their time. This was despite one person's care plan stating they needed to be engaged in activities as boredom was a known trigger for their behaviours that challenged. This meant people's need to participate in meaningful activity was not being consistently met.

Inadequate

Is the service well-led?

Our findings

At our last two inspections, we found that effective systems were not in place to assess, monitor and improve quality and manage risks to people's health and wellbeing. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, we found the required improvements had not been made.

After our 14 July inspection, the provider shared their 'standards improvement plan' dated 19 July 2016 with us. We found this plan had not been effective in driving the immediate improvements required to ensure people received care that was safe, effective, responsive and well-led.

The provider had still not identified that people were not always receiving their planned care. For example, one person's care records showed they were not consistently receiving their agreed care in order to manage their risk of skin damage. This showed that effective systems were not in place to ensure the quality of care was consistently assessed, monitored and improved.

The information contained in people's care records was still not being effectively monitored or analysed by the provider to ensure people's needs were being managed effectively. For example, the provider had not identified that incidents relating to behaviours that challenged, such as, suspected verbal abuse were not being appropriately reported.

One person's care records contained evidence that an audit of the content of their care plan had been completed. An action plan had been formulated to address gaps in care planning. However the actions needed to make improvements to this person's care plan had not been made in the agreed timescale. For example, it was identified that more information was needed to ensure this person's end of life care preferences were recorded. However, no action had been taken to address this in the four week period that had been set for this improvement to be made. This meant the care plan audit had been ineffective in driving improvement.

Records showed the activities coordinator met with people who used the service to talk about the quality of care. We found that the feedback people gave in these meetings was not always acted upon in a timely manner to improve people's care experiences. For example, one person had stated that the menu boards were not always filled in correctly each day. We saw that this feedback had not been acted upon as the menu board in the new wing recorded the menu from the previous day. This incorrect menu recording led to one person's visitor informing people in the new wing that they were going to eat Gammon for their lunch, when they were not going to be served this as they had actually had Gammon the day before. This meant effective action had not been taken to make improvements in the way the daily menus were displayed.

Effective action had still not been taken in response to concerns identified through medicines audits. For example, the medicines audit completed in May, August and September 2016 identified bottled medicines were not always labelled with an opening date. It is important to label the date of opening so that people can be assured that their medicines are safe to use if they are time limited. At our last two inspections we

found that some bottles of medicines that were time limited had not been dated to show when the bottles had been opened. At this inspection, we found more opened and undated bottles of time limited medicine. This showed the concerns identified through audit had not been effectively addressed and people could not be assured that their medicines were safe. When we fed this back to the interim manager they told us they were surprised to hear this as they had completed the most recent medicines audit and identified no issues with the labelling of medicines.

Quality monitoring checks were still not identifying that safety incidents were not always appropriately reported, investigated or managed to prevent further incidents from occurring. A health and safety audit completed in August 2016 was signed to show incident forms had been completed correctly and checked by the manager. However, we found that accurate records relating to safety incidents were not maintained. For example, one person's care records showed they had recently been verbally abusive towards other service users on at least nine occasions. However, care records did not record the names of the people affected by this person's behaviours. This meant we could not identify which people had been subject to verbal abuse during these incidents. As a result of this, retrospective safeguarding referrals could not be made to protect the people who had been exposed to this abuse.

We found that post incident reviews were not being completed for incidents that involved restrictive practice. Restrictive practice can include deliberate acts that restrict an individual's movement, liberty and/or freedom to act independently in the event of a potential safety issue. One person's care records showed that staff threatened to or actively moved this person from communal areas when they became verbally abusive to other people who used the service. This can be viewed as restrictive practice. In the event of restrictive practice being carried out, best practice guidance from The Department of Health's Positive and Proactive Care: reducing the need for restrictive interventions 2014 states that post incident reviews should be completed so that lessons can be learned and people and staff can be given the opportunity to share any emotional impact they may have suffered as result of the intervention. No post incident analysis was recorded in response to incidents that related to restrictive practice. This meant the provider was not monitoring that this intervention was being completed appropriately and they were also not checking for any potential emotional effects this practice may have had on the person.

Effective systems were still not in place to ensure the staff had the knowledge and skills required to meet people's needs and keep people safe. For example, there were significant gaps in the staffs' safeguarding and dementia training which placed people at risk of receiving unsafe care.

An effective system was still not in place to ensure staff were deployed effectively to meet people's needs in a safe and timely manner. For example, when the provider had identified that an increase in staff numbers was needed, this was not immediately acted upon to promote people's safety and wellbeing.

The above evidence shows effective systems were not in place to assess, monitor and improve quality and manage risks to people's health and wellbeing. This was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection, we found the provider did not inform us of notifiable events as required under our registration Regulations. This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009. At this inspection, we found the required improvements had not been made. The provider had failed to notify us of at least 19 incidents of alleged abuse as required under our registration Regulations. This was a continued breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

The registered manager had been absent from the service since our 23 June 2016 inspection. The regional manager and interim managers had managed the service in the absence of the registered manager. Staff told us they were looking forward to the imminent start of a newly recruited home manager. One staff member said, "We've had lots of manager's, but a new one is starting on Monday. Things should settle". Staff we spoke with during our inspection told us they could approach any of the managers with any concerns about the quality of care. However, immediately after our inspection, we were contacted by an anonymous whistleblower who told us they felt they could not approach the regional manager to report and escalate on-going going concerns. This meant that some concerns with the safety and quality of care could not be addressed as they were not being reported to the provider.