Sanctuary Care (South West) Limited

Lake and Orchard Residential and Nursing Home

Inspection report

Kelfield
York
North Yorkshire
YO19 6RE

Tel: 01757248627
Website: www.sanctuary-care.co.uk

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 27 March and 4 April 2018 and was unannounced.

Lake and Orchard Residential and Nursing Home is registered to provide residential and nursing care for up to 99 older people who may be living with a physical disability or dementia. The service is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection.

The service is purpose built and accommodation is provided in two units 'Lake' and 'Orchard' spread across two floors. Lake provides residential care; Orchard provides nursing care. Both units support people who may also be living with dementia. At the time of our inspection, there were 59 people using the service; 24 people were living on Lake and 35 people were living on Orchard.

The service had a registered manager. They had been the registered manager since February 2018. A registered manager is a person who has registered with the 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 2008 and associated Regulations about how the service is run. The registered manager was supported by a regional area manager and two deputy managers; one worked on Lake, the other worked on Orchard.

At the last inspection in January 2017, we rated the service Requires Improvement overall. We identified four breaches of regulation relating to safe care and treatment, premises and equipment, staffing and the governance of the service. We asked the provider to take action to address our concerns. At this inspection, we identified ongoing concerns about the quality of the care and support provided.

Staff did not consistently provide safe support with moving and handling. Care and support was not always person-centred and staff did not always provide effective care to meet the needs of people living with dementia. The care and support provided on Orchard was task-based. At times there was little or no interaction, activity or meaningful stimulation for people. Records did not evidence people were regularly engaged with meaningful activities.

Staff profiles and records of induction were not always available for the agency staff who worked at the service. The provider requested updated information to ensure agency profiles listed the correct dates of training completed, included previous experience and confirmed their professional qualifications and registration were up-to-date. Permanent staff raised concerns about the impact of using agency staff. Agency staff lacked supervision and direction and did not consistently provide safe, effective or caring support to meet people's needs. This showed us sufficient numbers of suitably skilled and experienced staff had not been deployed to meet people's needs.

Records were not always well-maintained. Care plans were not always kept up-to-date and did not consistently provide clear person-centred information about how people's needs should be met.

Whilst some improvement had been made and the breaches of regulation relating to safe care and treatment and premises and equipment had been met; this was the fifth consecutive time the service has been rated Inadequate or Requires Improvement overall. It was the third consecutive time we have found breaches of one or more regulation. This showed inadequate governance. The provider had not operated effective systems to monitor and improve the quality and safety of the service. It showed a failure to provide a consistently good service to meet people's needs.

There was a new breach of regulation relating to person-centred care and continued breaches of regulation relating to staffing and the governance of the service. You can see what action we told the provider to take at the back of the full version of the report. We will also meet with the provider and commissioners to address the ongoing concerns about the care and support provided at Lake and Orchard Residential and Nursing Home.

We made a recommendation about further developing a dementia friendly environment.

Medicines were managed safely, although improvements were needed to the records relating to medicines prescribed 'when required' and topical medicines such as creams.

The home was clean and well-maintained. Checks were completed to ensure equipment was safe to use. Action was taken to minimise the risks associated with a fire.

Some people told us staff were caring. There were inconsistencies in the caring support staff provided. Some staff provided kind, compassionate and very caring support to meet people's needs. However, staff did not consistently involve people in decisions. The support provided was not always caring and dignified.

People provided positive feedback about the food and staff supported people to ensure they ate and drank enough. Consent to care was sought in line with relevant legislation and guidance on best practice.

Staff received regular supervisions and annual appraisals.

The provider had a system to manage complaints.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Sufficient numbers of suitably skilled and qualified staff were not always deployed. Staff did not always use safe moving and handling techniques.

Checks were completed to help ensure the home environment and equipment was safe.

Staff completed safeguarding training. To help them identify and report safeguarding concerns.

Medicines were managed safely.

Is the service effective?

Requires Improvement

This service was not always effective.

Care and support was not always effective. Staff used unsafe moving and handling practices and did not provide effective support to meet the needs of people living with dementia.

Work was ongoing to develop a dementia friendly environment.

People gave positive feedback about the food and staff supported people to ensure they ate and drank enough.

Staff documented people's consent to the care and support provided. Application to deprive people of their liberty had been appropriately submitted.

Is the service caring?

Requires Improvement

This service was not always caring.

Staff did not always include people in decisions.

Care and support was not always dignified.

People gave generally positive feedback about the caring staff, but there were inconsistencies in the quality of the care provided.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Staff did not consistently provide person-centred care.

Activities were provided, but records and our observations showed limited activities and opportunities for meaningful stimulation had been provided for people living on Orchard.

The provider had systems in place to manage and respond to complaints.

Is the service well-led?

Inadequate

The service was not well-led.

The provider's systems of governance were inadequate in ensuring the overall quality and safety of the service.

There were ongoing issues with the service provided, which had not been identified or robustly addressed.

Records were not always well-maintained.

Lake and Orchard Residential and Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection 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.

The inspection took place on 27 March and 4 April 2018 and was unannounced.

The inspection was carried out by five inspectors, an assistant inspector and three experts by experience. An expert by experience is someone who has personal experience of using or caring for someone who uses this type of care service. The experts by experience who supported this inspection specialised in care for older people, people living with dementia and people who had nursing needs. They spoke with people who used the service and visitors to understand their views on the service. They also observed interactions including the care and support provided in communal areas, with activities and at mealtimes.

Before the inspection, we reviewed information we held about the service. This included notifications which providers send us about certain changes, events or incidents that occur and which affect their service or the people who use it. We contacted the local authority adult safeguarding and quality monitoring team as well as Healthwatch, the consumer champion for health and social care, to ask if they had any information to share. We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We used this information to plan our inspection.

During the inspection, we spoke with nine people who used the service and 12 visitors who were their

relatives or friends. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We spoke with the regional director, regional area manager, registered manager, two deputy managers and nine staff including nurses, care workers, a housekeeper, activities coordinator and chef. We also spoke with four health and social care professionals for their feedback about the service.

We had a tour of the service, which included people's bedrooms, with their permission. We reviewed nine people's care plans and risk assessments, medication administration records and four staff recruitment, induction and training files. We also looked at meeting minutes, maintenance records, audits and a selection of other records relating to the running of the service.

Requires Improvement

Is the service safe?

Our findings

At the last inspection in January 2017, risks to people's health and safety had not always been identified and addressed. Staffing levels were not safe. These concerns were breaches of regulation relating to safe care and treatment and staffing. At this inspection, we identified ongoing concerns about staffing.

The provider used a 'dependency tool' to help work out staffing levels. Target staffing levels were two nurses and 10 care staff on duty during the day and two nurses and seven care staff on duty at night. The ancillary support team included administrative support, and staff to work in the kitchen, laundry, to clean the service, for maintenance and to organise activities.

We received mixed feedback about staffing levels. People who used the service told us staffing levels were safe, but commented, "I think they could do with a few more staff at times", "There is a shortage of staff", "Staff have some time to chat, but they are extremely busy" and "They are sometimes short, they seem to be rushed."

We observed staff were busy, but responded to people's call bells. There was a visible staff presence in communal areas. However, one person on Orchard walked unsupervised in and out of other people's bedrooms. This placed them and other people who used the service at increased risk of harm. A relative told us, "It's not safe; staff can't see people when they're not in the lounge." The provider acknowledged these concerns and agreed to speak with staff about this incident.

The provider used agency staff to help maintain staffing levels. Staff raised concerns about the impact of using agency staff. They told us, "The regular staff are very dedicated and caring. I wish we had more staff, because we have a lot of agency staff and it can be quite difficult", "At the moment, we are using a lot of agency staff who do not know the residents. It puts an extra burden on staff" and "Agency staff are here a lot. Sometimes they don't do their jobs properly and we have to tell them. We could definitely do with more staff; it would make it a lot easier for us."

We observed agency staff lacked proper supervision and direction to ensure they were providing consistently safe and effective care to meet people's needs. We identified concerns about permanent and agency staff using poor moving and handling techniques. This included supporting people to transfer from wheelchairs without putting the brakes on, supporting a person to transfer by pulling their hands and lifting another person off the floor. These moving and handling techniques put people at increased risk of harm. The registered manager told us moving and handling competency assessments had been completed, but information about when these had been done was not available due to problems with the introduction of a new computer system. They told us they were completing further observations to monitor and address issues with moving and handling in response to our feedback.

Profiles were not always available or were out of date for some agency staff who worked at the service. Records did not consistently evidence agency staff had received an induction before working at the service. The provider sent us information about the quality checks completed on the companies they used to

provide agency staff. However, we spoke with the registered manager about the importance of verifying the identity of agency staff and documenting inductions to evidence they were given the information needed to work safely at the service.

These concerns showed us sufficient numbers of suitably qualified, competent, skilled and experienced staff had not been deployed in order to safely meet people's needs. This was a continued breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider explained the work they were doing to recruit staff to reduce the use of agency. They told us they requested the same agency staff so they were more familiar with the service and people's needs. Most of the agency staff used had worked at the service before. Staff explained how they reported any concerns about agency staff so the registered manager could take action and prevent them working at the service again.

People gave positive feedback about the support provided with their medicines. They told us, "I get my medicines at the same time each day", "They are usually on time" and "I always get them regularly."

The provider had a policy and procedure which guided staff on how to safely support people to take their medicines. Staff received training and the register manager used competency checks to ensure they had learnt, and were following best practice guidance.

Medicines were securely stored at a safe temperature. Staff used Medication Administration Records (MARs) to record the support provided with medicines and to monitor stock levels. There were minor discrepancies in stock levels and we reported these for the registered manager to investigate. Records used to document the support provided with topical medicines such as creams were not always completed appropriately. This meant we could not be sure topical medicines were administered as prescribed.

Records relating to medicines prescribed to be taken only when needed were not always linked to people's care plans. They did not consistently include detailed information to guide staff on when the medicine was needed. The registered manager agreed to address these issues.

Staff used risk assessments to identify risks and provide guidance on any actions or support needed to keep people safe. There were inconsistencies in the quality of risk assessments. Some contained detailed information about how risks should be managed and incorporated advice and guidance from relevant healthcare professionals about how to safely meet people's needs. However, detailed and up-to-date risk assessments were not always in place. For example, sufficiently detailed risk assessments were not in place for some specific conditions such as diabetes or chronic obstructive pulmonary disease (COPD). We have addressed these concerns in more detail in the responsive and well-led domains.

People told us they felt safe living at the service. Feedback included, "It's a safe place for us to live", "I am safe, they look after me" and "Yes, I feel safe, staff ask you if you're ok on a regular basis."

The provider had a safeguarding policy and procedure. Staff completed training and understood their responsibility to identify and report safeguarding concerns. Records showed safeguarding concerns had been reported for the local authority safeguarding team to investigate.

A record was kept of accidents or incidents involving people who used the service. These documented what had happened, whether there were any injuries and how staff responded. The registered manager reviewed these records to identify any further action needed to keep people safe. A monthly log was used to help

identify any patterns or trends in the accidents or incidents, but this did not record where or when the accidents had occurred. We spoke with the registered manager about developing this tool to support them to more effectively identify any patterns or trends that may emerge.

Staff were safely recruited. New staff filled in an application form, had an interview and provided references. Disclosure and Barring Service (DBS) checks had been completed to ensure staff were not barred from working with adults who may be vulnerable. Regular checks were completed with the Nursing and Midwifery Council (NMC) to ensure nurses employed to work at the service had active registrations to practice.

Regular checks helped ensure the safety of the home environment and any equipment used. Systems were in place to manage and reduce the risks associated with a fire occurring. Personal Emergency Evacuation Plans (PEEPs) provided guidance on the level of support people needed to evacuate the building in the event of an emergency.

Staff completed infection control training and used gloves and aprons appropriately to minimise the risk of spreading infections. The home environment was generally clean and well-maintained. People told us, "Everything I see is clean; it's well kept" and "It is clean and tidy and there are no smells." Domestic staff regularly cleaned and deep cleaned the service. We spoke with the registered manager about addressing some minor cleanliness issues in the kitchenettes. For example, fridges needed cleaning and food was not consistently labelled when opened. They agreed to address this.

Requires Improvement

Is the service effective?

Our findings

At the last inspection in January 2017, the environment did not support the needs of people living with dementia. These concerns were a breach of regulation relating to the premises and equipment.

At this inspection, action had been taken to improve the environment. People were able to move freely between their bedroom and communal areas. The provider had developed the gardens so there were accessible spaces for people living with dementia. Some contrasting colours were used to help people with a visual impairment see handrails and doorways.

Whilst there were signs of positive improvements, we spoke with the registered manager about further developing a dementia friendly environment. For example, bedroom doors had people's names on, but did not always have other person-centred decoration or detail to help them recognise their bedroom. There was dementia friendly signage to help people identify toilets and bathrooms, but further signage in corridors would help people navigate their way around the service.

At mealtimes, picture menus were not consistently used or prominently displayed in accessible places to help people with dementia make informed choices. The dining tables were set with cream table cloths, cream mats and cream plates. We spoke with the registered manager about using contrasting colours to make the dining experience more dementia friendly.

We recommend the provider reviews good practice guidance on maintaining a dementia friendly environment.

Staff completed practical moving and handling and first aid training as well as on-line 'e-learning' courses. This covered topics including conflict resolution, dementia, positive behaviour support, the Deprivation of Liberty Safeguards (DoLS), fire safety, health and safety, infection prevention and control and safeguarding adults. At the time of our inspection, staff had completed approximately 94% of the provider's mandatory training requirements.

We asked staff about the training provided. They told us, "If you want more training they give it to you", "We used to have a lot of in-house training, but it is a lot of e-learning now. I don't think you actually learn with e-learning", "I want more training, e-learning I think is rubbish it should be done as face to face courses" and "I think we could do with some training on dealing with violence and aggression. I've not seen any formal training in that area."

Staff did not consistently provide effective care and support to meet people's needs. Permanent and agency staff did not always follow safe moving and handling practices. We identified concerns about the quality of care and staff understanding of the support provided to people who may be living with dementia on Orchard, where care and support was not always person-centred. Interactions were task-based and staff did not consistently and effectively provide skilled support to defuse situations and reduce anxiety and distress. Our observation showed us staff needed more practical support and guidance to enable them to deliver

consistently effective and person-centred care to people living on Orchard.

The registered manager told us they had spoken with staff about our concerns and were completing additional observations in response to our feedback. The provider reported in their provider information return that they were replacing their e-learning system and this would "give staff a greater knowledge base and understanding."

Concerns about poor moving and handling practices and the lack of skilled and effective person-centred care on Orchard was a continued breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

New staff completed an induction programme which was signed off as training was completed. Staff received regular supervision and an annual appraisal of their performance. The majority of staff told us they felt supported by management and could speak with them if they had any issues or concerns.

At the time of our inspection, nursing staff did not receive clinical supervision and there was limited evidence of additional training provided to nurses to support them to develop their clinical skills. It is important nursing staff receive regular clinical supervision and additional training to support them to provide effective care based on up-to-date best practice guidance and to maintain their registration to practice. The registered manager told us they did not provide clinical supervision, but were in the process of introducing this for all nursing staff.

People on Lake provided generally positive feedback about the skills and experience of the staff who supported them. They told us, "They are well-trained; they are all very good", "I don't know what their training is, but they are efficient. I have never found anything I could complain about" and "They seem to know what they are doing. Occasionally they don't, but they're probably agency [staff]." Relatives told us, "They all seem to know what they are doing" and "I can't fault them."

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 MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. People's care plans recorded their consent to the support provided. Staff completed mental capacity assessments and made best interest decisions when necessary. Applications had been appropriately submitted to deprive people of their liberty.

People were regularly weighed to monitor and identify concerns regarding significant weight loss or weight gain. Staff liaised with healthcare professionals to respond to concerns about the risk of malnutrition and dehydration. Specialist diets were provided to minimise the risk of choking, for people with diabetes and to promote weight gain for people at risk of malnutrition.

People gave positive feedback about the food provided. They told us, "The food is nice, there is a good

choice", "Generally it is very nice; there might be the odd thing you yourself don't like, but it's very rare and I think there is an alternative" and "The food is brilliant, there is plenty of it and they will make something different if you ask."

The food served looked appetising and people appeared to enjoy the options provided. Staff prompted and encouraged people to eat and drink more and provided practical assistance when necessary.

People were regularly visited by their GP, podiatrists, tissue viability nurses, community psychiatric nurses and occupational therapists. Staff supported people to access healthcare services. People who used the service said, "They keep on top of appointments and things like that" and "The nurse comes to check up and to see what's needed."

We received mixed feedback from professionals. Some professionals told us they had good working relationships with staff who appropriately asked for their support. Other professionals told us staff did not always respond quickly to seek and act on their advice. Records showed staff did regularly liaise with healthcare professionals, although we noted one person was not being weighed weekly despite the advice and guidance given by a visiting healthcare professional. We informed staff who agreed to address this.

Requires Improvement

Is the service caring?

Our findings

People who lived on Lake and downstairs on Orchard gave positive feedback about the kind and caring staff. They told us, "Staff give loving care. They are very dedicated, they need a gold medal", "They are kind and caring" and "They are nice, they are kind and they care."

We received mixed feedback from relatives and visitors to the service. Some relatives said, "Staff are very good, nothing is too much trouble", "They do the best they can do to get to know people" and "The people are very nice." Other relatives raised concerns about the lack of attention, care and support provided to people on Orchard. One relative told us, "There is no continuity for them; the staff are always changing so they don't get to know each other."

There were inconsistencies in how staff cared for people on Lake and Orchard. We saw examples where staff were very kind, caring and attentive in the support they provided. They spoke with people in a compassionate way and demonstrated they knew people well. For example, one person became upset. The member of staff immediately got them a tissue and gently wiped their face offering reassurance. They were very kind and caring during this interaction and showed genuine concern for the person's wellbeing.

However, we observed interactions on Orchard which were task-based and there was little or no conversation outside the support provided. This was not caring. We observed staff did not always spend time providing support to people in an attentive and caring way. For example, on Orchard one member of staff stood over a person to assist them to eat their meal, but stopped numerous times to try and help other people.

Staff completed equality, diversity and dignity training. Most people told us staff treated them with dignity and respect. Comments included, "They always treat us with respect", "They close the doors and curtains [when supporting with personal care]" and "As far as I'm concerned we're treated as people not things." Relatives said, "It's a community where individuals are treated like people", "Staff absolutely treat them with respect" and "They ask me to leave the room before doing anything."

Other relatives raised concerns about the personal care provided on Orchard and told us this impacted on people's dignity. Concerns related to their relatives appearing unclean and wearing other people's clothes or dirty clothing. We observed some people on Orchard were wearing dirty clothes, had unkempt hair and dirty fingernails. We spoke with the registered manager about these concerns who explained people sometimes refused support. They told us concerns had been raised and explained the actions they had taken to investigate and address these issues to ensure people were offered regular support to meet their personal care needs.

Staff knocked on people's doors before entering their bedrooms. A person who used the service confirmed this was usual practice telling us, "They respect my privacy; they always knock on the door." We observed one person was supported with personal care in a communal toilet, but the door had not been locked. This did not maintain their privacy.

People's care plans contained communication assessments and support plans, which identified their preferred method of communication. They provided guidance on how staff could support people to make decisions and communicate their meaning. People told us they had choice and control over when they got up and went to bed and how they spent their time.

We observed inconsistencies in the support provided to enable people to have choice and control over their daily routines. On Lake we observed staff offering people choices and patiently supporting them to make decisions. However, we also saw examples where staff did not speak with people, listen to them or respect their choices. For example, on Orchard one person consistently refused the food provided saying they did not like it. Staff did not listen to the person or respect their wishes by providing an alternative. The person did not eat their meal and became increasingly distressed because staff were not listening to them. One member of staff wiped a person's face after lunch without speaking with them or explaining what they were doing. Other people were enjoying watching television. A member of staff entered the room and turned this off without any discussion stating it was nice to have "a bit of quietness." This did not evidence people were consistently supported to make decisions and have choice and control over their daily routines.

Requires Improvement

Is the service responsive?

Our findings

Care and support was not always person-centred. On the first day of our inspection, we identified concerns about the support provided to people living with dementia on Orchard. Staff appeared disengaged and there were very limited interactions with people who used the service. Conversations were brief and task-based around supporting people to eat and drink or to move around the unit.

There was limited meaningful stimulation or activities provided and people spent long periods of the day sat in a communal areas with little or nothing to do. Staff did not encourage, nurture or support people to maintain their independence.

Relatives we spoke with raised concerns about the lack of stimulation and activities for people on Orchard. One relative said, "It's just up, feed, sit, feed, bed."

The provider employed an activities coordinator and a list of activities was displayed throughout the service. Scheduled activities included baking, crafts, bingo, dominoes, 'pamper time' and 'trips out'. Activities had not been scheduled for the weekend, but the activities coordinator told us they left resources for staff to use, which included rummage boxes.

There were limited activities on Orchard and activity records did not consistently evidence people had been supported to engage in regular and meaningful activities.

Staff who worked on this unit explained the benefit of regular activities on people's wellbeing and told us they felt more stimulation and meaningful activities were needed. They said, "When they are here [the activities coordinators], they do a fantastic job, but I would like to see them here more often", "When we have time we talk to them, but we don't really know what activities to do with them. They need more sensory stimulation" and "We interact with them, take them outside weather permitting. You try to fit it in as and when you can."

We shared our concerns with the provider and registered manager. On the second day of our inspection, staff were more proactive in engaging people. Activities were taking place including ball games and singing. The atmosphere was calmer and more relaxed. People were seen enjoying themselves and clearly benefited from the increased level of activity and opportunities for meaningful stimulation. The provider told us they were in the process of recruiting an additional activities coordinator and minibus drivers to take people out for activities. Whilst the response to our concerns was positive, we spoke with the provider about ensuring the improvements were sustained.

Each person who used the service had care plans and risk assessments relating to their care and support needs. These covered different areas of people's daily lives including the support needed at mealtimes, with personal care and to engage in activities. A 'My day' section provided details about people's preferred routines, whilst other sections included information about people's personal preferences, hobbies and interests. This information supported staff to get to know people and to provide individualised and person-

centred care to meet their needs. Other areas, for example, communication care plans, provided very detailed and clear information to support staff to effectively engage with people, to share information and understand their meaning.

However, care plans and risk assessments were not consistently updated when people's needs changed so did not always provide up-to-date information about the care and support they required. For example, one person was nursed in bed on an air mattress, but their support plan referred to them using a foam cushion and mattress. One person had issues with their skin integrity for which they were seeing the district nursing team, but their skin integrity care plan recorded their skin was intact and did not include information about the involvement of the district nurses. We spoke with the deputy manager about the importance of creating management plans where people had issues relating to their skin integrity.

People's care plans and risk assessments did not always provide detailed information about how staff should intervene to reduce their anxiety and respond to behaviour that challenges. Mental wellbeing support plans did not consistently provide guidance about how to meet people's mental health needs. One person's assessments identified they were depressed, but this information was not included or addressed in the person's mental health or mental wellbeing support plans. One person's care plan did not contain sufficiently detailed information to guide staff on how to meet their needs if they refused necessary care.

Staff did not consistently follow best practice guidance on how to support people with dementia or who may become anxious or distressed. For example, staff missed clear opportunities to defuse situations by not listening to what people were saying. This showed us work was needed to develop a positive behaviour support approach to planning and delivering people's care and support.

The inconsistencies in planning and delivering person-centred care and lack of meaningful activities and stimulation was a breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's care plans contained information about any end of life wishes they had. A member of staff told us, "End of life care is talked about with families and residents have an end of life care plan. Anticipatory drugs are stored in the controlled drugs cupboard." Anticipatory medicines are those a person may require to ensure they remain comfortable and pain free approaching their end of life.

Feedback from people on other units was positive and they told us staff were responsive to their needs. Comments included, "They always listen to me and do what I want", "They get you anything you want" and "If I say I want to do something they try and accommodate me."

The majority of relatives and visitors told us staff made them feel welcome. They said, "We know them [staff] all, they talk to us" and "You can visit and stay as long as you like". Other people raised concerns about gaining access to the building and having to wait outside for long periods for staff to answer the doorbell. The provider told us this was because reception staff did not work evenings and weekends.

The provider had a policy and procedure for managing and responding to complaints. This was not displayed in an accessible format for people who may be living with dementia or a visual impairment. The registered manager agreed to address this in order to comply with the accessible information standard - a legal requirement for health and social care providers to present accessible information in a way people with a disability or sensory loss can understand.

People who used the service said they had not needed to complain, but felt able to speak with staff if they

had concerns. The registered manager told us there had been one formal complaint in the past six months. Records relating to this complaint showed they had investigated the concerns and provided a written response. This included information about how to escalate their complaint if they were unhappy with the response.

Staff had also received a number of compliment cards and thank you letters praising the care and support they provided. Comments included, "You are all so kind and considerate" and "Excellent care."

Inadequate

Is the service well-led?

Our findings

At the last inspection in January 2017, there were four breaches of regulation relating to safe care and treatment, premises and equipment, staffing and the governance of the service. At this inspection, some improvement had been made. The environment was more dementia friendly and the breaches of regulation relating to safe care and treatment and premises and equipment had been met. However, we identified new concerns about the level of person-centred care provided and there were outstanding issues relating to staffing.

This was the fifth consecutive time the service has been inspected and rated Inadequate or Requires Improvement overall and the third consecutive time we have found breaches of one or more regulation. We have therefore rated the service Inadequate in this domain. The ongoing failure to provide a consistent standard of care showed us the service had not been well-led. The provider had not established and operated effective systems and processes to ensure the quality and safety of the service. We will meet with the provider and commissioners to address the ongoing concerns about the care and support provided at Lake and Orchard Residential and Nursing Home.

Staff did not consistently follow safe moving and handling practices. There was a lack of meaningful activities and person-centred care provided to people on Orchard. At times, staff lacked leadership and direction. Staff practice was not adequately monitored and poor practice was not consistently and robustly challenged.

Permanent staff raised concerns about the impact of using agency staff and we identified issues and concerns about the quality of the care and support provided by some agency staff. Agency staff were not supervised and adequately directed. Profiles and induction records were not always available for agency staff who worked at the service.

At the time of our inspection, the provider had introduced a new computer system and changes were being made to the paperwork as well as the systems and processes staff followed. Because of these changes, records were not always well organised and easily accessible. For example, it took over an hour for staff to provide a handwritten list of everyone who used the service.

Records were not always well-maintained and did not consistently provide a complete and contemporaneous record of the care and support provided. Care plans had not always been updated and did not always provide person-centred information to guide staff on how to meet people's specific needs.

The registered manager completed a range of audits which covered food and mealtimes, medicines, care plans, the kitchen and infection prevention and control practices. Documented 'night visit records' were used to monitor the care and support provided during the night shift. This included a review of staffing levels and the conduct of the night staff. The provider also used 'monthly provider visits' to further monitor and audit the care and support provided. These involved a visit from the regional area manager who inspected the environment, spoke with people who used the service and staff, and audited paperwork. An action plan

was in place which was reviewed and updated monthly as issues were identified and addressed. Whilst this system was effective in identifying and addressing some issues, it was not sufficiently robust to ensure the overall quality and safety of the service. We found breaches of regulation relation to person-centred care and staffing.

This was a continued breach of Regulation 17 (Good governance) of the Health and Social Care Act (Regulated Activity) Regulations 2014.

There had been a number of changes in management at Lake and Orchard Residential and Nursing Home in the last three years and this had impacted on how consistently the service had been run. The current manager had managed the service since July 2017 and became registered manager in February 2018. They were supported by two deputy managers; one for Lake and one for Orchard. A regional area manager regularly visited the home to complete audits and provide guidance and support to the registered manager. There had been no changes to the provider's nominated individual since our last inspection.

We asked people who used the service if it was well-led. They told us, "I think it is pretty good" and "It seems to run well." Relatives told us, "As far as I'm concerned it seems to be well-led" and "I have no criticisms of them."

Staff said, "Management could be more approachable", "I get on well with management. They do try their best to get you what you need and they listen to you" and "The majority of the time management do listen to you."

The provider used surveys to gather feedback from people who used the service and their relatives. We saw 19 surveys had been returned in January and February 2018, but the results had not been collated and analysed. On the second day of our inspection, this had been completed and information was displayed in a public area about the actions taken in response to the feedback. Results from the survey were largely positive although a number of people had raised concerns about the lack of activities. The provider had reported that the activities schedule was reviewed monthly and they were in the process of recruiting another activities coordinator.

Meetings were used to share information and discuss any issues or concerns. A 'relatives and family' meeting had taken place in January 2018 and meetings with the staff team in January and February 2018. Information was also left in the entrance to the service encouraging people to review the service and give feedback. This showed us the provider was keen to gather and respond to feedback to improve the service.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care Care and treatment was not always appropriate and did not consistently meet people's needs. Regulation 9(1)(a)(b).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes had not been established and operated effectively to assess, monitor and improve the quality and safety of the services provided. Complete and contemporaneous records were not consistently maintained. Regulation 17(1)(2)(a)(b)(c).

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 Sufficient numbers of suitably qualified, competent, skilled and experienced staff had not been deployed to meet people's needs. Regulation 18(1).