Mrs G H Copley

Lands House

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?	Requires improvement
Is the service responsive?	Inadequate
Is the service well-led?	Inadequate

Overall summary

The inspection took place on 7 and 14 July 2015 and was an unannounced inspection. On the date of the inspection there were 25 people living in the home. Lands House Nursing Home provides accommodation and nursing care for up to 30 people at any one time. The home is located in Rastrick, Brighouse with accommodation spread over two floors. The client group was mainly older people, some of whom were living with dementia.

A registered manager was not in place. The provider was a single individual who also undertook the role of home manager.

Most people and their relatives spoke positively about the home and said staff were kind and caring and provided a good quality service. They raised some concerns over staffing levels and the tired décor in the building.

We found improvements had been made to some aspects of the medication systems, such as people receiving their medicines at the right time and in a more timely manner. However we identified one person did not receive two of their medication as prescribed, which could have had significant implications on their health and it was unclear from another person's records whether

Summary of findings

they received their Warfarin as prescribed. We were particularly concerned these issues were not routinely identified and investigated by nursing staff administering medication.

At the last inspection we were concerned about staffing levels in the home. This was still the case and no action had been taken to address the shortfalls. We observed people had to wait significant periods for assistance and there was a lack of supervision of communal areas.

Safe recruitment procedures were in place to ensure staff were of suitable character for the role.

Risks to people's health, safety and welfare were not appropriately managed. For example we identified bed rails were unsafely positioned in one person's room and a suitable policy and risk assessment surrounding their use was not in place.

There was no clear policy in place for staff to follow regarding interventions for people at risk of malnutrition. In some cases appropriate action was taken to manage weight loss, but this was not consistently applied.

We found the service was now meeting the requirements of the Deprivation of Liberty Safeguards (DoLS). However it was not fully acting within the requirements of the Mental Capacity Act (MCA) as relatives were consenting to elements of care without the best interest process being followed.

We concluded people were not offered sufficient choice as to their daily lives, for example where they sat in the home and where they went to bed.

Most people and their relatives told us staff were kind and caring. We saw some positive interactions with staff and management treating people well, with dignity and respect. However this was not consistently applied with some staff treating people less well. We found interactions were very task focused and there was a lack of stimulation and activities provided for people.

People's needs were not fully assessed for example information on how to meet the needs of people with complex health conditions was not always fully recorded. We found several instances where people were not receiving the required care in line with their assessed needs.

A complaints system was in place and most people reported that management was effective in dealing with their concerns.

The provider had not taken sufficient action to drive and action improvements to help ensure the service provided high quality care. We were particularly concerned that a number of issues raised in the February 2015 inspection had not been adequately addressed. An increased range of audits were now taking place, but these were not fully embedded and effective in help drive improvement to ensure compliance with the regulations of the Health and Social Care Act 2008.

We were concerned about the lack of nursing leadership in the home to ensure that competent policies were developed to ensure areas such as nutrition, and bed rails were appropriately managed.

Overall, we found significant shortfalls in the care and service provided to people. We identified seven breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'. The service 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."

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe. Risks to people's health, safety and welfare were not adequately assessed and managed. This included the management of bed rails. We found omissions in the administering and recording of medication posed significant risks to people's health and safety.

Staffing levels were not sufficient to ensure safe care. Action had not been taken following the last inspection and we found the same issues remained.

Improvements had been made to some aspects of the premises, with most outstanding issues addressed. However décor in many areas of the home were still tired and required further updating.

Is the service effective?

Inadequate

The service was not effective. Although people and their relative generally told us they thought the service provided good care we found risks to people still remained. For example there was a lack of clear policy and action taken to address and manage malnutrition.

Care staff demonstrated an adequate understanding of the topics we asked them about and we saw the service had provided staff with a range of training. However we were concerned about the service knowledge in areas such as MUST (Malnutrition Universal Screening Tool) and bed rails.

We found the service was now meeting the requirements of the Deprivation of Liberty Safeguards (DoLS). However it was not fully acting within the requirements of the Mental Capacity Act (MCA) as relatives were signing consent for some elements of care without following the best interest process.

We judged the improvements made were not sufficient to improve the rating for this domain.

Is the service caring?

Requires improvement

People and their relatives told us they thought the service was caring and we saw a number of positive interactions between staff and people who used the service. The management were also caring and showed concern for people's wellbeing.

However this was not consistently applied, we saw a number of negative interactions where people were not treated with dignity and respect or given adequate choice. There was a lack of information within some people's care plans about their life histories and preferences with regards to their daily lives.

Summary of findings

Is the service responsive?

Inadequate 

The service was not responsive. People's needs were not fully assessed. The pre-assessment process was not sufficiently robust to ensure all people's care needs were identified.

We saw examples where care was not delivered in line with people's assessed needs, this included not delivering the required pressure area care and not following the recommendation of external health professionals.

There was a lack of interaction and stimulation provided to people. Our observations and activity records showed very little went on within the home on a daily basis.

Is the service well-led?

Inadequate 

The service was not well led. Although some improvements had been made since the last inspection, these were not widespread enough. The service was receiving significant support from external health and social care professionals, yet significant risks to people's health, safety and welfare still remained. The provider had failed to address concerns raised during the February 2015 inspection and as such breaches of regulation still remained. We were concerned about the lack of clinical expertise available within the home to drive improvement in technical or clinical subjects such as bed rail management, and the management of malnutrition.

A system of audits was in place, however some of these did not contain clear actions of how issues were assigned to individuals and resolved. Care plan audits were not sufficiently structured to ensure they were effective.

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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 required improvements had been made to the service following our inspection in February 2015. As the inspection was a comprehensive inspection we also looked 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 7 and 14 July 2015 and was unannounced. The inspection team consisted of three inspectors and an Expert by Experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We used a number of different methods to help us understand the experiences of people who used the service. We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. We spoke with six people who used the service, six relatives, two registered nurses, five members of care staff and the cook. We also spoke with the provider, deputy manager and clinical lead. We spent time observing care and support being delivered. We looked at nine people's care records and other records which related to the management of the service such as training records and policies and procedures.

Prior to our inspections we normally ask the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We did not ask the provider to complete a PIR on this occasion. We reviewed all information we held about the provider. We contacted the local authority safeguarding team, clinical commissioning group to ask them for their views on the service and if they had any concerns. As part of the inspection we also spoke with two health care professionals who regularly visited the service.

Inadequate

Is the service safe?

Our findings

At the last inspection in February 2015 we identified concerns relating to the medicine management system. At this inspection we found although improvements had been made in some areas, significant risks still remained to people who used the service.

We saw on one occasion a person had been prescribed an anti-depressant to be taken at night. Medication administration records (MAR) showed on seven occasions over 18 consecutive days the medicine had not been administered. This showed the person had not received their medicines as prescribed. Failure to administer this medicine as prescribed could have had a significant impact on the person's wellbeing and sleep patterns. We also found this person did not receive their nutritional supplements as prescribed for a 15 day period in May/June 2015 as stock was unavailable. This was of particular concern as the person was at of risk of malnutrition, of low body weight and continued to lose weight. In July 2015, one of their supplements which stated to be given twice a day had not been signed as given. The clinical lead told us this person refused this medication, but this was not documented.

We saw two people were currently prescribed Warfarin on a variable dose dependent upon the results of regular blood clotting tests (INR). Whilst the manager had put in place an appropriate system to ensure the correct dose of Warfarin was administered we found irregularities concerning one person's care. We found this person required INR testing each week with consequential changes to the dose on each occasion. We found the recording of Warfarin administration on the MAR did not provide the necessary information for us to be assured the medicine had been administered as prescribed. The MAR sheet had not been signed on four occasions out of the previous 12 days. Furthermore the recordings of stock levels were absent or inaccurate. Without appropriate recording, staff could not effectively assess the Warfarin dose the person was receiving, and therefore whether it needed adjusting. We were particularly concerned that these omissions were not identified and investigated by nursing staff on the medicines rounds immediately following the error.

Due to the level of concern identified in these cases, we made safeguarding referrals to the local authority safeguarding team.

During our inspection of medicines we were informed that one person received their medicines covertly. Our subsequent scrutiny of the person's care plan showed evidence that, following an assessment of mental capacity, a best interests meeting had taken place attended by a GP, senior care staff and the person's next of kin. This demonstrated the provider was ensuring that covert administration of medicines was only taking place in the context of existing legal and good practice frameworks to protect both the person receiving the medicines and the registered nurses involved in administering the medicine. However we discussed with the manager the issue of reviewing the need to continue administering medicines covertly. The National Institute for Health and Care Excellence (NICE) document "Managing medicines in care homes guideline (March 2014)" indicates (recommendation1.15.3) the process for covert administration of medicine should be subject to regular review. There had been no review of the person's need to take their medicines covertly since 7 August 2013. Furthermore following our visit on 7 July 2015, the provider assured us a review would take place but when we returned on 14 July 2015, this had not taken place and the clinical lead was not aware of the issue.

This was a breach of the Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Our previous inspection found the lateness of finishing the morning medicine round compromised the administration of lunchtime medicines with as little as two hours between people's morning and lunchtimes medicines. On this inspection we found action had been taken to ensure the medicine round finished mid-morning thus not compromising lunchtime medicine administration.

We found on our previous inspection when PRN (as required) medication had been prescribed staff had not always recorded when medicines had been offered but refused. On this inspection we found PRN protocols and prescribers instruction had been followed and our observations of the medicine round showed people were asked if they needed PRN medicines.

In some cases we found updated plans of care had been put in place following incidents to help keep people safe. However we found risks to people's health and safety were not always safely managed. People and their relatives generally spoke positively about safety in the home and

Is the service safe?

said they felt safe using the service. However one relative raised concerns about a number of risks which when highlighted with the provider they felt had not been taken seriously and effectively addressed. We found these were legitimate concerns which the provider had still not taken action to address. We saw the cleaner was cleaning bedrooms using a vacuum cleaner which was plugged in much further down the corridor, a significant distance from where it was being used. There was a mass of surplus coiled electrical wire in the corridor. This was a significant trip hazard to elderly and vulnerable people who use the service. We looked at documentation of an incident where a person had been found outside of the home. When we spoke with the manager they told us the person had bypassed the small gate which was often put in place during warm weather when the usually secure front door was opened. However the incident investigation had failed to mention that the person had bypassed the gate, and had not considered the risk posed by having the gate in place. This gave us no assurance that a similar incident would not reoccur. During both days of the inspection we also saw that at times the front door was open with the gate in place. There was no risk assessment in place detailing the reasoning behind why the secure front door was frequently opened and how this would affect resident safety. A relative also raised a concern with us about the use of this gate and the safety issues it presented.

At the previous inspection in February 2015 we raised concerns about the safe management of bed rails in the home. During the first day of our inspection on 7 July 2015, we looked at the bed rails in situ in one bedroom. The gap between the headboard and bedrails was between 20-30cm, which is not in line with safe operating standards and presented an entrapment risk. This had not been identified by the service. Furthermore we found the deputy manager had interpreted guidance incorrectly in the production of the bed rail policy and as such it needed changing to ensure that safe procedures were in place. Risk assessment documentation did not consider whether the correct combination of equipment and bed rails was in place and there were no regular documented checks on bedrails.

We saw four people in the upstairs lounge were hoisted using the same sling. As well as being an infection control risk we were concerned that this generic sling did not fit as some people looked very uncomfortable and unsecure whilst being lifted. The deputy manager told us each person had their own sling but this was not being practiced in our observations of care. Manual handling assessments did not specify which slings were to be used for each person. This was a risk to people's safety.

We found further infection control risks. The mattress on one person's bed was heavily stained and staff proceeded to make their bed, ignoring the staining. On both days of the inspection a sling was found stuffed behind the radiator in the upstairs toilet and on the 7th July 2015 there was faeces staining on the toilet seat. We also found the upstairs toilet was cluttered with equipment such as wheelchairs making it difficult to maintain appropriate hygiene. We found unpleasant odours in the home particularly in the first floor corridor close to the upstairs lounge.

Some other risk assessment documentation was of poor quality. Personal evacuation plans were in place for each person: However these were poorly completed, for example stating "1-2 carers needed to evacuate" with an absence of further information. Some risk assessments such as MUST (Malnutrition Universal Screening Tool) were incorrectly completed meaning the level of risk was not properly calculated.

This was a breach of the Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection, people and relatives generally told us they thought the home was safe, although one person and a relative raised concerns that they had lost personal possessions whilst living in the home. Staff we spoke with had a basic understanding of safeguarding. We saw evidence the manager had made some safeguarding referrals and had an increased understanding of recognising conflict between people who used the service as abuse and taking appropriate action. However, the service had not done enough to protect people from harm. At the time of this inspection, the service was under "Whole Service Safeguarding" by the local authority due to a number of concerns they had with the provider. At the inspection, we identified a number of risks to people that we judged constituted abuse. This included omissions in key medication, and a lack of evidence of documented action following weight loss. These risks should have been identified and rectified by the provider through systems to ensure people were safe from harm. Bruises and sores were not routinely being recorded on body map charts which

made it difficult to establish whether they were being correctly managed. In one case daily records showed bruising had been found on one person but the investigation into the incident was not sufficient to determine the cause and assure us that a re-occurrence would be prevented.

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

We completed a tour of the premises as part of our inspection. We inspected eight people's bedrooms, bath and shower rooms, the laundry, linen storage room and various communal living spaces. During our inspection in February 2015 we found significant defects to the premises which needed addressing. During this inspection, we saw evidence of improvements with previous defects repaired or replaced and a redecoration programme underway. However, there was still work to be done to bring the premises up to a high standard. We found one upstairs window had a defective window opening restrictor which we brought to the manager's attention. Some areas of the building were still tired and the upstairs lounge was not a pleasant or homely environment. People mentioned that the premises could be further improved; for example, one person told us, "I would change the décor and fabric of the building; it's jaded." We inspected records of lift and hoist maintenance and found all to be correctly inspected by a competent person. We saw certificates confirming safety checks had been completed for gas installation, electrical installation, fire appliances and alarms, legionella and boiler maintenance. We saw all portable electrical equipment had been tested and carried confirmation of the test and date it was carried out.

Safe recruitment procedures were in place and we saw evidence these had been followed to ensure staff were of suitable character for the role.

In February 2015, we assessed staffing levels were insufficient to ensure safe care. We found this was still the case. At the last inspection the provider told us they were to increase staffing to five care staff in the morning, however we found this was not the case and staffing levels were still the same as at our last visit, despite having two additional people living in the home. When we raised this with the provider they said they had been unable to do this due to staff sickness and recruitment issues. We assessed that increases in staffing levels in the morning were still required to ensure safe care. Although two relatives told us they thought there were enough staff, one person and two relatives raised concerns about staff not always being available and this was corroborated by our observations.

On the first day of the inspection we observed care in the downstairs lounge during the morning. We found one person was constantly calling out for assistance to the toilet. However it took 32 minutes for care staff to arrive with the hoist and transfer them to go to the toilet. Two relatives also told us they had witnessed similar occurrences saying, "I have had to tell them twice when someone needed the toilet; they didn't come the first time" and "I've no concerns other than the response times. It can take staff time to take people to the loo for instance. (Person's name) asked three times. They do care but there isn't enough staff."

During the course of the inspection, people were sat in three communal areas and there was a lack of supervision of these areas at times. For example, in the upstairs lounge, people were left alone with no access to the call bell which was behind a chair; a person who used the service raised a concern that this bell was not within easy reach. We observed a person in discomfort and prompt action was not taken by staff to comfort them or investigate and we had to inform staff to intervene. A person who used the service also told us staff did not address concerns quickly enough, stating, "On the whole, it's quite good but staffing is not enough. That lady there (pointing to a lady asleep and slumped in a chair) nearly fell out of her chair, she was doubled up and no-one spotted it for half an hour."

The provider had started using a dependency tool to calculate staffing levels, however neither the manager or the deputy understood it, and they were responsible for making decisions over staffing levels. The tool was explained to us by the clinical lead but it was not an accurate reflection of the ' staffing needs and suggested the home was currently 30% overstaffed.

Following the last inspection, the clinical lead had been given supernumerary time of 12 hours per week to assist in nursing leadership of the home. However, this was part of three 12 hour shifts a week, which meant that on an average of four days a week the home was without clinical leadership. We judged that a lack of consistent clinical leadership was responsible for some of the risks identified during this inspection.

Inadequate

Is the service safe?

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

Inadequate

Is the service effective?

Our findings

People and their relatives generally told us that they thought the home provided good care and gave examples of how their relatives health and improved. For example one person told us, "Totally happy with the level of care here." Another relative told us, "She thinks it's lovely here, it's cosy. Her physical health has improved. She goes to the loo alone now, she couldn't before; it used to take two." Another relative told us, "They are absolutely brilliant, the staff. They have absolutely looked after him; he's talking better, he looks better and he has put on weight. He looks clean and they shave him every day. They stimulate him and they talk to him every day." However one relative raised concerns about how they thought their relative had deteriorated and lost weight recently under the care of the home.

Staff told us they received appropriate training. New staff received a range of induction training. We saw staff had received training in a range of subjects which included manual handling, fire safety, infection control, safeguarding , health and safety and food hygiene. Care staff had an adequate knowledge of the subjects we asked them about. We found although in the past there had been poor uptake of specialist training from external health professionals such as tissue viability nurses. This had now been agreed and implemented to help develop staff skill and knowledge. We found staff were subject to supervision and appraisal and saw evidence that they were supported to develop further. However, we saw some examples where there was a lack of nursing skill and knowledge within the home. In one case the Malnutrition Universal Screening Tool (MUST) was incorrectly completed over a number of weeks by nursing staff demonstrating a lack of understanding of how to use the tool. Bed rail management was also poorly understood by the staff in the home and in one case this had resulted in bed rails being incorrectly positioned. A health professional we spoke with told us, "The staff seem to care but they lack knowledge. They need to update with the changes."

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. At the time of our inspection in February 2015 no authorised DoLS were in place nor had any applications being made by the managing authority.

We found the management team did not collectively or individually have the required level of knowledge to effectively apply the requirements of the Mental Capacity Act 2005.

At this inspection, we discussed DoLS with two members of the management team. They demonstrated a much improved understanding of their responsibilities and had established a closer relationship with the supervisory body to enable them to seek guidance where necessary.

We saw 16 people had been assessed and authorisation sought from the supervisory body. No approvals had yet been received. We looked at three care plans for people who had been subject to a DoLS authorisation request. The care plan and our evaluation of the environment in which people were cared for suggested the manager had made appropriate authorisation requests. We also looked at a care plans for a person we were told did not require authorisation to deprive them of liberties. The care plan clearly showed they had capacity to make decisions for themselves and had strong family support with whom they could discuss their needs. We saw this was replicated in another file we looked at.

However, we found inconsistencies in the way the Mental Capacity Act 2005 (MCA) was applied. One person's care plan stated that they did not want bed rails. However a consent form had been signed by the person's relative authorising the use of bed rails in the future. This was contradictory and it was therefore unclear whether the person had capacity to make this decision for themselves. The correct process, i.e. assessing the person's capacity to make a decision for themselves and if they lacked capacity, undertaking a best interest process had not been followed. Consent forms indicating whether people had agreed to elements of their care were also blank in some records we looked at.

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

We saw care plans recorded whether someone had made an advanced decision on receiving care and treatment. The care files held 'Do not attempt cardio-pulmonary resuscitation' (DNACPR) decisions. The correct form had been used and fully completed recording the person's name, an assessment of capacity for this element of care, communication with relatives and the names and positions

Is the service effective?

held of the healthcare professional completing the form. Entries on the whiteboard where people had a DNARCPR matched what was actually in place which assured us the correct procedure would be followed by staff.

We received a range of feedback about the quality of the food. Some people were very complimentary for example one person told us, "Food is very good, enjoy all my meals" and another person told us, "Quite good, I usually enjoy mine. I normally go into the dining room. Another person told us, "It's a bit monotonous. You get a choice, not a wide one. There's too much stew-like food." "The food isn't good." We found there was no real choice of meals at lunchtime, with one main meal option each day. One person confirmed this saying, "No, they don't give alternatives, there is no choice." We saw this person didn't eat their food and a staff member took it away without offering them an alternative. During observations of breakfast, we noticed another person wasn't eating their breakfast, we asked if they knew what it was, they said no. When we told them it was Weetabix they said they didn't like it. We observed lunchtime in the dining room, everyone had the same dish which was chicken stew, potatoes and vegetables. It was already plated so people could not choose the amount of vegetables and stew that they wanted.

At the last inspection in February 2015 we found the service was not taking effective action following weight loss. At this inspection we found these concerns still remained. The home used the MUST tool to identify those at risk of malnutrition. However there was no local policy or management guidelines (as recommended by the MUST tool) to ensure a clear procedure was followed in promoting weight gain strategies and liaising with local health professionals should nutritional concerns be identified. We found this resulted in inconsistent decisions being made with regards to intervention. In some cases weight was being appropriately monitored and liaison with health professionals was occurring where weight loss was identified. However one person had lost over 10% weight between March and June 2015, however their MUST assessment had not identified the scale of the loss and as such as the MUST score did not reflect the risk level. It was written in the care plan review in May 2015 that a dietician review was needed, but there was no record of this within the health professionals log and the deputy manager said they didn't know if it had taken place. Since May 2015 they had continued to lose weight.

In another person's records we saw staff had identified weight loss and recorded that they needed to speak with the dietician. However this was only done once we pointed out to the service it had not been done on the first day of our inspection. We also saw that the home was not conforming to the dietician's initial advice and their own care plan regarding offering and documenting a range of nutritious snacks to this person: For example, records showed on one day they were offered no nutrition after 13.00. This person had continued to lose weight.

This was a breach of the Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found that nutritional supplements for one person were not given for 11 days in May/June 2015. This was of particular concern due to the fact the person was still losing weight and of low body weight.

Where food and fluid intake was being documented this was not being evaluated over a period of time to establish whether people were getting the required nutrition and fluids. We were particularly concerned as three people who were on these charts continued to lose weight, and there was a lack of nursing review of whether they had received adequate nutrition.

This was a breach of the Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Information on people's healthcare needs and medical diagnosis was not always robustly assessed and relevant plans of care put in place. We identified a number of people had complex conditions and the lack of information available for staff meant there was a risk staff would not meet their individual needs. People and their relatives reported access to health professionals such as doctors and opticians. The home was receiving significant support from local health agencies and as such people had regular contact with health and social care support workers this included QUEST matrons, district nurses and doctors. We saw their advice was recorded in the people's files to assist staff.

Requires improvement

Is the service caring?

Our findings

People and their relatives generally told us staff were kind and caring and treated them well.

For example one relative told us, “This home impressed me. They have a caring attitude and their priorities are right.” Another relative told , “I visit every week and I am generally happy. The staff are caring although a bit disorganised. ” A person who used the service told us, “It’s a nice place. The attitude; they are very caring.”

We observed care in the communal areas of the home on both days of the inspection. We saw a number of very positive interactions between staff and people who used the service which demonstrated a caring and kind attitude and compassion. For example, we saw that staff provided reassuring words to reduce anxiety when transferring a person using a hoist. The provider and deputy regularly asked people if they were okay and we could see they cared about people who used the service.

At the last inspection we had concerns over attitudes to dignity and respect displayed by some staff members. Dignity audits and dining experience audits had been introduced by the provider to try and improve the consistency of staff interaction within people who used the service. Although we saw most staff were friendly and kind to people some negative interactions remained. For example, one staff member did not effectively address a concern a person had about discomfort and told them to, “Put your belly away” rather than addressing their obvious discomfort. When we asked this person about staff they told us “Two or three staff do not give a damn.” One person we spoke with told us about staff, “Only one is bossy, she will say get up, get up; a bit of a bully type. She’s a bit rough, a little bit sharp she is.”

We observed the care was very task orientated with people subject to limited interaction with staff, particularly in the upstairs lounge. We looked in the room of one person. Their bed was stripped and there was heavy and obvious staining on the mattress. When we returned later in the day we saw the bed had been made over this staining without it being cleaned. We were concerned that staff had made the bed up when it was very obvious that the mattress needed cleaning. As well as an infection risk this was an example of undignified care. We raised this with the clinical lead and provider who told us they would address with the relevant staff.

During care observations, people appeared well dressed and clean indicating the provider was ensuring they received the required personal care.

People and their relatives told us they generally felt listened to by management and said they were attentive, kind and caring . For example one relative told us, “[deputy manager] is approachable there is nothing I can’t say to her, in fact, to any of them. They listen and she is good at her job.” Some care plans we looked at lacked evidence they had been agreed with the person or their family. This showed that mechanisms to record people’s views in relation to the care and treatment were not sufficiently robust.

Information on people’s life histories was present within some people’s care records. However, this was not consistently applied; for example two people who had been at the home for several months had nothing present. Life histories are important to help staff understand the person’s experience and assist them to deliver personalised care and support.

We found some regimes in the home were very task focused and not focused on people’s individual preferences. During the inspection we saw there were two lounge areas where people could spend time. Through observations of care over the two days of our inspection, we saw there was significantly less interaction upstairs and the general environment in this area was not pleasant or homely. One relative raised concerns with us that they did not know why their relative sat upstairs and they were concerned about the environment up there. They told us that a nurse said people sat in that environment because it easier to ensure they were ‘effectively toileted’. When we asked a staff member they said that the ‘heavier’ (more dependent) people sat upstairs. When we spoke with the manager and deputy they said it was people’s choice where they sat. However this was contradictory to what care staff and a relative had reported. We concluded people had a lack of choice as to where they spent their time. There was nothing noted in care plans about this and some of the people we looked at would not have the capacity to make this decision for themselves.

Requires improvement

Is the service caring?

We also saw there was a list of people for staff to get up each morning before the day shift started. Staff we spoke with knew who to get up early but did not know why they had to get these people up early. There was no information in care plans which stated what people's preferences were in terms of getting up and going to bed. We also saw the television in the upstairs lounge was changed by the provider without asking the people who were sat in the room what they wanted to do/watch.

This demonstrated a lack of involving people in decisions with regards to their care and support.

This was a breach of the Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service responsive?

Our findings

At the last inspection we found the service was not responsive in fully assessing people's needs and delivering appropriate care which met people's individual needs. At this inspection, we found this still to be the case.

We found examples of people's needs not being fully assessed. We looked at one person's care record and saw the pre-assessment document had not been signed, therefore we were unable to establish whether this was completed by a competent person. Investigation showed the person had complex needs, however there was a general lack of assessment of these needs on the pre-assessment to establish whether the home could meet their needs. The pre-assessment documentation did not record whether the person was receiving nursing or residential care. The local authority who commission the service told us this person should be receiving nursing care but the home told us they had been a residential client. This was particularly concerning as there was an obvious discrepancy between the care the person required and what staff at the home thought they were providing.

Pain assessments were not updated and did not reflect people's current needs. For example, one person's records showed they had recently been in pain but their pain assessment had not been updated since 2013. Without clear pain assessments showing how to identify and manage pain there was a risk people would experience unnecessary discomfort.

We found inconsistencies in the provision of pressure area care. In one person's records it was noted that the tissue viability nurse had recommended a weekly pressure risk assessment be carried out. This was not taking place, which meant there was a risk any changes in the risk level would not be responded to quickly enough. We saw evidence one person had a pressure ulcer which was noted by an external health professional . Internal documentation completed by the provider showed that staff at the home had failed to identify this and concluded staff should have identified it sooner. We also found the pressure mattress for one person was set incorrectly for their weight which meant there was a risk it was not working effectively in its role to reduce the risk of pressure sores.

We found examples of care not being delivered in line with people's individual needs. One person's care records showed that they needed a cushion behind their head whilst eating as they had a tendency to put their head back. We observed staff supporting them with food, we saw there was no cushion in place and a staff member kept asking the person to put their head forward. This showed adequate support was not offered and a lack of understanding of the care plan.

In another person's care records we saw advice was recorded from an external health professional asking staff to keep the persons legs elevated and trial them on a recliner chair. During the inspection we saw this person was not encouraged to elevate their legs or encouraged to use a recliner chair. They were sat in the hallway with very limited interaction or stimulation from staff. In the 11 days since the advice was given, daily records showed only once their legs were elevated and on one further occasion they had refused to elevate their legs. Advice also stated to ensure 2 litres of fluid was provided within each 24 hours period, but this person's fluid intake was not being monitored, so staff could not measure and evaluate to ensure this was happening.

We found that many care plans did not contain the required level of detail to ensure appropriate care. For example one person's sleeping plan just said "check regularly through the night" but was not specific about how often these checks should take place. Where people were at risk of malnutrition, eating and drinking care plans did not contain specific goals around eating (as recommended by the MUST tool) and what type of snacks to promote to help maintain a healthy weight. Conflicting advice was often recorded in the care plan and care plan review section of care plans making it difficult to establish what the current plan of care was. For example, one person's care plan stated they should have a soft diet but the review section stated that they should now have a suppliment in their drinks and food the consistency of thin custard. There was also conflicting information recorded in different areas about the amount of suppliment they should have in their drinks and staff we spoke with gave inconsistent responses. This meant there was a risk they received inconsistent and inappropriate care.

In another person's records we saw the service had not been responsive in obtaining professional advice about whether the person should still be having their medicines

Inadequate

Is the service responsive?

through a Percutaneous endoscopic gastrostomy (PEG) tube now that food/fluids through the PEG had been discontinued. The service had failed to arrange a meeting with their necessary expertise to address this issue.

This was a breach of the Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During both days of the inspection we saw there was a general lack of activities provided to people. There was only limited interaction between staff and people and interaction was very task focused. There was no dedicated activities co-ordinator and we observed staff were too busy to provide any meaningful activity or interaction. We looked at activity records for some people, they showed very little had been going on. For example a number of people's activities records for July 2015 showed that watching TV was the only activity they had been involved in. We concluded that a more varied and structured activities programme could have helped meet people's social and emotional needs. Some people reported that occasional events and entertainers visited. For example one person told us, "A choir came to sing at one time and there was someone who came in throwing a ball." Another person raised a concern about activities stating, "I need to be somewhere where there is something going off that I could take part in. Sometimes people come to entertain but they forget about me or they come late and in a rush to take me there."

There was a sheet pinned up in the hallway on which was written ' Activities' but the rest of the sheet/area was empty and there was no calendar of activities.

People and the relatives we spoke with generally said they had no cause to complain and the feedback we received indicated a high level of satisfaction with the service. People said

where minor issues had arisen they had been addressed by staff. However, one relative told us that they thought their concerns had not been acted on appropriately by the home and we found evidence this was the case for example in addressing risks that had been identified. We looked at the complaints register which showed no formal complaints had been received since our last inspection and a number of compliments showing where the service had exceeded expectations.

Inadequate

Is the service well-led?

Our findings

Since the previous inspection, the home had received support from external consultants, health and social care professionals in an attempt to help raise standards within the home. Some improvements were evidenced, for example to some elements of the medication system and premises. However, especially given the level of support the home had received, we were particularly concerned that significant risks still remained in a number of areas. We were concerned that risks previously raised with the provider had not been effectively resolved. This included a failure to ensure malnutrition was effectively managed, and ensuring the safe management of bed rails. In addition, on the first day of this inspection (7th July) we raised the issue of a single sling being used to hoist four people, this was still happening on the second visit date (14 July).

Throughout this inspection , we found there were inconsistencies in the responses given to us by the clinical lead, deputy manager and provider when we asked questions about the home's policies and ways of working. This combined with the service unable to produce some written policies for us suggesting they were not readily available or used resulted in a risk of the continuation of inconsistent decision making. For example the home was unable to produce a policy detailing intervention strategies for weight loss. We found there was a lack of expertise in place to correctly interpret and implement guidance to help ensure a high quality service. For example a bed rail policy had been developed although the technical information on how bed rails were positioned was incorrect and the required assessment of the equipment had not taken place. Although a staffing/ dependency tool had been introduced, we found the provider who was responsible for determining staffing levels did not understand it and the dependency scores generated by the tool were inaccurate and the overall tool did not reflect the reality of the staffing requirements. We found the home had introduced an early warning tool to assess if people needed medical intervention. We saw that one person had fallen into the amber risk parameter but the GP had not been contacted as per the tool guidance. We raised this with the clinical lead who told us they didn't understand the tool or the procedure surrounding its use. Some health and social care professionals we spoke with described the home as being managed in a "chaotic way" and also had concerns over the level of expertise present at the home.

Since the previous inspection a range of audits and checks had been put in place. These included dignity and dining experience audits and a "first impressions audit". However audits did not contain clear action plans and assigned responsibilities and as a result it was difficult to track who was responsible and within what time scale. For example one audit found that a noticeable odour had been found in some areas of the home but there was no evidence of action taken to prevent a re-occurrence and we found unpleasant odours remained in some areas of the home during both days of our inspection.

Care plan audits were not of a structured format with a lack of prompts to assess the quality of care plans against. The lack of a structured format meant there was a risk that key quality issues would be missed. We found a number of issues with regards to care assessment and delivery that should have been identified and rectified by a robust system of care quality audit.

Medication audits took place and we saw evidence they were identifying issues such as missed signatures. We saw these had been addressed with staff through meeting and supervision. However given the medication risks we identified, diligent checks by all nursing staff should have identified these missing signatures immediately and investigated the cause.

Skin bundle charts were completed to document pressure care, and some people's food and fluid intake was measured where malnutrition was deemed a risk. However documentation relating to each individual was scattered in a number of places with some days missing and there was no evaluation of the food /drink input and pressure care delivered to ensure it was sufficient. For example one daily chart showed no nutrition had been offered to one person of very low body weight after 13.00, but this had not been flagged for investigation. This lack of system was of particular concern as a number of people were steadily losing weight over a number of months and proper evaluation of their dietary intake was crucial.

Records relating to people's care were not always readily available. Charts showing people's food and fluid charts were not well ordered. We found the service was unable to obtain all the charts we asked for , such as pressure bundle charts covering all dates. Pressure relief was on occasion recorded on the same charts as food/fluid and on other occasions on skin bundle, this made it difficult to track the pressure relief they had received.

Inadequate

Is the service well-led?

Since the last inspection more detail had been added to incident forms which included a detailed investigation section. Incident analysis also took place. However we found some incidents had not always been reported, such as a fall to one person and an incident where an agency nurse incorrectly operated someone's PEG. If incidents are not reported themes and trends cannot be analysed and appropriate action taken. Another incident we looked at had failed to analyse the cause of why someone had got out of the building (door left open because of hot weather). Another person's moving and handling care plan showed that person had sustained a few bruises whilst being hoisted, but there was no proper record of how this was investigated to provide assurance that lessons were learnt.

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

Most people and their relatives we spoke with told us that they thought the manager was effective in dealing with any issues which they raised. For example they told us, "I wouldn't put him anywhere else, [deputy manager] always talks to us. They make a special effort." Another relative told us, "You know who the boss is, [deputy manager] is very hands on." One relative did express concern that matters were not always dealt with appropriately. Staff also praised the management team and said they had no issues with the way the home was run.

Regular staff meetings took place, we saw these were an opportunity to discuss quality issues and help improve staff working practice.