Community Integrated Care

St Lukes Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This was an unannounced inspection which meant the staff and provider did not know we would be inspecting the service. The inspection took place on 2 and 3 October and 18 and 19 December 2017.

St Luke's Care Home provides nursing care for older people who have Alzheimer's disease or other forms of dementia. St Luke's is located in Runcorn close to local amenities. It is a two storey purpose built property comprising of 56 single bedrooms. It has a range of communal spaces including: lounges; dining rooms; sitting areas and a courtyard garden. A car park is provided for visitors.

There was a registered manager in post at the time of this inspection, but they were on leave and subsequently resigned. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are "registered persons". Registered persons have a legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The service was last inspected in July 2016. At the last inspection we found the service was not meeting the requirements of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Good Governance) because care plan audits had not identified changes in people's dietary needs had not been recorded appropriately.

At this inspection we found that the quality and safety of the service had deteriorated.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration. For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

During the inspection we found a number of breaches of the Health and Social Care Act 2008 (Regulated

Activities) Regulations 2014 related to safe care and treatment, staff training and support and good governance. We also identified an offence under the Care Quality Commission (Registration) Regulations 2009 as the registered person had not always notified the Commission of matters they were required to.

We found the checks completed by the registered provider to assess and improve the quality of the service were not effective to ensure people were protected against the risk of inappropriate or unsafe care.

We found that there was a risk that people's behaviour was not managed consistently and the risk to their health, welfare and safety was not managed effectively. Accidents and untoward occurrences were not monitored by the registered provider to ensure any trends were identified.

Shortfalls in recording meant that we could not be sure that medicines were always given to people as prescribed by their doctor.

Although people told us they felt safe, at the start of the inspection we found that people were not safeguarded from the risk of harm. We saw the service had not always followed the local safeguarding protocols and made a safeguarding alert in line with the local multi agency agreement. This had been addressed by the third day of the inspection.

Not all staff were familiar with the codes and principles of the Mental Capacity Act 2005 and could potentially provide care or treatment without lawful consent. Not all people who lacked capacity to make decisions about their care had Deprivation of Liberty Safeguards in place.

Staff were not receiving sufficient training or supervision.

People's care needs were not always reassessed regularly which resulted in their care plan not reflecting all of their current needs. This could potentially put them at risk of inconsistent care and/or not receiving the care and support they need.

The complaints system was not widely publicised and the provider did not review complaints to identify areas for improvement.

Staff recruitment records showed that the correct information was obtained about staff prior to employment. This meant we could be confident that people were cared for by suitably qualified staff who had been assessed as safe to work with people.

People spoken with were satisfied with the care they had received and were complimentary about the staff at the service. We observed that interactions between people who used the service and staff were positive. People's relatives and visitors were greeted in a friendly way.

People's dietary preferences and needs were being met.

In people's record we saw evidence of involvement from other professionals such as doctors, opticians, dietitians and speech and language practitioners.

St Luke's provided a 'dementia friendly' environment. A varied programme of activities was provided at the service to provide stimulation and meet the social needs of people living at the service.

Equipment was well maintained.

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.

Shortfalls in recording meant that we could not be sure that medicines were always given to people as prescribed by their doctor.

Risks to people's health and safety were inadequately assessed and the provider was not doing all that was necessary to reduce risk.

Is the service effective?

Inadequate

The service was not always effective.

Staff were not receiving sufficient training or supervision to enable them to fulfil their roles effectively.

Not all staff were familiar with the codes and principles of the Mental Capacity Act 2005 and not all people who lacked capacity to make decisions had Deprivation of Liberty Safeguards in place. This meant staff could potentially provide care or treatment without lawful consent.

People were supported to eat and drink.

The premises were adapted and designed to meet the needs of people with dementia.

Is the service caring?

Requires Improvement

The service was not completely caring.

People and relatives made positive comments about the staff and told us they were treated with dignity and respect.

Staff were able to describe people's individual likes and dislikes and their personal care needs.

However, the registered provider did not demonstrate a caring approach because they did not give staff the support they needed to provide compassionate care.

Is the service responsive?

Requires Improvement

The service was not fully responsive.

People's care needs were not always reassessed regularly which resulted in their care plans not reflecting all of their current needs. This could potentially put them at risk of inconsistent care and/or not receiving the care and support they need.

The complaints system was not widely publicised and the provider did not review complaints to identify areas for improvement.

People had choice about who provided their personal care.

There was a varied programme of activities available for people to participate in if they wished.

Is the service well-led?

Inadequate

The service was not well-led.

During the inspection we identified breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and offences under the Care Quality Commission (Registration) Regulations 2009.

We found the checks completed by the registered provider to assess and improve the quality of the service were not effective to ensure people were protected against the risk of inappropriate or unsafe care.

St Lukes Care Home

Detailed findings

Background to this inspection

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

This inspection took place on 02 and 03 October and 18 and 19 December 2017. The first and third days were unannounced.

The inspection team on the first day consisted of three adult social care inspectors, a nurse specialising in the care of people with dementia and an expert by experience, who is a person who has personal experience of using or caring for someone who uses this type of care service. On the second day the team consisted of two adult social care inspectors. On the third and fourth days there was one adult social care inspector.

Before our inspection we reviewed the information we held about the service and the registered provider. We also gathered information from the local authority, commissioners and Healthwatch. (Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.)

We used a number of different methods to help us understand the experiences of people who lived in the service. We spent time observing the daily life in the service including the care and support being delivered. We also undertook a Short Observational Framework for Inspection (SOFI) observation in one unit in addition to other observations we made. (SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.)

There were 48 people using the service at the time of our inspection. We spoke with six people living at the service, eight relatives, a director, two regional managers, seven nurses, eleven support workers and two domestic staff. We also spoke with a visiting GP and a visiting mental health nurse. We looked around different areas of the service; the communal areas, the kitchens, bathrooms and some people's rooms. We examined a range of records including the following: twelve people's care records, seven people's medication administration records, four staff files and records relating to the management of the service.

Inadequate

Is the service safe?

Our findings

All the people spoken with who used the service told us they felt safe but the relatives spoken with expressed concerns. Relatives comments included: "My relative was attacked by another resident who's been moved to another unit now"; "I would say safe most of the time because my relative has one to one support during the day but might have a fall when he goes to the toilet himself at night and his eyesight and mobility are poor".

On the first two days of our inspection people told us that they were given the medicines they were prescribed and were offered pain relief if necessary.

We observed a nurse administering medicines and saw they made sure the trolley was closed and locked when out of sight. The nurse showed sensitivity to people's needs and gave them time, nothing was rushed and medication administration records (MARs) were completed once the medicines had been taken. We also observed that the nurse checked whether people required any painkillers.

We saw in one person's file that they received medication covertly. A mental capacity assessment tool had been completed appropriately and a best interests decision had been recorded. A relevant care plan was in place, which had been signed by the GP and pharmacist.

We saw that medicines were stored correctly at the correct temperatures and there were satisfactory systems in place for their receipt and disposal. However, we could not be sure that people were always given their medicines as prescribed because of discrepancies in the records. One person was prescribed a liquid medicine morning and evening but several entries on the medication administration record (MAR) in the evening described the medicine as being out of stock, although it was signed as having been administered in the morning. Two other people's MARs contained gaps where medicines should have been signed as administered, in one case this was on one day only during the month of August, but in another case there were gaps on five days. If the medicines had not been administered there should have been an explanation recorded.

We looked at how the application of creams and ointments was recorded. On each unit there was a file in the nurses' office that contained charts for each person who required creams to be applied with instructions on which creams were to be applied, how often and a body map to show where they should be applied. Support workers applied the creams and recorded when they had done so. However, these records did not always tally with the MARs. For example one person's cream chart recorded that two creams had not been applied because they were out of stock, but the MAR chart showed they were no longer prescribed.

Some people's MARs consisted of several sheets, but a lot of the medications said 'none supplied this cycle' because they had been discontinued by the doctor. There would be less room for error if only the current medicines prescribed were listed on the MARs. We recommend that a manager liaises with the dispensing pharmacy to request this.

We looked at the arrangements for managing controlled drugs (CDs), which are strong medicines subject to the Misuse of Drugs (Safe Custody) Regulations 1973. These were also stored correctly and documented within a CD register. There was a kit available to destroy those no longer needed. We checked those in stock against the CD register and found that the number tallied with the register apart from buprenorphine patches for one person. The register stated there were four in stock but they were not in the CD cupboard. Underneath the stock balance of four written in the CD register somebody had written 'discontinued', but there was no record that these had been destroyed.

One person's care file included a letter from a speech and language therapist following a swallowing assessment. The letter instructed staff to thicken the person's fluids to syrup consistency with one scoop of thickener in 200mls of fluid. We observed that a drink given to the person was much thicker and looked difficult to drink. There was no care plan for this in the person's file. We asked a support worker if they were aware of such a care plan and they said it was on a cupboard in the kitchen. We checked and found that it said two scoops of thickener in 200mls. The support worker told us that staff always put two scoops in 200mls. This would not present a risk to people receiving thickened drinks but may make people more reluctant to take fluids if they were thicker than they needed to be.

We spoke with a visiting mental health nurse who advised on management of people's behaviour when they challenged the service. She said that sometimes it was difficult to assess whether medication prescribed was effective because nurses often didn't record why 'when required' medicines had been administered or if they'd been effective.

We saw from the training records that only eight out of twelve nurses had received up to date medication training and only three had had their medication competency assessed in the last year.

On the second two days of our inspection we checked the medicines for six people who used the service and found that all oral medicines were signed for as having been given and people were being given the correct amount of thickener in their drinks. However, we still found that creams were not recorded as being applied as prescribed. One person was prescribed an eyelid cleansing gel to prevent infection but this was recorded as out of stock. It had last been administered three weeks previously and noted as ordered 12 days before the inspection, but no-one had followed this up with the GP or pharmacy. The same person was prescribed dietary supplements but there was no record of them being given, although the person was not underweight and staff thought they had been discontinued. Three nurses had still not received training in the administration of medicines nor had their competency assessed. A medicine audit programme had just been carried out but no action plan had been devised to address the shortfalls identified.

These findings evidenced a breach of Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014 (Safe care and treatment), because shortfalls in recording meant that we could not be sure that medicines were always given to people as prescribed by their doctor.

On the first two days of our inspection, when we reviewed the accident/incident records (events tracker) completed by staff we identified that staff were not recording appropriately whether accidents and incidents were serious. The forms were then submitted to the registered manager for review, but we saw that those that had occurred in August and September had not been reviewed by the manager, and for those that had been reviewed prior to that date the manager had not picked up that some were serious and should have been notified to CQC. For example, in November and December 2016 and August 2017 three people who used the service had fallen and suffered a head injury and in January and April 2017 another person had fallen and fractured their hip, which in all cases required the person to be transferred to hospital. There had been no analysis of these accidents and no notifications.

When we reviewed people's care records we found that risks were not appropriately identified and managed. For example, one person had had two falls in September but their falls risk assessment had not been updated and the accidents had not been recorded on the events tracker. Another person was known to exhibit behaviour that challenged the service, but their care plan relating to this behaviour had not been evaluated, amended or re-written since May 2017, despite a significant number of known events occurring on the unit. The care plan advised staff to 'maintain safety' yet gave no examples of triggers or observable cues that the person may be becoming hostile, nor did it include interventions specific to the person's needs. Incident forms had been completed when this person had assaulted staff but no analysis of the events had taken place.

One person's care file noted that they were involved in an incident but staff were reportedly unable to submit an online form. We asked a nurse what measures were in place for agency nurses (who would not have a log in to the computer system) to report accidents and incidents and the nurse told us that there is a St Luke's training account they could log in with, but in practice this was unlikely to be explained to agency staff and they may not know how to access this. We also asked what happened to accident and incident records once submitted to the manager, and whether the staff themselves had opportunities, with senior staff support, to reflect upon incidents. The nurse advised that they did not know what happened once forms had been submitted, and that they had raised this with the clinical lead who was unable to advise. The nurse told us that incident form data appears on the unit's event tracker however reflection and analysis does not take place formally.

There was no evidence of a post fall protocol being easily accessible to staff, as advised by the National Institute for Health and Care Excellence (NICE), who suggest a laminated copy be on clear view to staff.

A fire risk assessment was in place and fire systems were tested regularly. However, there was only one fire marshal employed at the home two days a week. Only 22 out of 76 staff had received up to date fire safety training, although when this was pointed out to a senior manager during the inspection they immediately arranged dates for the staff to attend this training. Fire drills were not being carried out effectively. The fire marshal rang the fire alarm monthly and recorded how long it took staff to come to the fire panel to see whether there was an actual fire. However, there was no evidence that staff took part in any rehearsals of what they would do in the event of a fire.

On the second two days of our inspection agency staff confirmed they were now able to access the event tracker to record accidents/incidents. However, we found there was still no analysis taking place of accidents/incidents and the new manager was still waiting for access to the system. The registered provider told us they were planning to introduce a new audit tool the following month.

We also found that care plans were still not always being updated following accidents. For example, one person who used the service had had seven falls in November but their falls risk assessment had not been reviewed and their care plan evaluation recorded the falls but did not assess whether any further measures could be taken to reduce risk.

We found that 73% of staff had now attended fire safety awareness training but no fire drills had taken place.

These findings evidenced a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Safe care and treatment) because risks to people's health and safety were inadequately assessed and the provider was not doing all that was necessary to reduce risk.

The service had a copy of Halton Borough Council safeguarding protocols. This protocol provides guidance

for staff in all service sectors in Halton to make a safeguarding alert in line with the local multi agency agreement. It is important that staff follow these protocols to safeguard people from the risk of harm.

On the first two days of our inspection we became aware that these protocols had not been followed because when we reviewed the accident and incident records we saw that some safeguarding issues had not been reported to the local authority or notified to the Care Quality Commission (CQC) as required by law. For example, in September one person who used the service had hit another in the mouth resulting in an injury to the victim's lip and in July there were six occasions when a person who used the service had assaulted another person who used the service. None of these incidents were reported to the appropriate authorities.

We spoke with three members of staff to find out whether they knew the correct reporting procedures to follow if they had any concerns about the care and treatment of people who used the service. Two had received training and knew who to report safeguarding concerns to, but one had not had any training and did not know the reporting procedures.

There was a whistleblowing policy in place but none of the staff we spoke with were aware that whistleblowers were protected under the Public Interest Disclosure Act 1998 if they reported issues in good faith or that they could report matters to external agencies.

On the second two days of our inspection we found that safeguarding incidents were being reported to the appropriate authorities and the whistleblowing policy had been updated.

On the first two days of our inspection people we spoke with said they thought the home was clean. Hand sanitiser and paper towels were provided in all areas and all staff had undergone a hand washing audit to check they washed their hands thoroughly. Toiletries were labelled with individuals' names to prevent cross infection.

We observed that most of the home was clean and spillages were cleaned up promptly, although one unit smelled strongly of urine and the staff offices on the units had dusty floors. Domestic staff spoken with told us they were short staffed and finding it difficult to keep the home clean and free from odours. They expressed concern that they were unaware of which people who used the service presented a risk of infection. The head housekeeper told us that she had been told she was the lead person for infection control in the home but had had no training. We looked at the home's training matrix and could only find evidence of two staff that had received training in infection control. There had been no recent infection control audits.

One person who used the service was reported to have been involved in assaultive behaviour towards staff, including actions (scratching and spitting) which pose risk of infection to others due to the person having a blood borne infection. In the records available on inspection, there was no clear risk assessment for management and prevention of spread of the infection, and no evidence of local infection prevention and control advice being sought or implemented. One staff member expressed concern that they had not been supported in receiving an appropriate vaccination, despite being at risk, and had been informed by a senior member that no funding was available to provide vaccines. It is of note that both the Department of Health and the Health Protection Agency (2013) identify health workers as being an at risk group for contracting the particular infection, and advise vaccination.

On the second two days of our inspection we found that the home was clean and free from malodour. Domestic staff told us they were now informed of who was an infection risk. The person who presented risk to staff now had a risk assessment in place and advice had been sought.

Staff had still not received any training in infection control, but this had been arranged for the following month. Infection audits had taken place on three of the units and all those with infections had seen a doctor and been prescribed antibiotics.

On the first two days of our inspection we asked people whether they thought there were enough staff to meet people's needs. Comments included: "At the moment they're very short of staff."; "Some days there are plenty on, now and again one or two short but they seem to cope alright"; "I think they could do with more as this is a difficult unit, residents can be quite challenging"; "Adequate day time but I wouldn't say it's brilliant at night time"; "Sufficient"; "I'm concerned about the lack of permanent nursing staff, it doesn't feel like anyone is taking overall responsibility". One family said that at times only two staff were working on the unit, and they felt this was insufficient as many people appeared to require two staff to undertake care. An example was given of how when family requested that their mum was assisted to bed for a rest, all staff were already engaged in care duties and, although staff were apologetic and appeared to be trying their best, this resulted in their mum having to wait to have her care needs met.

We spoke with two support workers and two nurses about staffing levels in the home. All said there were insufficient staff at times, particularly nursing staff. They reported that often a nurse would be covering two units. One staff member said "There often aren't enough staff on the unit as most people require two staff to provide personal care. Staffing levels can vary from day to day and Saturdays seem to be often understaffed with only two carers on duty on this unit and one nurse covering two units. This impacts upon staff's ability to meet residents' care needs promptly, and also leaves staff the choice of either missing their breaks, or leaving one staff member on the unit."

When arriving on Aspen unit in the late morning a member of the inspection team approached a support worker and asked to speak to the nurse in charge, however the staff member initially was not sure who this was, and then when another staff member advised who was the nurse in charge, neither could be sure where the nurse was but thought they may be on Willow unit. Movement of nurses between units was observed throughout the inspection and support workers did not always know where they were in the event of an emergency. Nurses told us that they had very little time to review and amend people's care plans as their needs changed.

We shared our observations with the provider's senior managers. They informed us they were currently carrying out a recruitment drive for nurses and showed us a tool that was used to determine staffing levels based on the dependency of the people residing in the service. The director told us there should be a minimum of four nurses and 13 support workers during the day and two nurses and nine support workers at night. On the days of the inspection there were only three nurses on duty during the day. Rotas showed that the home was not always achieving these staffing levels. We recommended that the dependency levels and rotas were reviewed by the senior management.

On the second two days of our inspection we found that staffing levels were much improved and during these two days only two agency carers were deployed in the home. There was at least one nurse and four carers on each unit during the day and rotas seen for the rest of the month showed that these levels would be maintained.

A recruitment and selection policy was in place which identified all the information the registered provider needed to obtain about a prospective member of staff prior to employment. Staff recruitment records we examined showed that the information was always obtained, which meant the recruitment of staff was carried out in such a way as to ensure that staff were suitable to work with vulnerable people.

Gas appliances and the electrical installation had been inspected and were safe. Other equipment was inspected, serviced and maintained at the required intervals. Relevant liability insurances were in place.

Inadequate

Is the service effective?

Our findings

During the inspection we observed staff obtaining consent from people before providing personal care and that people's choices were respected.

The Mental Capacity Act (MCA) 2005 is an act which protects and promotes the rights of people who are unable to make all or some decisions about their lives for themselves. It promotes and safeguards decision making within a legal framework. The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which apply to care homes. The Deprivation of Liberty Safeguards (DoLS) are part of the Mental Capacity Act (MCA) 2005. They aim to make sure that people in care homes, hospitals and supported living are looked after in a way that does not inappropriately restrict their freedom.

On the first two days of our inspection we found the provider was unable to demonstrate compliance with the MCA because they did not have access to central information to inform them whether DoLS authorisations had been applied for or obtained for people living at the service who lacked mental capacity. There was a file in place but it had not been updated since the deputy manager had left six months previously. A nurse told us she had had no training in MCA and DoLS and did not know how to assess whether a person had the capacity to make decisions such as whether they wanted to live in the home. One support worker said they had had training in MCA and DoLS but did not know which people had DoLS in place. Two other support workers told us that they did not know what DoLs were, and one of them added that she would not let any of the people who resided at St Luke's go out on their own. This would be unlawful if the person did not have a DoLS in place. We looked at the staff training matrix and could only find evidence of three staff having completed training in the MCA and DoLS.

On the second two days of our inspection we found that some people had had their mental capacity assessed and applications for DoLS had been made for 16 out of 48 people who used the service. The manager was working with the local authority to ensure that appropriate safeguards were put in place for those that lacked capacity to make their own decisions.

These findings evidenced a breach of Regulation 13(5) of the Health and Social Care Act (Regulated Activities) Regulations 2014, Safeguarding service users from abuse and improper treatment because not all those who lacked capacity to make decisions regarding their care had deprivation of Liberty Safeguards in place.

On the first two days of our inspection staff told us that they received supervision and records confirmed this, but this was not carried out on a regular basis. Supervision should be regular, planned and recorded sessions between a staff member and their manager to discuss their work objectives and wellbeing. A nurse told us that she did not receive any clinical supervision. Clinical supervision is a formal process of professional support and learning which enables nurses to develop knowledge and competence, assume responsibility for their own practice and enhance protection of people they care for and safety of care.

We looked at staff training records and saw staff received some training relevant to their role. The training

provided covered a range of areas such as moving and handling, managing actual and potential aggression (MAPA), first aid, safeguarding, food safety, fire safety and medication. However, we saw from the spreadsheet that only eight out of twelve nurses had received up to date medication training and only three had had their medication competency assessed in the last year. We also saw that most staff had not received any training in infection control or care of people with dementia. In addition, one member of staff told us they had not had any safeguarding training.

Support workers told us that they never had time to read people's care plans and we observed that written handover sheets gave no detail about people's care needs. Support staff were reliant on verbal information from nursing staff.

On the second two days of our inspection the nurses told us they were now receiving group clinical supervision. Staffing levels were much improved so support staff had time to read care plans and written handover sheets contained more detail regarding people's needs. However, there were still many gaps in training, such as infection control, equality and diversity, medication, fire drills and dementia care.

These findings evidenced a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Staffing) because staff were not receiving sufficient training and supervision to enable them to carry out their duties effectively.

People spoken with said they were satisfied with the care they had received and their medical needs were addressed. One person who used the service said "They will get the doctor for me if I need one" and a relative said "Yes, I am satisfied. I have been here when the doctor has been here."

We found evidence of involvement from other health professionals in people's records, such as GP, speech and language therapist and optician. A visiting mental health nurse told us that the staff were good at contacting the care home liaison team at the local mental health trust if they had any concerns. A GP also told us that the staff contacted them if they had concerns about someone's health. However, both said that if there was an agency nurse on duty when they visited that it was not easy to obtain relevant information about the person they had been asked to visit, which could lead to delays in people getting the correct treatment This shows a lack of communication between staff deployed in the home and indicates that good governance systems were not in place.

In the main people were positive regarding the food provided at the service. People who used the service said "The food is ok" and "It's very good food". Relatives' comments included: "Every time I have been, it was very good. They get plenty and if they need more, they can ask for more"; "I think the food is lovely from what I've seen"; "I think it has room for improvement. There is a choice but Dad sometimes refuses to eat. They do offer alternatives and snack and biscuits throughout the day."

During the first day of the inspection we observed the arrangements at mealtimes on two units. We saw there was a choice of options; soup, tuna pasta bake and mixed vegetables or sandwiches and a selection of desserts. We saw that people were offered a cold drink with their meal and a cup of tea afterwards. During lunch staff sat and chatted with people and provided assistance as required. We saw that one person did not eat their meal and staff made attempts to encourage the person to eat, but they refused. Staff then offered other alternatives and the person chose a yogurt. We saw that some people were supported to eat by staff in areas other than the dining room if they did not want to sit at a dining table.

Staff provided us with details of people who had allergies or required a specialist diet and/or soft foods such as fork mashable, pureed, diabetic and vegetarian. Meals were ordered from a catering service according to

people's special needs and there were a variety of snacks available on each unit for staff to provide to people if required. People's dietary likes and dislikes were recorded in their care files.

We saw that people's weights were monitored and action taken if they suffered weight loss, such as contacting their GP or a dietitian for advice. Food and fluid charts were implemented for those at risk of malnutrition or dehydration. However, we did note that not everyone had been weighed every month and some people had not been weighed for four months. We recommend that people are weighed at least monthly to ensure they are maintaining a healthy weight.

St Luke's provided a 'dementia friendly' environment in that the lighting was adequate but not too bright, walkways were free from trip hazards, toilets and bedrooms were clearly signed with pictures, and the home had several themed areas, such as cinema and pub, which were appropriately stimulating for people.

Requires Improvement

Is the service caring?

Our findings

People told us they were treated with dignity and respect and made positive comments about the staff. These included: "Yes, very happy with the carers"; "Oh yes, without a doubt." Relatives commented: "I think the staff are marvellous"; "Yes. My dad is very confused but they try to work out what he is saying. They speak and write things down for him"; "Staff on the unit are caring to both residents and their families, visitors are always welcome at any time and this helps the unit to have a home from home feeling"; "Dad smiles at the carers, so you can see he likes them and is settled here".

We asked people whether staff responded promptly when they called for assistance. People said: "Within a minute, they don't hang about. If they are short of staff, takes a bit longer"; "I have seen others pull the cord and staff went straight to them" ;"Did it yesterday, three of them came very quickly."

We asked if people had a choice about who provided them with personal care. One person told us "They tend to allocate the ones that I get on well with to me". Relatives told us: "My relative gets on better with one of the staff and they tend to allocate that person to look after him" and "Staff know who he likes. He likes the female carers to change him."

People could choose where they wished to spend their time. Some people chose to spend time in their rooms and to have their meals in their room.

We observed that interactions between staff and people who used the service conveyed warmth and respect. Although staff didn't appear to have time to sit for periods with people who used the service, they would greet them in passing and enquire as to their wellbeing. The staff we spoke with all expressed a clear desire to provide quality care to those at St Luke's. Staff also respected people's privacy by knocking on doors and calling out before they entered their bedroom or toilet areas.

We saw that one person was distressed and cried out at times, however staff did stop and spend a few minutes with them, speaking softly and holding their hand until they settled again. Another person started banging on the table and a support worker responded appropriately and sat with them for a while until they were settled.

We also observed laughter and friendly 'banter' between people and staff. We saw that people got on well with staff and that people's relatives and visitors were greeted in a friendly way.

Staff we spoke with had a good knowledge of people's individual needs.

We undertook a Short Observational Framework for Inspection (SOFI) observation. (SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.) We saw that staff were caring in their approach to people and their interactions with people who used the service were positive.

Although the staff were caring, the registered provider did not have a caring approach because they did not make sure that staff had the time, information and support they needed to provide care and support in a compassionate and person-centred way. For example, care plans and risk assessments were not kept up to date and staff had not had all the training they needed.

In the main reception area there was a range of information available for people and/or their representatives, which included information about the Alzheimer's Society and advocacy services.

Requires Improvement

Is the service responsive?

Our findings

People had a written care plan in place. We saw that people's plans covered a range of areas including: nutrition, personal hygiene and mobility. We found that people's plans were person centred. For example, we saw people's life stories were detailed. Understanding a person's life story can have a very positive benefit for people living with dementia. We saw that care plans included information on what a good day for that person included, how best to present information to the person and the best or worst times of the day for the person to be asked to make decisions.

However, on the first two days of our visit we found that some care plans we looked at lacked detailed instructions for staff on how to care for the person. For example, one person had an 'It's personal about me' care document completed on file which noted that they could become aggressive and hit out when other people invaded their personal space. The document advised that staff should divert the person and escort them to another area. A support worker told us that she was not trained in safe hold techniques to escort the person away from such situations, and the care plan did not instruct staff on how the person could be safely physically escorted away from causing harm to others. The person's risk assessment to address harm to and from other people who used the service advised staff to use distraction if the person approached others but there were no specific notes on what sort of distractions were likely to be successful, or what to do if distraction did not succeed. The person's care plans and risk assessments did not contain information about what signs the person may display prior to aggression towards others, and on face value the care plan appeared to suggest that they should be prevented from approaching all other people regardless of their intentions, potentially causing social isolation without clear risk assessment to support such an intervention. A support worker told us that this person displayed physical aggression towards staff upon physical interventions such as washing, dressing and continence care. They said that the person had a preference for some staff, and that as incidents were less likely when these staff undertook care, the care staff tried to ensure that they provided the care. This information was not included in the care plan. Neither care plans nor risk assessments suggested that senior staff had sufficiently evaluated information from incidents, or the circumstances where the person received care without resistance, and used the information to formulate care plans that responded to the person's individual needs.

Another person's care plan relating to their challenging behaviours had not been evaluated, amended or re-written since the start date of 28 May 2017, despite a significant number of known risks and events occurring on the unit. The care plan advised staff to 'maintain safety' yet gave no examples of triggers or observable cues that the person may be becoming hostile, nor did it include interventions specific to the person's needs. This person also had a care plan in place for personal care, which again did not contain specific instructions, and did not include information from a risk assessment that singing could help in distracting the person. That care plan had not been reviewed since 27 June 2017. We discussed one person's nutritional needs with a support worker, who explained that the person often refused food, particularly if they were in bed, and would not let staff feed him. The support worker said they made sure this person was up for meals, and that snacks such as finger foods were offered frequently. Although the person had a care plan in place for nutrition, this detailed information was not included.

Some care plans we reviewed seemed to be 'jumbled up' and information was not easy to find or follow.

The staff office in one of the units had a chart on display indicating when each person's care plan reviews were due. The chart indicated that no care plan reviews had been undertaken since June 2017. The files reviewed on this unit confirmed that monthly care plan reviews had not taken place since June 2017.

On the second two days of our visit we found that care plans were in the process of being reviewed and updated but some still lacked detail in relation to the management of behaviour that challenges the service, wound care and nutrition and hydration. The registered provider told us that a new care plan system was going to be implemented in the New Year.

These findings evidenced a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Good governance) because the registered provider had not ensured that there was an accurate, complete and contemporaneous record in respect of each person who used the service.

The home employed an activity coordinator and there was a varied programme of activities. These included chair based Tai Chi, cards, dominoes, arts and crafts, hand massages and manicures and reminiscence. External entertainers visited the home every month.

On the first day of the inspection a number of residents were seen to be enjoying a film in the cinema, which included an interval when they were served ice cream or popcorn. The home provided pub lunches in the pub themed area of the home, serving dishes such as pie and mash and scampi and chips. There was also a sweet shop that was open at certain times for people to go and purchase sweets.

Staff provided activities on an individual basis for people who did not wish to or were unable to attend group activities. These included sitting and chatting with people and playing board games or discussing the news in the papers.

Relatives were aware of the activities on offer. They told us, "There is a notice on the board, activities in the morning and afternoon, cinema, Tai chi, all sorts of things. They all get a choice as to what to do" and "They do have an activity board. My Dad is very shy and needs encouragement to join in and staff are trying hard to get him to join in".

Accessing the outdoors is an important aspect of maintaining people's wellbeing. One person we spoke with said they thought their relative should have more opportunities to go out. We observed over the two days of the inspection that people did not go into the garden, despite there being quite pleasant weather on the first day.

In the complaints folder there was a comprehensive complaints policy for staff and a one page guide for people who may wish to make a complaint. There was a laminated notice about making complaints in the foyer but the contact name was out of date. There was no information about how to make a complaint within the service user guide or displayed on the units.

We looked at the complaints file and saw that there were no complaints recorded for 2017. Complaints prior to that were well documented with details of the investigation and feedback to the complainant. We asked a regional manager and the director about any recent complaints and were told complaints were now handled centrally by the provider. We were shown three further complaints held electronically, but one didn't show how this was dealt with other than it was resolved. We asked the director about how complaints were reviewed and how learning and trends were identified, but he was unable to provide an answer and

accepted there was some work to be done in how complaints were handled.

Inadequate

Is the service well-led?

Our findings

The current manager had been registered to manage the service in December 2016 and had previously worked there as deputy manager. She was on leave at the time of the start of the inspection and had resigned by the end of the inspection.

On the first two days of the inspection we asked people what they thought of the manager. People who used the service and relatives commented: "She is nice"; "I have only have seen her two or three times"; "Yeah, she is approachable"; "I've only seen her once".

We also asked staff what they thought of the management of the service and views were mixed. Two people said "The manager is very nice and I feel supported". Other staff we spoke with said they felt unsupported. Domestic staff said they were upset because they felt there were not enough of them on duty each day to keep the home clean and odour free. Support workers all expressed concern about not having time to read care plans, staffing levels and inadequate leadership and supervision due to the number of agency nurses being used. Nurses also expressed concern about staffing levels and the impact this was having on maintaining up to date care plans. One nurse told us how they had recently been instructed to attend a safeguarding meeting relating to an event and resident whom they were not involved with. They said that no cover was provided on the unit during their absence, and they were under pressure to get back from the off-site meeting in order to administer evening medications on time. The nurse said that they were unsupported in preparation for the meeting, and felt uncomfortable being accountable for actions that they had not been involved with, but that management insisted that they went rather than a senior member of staff.

We asked to see evidence of staff meetings in 2017 and were shown an agenda for one meeting with registered nurses that had taken place in August. There was a record of five attendees but no minutes of the meeting.

We asked to see evidence of meetings with people who used the service and relatives. The director told us he believed some had taken place but could not provide any evidence of them.

We saw evidence that a survey of people who used the service and their relatives had been conducted but were not provided with evidence of any action taken as a result of the survey. We were told that a staff survey had taken place but were not provided with any evidence of this.

There was a system in place to carry out monthly clinical audits of unplanned hospital admissions, deaths, weight loss, pressure ulcers, bed management systems and infection control surveillance, but they had not been fully completed since March 2017 when the deputy manager left and were not completed at all for the previous two months.

Accidents and incidents were not analysed to identify any trends or actions that could be taken to prevent them occurring. Information such as accident/incident forms were not held within care files or on the units themselves. This was a barrier to nursing staff having the opportunity to reflect upon incidents and identify

patterns or triggers, therefore their potential to reduce the amount and severity of incidents was minimal. The centralisation of incident forms, and the lack of involvement of unit staff in reflection and learning from incidents, appeared to have removed those who had the greatest knowledge of people who used the service from the process. There was also lack of critical reflection on incidents at service level.

We asked to see audits the provider had carried out of the service. We were shown a file that contained the service's quality improvement plan. Members of the provider's Quality Excellence team had visited the service in April 2017 and provided the manager with an action plan for improvement. They had visited again in July and found that the required improvements had not been made. A regional manager had visited the service in the previous two months and had also provided the manager with an action plan for improvement, but no improvements had been made. The registered provider should have acted sooner to make sure that the required improvements were made.

On the second two days of the inspection staff morale was better. Staff told us that they felt they were being listened to and supported more.

We were told that the registered manager had resigned. A new manager was in post and had submitted application to register with CQC but was not a registered nurse. The registered provider informed us that they were currently interviewing for a clinical nurse lead. A permanent lead nurse had been appointed for each unit and regular agency staff were being used to maintain continuity. Regular staff meetings were being held and two meetings had been held with people who used the service and their relatives.

We saw evidence of the findings of the staff survey and service user/ relative survey but no action plans had been produced to address any shortfalls identified. Clinical audits had recommenced but accident/incidents were still not being analysed to identify any patterns or trends.

We viewed reports of further visits from the regional manager and quality excellence team with action plans produced but there were still many outstanding actions that hadn't been addressed. In the service visit reports carried out by the Quality Excellence Team we noted that the section entitled "Support Offered" was blank.

The registered provider showed us a new quality assurance programme they intended to introduce in the New Year to address the shortcomings of the current system.

These findings evidenced a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Good governance) because the registered provider had not ensured there was an effective system in place to regularly assess and monitor of the quality of the service provided.

On the first two days of the inspection we found that the provider and/or registered manager had failed to notify CQC of events they were required to notify us of by law. These included deaths, serious injuries and safeguarding incidents. We had not received notifications of any events since July 2016.

This is an offence because the registered provider failed to comply with Regulation 16 (Notification of death of a service user) and Regulation 18 (Notification of other incidents) of the Care Quality Commission (Registration) Regulations 2009 and will be dealt with separately by CQC.

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 12 HSCA RA Regulations 2014 Safe care and treatment Shortfalls in recording meant that we could not be sure that medicines were always given to people as prescribed by their doctor and risks to people's health and safety were inadequately assessed. The registered provider was not doing all that was necessary to reduce risk.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Not all those who lacked capacity to make decisions regarding their care had deprivation of Liberty Safeguards in place

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 Staff were not receiving sufficient training and supervision to enable them to carry out their duties effectively.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	The registered provider had not ensured that there was an accurate, complete and contemporaneous record in respect of each person who used the service and had not ensured there was an effective system in place to regularly assess and monitor of the quality of the service provided.

The enforcement action we took:

We issued the registered provider with a warning notice