KRG Care Homes Limited

Lound Hall

Inspection report

Jay Lane
Lound
Lowestoft
Suffolk
NR32 5LH

Tel: 01502732331

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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

Lound Hall is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Lound Hall is registered to provide nursing and personal care to a maximum of 43 older people, some of whom may be living with dementia. At the time of our visit there were 24 people using the service.

The inspection was unannounced and took place on 30 and 31 May and 5 June 2018.

At our previous inspection on 31 October and 1 November 2017, we identified shortfalls in the service which meant people did not always receive the care and support they required. We found that the service was in breach of regulations and needed to make improvements to staffing levels, the management of medicines, care planning, risk management, activities, the support people received to eat and drink, practices around the Mental Capacity Act 2005 (MCA) and the governance system in place. We rated the service Inadequate overall and asked them to provide us with an action plan stating how they would make improvements to the service.

At this inspection we identified continued failings which put people at risk of harm. The service continued to breach regulations and had not made all of the improvements they were required to make following the previous inspection.

The service had a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People were put at the risk of significant harm in the absence of clear records and assessments which reflected all current areas of risk and how these should be managed to protect the person from harm.

There were limited care plans available to guide staff on how to meet people's needs. Some people's care plans had been updated to a newer format. However the care plans for some, including those with identified risks, had not been updated. Staff did not always know information that senior staff told us about people.

The support people needed to reduce the risk of malnutrition was not always care planned or updates to care planning had not been made where their needs changed significantly. Food charts did not evidence that people were supported as far as possible to boost their nutritional intake with extra foods outside of structured meal times.

Clear action was not always taken where people had unexplained bruising that required investigation.

Whilst the provider had identified and taken action to reduce some environmental risks, other risks in the environment such as uncovered radiators and unsecured substances which may be harmful if ingested had not been identified by the service.

Whilst some improvements had been made to the cleanliness of the service, improvements were required to ensure that the service was consistently clean and free of unpleasant odours.

People had access to other healthcare professionals. Whilst some records were kept of the contact people had with health professionals, where advice was given this was not always transferred into care planning which meant it was unclear how staff could consistently follow this advice.

Medicines were not managed and administered safely. There were discrepancies in Medicine Administration Records (MAR) where it was unclear if medicines had been administered and some tablets remained in blister packs.

People were not supported by staff to have maximum choice and control of their lives. Some people had not had an assessment of their capacity. Care plans demonstrated a poor knowledge of the formal process of making a best interest decision and care plans did not always reflect where people had a power of attorney who should be involved in all decision making. Staff did not always support people to make decisions independently.

Whilst activities provision had improved with the addition of two new activities staff, people did not consistently have access to activities that were meaningful and engaging in line with their individual needs. The activities provision in the service required further development and structure and the activities team required further training to develop their knowledge. People who were nursed in bed or preferred to stay in their bedrooms had inconsistent access to engagement and activity.

People's care plans required further personalisation to ensure they were individualised. Care plans did not always reflect the views of the person or their relatives.

Whilst some areas of the service had benefitted from redecoration, improvements were required to the décor, adaption and design of the service to ensure it was suitably orientating for people living with dementia.

Improvements were required to the knowledge of the staff team. Staff we spoke with and observations of staff practice did not demonstrate a good knowledge of subjects they had received training in, such as nutrition, MCA and Medicines.

On 31 October and 1 November 2017 we rated the service inadequate following the identification of significant widespread shortfalls which meant people did not always receive the care they required to protect them from harm. The report resulting from the inspection made clear the areas of particular concern. Despite this, timely enough improvements had not been made in some areas identified at the previous inspection. For example, clear care plans had not been implemented for people at risk of choking.

There was a failure of the management team to ensure that systems in place to monitor the quality of the service were effective in identifying continuing shortfalls and areas for improvement. Improvements, particularly around risk management and care planning, had not been made in a timely way. The management team had not prioritised the updating of care plans for people who had been identified as at risk. This meant people had been placed at continual risk of receiving poor care.

Progress had been made in improving the culture in the service. We observed staff were caring and kind. However, they were still failing to identify the poor practice of themselves and others.

The registered manager and provider were honest, open and transparent with people and their relatives about improvements that needed to be made. People and their relatives told us they felt more listened to and were more positive that issues they raised would be taken seriously. Regular meetings had been organised where people had the opportunity to feedback their views.

The staffing level in the service had been much improved, with a new structure in place to ensure staff had set responsibilities. A review of call bell records demonstrated that response times were much more prompt. People and their relatives told us they were happy with the staffing level and that staff were prompt when support was requested.

The overall rating for this service is 'Inadequate' and the service therefore is 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.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Improvements were still required to ensure appropriate risk management strategies were in place to minimise the risk of people coming to harm.

Medicines were still not consistently administered safely.

Improvements were required to ensure that the service was consistently clean and free from unpleasant odours.

There were enough staff to meet people's needs.

Is the service effective?

Inadequate

The service was not effective.

Improvements were required to ensure that people's capacity to make decisions was appropriately assessed and that staff acted in accordance with the Mental Capacity Act 2005 (MCA)

The support people required with eating and drinking was not always clearly care planned. Records did not evidence that people always received appropriate support to reduce the risk of malnutrition or dehydration.

Improvements were required to develop the knowledge and skills of the staff team.

People had access to other healthcare professionals. However, improvements were required to ensure that clear records of contact were kept and that advice was transferred into care planning.

Is the service caring?

Requires Improvement

The service was not consistently caring.

We observed staff were intuitively caring and kind towards people. However, they were failing to identify the poor practice of themselves and others and take action to improve.

Staff did not always identify issues which may compromise the dignity and respect of people using the service.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Care records did not always reflect the views of people and their relatives.

Care records required personalisation to ensure they reflected people's preferences, hobbies, interests and personal history.

Improvements were required to ensure activities provided were engaging, individualised and meaningful.

Complaints were recorded and investigated. However, written outcomes were not always provided to complainants.

Is the service well-led?

Inadequate

The service was not well-led.

Whilst some improvements had been made, those that required prioritising had not been completed in a timely manner.

The governance system in place did not always identify shortfalls that continued in the service.

Risk management oversight systems did not always contain accurate information about people's needs and were not used to prioritise tasks.

Progress was being made in improving the culture in the service. Communication between the service, people and relatives was improved.

The registered manager and provider were transparent and open about the improvements that needed to be made.

Lound Hall

Detailed findings

Background to this inspection

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

This inspection took place on 30 and 31 May 2018 and 5 June 2018 and was unannounced. The inspection was carried out by two inspectors, a medicines inspector, an Expert by Experience and a specialist advisor in nursing care. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we examined previous inspection reports and notifications we had received. A notification is information about important events which the service is required to tell us about by law.

We spoke with six people who used the service, three relatives, four members of care staff, two nursing staff, the registered manager, nominated individual and clinical lead. We looked at the care records for 12 people, including their care plans and risk assessments. We looked at medicine administration records, minutes of meetings and documents relating to the quality monitoring of the service. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

Inadequate

Is the service safe?

Our findings

In October 2017 we received information of concern which prompted an urgent unannounced comprehensive inspection which took place on 31 October and 1 November 2017. At that inspection we identified widespread, significant failings which put people at risk of harm. We were so concerned that we took urgent action to stop the service admitting anyone else. The service was rated inadequate overall and placed into special measures.

In January 2018 we received further information of concern which prompted an urgent unannounced focused inspection which took place on 8 January 2018. At this visit we found that little progress had been made and people remained at significant risk of harm.

At this inspection in May and June 2018 we found that the service has failed to make all of the necessary improvements to ensure people are consistently protected from the risk of harm.

Risk management processes and procedures were ineffective in identifying all the risks to people using the service. The service had implemented a risk tracker following our previous inspection. However, we noted that this risk tracker stated two people who had current pressure ulcers were not at risk of pressure ulcers. This meant we were not reassured this risk tracker accurately reflected the risks to people. The management team told us, following our last inspection, that all care records would be rewritten to a new, more detailed format. Shortly before this inspection the management team told us they were now planning to implement electronic care planning systems. However, the management team had not used this risk tracker or any other records to identify those whose care plans needed to be prioritised. For example, one person who had a very low weight and was at risk of malnutrition still had an old care plan in place which did not reflect their current needs.

Improved care plans had been implemented for two people at risk of pressure ulcers. However, other care plans conflicted with the information in pressure ulcer care planning which could cause confusion. For example, one person's night time care plan stated they required repositioning four hourly but their pressure ulcer care plan stated they required repositioning two hourly day and night. Some care plans did not reflect information which was included elsewhere in care records. For example, a record from April 2018 stated one person now required pressure relieving boots as soon as possible but there was no update in the care plan with regard to whether these had been obtained and if they were in use. This meant that there was the potential that staff may not know of this person's needs and therefore be unable to provide them with adequate care.

We reviewed the repositioning records for three people and found that these did not demonstrate that these people had been repositioned at the required frequency. There was confusion over where these repositions should be recorded, with staff using three different forms interchangeably to record repositioning. Where people's care plans stated they needed to be repositioned whilst sitting in their chair, repositioning was not recorded in these instances. Two staff members told us people didn't need repositioning when they were out of bed. This meant we were concerned people may not be repositioned frequently enough to protect

them from the risk of skin breakdown. Where people had current pressure ulcers, a record was in place to record wound care interventions. However, we found that whist staff recorded when they changed the dressings on pressure ulcers; they did not record the state of the wound so there was no timeline as to whether it was healing or deteriorating further. We raised this with the registered manager who told us that they would have expected more to be recorded. They had not, however, identified this lack of recording independently.

Where people were prescribed creams to improve the condition of their skin, these were not consistently applied. We reviewed the cream charts for four people and found that recording of cream application was sporadic and it was unclear if people had received their creams in line with the instructions of the prescriber. One person who was meant to have a cream applied daily told us this didn't always happen and the records confirmed that this person had only had six applications in the last 21 days. For another person, records indicated that a cream that was meant to be applied a minimum of twice a day, had not been applied for the last 21 days. Another person told us that staff sometimes remembered to apply their creams but they often had to remind staff if their skin got itchy. For another person the only record of a prescribed cream being applied was 11 May 2018. We queried this and staff could not provide any evidence to suggest this cream had been in use as there was none present in the person's bedroom. Later in the visit a tube of the cream was located but no further evidence could be provided to demonstrate staff had been applying it.

In November 2017 we highlighted to the service that they were not identifying people at risk of choking and ensuring management plans were in place to minimise these risks. At this inspection we found that there remained inadequate procedures to manage and minimise the risk of people choking. A choking assessment had been implemented, however, several of the assessments we reviewed did not reflect people's medical history or risk of choking accurately. Where a risk was identified, no actions were specified to reduce the risk and a care plan was not implemented to instruct staff on how to reduce the risk.

We asked the clinical lead which people were at risk of choking. They told us the names of two people. The clinical lead told us one of these people was on a pureed diet but requested to be able to eat normal foods. They told us that the person was now able to eat softer foods such as sandwiches but no hard meats and that the person needed to be supervised at all times when eating. There was no choking care plan in place for this person which included this information. This information was also not included in their nutrition care plan. We spoke with an agency nurse about who was at risk of choking and they told us this person was not at risk of choking and did not require supervision when eating. Due to the lack of care planning and the use of agency staff we were concerned that this person may not consistently receive supervision when eating and could be at risk of choking. We reviewed the records for the other person the clinical lead told us was at risk of choking. A note in their care records stated that a healthcare professional had carried out a swallowing assessment and observed that they could tolerate soft foods but presented with coughing when eating food with lumps. We looked at the choking assessment for this person and saw that this incorrectly stated they had never had an episode of coughing when eating. There was no care plan in place for this person to instruct staff on how to minimise the risk of them choking.

The agency nurse we spoke with told us of three further people who were at risk of choking and required supervision to eat. These people had not been identified to us by the clinical lead previously. We reviewed the care records of one of these people and found that they had a swallowing assessment earlier that month. The assessor was unable to fully assess their swallow because they were drowsy, but advised that pureed food was the safest option. There was no choking care plan in place for this person and their choking assessment stated they were not at risk of choking. The person's nutrition care plan did not state they required pureed food. Records of food intake evidenced that the person had been receiving solid foods. We queried this with the registered manager who told us that they had not received an official letter following

the swallowing assessment, but accepted that the advice given was to commence pureed food. Whilst the registered manager stated the person had been tolerating solid foods since the swallowing assessment, we were concerned that the advice given by qualified specialists had not been followed until another swallowing assessment could be carried out.

Where investigations had been carried out, these investigations made assumptions about the way people obtained injuries. It was not always clear what actions had been taken where incidents occurred which were potentially avoidable. One incident record stated someone had received bruising after their head was knocked on a wall whilst being moved by staff. Records did not demonstrate action had not been taken to investigate whether potential shortfalls in staff practice may have led to these incidents and the registered manager did not produce any further evidence to this effect when we queried this. Another incident form stated that one person had bruising to their arms and stated staff were 'reminded to be gentle' but no other investigation and outcomes could be provided.

Some risks in the environment had been addressed, for example the addition of a new fire system and carrying a risk assessment out for risks relating to the stairs and fitting safety gates, however, some risks had not been identified and addressed. For example, there were radiators and hot water pipes throughout the service which were not covered. One person's bed was pushed up against the radiator which presented the risk of scalding. Additionally, there were two portable heaters in the dining room which did not have protective covers. We tested a sample of hot water taps and found that some reached scalding temperatures and did not have a thermostatic control. The service had not assessed the risk associated with uncovered pipes and radiators and therefore there were no strategies in place to manage the risks.

Some substances that may be harmful if ingested were not stored securely in the service. For example, in many rooms there were prescription creams, mouthwashes and denture cleansing tablets which were not locked away. These substances can pose a risk to people living with dementia who could mistakenly ingest these. Following our visit, the management team told us that in their view there was no one at risk of ingesting potentially harmful substances. However, there was no formal risk assessment to evidence this.

Whilst the service appeared clean in most areas, some carpets remained soiled and in need of cleaning or replacement. There was a strong unpleasant odour in one person's bedroom throughout our three visits and action had not been taken to resolve this until we raised it as an issue with the registered manager. This presented a potential infection control risk as well as compromising this person's dignity and respect. At the conclusion of our visit the registered manager told us they were going to replace the carpet in this room with an alternative flooring which would be easier to clean. This was confirmed by the person's relative who was happy with this outcome. Some equipment such as slings and medical observation equipment appeared dirty and required cleaning to ensure the risk of the spread of infection was reduced.

The service had a maintenance person who carried out repairs and performed regular checks to ensure the environment was safe. These included flushes of the water system to reduce the risk of legionella. Other checks were carried out on the safety of equipment such as wheelchairs and to ensure the fire detection systems were in working order. However, where issues were identified it was not clear whether these actions had been completed as there were no records of them being signed off. For example, following a Legionella inspection by an external company in March 2018 there were a number of actions the service was recommended to take. Whilst we were assured all actions had been completed, no records to this effect could be provided and the actions had not been signed off on the action plan. A record of checks on water temperatures stated that the maintenance person had identified one thermostatic valve was not working and had been leaking since 16 April 2018. This was identified at every subsequent weekly check but had not yet been fixed at the time of our visit. Records stated that as a result of this the maintenance person was

unable to perform a flush of this water pipe to reduce the risk of presence of legionella bacteria. We were told that at present this sink was not in use and that they had requested an engineer to fix the tap. Another record made by the maintenance person stated the fire doors on the top floor didn't meet safety requirements. Whilst we were reassured action had been taken to make this safe, no records were kept of when this work was completed.

At our previous inspection medicines were not managed and administered safely. On this visit although compliance had improved, people were still not always receiving their medicines as prescribed.

Administration of medicines was recorded on medicines administration record (MAR) charts which were provided by the pharmacy. During our inspection we looked at 16 people's MAR charts and found that there were 13 gaps in the records. Some medicines were still in the blister pack which indicated that they had not been administered. These included antiviral medicines, medicines for blood pressure, gout and depression, eye drops, medicines to protect the stomach and an antipsychotic. Whilst the service had identified one occasion where medicines were not administered correctly and taken action, they had not identified the other instances we found.

Handwritten additions or changes to the MAR charts had not always been signed and checked by a second member of staff. The homes policy stated that all handwritten MAR entries and amendments should be double signed in full by two staff. Variable doses were not always recorded on the MAR chart, therefore the actual does of medicines given to people was not identified. Medicines information held within the care plans did not always reflect current MAR charts.

People who were receiving their medicines covertly had not always been assessed by a multidisciplinary team and involved a person lawfully able to consent on behalf of the person. Covert medicine administration involves hiding the medicine in food or drink. In one case there was no evidence of a best interests meeting taking place but instructions stored with the MAR chart told nurses that they could administer covertly if needed. Lists of medicines being administered covertly were not up to date. Tablet crushers used to administer these medicines had not been washed recently and contained powder residue which could potentially cause harm if reused for someone with allergies to certain medicines.

When people need end of life care they sometimes require subcutaneous injections to manage symptoms. In one case the dose of analgesic had been incorrectly written on the MAR chart at four times the dose required. Administration had not been necessary but the records had the potential to overdose the person should the analgesic be required.

Homely remedies were available and this allowed staff to respond quickly to minor ailments such as a headache, cough or sore throat. However a duplicate entry had been made on the MAR chart for the administration of paracetamol and this led to duplicate administration or recording in one case.

In some cases, protocols for the administration of 'as required' medicines were not available. These protocols provide guidance to staff as to when it is appropriate to administer medicines that are not required regularly. Protocols to help staff know when to give medicines used to control agitation, analgesics, laxatives and inhalers were missing.

One person required insulin to manage their diabetes, they were having their blood glucose monitored three times a day. Blood glucose readings were consistently high but we could not find details in the care plan to instruct staff caring for this person what to do about high readings or when to inform the GP.

There were records for medicines being applied topically such as creams and ointments in people's bedrooms. Administration records were not always clear about which creams to apply where and how often. Records of application had not always been completed.

The service had reported some medicine incidents within the last six months. Audits were being performed monthly but issues that we found on inspection had not been picked up.

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

The systems in place to safeguard people from abuse were still not robust, thorough and questioning enough. The registered manager told us about the process in place when a person using the service was found to have unexplained bruising. This process included the completion of an incident form which could then be reviewed and an investigation carried out to try and determine the cause of the bruise. Whilst reviewing care records, we noted one instance where staff had recorded unexplained bruising one person's care records but not completed an incident form. The registered manager was not aware of this instance and therefore they had not been investigated to ascertain possible causes. The registered manager had made some safeguarding referrals for incidents that occurred in the service but this omission evidenced that the system in place was not robust and incidents were not always being correctly recorded and followed up

Despite what we had found during our inspection, people told us they felt safe living in the service and that staff helped them to feel safe. One person told us, "I do feel safe here and I have no worries." Another person said, "I do feel safe here. They are very good at making sure everything is just right for me." A relative commented, "I do think he my [family member] is safe here. There are now enough observations to keep a check on [them]."

People told us there were enough staff to meet their needs and that there had been improvements in the staffing level. One person told us, "I think there are enough staff as they respond pretty well when I press the buzzer." Another person said, "If I need anything now and then I just need to press my buzzer and they will come." A relative of one person commented, "They are very good at coming to help [person] if [person] presses [their] buzzer." This confirmed our observations that staff were prompt when people requested support. Following the previous inspection, the management team had restructured the way the service was staffed and split staff between two different sections of the building. The staff were better organised as a result and had clear responsibilities to certain people. We reviewed call bell records for May 2018 and found that the response times when people rang for assistance were significantly improved. Whilst the service was still trying to recruit more permanent staff, they had been able to fully staff the service consistently according to the needs of people using the service. This included with the use of agency staff where required. The service had implemented a new management rota to ensure more effective management cover outside of office hours.

Inadequate

Is the service effective?

Our findings

At our last inspection on 31 October and 1 November 2017, we rated the service 'inadequate' in this key question. The service was required to make improvements to the monitoring of people's nutritional needs and to ensure compliance with the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). At this inspection, we found that the service remains 'inadequate' in this area and has failed to make the necessary improvements to comply with regulations.

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

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

Some people had their capacity to make decisions assessed. However, records were confusing around whether people had capacity to make certain decisions. Some care plans stated people had capacity to consent, but others stated they did not have capacity to make decisions. Care plans were not focused around supporting people to make decisions according to their abilities. For example, one person's care plans stated they could not verbally communicate so would require staff to make decisions in their best interests. The care plans did not evidence that the service had explored whether the person could make decisions or imply consent in other ways, such as by facial expression or with gestures. There was a lack of understanding about the formal and lawful process around making best interests decisions for people who lacked capacity. Care records stated staff should make decisions in people's best interests but no further information was available to guide staff on the process of making lawful decisions. One person had a next of kin who had power of attorney over health and finance, but this relative was not referred to in care records and there was no information about how they should be involved in decisions about the care of their relative. A power of attorney is a nominated person who is legally authorised to make decisions in the best interests of someone. We saw in some people's records that decisions had been made, such as a decision to install bed rails or equipment such as pressure mats, but there was no evidence that these were discussed with relatives or other professionals involved in the person's care or made in the best interest of the person.

We observed that staff did not consistently support people to make day to day decisions. For example, we observed one person was brought a meal which they refused and said was horrible. Staff removed the meal and brought something else without asking the person what they would like to eat. We observed another member of staff moving one person in a wheelchair without first asking their consent or telling them what was happening or where they were going.

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

The service had not made the necessary improvements to how people's nutritional needs were monitored and how the service ensured people were supported as much as possible to reduce the risk of malnutrition and dehydration.

One person had lost 4.2kg since December 2017 which accounted for 8% of their body weight. Their nutrition care plan had not been updated since their loss in weight and stated that the person could eat and drink independently. However, a note had been made on the back of the care plan in the review section which stated the person required prompting and supervision at meal times. This information had not been transferred into their care plan so this was not an accurate reflection of the person's current needs. Additionally, a tissue viability care plan for the person stated they required a diet high in protein because they had a current pressure ulcer. This increased dietary need was not documented in the person's nutrition care plan.

We reviewed the records of food intake for this person for the two weeks prior to our visit. These did not evidence that the person was offered regular nutritious snacks between meals to boost their intake or that snacks were supportive of a high protein intake. We spoke with the cook who told us there was no one in particular who staff were required to offer extra snacks to. Care staff told us they did not offer this person regular snacks in between meals but stated that the hospitality staff would offer the person a biscuit when the tea trolley was brought round. Daily records we reviewed showed that the person usually had their breakfast between 8am and 9am and was brought their lunch between 1pm and 2pm. There was no record of additional foods offered in between and we were concerned that there was such a gap between meals for someone who had been losing weight. The notes recorded for one day stated the person had their breakfast at around 9am and that at around 1pm they told staff they were hungry. We were concerned that staff were missing opportunities to support this person to eat more.

We reviewed the records of one person who had a BMI of 13. A BMI under 18.5 is considered clinically underweight. A letter from a dietician dated March 2018 stated they had been prescribed an additional supplement because they had lost 8% of their body weight since they were previously seen by the dietician in December 2017. Their nutrition care plan had not been updated to reflect this. There were no specific instructions for staff on how to support this person to reach and maintain a healthy weight. No food preferences were recorded, which meant staff may not know what foods the person may be more inclined to eat. Their care plan stated they should not be given any foods which flared up Diverticulitis, a condition affecting the bowels, but did not state the foods which the person needed to avoid. The daily food records for this person did not evidence that they were offered extra foods in between meals to boost their intake and support an increase in their weight. This meant we were not reassured that the service was doing everything practicably possible to protect this person from the risks associated with malnutrition.

We reviewed the records of one person who had lost 4.4kg in a month. Their care plan had not been updated to reflect their recent weight loss and the actions that staff needed to take in order to support them to reduce the risk of further weight loss. It was unclear how the service would promptly identify further weight loss so action could be taken. Their food charts did not evidence any extra intake outside of structured meal times.

Whilst we did observe that there were snack bowls available in communal area's and saw staff offering these to people in communal areas, we did not see this being extended to people who preferred to stay in their bedrooms and could not verbally request these.

The care plans for some people stated they should have a certain amount of fluids per day. We reviewed the fluid charts for four people whose care plans stated they should have a specific amount of fluids per day.

These did not evidence that these people were offered sufficient fluids to meet this target. We observed that a number of people had jugs of fluids on tables in their bedrooms. However, for some people these were placed out of reach so they could not access these independently.

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

The service had reassessed the needs of some people using the service to ensure they had accurate information about their requirements. However, the clinical lead told us they thought there were a further 10 people who had not yet had their needs reassessed to ensure the care they were provided with was effective and appropriate. Some of the updated care plans we reviewed still did not reflect evidence based best practice guidance which is publicly available. This meant that the author of these care plans was not guided towards including sufficient information to ensure staff could provide people with effective care that met their needs.

Whilst we could see some records to indicate that referrals had been made to other professionals to gain expert advice, the records kept of the advice received were poor. There was no robust system in place for recording the communications between other health professionals and the service. The clinical lead told us information about contact people had with external healthcare professionals and advice they gave. However, this was not recorded anywhere or reflected in care planning. This meant that there was a risk that expert advice would not be followed and care delivered to people may not be effective in meeting their needs.

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

Observations of staff practice and discussions we had with staff demonstrated that some staff could benefit from further training and development. One member of staff had started working for the service a month prior to our visit and had completed an induction. However, when we asked this member of staff if they knew about safeguarding they were unsure what we meant by this and their comments did not reflect an understanding of safeguarding people from abuse. The training matrix provided to us showed that the majority of staff were up to date with training in MCA. However, observations of staff practice did not always demonstrate that they fully understood and acted in accordance with the MCA. Staff had not received training in subjects specific to the needs of people they cared for. For example, several people had Diabetes and Parkinson's disease but staff had not received training in these areas. In addition, staff had not received training in supporting people with behaviour that challenged them. We observed that some staff did not show an understanding of the support one person required and they became distressed as a result. Despite identifying issues in staff practice around pressure care, record keeping, nutrition and hydration at the last inspection, most staff had not completed training in these subjects.

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

Whilst the records of staff supervision were not available for us to review, staff told us they had regular supervision with their line manager. They told us they felt better supported by the new management team and felt able to raise concerns with them or ask for assistance if needed.

Whilst some areas of the service had been redecorated since our previous inspection, the service had not considered and utilised best practice guidance around the decoration and adaption of care services. For

example, they had not considered how the way the service was decorated could support people living with dementia to find their way around better or navigate to key areas such as the toilet or their bedroom. We recommend the service refers to best practice guidance around the adaption and decoration of care homes for people living with dementia.

Whilst we found evidence of the breaches above, we did find some areas of good practice.

People told us the food was good quality and they had a choice of meals. One person said, "The food is very good and if I don't fancy what is on the menu for the day then they will make me something I do like." Another person told us, "The food is really lovely here and when they have different themes they are good. We had a Mexican theme last week, it was excellent." One other person commented, "The food is very good and I can't complain. There is always a good choice and they will make something for you if you don't want what is on offer." A relative told us, "My [relative] thinks the food is very good and [relative] does enjoy [their] mealtimes. The choice is much better now and they have theme days." We spoke with the cook who had a good knowledge of food safety procedures and had knowledge of preparing foods to different consistencies for people who could not tolerate solid foods. They also demonstrated a good knowledge of how to fortify foods to increase their nutritional value. People's allergies and intolerances were displayed on a board in the kitchen. One person said, "I am on a soft diet and they prepare [it] well." The last inspection carried out by the Food Standards Agency awarded the service 5 out of 5 in their food safety and hygiene procedures.

We observed that people were provided with the practical support they required to eat their meals and that this was provided in a dignified manner. Special equipment was provided to enable people to eat independently where appropriate.

Following our visit, we were provided with a copy of a completed dining experience audit. This demonstrated that the management team were monitoring people's experience at meal times. A further more comprehensive dining observational tool had been developed.

People told us they could have access to external healthcare professionals such as doctors and chiropodists when they required it. One person said, "I can see the doctor if I need to and I have recently had my nails cut by the chiropodist." Another person told us, "We get weekly visits form the doctor, so if I need to see them I just have to tell the manager." One other person commented, "I can see the doctor when I need one. I also see the chiropodist when my feet need doing. I went to the dentist about three months ago." A relative said, "[Relative] has good access to the doctor who comes each week, so if there is anything we are concerned about they can start to sort it out."

Requires Improvement

Is the service caring?

Our findings

At our last inspection the service was rated requires improvement in 'Caring'. At this inspection the service remains requires improvement in this key question.

We identified widespread failings in the service provided to people which meant that people did not always receive the care and support they required to uphold their health, dignity, safety and welfare.

These failings were identified at the last inspection on 31 October and 1 November 2017 but sufficient action had not been taken to ensure that people consistently received safe, effective care. The management team had failed to independently identify that some of these failures continued and take action to improve the quality of the care people received. This meant that the provider and management team had failed to fully embed a culture focused around good practice.

Whilst we observed that staff were kind to people, they were failing to identify and address the poor practice of themselves and other staff members. This meant people were put at risk of harm and received care that did not always meet their needs.

Staff and the management team failed to identify instances where people's dignity could be compromised. For example, staff and the management team had not ensured prompt action was taken to reduce an unpleasant odour in one person's bedroom. This compromised their dignity and respect but the management team had not fully explored the reasons for this odour and action was not taken to rectify the situation until we requested this. On the day of one of our inspection visits, staff from the local authority identified that one person appeared unkempt and had dirty nails which required staff attention. Staff had not identified this and the person's daily records did not make clear what personal care the person had received and when. Following our inspection visits, a staff member from the local authority raised further concerns about an instance where a person's dignity could be compromised. They stated one person rang for support with their continence needs and a carer said they would come back as they were supporting someone else. The person told staff from the local authority that they had been waiting a long time to have their needs met. The member of staff from the local authority went back later and found the person had still not been supported with their continence needs and they were visibly upset. They stated that the person's records did not make clear when they were last supported with their continence. This compromised the person's dignity, respect and emotional health.

A relative for one person stated that despite raising it with staff and the registered manager, there continued to be inconsistency as to whether their relative received necessary personal care. They said, "We have had to complain a few times about things related to [relatives] tooth care and hearing aid. It's been a bit stop start with this. There has been no consistency with all the staff." They told us that they had found that their relative had not always had their dentures removed at night and had been found lying on these on one occasion.

Staff were not always mindful of supporting elderly frail people to maintain a comfortable body

temperature. We observed one member of staff open a window in a communal area saying it was hot. One person said they were cold so the staff member closed the window and said to the person that it is hot and they had their blanket. The staff member then proceeded to open another window in the room.

We found that care records were not always updated where people had significant life events whilst living in the service. We were told that the relative of one person had passed away and this had a big impact on the person. Their care records still referred to this relative throughout and had not been updated to reflect that they had passed away. The service was using agency staff and recruiting new staff at the time of our visit so we were concerned this person's emotional wellbeing could be compromised by staff not knowing of their recent bereavement.

People's care records did not always set out the tasks people could complete independently. For example, the parts of their personal care routine they could complete themselves and the parts they required staff to support them with. This information could reduce the risk of staff over supporting people and limiting their independence.

This was a continuing breach of Regulation 10: Dignity and Respect of the Health and Social Care Act 2010 (Regulated Activities) Regulations 2014.

Despite the concerns we identified at this inspection, people told us they felt the care they received had improved and that the staff were caring. One person said, "I think the staff here are caring. There are always there for me when I need anything which means I feel safe." One other person commented, "The girls here are very caring. They always put you first and they are all so polite." One relative told us, "The care is much better than it was in the past. Staff are more attentive and always smile around the place which can lift the mood of the residents."

Requires Improvement

Is the service responsive?

Our findings

At our last inspection the service was rated inadequate in 'Responsive'. At this inspection the service is rated requires improvement in this key question.

At our inspections in January and November 2017 we identified that improvements were required to ensure people received personalised care, had access to appropriate sources of meaningful activity and were protected from the risks of social isolation. At this inspection whilst we found that the service had made some improvements, further improvements were needed.

Widespread shortfalls throughout the service meant that people did not always receive personalised care that met their individual needs.

Whilst some care records had been updated and were more personalised, these still required development and did not reflect all of people's preferences, likes and dislikes. Some of these care plans did not uphold people's respect, as they referred to people by the wrong name or the wrong gender. Some of these newer care plans contained generic statements rather than being completely personalised to the individual. Many care records had not yet been updated in the six months between our inspections. These care plans remained generic and did not reflect people's current needs. Information people told us about themselves was not documented in their care records. We observed one person being provided with a meal which included liver that they said they disliked, but this was not recorded in their care records to ensure that they were provided with alternatives according to their taste. Not all staff had knowledge of people on an individual basis and the service had recently recruited new staff. The service was also using agency staff on a regular basis to cover some shifts. One member of agency staff present on the day of our visit was new and spent time reviewing care plans. However, these care plans did not contain sufficient information which meant they would be unable to provide people with personalised care according to their individual preferences. One member of staff told us about a specific way one person needed to have their personal care delivered in order to reduce their anxiety levels. Despite the fact their care plan had been updated to the new format, this information was not documented in their care records which meant that the service could not guarantee continuity of care.

Where people were living with dementia, there remained limited information about their life history. Some life history documents had been implemented, but these remained blank for many of the people whose records we reviewed. Some people were unable to verbally communicate or may not recall this information themselves. This information would help staff to better understand the person and respond to their needs more effectively.

Where people were unable to verbally communicate there was limited information about the other ways they may express their thoughts and feelings. For example, one of the care records we reviewed stated the person communicated with facial expressions. However, it did not state what facial expressions and what these may mean. This could result in people not receiving support they required to relieve their distress. Where people were unable to verbally consent to care and treatment, the service had not explored the other

ways they could imply consent and ensured this was documented. One person in particular was receiving one to one care which we were told was being mainly covered by agency staff. In their care records staff were guided to use their knowledge of the person to provide the care they required, however, the agency worker providing one to one care told us it was their first day working in the service. They had been provided with the person's care plan to read to understand their needs.

The service had recently employed two members of activity staff who were supporting some people with activities throughout our visits. This was an improvement on our previous inspection; however, the provision of activities still required significant development. One member of activities staff was on their own during the first two of our visits and said this was their first job as an activities coordinator. They had not received any training or development to guide them in what activities would be meaningful and engaging for people. However, we were told after the visit that training had been booked for July 2018. Whilst they were very friendly and people responded to them well, it was clear from our observations that they were unsure of what to do with people. The owner of Lound Hall also owns another care home which provides good meaningful activities for people. We asked the general services manager whether or not they had arranged for the new activities staff to go and share ideas and experiences with the staff at the other care home. We were told this had not yet been arranged which meant they were missing an opportunity to share expertise across the company and further develop their activities team. The general services manager told us that the staff would be receiving training from Suffolk County Councils Provider Support Team in June 2018. However, Suffolk County Council does not provide formal training and there was no timescale for obtaining formal training for the activities staff. We observed that the activities staff did not always demonstrate an understanding of ensuring people did not become overwhelmed or overstimulated. For example, we observed the activities staff singing to one person in their bedroom but the television remained on with the sound turned up very loud.

We observed that there was an activities board in a communal area which advertised the activities on offer each day. We saw that the activities advertised for that day were not taking place. The activities on offer lacked structure and organisation. We saw that activities were often short lived, even where people were visibly enjoying themselves. For example, on one of our visits the activities staff were singing songs with people. People were very engaged in this activity and visibly enjoyed it, but the activity ended after three songs and the staff left the area and went outside. After we raised this with the management team the coordinators went back to continue this activity further. We spoke with one activities coordinator about the budget they had for activities provision. They told us they did not have a budget and were looking into free entertainment as they were unable to have paid entertainers. They told us that at present there were no planned trips to give people the opportunity to visit the community. One person told us, "I don't get many trips out; in fact I can't remember the last one."

We observed that there was no availability of activities around the service that people could access independently. For example, we did not see books or other sources of entertainment in communal areas of the service. During our visits, we noted that most people had televisions on in their bedrooms but that these were all on the same channel. Some of these people were unable to independently change the channel themselves and this did not demonstrate that thought was given to individual's personal interests. This meant we were not assured that people consistently had appropriate access to sources of meaningful entertainment within the service.

Whilst adequate end of life care plans had been implemented for some people, most people did not yet have one in place. NICE guidelines state that end of life care planning should be implemented when a person is believed to be in the last year of their life. We were told one person had been placed on end of life care and prescribed anticipatory medicines. Anticipatory medicines are provided to care homes to ensure

that medicines to make people comfortable at the end of their life can be administered without delay. This person's condition had improved but there was no adequate end of life care plan in place in case their health deteriorated again. Their care plan was generic, not personalised and didn't contain up to date information regarding their current condition and that they had been prescribed anticipatory medicines. An appropriate end of life care plan would reflect things such as where a person wanted to be cared for at the end of their life, preferences such as to who they might like present and if they wanted music playing. The care plan should also take into account all of the complex needs the person may need fulfilled by staff to keep them comfortable and pain free. The absence of appropriate care planning meant that the service was not ensuring that people's wishes in coming to the end of their life were planned for and that there were plans in place around how people should be supported to be dignified, comfortable and pain free.

Whilst some people and their relatives said they had recently been asked to participate in updating their care plans, most people said they had not been consulted about their care planning since their admission to the service. One relative said, "We had a review of my relatives care some time ago, but I can't remember the detail." Most people told us that relatives had planned their care before they arrived and did not speak of involvement in their own care planning. One person said, "My family did all the planning of my care here." Care plans we reviewed still did not reflect people's views on their care and personal preferences. This meant we were not reassured that staff could consistently provide people with person centred care.

This was a continuing breach of Regulation 9: Person centred care of the Health and Social Care Act 2010 (Regulated Activities) Regulations 2014

Records demonstrated that complaints were recorded and investigated. However, the service did not write to complainants with the outcome of their complaint or an apology. The registered manager told us they communicated this verbally with complainants but records did not demonstrate this. One relative told us that they had made several complaints about a particular issue around personal care but that these issues sometimes still continued. However, we spoke with one relative who had made a complaint at a relatives meeting. They told us that whilst they did not receive a written response from the registered manager, the issue had been resolved to their satisfaction and they were happy with the outcome. The provider told us after the visit that they had re-issued the complaints policy to residents and relatives in May 2018. They had also held regular relatives and resident's meetings where people were encouraged to share their views with the provider and senior management team. The service is no longer in breach of the regulation regarding complaints.

Inadequate

Is the service well-led?

Our findings

At our last inspection the service was rated inadequate in 'Well Led'. At this inspection the service remains inadequate in this key question.

On 25 and 30 January 2017 we identified shortfalls in the service which meant people were not consistently provided with safe, effective care which met their needs. The service was rated requires improvement overall. We found the service was in breach of Regulations 9, 12, 17 and 18 of the Health and Social Care Act 2010 (Regulated Activities) Regulations 2014. We asked the service to provide us with an action plan stating how they intended to improve. They told us they would complete all the required improvements by 19 June 2017.

In October 2017 the Clinical Commissioning Group (CCG) raised concerns with us about the quality of the care the service was providing to people. Shortly after this Suffolk County Council shared with us the details of a concerning safeguarding referral that had been made about a person using the service. As a result of this information we carried out an urgent inspection on 31 October and 1 November 2017. There had been a significant decline in the standard of care people were provided with which placed people at an increased risk of harm. We identified that the service was in breach of Regulations 9, 11, 12, 14, 16, 17 and 18 of the Health and Social Care Act 2010 (Regulated Activities) Regulations 2014.

The report issued following our inspection on 31 October and 1 November 2017 made clear the areas of particular concern and which required addressing urgently. Following this inspection, we were so concerned that we issued a Notice of Decision to impose conditions on the service's registration. As part of this, the service was required to provide us with urgent information around risk management strategies by 7 November 2017. Specifically, we made reference to people at risk of choking because of swallowing difficulties. We told the service that it needed to 'assess the risks to all service users in relation to swallowing difficulties.' In addition, we stated the service must 'include detailed, informative plans specific to the individual for managing the risks associated with these conditions.' The service responded to this notice within the agreed timeframe with reassurances that they had met the conditions imposed. However, at this inspection we found that whilst people's risk of choking had been assessed, no care plans had been implemented to state how this risk could be mitigated. This meant that there was no information available for staff on how to minimise the risk to the person and the service was in breach of conditions on their registration.
The previous manager ceased working for the service in January 2018 and the Commission cancelled their registered manager's registration in February 2018. The new manager was appointed in January 2018.

The service had designed and implemented a risk tracker which they were regularly providing to other agencies. The purpose of this risk tracker was to reflect all the risks to people using the service so that the manager had oversight of these and could ensure the risks were being minimised. We found that care plans had not been implemented for people with identified risks, which meant that the service had not used the risk tracker tool or other records to effectively identify risk.

We were previously told that the service would be updating all care plans to a new, improved format which would be more in depth and provide sufficient information for staff to provide safe and effective care to people. However, at this visit we found that the care plans for many people had not been updated and this included people with identified priority risks. This meant that for these people there continued to be inaccurate, unsafe care planning in place. The service was in the process of recruiting new staff and was also using agency staff to cover some shifts. There was a risk that new or agency staff would not know about the risks to people and therefore people could be provided with unsafe and inappropriate care

At our last inspection we identified that daily records, such as records of repositioning or of food and drink consumed were poor. Since our last inspection other agencies have consistently raised this as a continuing area requiring improvement. For example, a staff member from Suffolk County Council raised concerns about poor recording with the service on 24 April 2018. Despite concerns being continually raised regarding record keeping, there was still no effective system in place to monitor the recording in daily records. During our visits we identified that poor record keeping continued and that it was difficult to ascertain whether people had received necessary care interventions such as repositioning or regular food and fluids. The registered manager told us that senior care staff were tasked to check daily records at the end of their shift to ensure they had been completed correctly. However, the registered manager had not been checking that senior care staff were performing this role adequately. This means the service failed to independently identify continuing concerns around record keeping and ensure improvements were made. Despite raising this with the registered manager during our first and second visit, we found that these issues continued at our third visit five days later.

Some audits that had been carried out were ineffective in identifying issues that we identified. For example, an audit of care records had been carried out for two people whose care plans we reviewed. These audits had failed to identify the significant actions that needed to be taken to update the information in these care plans. In addition, the registered manager had been completing a regular 'walk round' audit, where they walked around the home observing things such as staff practice, environmental safety and cleanliness. In these audits they had stated the service was clean. However, this audit had failed to identify the strong unpleasant odour in one part of the home which had not been rectified.

Since our last inspection, the new registered manager had created two clinical lead roles, with each clinical lead being responsible for one half of the home. However, there remained little clarity around the responsibilities and accountabilities of each staff member forming the senior management team. The clinical lead present during our visits told us it was their role to review and update all the care plans. However, they were also required to provide direct nursing care to people, administer medicines, liaise with other health professionals and oversee the practice of staff less senior. This meant that they were unable to dedicate time to one task. The result of this lack of clarity around responsibilities and accountabilities meant that the clinical lead told us there were still approximately 10 care plans that still required review and updating at the time of our visit.

Following our inspections in November 2017 and January 2018, the service has received significant support and input from external agencies such as the CCG (Clinical Commissioning Group) and Suffolk County Council. This includes significant support from the CCG to help improve medicines practice within the service. Despite all the support and guidance offered to the service, the provider and management team had failed to bring about sufficient improvements to make the service safe.

This was a continuing breach of Regulation 17: Good Governance of the Health and Social Care Act 2010 (Regulated Activities) Regulations 2014.

Despite the concerns we had about the quality of the service, people told us they were happier living there and made positive comments about the new registered manager. One person said, "I have spoken to the new manager and I think she has made a difference to the way things are done." Another person told us, "The home is more organised now. The new manager has been a positive move." One person posted a review on Carehome.co.uk and said, "At first I didn't think things were very good but as time was going by it was getting better and it is improving all the time."

We observed that the registered manager was visible in the home and people knew them well. They participated in providing care to people, such as by providing support to people at meal times. This meant they were there to observe staff practice and lead by example. The manager had introduced daily mini management meetings where a representative from each team in the service met to discuss issues relating to the management of the service and care provided to people.

People told us they felt more listened to than they had before. One person said, "The home is managed much better now and they staff are more approachable. You are able to ask questions without any fear." A relative of one person said, "The culture is moving forward, which is a good thing." We observed that the atmosphere had improved in the home and we could see improvements were ongoing with regard to changing the culture in the service. Robust disciplinary action was being taken where staff continued to demonstrate poor practice.

The registered manager and provider were transparent and honest with people and their relatives about the improvements that needed to be made. They organised regular meetings for relatives and residents, some of which we attended. In these meetings the provider and registered manager gave relatives and residents an opportunity to provide feedback on the progress of improvements and any areas that still required attention. Improvements that were suggested, such as improving the drive outside the service, had been completed.

Following the previous inspection, the provider had employed a consultant to support with the process of making improvements in the service.