Lifestyle Care Management Ltd

Coniston Lodge Nursing Home

Inspection report

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Date of inspection visit:
10 January 2017
11 January 2017
12 January 2017

Date of publication:
03 March 2017

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We undertook an unannounced inspection of Coniston Lodge Nursing Home on 10, 11 and 12 January 2017.

Coniston Lodge Nursing Home is a nursing home and is part of Lifestyle Care Management Ltd. It provides accommodation for up to 92 older people in single rooms. The service has four units but at the time of our inspection only three were in use. The home is situated within a residential area of the London Borough of Hounslow. At the time of our visit there were 55 people using the service.

At the time of the inspection the manager had been in post since October 2016. The new manager was about to start the registration process with the Care Quality Commission. A registered manager is a person who has registered with the CQC to manage the service and has the legal responsibility for meeting the requirements of the law, as does the provider.

At our last comprehensive inspection on the 23, 24 and 26 February 2016 we found breaches in relation to good governance in respect of information provided on 'do not attempt resuscitation' (DNAR) forms, maintenance records and equipment levels. During the inspection on 10, 11 and 12 January 2017 we found improvements had made in relation to these areas.

Risk assessments did not provide up to date information in relation to individual's risks when receiving care.

Some people using the service did not receive appropriate support when eating and food was often cold due to delays in serving and providing support.

Care was often task led which meant staff did not always provide appropriate support for people's emotional and social needs as they were focused on tasks.

Activities were organised at the home but some of these were not meaningful for people and when the activities coordinator was unavailable there were limited activities organised.

Care plans were not written in a way that identified each person's wishes as to how they wanted their care provided. Daily records were focused on the tasks completed and not the person receiving the support.

The records relating to care of people using the service did not provide an accurate and complete picture of their support needs.

A range of audits were in place but some of these had not provided appropriate levels of information to identify aspects of the service requiring improvement and action had not always been taken to address issues.

People told us they felt safe when they received support and the provider had policies and procedures in place to deal with any concerns that were raised about the care provided.

The provider had processes in place for the recording and investigation of incidents and accidents. Each person using the service had an evacuation plan in place in case of an emergency.

The provider had an effective recruitment process in place. There was a policy and procedure in place for the administration of medicines and these were administered in a safe way.

The provider had policies, procedures and training in relation to the Mental Capacity Act 2005.

Care workers and nurses had received training identified by the provider as mandatory to ensure they were providing appropriate and effective care for people using the service. Also care workers and nurses had regular supervision with their manager and received an annual appraisal.

The care plans identified the cultural and religious needs of people using the service. The provider had a complaints process in place and people knew what to do if they wished to raise any concerns.

We found five breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. 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?

Requires Improvement

Some aspects of the service were not safe.

There were enough staff to provide care but this was sometimes delayed due to a lack of organisation of staff.

Risk assessments did not provide up to date information in relation to individual's risks when receiving care.

The provider had appropriate processes and training in place for the safe administration of medicines. The provider had processes in place for the recording and investigation of incidents and accidents.

Is the service effective?

Requires Improvement

Some aspects of the service were not effective.

Some people did not receive appropriate support when eating and food was often cold due to delays.

Care workers and nurses had received the necessary training, supervision and appraisals they required to deliver care safely and to an appropriate standard.

The provider had a policy in relation to the Mental Capacity Act 2005. Care workers and nurses received training on the Act and understood the importance of supporting people to make choices.

There was a working relationship with health professionals who also provided support for people using the service.

Is the service caring?

Requires Improvement

Some aspects of the service were not caring.

Sometimes when care workers were busy they did not appropriately support people's emotional and social needs as they were focused on tasks.

Care workers and nurses demonstrated a good understanding of

the importance of supporting people to maintain their independence.

Care workers and nurses explained how they helped people maintain their privacy and dignity when they provided care.

Is the service responsive?

Requires Improvement

Some aspects of the service were not responsive.

Activities were organised at the home but some of these were not meaningful for people and when the activities coordinator was unavailable there were limited activities organised.

Care plans were written in a way that did not identify each person's wishes as to how they wanted their care provided. Daily records were focused on the tasks completed and not the person receiving the support.

The provider had a complaints procedure in place and complaints had been responded to in line with the procedure.

Is the service well-led?

Requires Improvement

Some aspects of the service were not well-led.

Records relating to care and people using the service were not completed accurately to provide a current picture of the person's needs and support provided.

The provider had a range of audits in place but some of these had not provided appropriate levels of information to identify aspects of the service requiring improvement and action had not always been taken to address issues.

Coniston Lodge Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider 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 the 10, 11 and 12 January 2017. The first day of the inspection was unannounced with the following days being announced. One inspector visited the home over the three days. A pharmacist inspector, a specialist advisor, a second inspector and an expert by experience each visited the home for one day. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert-by-experience at this inspection had personal experience of caring for people who had dementia.

Before the inspection we reviewed the notifications we had received from the service, records of safeguarding alerts and previous inspection reports. Notifications are for certain changes, events and incidents affecting the service or the people who use it that providers are required to notify us about.

During the inspection we spoke with nine people using the service, eight relatives and 19 staff including nurses, care workers, activities coordinator and support staff. We also spoke with the manager, clinical lead, a peripatetic manager, the clinical and operations director who was also the Nominated Individual for the provider, and a visiting healthcare professional. We used the Short Observational Framework for Inspection (SOFI) on the first floor. SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We also observed interaction between people using the service and staff on all floors.

We reviewed the care plans and records of daily care for eight people using the service, medicine administration records for 19 people, the employment folders for one nurse and five care workers, the training and supervision spread sheet for 77 staff as well as records relating to the management of the

service and a selection of other records including safeguarding records, incident records, audit and monitoring reports and policies and procedures.

Requires Improvement

Is the service safe?

Our findings

The risks to people's safety and wellbeing had been assessed, but these assessments were not always completed correctly or regularly and therefore information did not accurately reflect people's needs. Risk assessments in relation to pressure ulcers, falls and nutrition were in place and the manager confirmed these should be reviewed monthly. The falls risk assessment for one person had been completed in September 2016 but the records showed the person had a fall following that assessment which resulted in bruising and a cut to the skin. The next review of the risk assessment took place in January 2017 but the overall level of risk had not been considered in the interim.

A hearing assessment identified one person had lost their hearing aid whilst in hospital but there was no record of any action being taken and when the assessment was reviewed a month later it was still indicated that the hearing aid was lost but not what had been done to resolve the issue.

The mobility assessment for one person had progressed from them being able to walk independently with supervision to the next month requiring assistance with mobility aids. No additional information was identified to support the reason for this change in assessment.

The risk assessment in relation moving and handling for another person indicated there were no issues but for a two month period the risk assessment stated the person could not lie on their back. The assessment then showed an improvement and this change in risk level was not recorded. The clinical lead commented the nurse may have selected the wrong box on the assessment form.

We looked at the skin assessment forms for various people, which were completed when a bruise, skin tear or other injury was identified. The forms for each person included the information for issues identified on a number of different dates. The body map on each form had marks indicating where the injuries were located but did not identify which date they related to. This meant monitoring of the injuries and ongoing assessment of the person's skin could not be carried out and therefore people were at risk of appropriate action not being taken to resolve any injuries. .

The tissue viability assessment for one person stated the person had an average appetite but the care plan for nutrition indicated that the person did not eat well which was also linked to increased risk of falls.

People at risk of falls had risk assessments in place. A number of measures such as observation, the use of bed rails and the use of crash mattresses were used to minimise the risk of falls and injuries to people. However three of the beds did not have protective covers on the bedrails and these put people at risk of limb entrapment. One person had a bedrail on their bed although they did not require it. We also noted that the height of three beds had not been set at an appropriate level as a crash mattress was in place on the floor. One person with a risk of falls from rolling off the bed had a crash mattress in place and the bed height which was meant to be at its lowest height was at a higher level. We asked the care workers to adjust the height of the beds but half the care workers on the unit did not know how to adjust the height of the bed. This meant that the person was at risk of injury had they fallen from the bed. There were no bed rails risk

assessments in place.

This meant that care workers were not always aware of any increased risk in relation to the person's support needs and how to reduce these risks as the assessment did not provide a current picture of people's support needs.

The above paragraphs demonstrate a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We observed care workers were not always complying with hand washing procedures. We saw care workers were helping people with food after helping them with transfers without washing their hands. However, we also saw the care workers and nurses used appropriate equipment including aprons and gloves when providing other forms of support. We saw care workers, nurses and support staff had completed infection control training. During the inspection we saw there were members of housekeeping staff cleaning the communal areas and people's bedrooms.

We asked care workers and nurses if they felt there were enough staff on duty during the day, at night and at weekends. We received mixed comments which included "Almost everyone on each unit has a high level of support needs and it can take a long time for care if people need extra support", "We are short sometimes, especially weekends. Usually get agency, sometimes they are new but usually they are the same people and worked here before", "We do our job anyway. We work as a team and that is the important thing" and "Sometimes enough, sometimes not." Other comments included "We have enough staff but sometimes short. We just follow the nurse, she is doing the allocation and we follow the rules", "Not all the time. We are always falling short and it is a bit annoying. People call in sick or agency doesn't show up" and "It varies, depending on the staff you have, especially in the dementia units, they are trying to do personal care in pairs and someone is walking around not dressed appropriately and the nurse is busy doing medicines. Afternoons are not as busy as in the morning."

The manager explained the number of care workers and nurses on each unit was based on the levels of support. At the time of the inspection there were 19 people being cared for in Heron Unit, 18 people being cared for in Wren Unit and 18 people being cared for in Robin Unit. We asked the manager how many people on each unit required the support of two care workers and he confirmed 13 people in Heron Unit, 10 people in Wren Unit and 11 people in Robin Unit. Many of these people only required the assistance of two care workers when being moved and only one care worker to provide personal care. In each unit there was one nurse and four care workers which included a senior. At night there was one nurse and two care workers in each unit.

The manager told us they were relying on agency nurses and care workers to fill shifts as there were a number of vacancies at the home. They tried to ensure a regular group of agency staff worked at the home so people had consistency in the staff providing care and the agency staff got to know people at the home.

During the inspection we observed there were some delays in care being provided, there was a lack of organisation and both care workers and nurses appeared to be busy during the morning. This was discussed with the manager and they suggested this could be a result of agency staff not being aware of the schedules on each unit and how they worked.

People we spoke with said that they felt safe when they received support from the care workers and they had no concerns about their safety. We saw the service had effective policies and procedures in place so any concerns regarding the care being provided were responded to appropriately. We looked at six records of

safeguarding concerns and we saw information relating to the concern, notes of the investigation, any actions taken and the outcome recorded.

Not all the care workers we spoke with had the knowledge and skills to recognise the signs of potential abuse. Some care workers could not identify the different types of abuse with two care workers not able to explain their understanding of the terms abuse or safeguarding. Other care workers and nurses we spoke with did confirm they would inform the manager if they had any concerns. The manager confirmed there was on-going safeguarding training scheduled as part of the mandatory training programme and they would check the levels of understanding of the staff who had already completed the course.

We saw Personal Emergency Evacuation Plans (PEEPs) were in place in case of an emergency which provided care workers with guidance on what action should be taken to support the person appropriately. The record we saw during the inspection had not been amended since people had been moved to different units as one had been closed for refurbishment. The manager had updated the records by the end of the inspection.

We looked at how accidents and incidents were managed in the service. There was a process in place for the recording of incidents and accidents. Information was recorded depending on the type of event, for example injury, incident or conflict between people using the service. If required photographs of any injuries were taken and placed with the incident record. Statements were also on file as well as copies of any relevant records and the outcome of any investigation. The record form also included if the person had been seen by the GP or other healthcare professional. During the inspection we looked at 10 incident and accident records completed since October 2016 and saw they detailed and identified what actions had been taken.

The service followed suitable recruitment practices. The manager explained that as part of the recruitment process applicants were asked to provide the details of two referees and details of their employment history. During the inspection we looked at the recruitment records for five care workers and one nurse which detailed that the relevant checks had been completed before each person began work. These checks included suitable written references, interview records and a check for any criminal records had been completed.

The manager confirmed the service used nurses and care workers provided by an external agency. We saw an information sheet had been provided for all the staff provided by the agency which included a photograph, their current training record, proof of their right to work and for nurses their registration number with the Nursing and Midwifery Council.

During this inspection, we checked medicines storage, medicines administration record (MAR) charts, and medicines supplies. All prescribed medicines were available at the service and were stored securely in locked medicines cupboards within each treatment room. This assured us that medicines were available at the point of need and that the provider had made suitable arrangements about the provision of medicines for people using the service.

Current fridge temperatures were taken each day (including minimum and maximum temperatures). During the inspection (and observing past records), the fridge temperature was found to be in the appropriate range of 2-8°C. This assured us that medicines requiring refrigeration were stored at appropriate temperatures.

Overall, people received their medicines as prescribed, including controlled drugs. We looked at 19 medicine administration record (MAR) charts and found minimal gaps in the recording of medicines

administered, which provided a level of assurance that people were receiving their medicines safely, consistently and as prescribed. We found that there were separate MAR charts for people who had topical medicines prescribed to them (such as creams). These were filled out on a daily basis by carers. However, we found that staff did not sign to indicate they had transcribed the instructions from the prescription/MAR and they were no countersignatures. Also, we found that several creams were written on a single sheet of paper. This meant we could not tell which cream had been applied at a specific time for a person. We found five forms where this was the case.

We spoke with one person's relative who reported that they received their medicines in a timely and correct manner. Running balances were kept for medicines that were not dispensed in the monitored dosage system. This meant that staff were aware when a medicine was due to run out and could make arrangements to order more. Where a variable dose of a medicine was prescribed (e.g. one or two paracetamol tablets), we saw a record of the actual number of dose units administered for the person. For entries that were handwritten on the MAR chart, we saw evidence of two signatures to authorise this.

Medicines to be disposed were placed in appropriate pharmaceutical waste bins and there were suitable arrangements in place for their collection by a contractor. Controlled drugs (CDs) were appropriately stored in accordance with legal requirements, with daily audits of quantities completed by two members of staff. However, we found that the index page of a CD register was not always updated to include the latest page number of a person's CD record, as per recommended National Institute for Health and Care Excellence (NICE) Guidance.

We observed that people were able to obtain their 'when required' (PRN) medicines at a time that was suitable for them. However, there were not appropriate, up to date protocols in place which covered the reasons for giving the medicine, what to expect and what to do in the event the medicine does not have its intended benefit. We saw seven instances where a person was receiving a PRN medicine, but did not have an appropriate PRN protocol. Also, we saw one PRN protocol attached to a resident's MAR chart which had not been archived although the person was not receiving that medicine anymore. During the inspection the manager and clinical lead explained the PRN protocols had been reviewed on all the units and should have been in place. They confirmed these had been checked by the end of the inspection and were now in place and staff were aware of them.

Medicines were administered by nurses who had been trained in medicines administration. We observed a member of staff giving medicines to a person and found that staff had a caring attitude towards the administration of medicines for people.

We looked at five MARs for those people who were administered their medicines covertly. We found that they had the appropriate authorisation and input from professionals to enable them to have their medicines administered covertly. For example, there was evidence of a medicines form which was signed by the GP and the pharmacist. This assured us that people were being administered medicines covertly in an appropriate manner in accordance with legislation.

The provider followed current and relevant professional guidance about the management and review of medicines. For example, we saw evidence of several recent audits carried out by the provider and CCG pharmacist, including safe storage of medicines, room and fridge temperatures and stock quantities on a daily basis.

The provider confirmed they were happy with the arrangement with the supplying community pharmacy and GP, and felt that they received effective support with regards to the training of nursing staff in medicines

administration and medicines reviews. This was evidenced by checking the record of several medicines reviews that had been carried out within the last two months for people. Where a GP had amended a medicine, we saw evidence of a 'important medication changes' form filled out appropriately for that person, with the corresponding medicine ordered and administered on time.

We saw regular checks were carried out in relation to electrical equipment, gas supplies, legionella checks for water supplies and the fire system.

Requires Improvement

Is the service effective?

Our findings

We asked people using the service and relatives about the food at the home and they appeared to be satisfied about the food quality but they complained that the food was often served cold which reduced its quality. We saw people had access to drinks in their rooms and in the lounge areas. One relative commented, "My [family member] is a good eater. Good food here."

People were not always provided with information on the menu options available and menus did not include pictures of the food to make it easier for people to choose. On one unit we saw there was a pictorial display of the menu which was partially covered by curtains but this did not reflect the options available that day. There was also a white board on the wall but this had not been cleaned and had been overwritten so it was difficult to see the menu information. During the inspection we saw the manager visit this unit during lunch and asked the care workers where the menu was. The menu for that day could not be located.

We saw when care workers were busy people often did not receive the support they required during meals but this was available at quieter times of the day. People were often given their meal but were then left as the care worker was busy with other tasks so either their food went cold or the person tried to eat without help.

There were soft and pureed food options for people with chewing or swallowing difficulties. Care plans included information in relation to specialist diets required by people but the preferences of people's choice of food was not evident in their care records.

Not all care workers were aware of people's nutritional needs. On one unit the care workers did not have any directions during breakfast time in relation to peoples' nutritional requirements and relied on a senior care worker for guidance.

The above paragraphs demonstrate a breach of Regulation 14 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People who were at risk of malnutrition had a nutrition assessment in place. This was reviewed monthly by people who were at risk being weighed and their weight recorded. People with an increased risk of nutritional issues had their weight monitored weekly and were referred to the dietitian. They were also prescribed food supplements. The records showed that Speech and Language Therapists had assessed people's eating and drinking needs and Dieticians were involved to ensure their nutritional needs were met.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The 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).

We checked whether the service was working within the principles of the MCA.

During the comprehensive inspection on the 23, 24 and 26 February 2016 we found limited information in relation to people's capacity to make decisions relating to their care and some completed 'do not attempt resuscitation' (DNAR) forms did not provide accurate information.

At the inspection on 10, 11 and 12 January 2017 we saw improvements had been made in relation to the information regarding people's capacity to make decisions and the completion of DNAR forms. We saw some DNAR forms had been completed following discussion with the person's relatives. A nurse explained that the General Practitioner (GP) would usually only consult a person's relatives if they had a Lasting Power of Attorney in place.

We saw a range of mental capacity assessments were completed for people which included oral hygiene, communication, personal care and mobility. These indicated if the person had the capacity to make decisions in relation to these areas of care and the level of support they required.

The manager showed us a record of all the DoLS applications that had been made, when they were approved and when they needed to be renewed. We saw that some applications had been made a number of months previously and the outcome had not yet been received. The manager explained they were in regular contact with the local authority to monitor the progress of the applications.

We saw people were being cared for by care workers who had received the necessary training and support to deliver care safely and to an appropriate standard. The manager confirmed new staff would complete safeguarding vulnerable adults, infection control and moving and handling training as part of their induction and the rest of the training identified as mandatory by the provider during their 12 week probation period. New care workers also completed the Care Certificate during their probation period. The Care Certificate identifies specific learning outcomes, competencies and standards in relation to care. New care workers were allocated an experienced colleague as their mentor and completed a minimum of three shifts shadowing them. We looked at the employment records for five care workers and one nurse and we saw people who had recently started working at the home had completed their induction paperwork including records for shadowing their mentor.

The provider had identified specific mandatory training courses to meet the needs of each staff role. The training included first aid, infection control, moving and handling and health and safety. We looked at the training records for 77 staff which included care workers, nurses, housekeeping and catering staff who worked at Coniston Lodge. We saw the majority of staff had completed the training identified as mandatory and the records indicated when they were due to complete the refresher sessions.

The manager explained all staff should complete regular supervision with their line manager and confirmed staff had not had regular supervision meetings during 2016. We saw the number of supervision meetings had increased since the new manager and clinical lead had started at the home and they confirmed they were aiming for all staff to have monthly supervision sessions to support the on-going improvements in the service. Annual appraisals were also organised and we saw records demonstrating both supervision meetings and appraisals had occurred.

The home worked with a range of healthcare professionals to provide support for people using the service. Records showed Physiotherapists, Occupational Therapists, Speech and Language Therapists, Dietician, Dentists, Opticians and Tissue Viability Nurse were involved in people's care.

Requires Improvement

Is the service caring?

Our findings

People using the service told us they felt the care workers and nurses were kind, caring and treated then with dignity and respect when they provided support but we also received some less positive comments. Some of their comments included, "They are looking after me. They are nice. They keep me clean" and "They look after me very well. I feel comfortable here." Other people we spoke with said "The regular care workers are very kind and caring. I don't blame them because they have a lot on their plate. The agency staff is a lottery depending on who you get. Most of them don't know what they are doing" and "Most of the staff who have been here a long time are kind and caring, but there are only a few of them." One person told me "I have to get up in the morning to allow staff to make my bed. I don't have a say in the time I want to get up and it is the same when I need to have my personal care. It depends on which group the staff have allocated me to".

Relatives commented "My family member is very shy. They never liked interactions with people but here they do and they love the activities coordinator here" and "They make sure we are informed what is going on. They phoned me to say my family member had a chest infection."

In general people were cared for by kind and gentle staff. Throughout the inspection we saw examples of care workers and nurses having an understanding of people's specific needs and they knew how to communicate appropriately with the people they supported. However, there were times during the inspection when the care workers and nurses were unable to support a person's emotional and social, in addition to their physical needs, as they were busy completing other tasks, or they had not identified an occasion when people may feel isolated and bored.

We observed that in some units there was a lack of organisation in relation to how care activities were allocated and managed. In one unit we saw two people had been taken to the lounge after personal care and had been given a cup of tea and two biscuits as breakfast was not due to be ready for more than an hour. The care workers and nurse were busy around the unit and were not able to support people in the lounge. We saw one person had spilt their tea in the saucer on their biscuits and was licking the wet biscuits from the plate. Later we saw this person was being brought into the lounge in a wheelchair after their breakfast and their clothing was wet as they had spilt their drink during the meal. The care worker had not seen the person was in wet clothing until we pointed this out to them.

During breakfast time in one unit most of the care workers were assisting people with their personal care which resulted in one care worker serving and assisting people with breakfast. There was one agency nurse, one senior care worker and three care workers. One of the care workers told us, "This is my second day in the service. I was working on another unit and was asked to come here because they were short. I don't know the unit." The nurse was administering medicines. Three care workers were assisting people with their personal care and getting them ready to have their breakfast. The senior care worker was serving breakfast in the small kitchenette and there was no one observing and assisting the people in the dining room. People were served breakfast by the senior care worker and by the staff as they brought people into the dining room.

There was one person in the dining room that had become upset and was calling for help. There were no care workers near the dining room and the senior care worker had to call to the person from the serving area to let them know someone was there. A care worker was not available to go to the person for around 20 minutes and the person became calm and started eating their breakfast but this had been on the table for around 25 minutes so was no longer hot.

Care workers brought people into the dining room once they had completed personal care then went to assist other people. We saw people had been given their breakfast but were unable to eat without support, or they required encouragement. By the time a care worker was available to assist the food had gone cold. One person told us "My cereal was served cold after I had to wait for my porridge, then I had to wait for nearly one hour for my bacon and egg. Breakfast is very often late and it is not the fault of the staff. They need more staff." One person was not assisted to cut up their bacon and eggs so started to eat using their fingers and another person appeared confused as they were trying to eat another person's breakfast.

In another unit we saw a person in the lounge had been served breakfast but they were asleep so their porridge, cooked breakfast and tea had gone cold but care workers had not come in to check they were eating their food as they were busy supporting people with personal care. We also saw the lunch for a person who was in bed had been left on the table next to the bed but they were asleep and the food was left uncovered, so it was going cold.

During the inspection we saw people were in the lounges without a care worker and we needed to locate care workers to assist three people to use the toilet. We also saw the nurses handover on one unit where we observed the two nurses went into people's bedrooms, turned on the light and woke them as they were discussing the care provided overnight. They left the light on in one person's room after they left and we had to remind them to turn it off as the person had been asleep. This meant people were not being treated with privacy and dignity.

Throughout observations during the inspection we saw there were times when the care workers and nurses were entirely focused on the tasks they had to complete and their allocated task did not include spending time with people in a social setting. People's physical needs were not neglected but were delayed and there were occasions where their social and emotional needs were not met.

The above paragraphs demonstrate a breach of Regulation 9 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked care workers and nurses how they maintained people's privacy and dignity when providing care. They told us, "When you transfer people from the shower use a bathrobe or a big towel. When I start I ask how are you doing and say let's try to start here with your feet", "When I walk into a resident's room I have to knock. If I want to help with personal care for the person I close the door", "When you go to support with personal care you close the curtains and the door", "When we are caring the first thing we do is make sure the person is covered well and we always ask them what they want to wear. We speak to them and tell them what we are doing with personal care" and "I knock on the door and don't turn on the lights when a person is sleeping. If someone wants to go to the toilet I take them, I don't just stick a pad on."

Care workers and nurses we spoke with demonstrated a good understanding of the importance of supporting a person to maintain their independence. Their comments included "If they can eat, we help them to eat by themselves. I give one person their beaker and they can hold it themselves. When you choose clothes you show them and they tell you what they want", "I bring choices of clothes from the wardrobe and they will point. You ask the person things like 'do you want to eat now' or 'do you want to get up' and they

say "No" so I will say okay, I will tell my manager and I will go to them again later" and "You let the person choose what they want and what they like." Other comments were, "If someone is mobile and using a frame I try not to use a hoist with someone who can walk because that's not fair on them. Try to make them more independent as much as you can", "There is one person who likes to walk around at night. We don't say go back to your room. We ask them if they want a drink and sometimes they sit in the lounge and watch television. Always give them choices" and "I give people sets of clothes to choose from. If they don't have capacity I show them and they can grab things because sometimes a colour is an attraction."

The care plans identified the person's cultural and religious needs. We saw care workers and nurses were provided with information about the personal history of the person they were supporting. The information included which members of their family and friends knew them best, the person's interests and hobbies as well as their work and family history.

Requires Improvement

Is the service responsive?

Our findings

During the inspection we saw that activities were organised but some of them were not meaningful for the people using the service. We also saw when some activities were being held which involved a small number of people there were no alternatives for everyone else as care workers were busy. An activities coordinator worked at the home and there were notice boards in all the units displaying a range of activities but these did not reflect the activities planned for that week.

During the inspection we spent time on each unit and saw when a main activity had been arranged in one unit there were not alternative activities organised in the other units. We saw people were in the lounges with the television on often with subtitles and the sound turned down. Sometimes there was also music left on but care workers were not interacting with people or giving them a choice of what to watch or listen to.

One staff member we spoke with told us when church services were held at the home care workers would often bring people to the service even if they were not of that religion or religious, as it was seen as an activity. This did not respect people's religious and cultural needs.

The activities coordinator explained they often held karaoke sessions in the lounges as it was easy to move the equipment between lounges. They also confirmed that a Physiotherapist was visiting the home once a week to help some people with exercises.

The records showed that people were not able to follow their hobbies and interests. There was a list of people's hobbies and interest and these were reviewed monthly. However there were no plans in place to indicate how they had been actioned. One person told us, "It is boring here and there is very little to do. I love gardening and if I was at home this is what I would be doing. I am sat by the window watching my life passing away."

There was no daily or weekly timetable available for care workers to share with people about what activities were available. When we asked a person about their plans for the day they told us, "I don't know. This depends on the staff. There is nothing new." However this person's activities assessment showed they liked going out, listening to music and also enjoyed gardening.

The service did not make adjustment for people with dementia care. There were no calendars with day, time and season clearly displayed. There was lack of physical exercise and activities for people. Most people stayed in their seat in the lounge area or, where people were unable to move, in their rooms without any form of stimulation. There was very little evidence of any reminiscence therapy.

The above paragraphs demonstrate a breach of Regulation 9 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During the inspection we saw there were a range of care plans in place. These included nutrition, falls, mobility and personal care. Care plans had also been developed when bruising, pressure ulcers or skin tears

had been identified. The care plans we looked at had been reviewed monthly.

The records showed that people were not always involved in the planning of their care plans. They showed that people were not asked how they wanted to be supported. For example one person told us that they did not have a choice about the time they got up and the time they had personal care. These were decided by the staff. There were no records of people's routine.

The records did not show clear goals in terms of helping people to improve their level of independence and their future plans. Although people had key workers, there were no records to indicate how the key workers met regularly with the person to discuss their care and how their day to day care needs were going to be met.

The care workers completed daily records of care and support provided for people using the service. The records we saw were focused on the tasks completed by the care worker and did not provide information relating to the person's experiences and feelings during the day. This did not provide a complete picture of the person during each day.

The above paragraphs demonstrate a breach of Regulation 9 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's needs were assessed prior to them using the service. We saw detailed assessments were carried out before a person moved into the home to identify if the appropriate care and support could be provided. These assessments reviewed their individual support needs including mobility, social and health issues and were kept in the person's care folder. This information was used in the development of people's care plans. The manager explained the care plans were reviewed daily once the person moved into the home as they got to know the person. Relatives were also to be encouraged to be involved in how care was provided.

A 'resident of the day' system had been introduced at the home. This meant a schedule had been developed to identify one person each day who would have their care plans and risk assessments reviewed as well as their room deep cleaned. The manager told us relatives had been contacted to confirm when their family members were resident of the day each month and they were invited to be involved with this.

People using the service confirmed they knew how to make a complaint in relation to the care provided. We saw there was a complaints policy and procedure in place. If a complaint was received the details were recorded on a form with any supporting evidence, any action taken and the outcome of the complaint. The records also indicated if the person who made the complaint was satisfied with the outcome and if they wished to discuss the issue further with the manager. During the inspection we looked at the records for three complaints and saw detailed records were on file.

People using the service and their relatives could provide feedback on the quality of the care provided. The manager explained a questionnaire had been recently sent to people using the service and relatives asking for feedback on the service. The results had been analysed and we saw the responses were varied but the majority were positive. People were also able to make general comments about the care and we saw these reflected some of the issues identified in this report. There were also meetings organised for relatives to discuss the care provided and any other issues relating to the service. During the inspection we saw detailed notes from the most recent meetings held.

Requires Improvement

Is the service well-led?

Our findings

Records relating to care and people did not provide an accurate, complete and contemporaneous record for each person using the service.

We saw the air mattress for one person was not providing the appropriate level of support required but the records of daily checks carried out on the air mattress indicated it was at the correct pressure level. We looked at the maintenance record book for the unit and saw the fault with the air mattress had been recorded over two weeks before the inspection. The manager explained that the maintenance staff had attempted to repair the mattress on a number of occasions and during the inspection the mattress was replaced.

The records for the administration of creams for one person did not record the frequency for application. Their care plan also stated they needed to be repositioned every two hours. The record chart for repositioning did not indicate the frequency for repositioning and we saw the records for one day showed there were gaps of between three and five hours between when the person was repositioned during the day.

The repositioning records for another person did not indicate the frequency the person should be moved. The care plan stated the person should be repositioned every three hours but we noted the repositioning records indicated on some occasions every two hours and at other times every four hours.

The application of cream record for one person did not indicate the frequency it should be applied. We looked at the records showing what personal care the person had received and saw during January 2017 the information recorded for seven days had been crossed out and no alternative information had been recorded.

We looked at the records for the application of creams for another person. The cream had been prescribed to be administered twice a day but the record showed it had only been applied once a day on four occasions during January 2017. The person's personal care record for December 2016 had no record of mouth care being provided. The charts indicated that the person's optimum fluid intake per day should be around 2000ml but the daily records varied between 50ml and 1200ml intake per day. There was no record of any action being taken in relation to the varied fluid intake levels.

We reviewed the care plan and risk assessments for one person and saw they indicated that the person had a restriction on their total daily fluid intake linked to a medical condition. We then looked at the food and fluid records for this person and saw that the person's daily fluid intake was regularly higher. This had not been identified as the fluid charts had not been regularly reviewed and monitored. During the inspection the clinical lead asked the GP to review the person's records. The GP identified that the fluid restriction was originally in place for an initial period and should no longer be in place so the care plan was amended. This meant that the need for the fluid restriction had not been assessed over a number of months when the care plans were reviewed.

The issue with the accuracy of the records meant the provider could not ensure people received the appropriate care they required.

The above paragraphs demonstrate a breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had a range of audits in place but those in relation to care plans and other records of care provided were not effective in identifying issues. During the inspection we identified a number of issues in relation to the care plans not reflecting people's wishes as to how they wanted their care provided and risk assessments did not always provide current information on possible risks. In addition when other records had not been completed in full this had not been identified through the audits in place.

The above paragraphs demonstrate a breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During the comprehensive inspection on the 23, 24 and 26 February 2016 we found staff commented on shortages of equipment and maintenance activity had not been recorded accurately or completed.

At the inspection on 10, 11 and 12 January 2017 we saw improvements had been made in relation to these issues. We saw each unit had sufficient equipment including crockery, cutlery and bed linens. There were also enough hoists located on units and there were allocated hoist slings for people.

We looked at the maintenance records for the home and saw monthly checks were carried out in relation to water temperature around the home. The water temperatures were generally within or close to the maximum safe level and these were being monitored. Each unit had a maintenance record book which was regularly checked by staff and there were records of any issuers identified around the home. We noted that the maintenance records indicated that a number of external emergency lights had been recorded as not working. We asked the manager about the process of reporting maintenance issues and he confirmed that once the maintenance staff member had identified an issue, the request was passed to head office who contacted an external maintenance company who would complete any required work. Following the inspection the manager confirmed the lighting had been assessed and they were still not working as there were ongoing issues which would be resolved shortly.

A range of other audits had been regularly completed by the manager since they joined the home. The manager completed a daily audit which included walking around the home to check the environment for any health and safety issues and security. A clinical audit was completed which reviewed information relating to pressure ulcers, catheter usage, falls, incidents and accidents and medication.

An infection control audit was completed every three months and a health and safety audit was carried out six monthly.

Monitoring checks were also carried out in relation to any invasive devices that were used including catheters to ensure these were correctly managed. Other checks included pillows to ensure they were free from stains and suitable for use. The number of skin tears and their management was also monitored monthly as well as the use of bed rails to ensure they were used correctly.

The manager explained that following an internal quality audit the provider had identified a number of issues in relation to the quality of care and processes used at the home and had implemented an action plan to make improvements. The manager provided weekly feedback to the provider in relation to progress

on the action plan, any improvements and any on-going issues.

At the time of the inspection the manager had been in post since October 2016. The new manager was about to start the registration process with the Care Quality Commission. A registered manager is a person who has registered with the CQC to manage the service and has the legal responsibility for meeting the requirements of the law, as does the provider.

Care workers and nurses were asked if they felt supported by their manager. They commented "The last time I need to sort my holiday they were understanding", "Yes very well. Encouragement – everyone is not the same. When I call my manager they are always nice and says don't worry", "If we need something we ask for help", "The manager walks around almost every morning, he checks on care", "The manager is a good man ever since he came here", "The manager is the only person I feel supported by and he is the only one who talks to us nicely" and "There is a new manager. If I had an issue I would go to the senior nurses or sometimes a nurse. Most of the time the clinical lead will deal with things."

Care workers and nurses were also asked their view of the culture of the service and if it was fair and open. They told us "It is not too bad but it is not too good. Sometimes they listen and sometimes they say no, no, no you have to do that", "We are all the same and they don't treat me in any other way", "They listen to me very well. I go to my manager for help because I don't want to have trouble", "We work as a team. When there are problems the senior care workers are supposed to tell us what to do. We follow the rules of how to do things and the rules change again", "Yes if you go to speak to the manager they listen" and "I like the manager. The rest of the management don't talk to us nicely. The rest pick on things, which is fine but it is how you say it. They don't realise the impact it has on staff. The way they talk is really rude."

A healthcare professional we spoke with commented, "This place has lacked leadership for a long time, managers come and go. There is no stability. Staff don't stay here for very long. There are very few staff who knows the place. Communication is often poor for example the staff sends me a list of what they would like me to attend to before coming here well in advance, and on arrival I find that nobody knows about it because the message has not been passed on. This normally happens when there is agency staff in charge. One or two occasions they sent me a prescription for somebody who was not here and for somebody who was discharged. I still don't have the list of the people who had received the flu jab." They told us they had not been approached by the provider to ask their views about on how best they can provide input into the home.

We asked relatives if they felt the service was well-led. Relatives told us, "I am fine with the staff. Sometimes I feel they are over pushed/over stretched. I feel pity for them", "The new manager is amazing", "I am satisfied with the new manager. He is very smart. He explained things and makes sure they are done."

We spoke with care workers and nurses as well as support staff such as housekeeping and catering workers and asked them if they thought the service was well-led. We received a range of comments which included, "The manager is interested to know how every care worker does their job. It used to be that every unit had their own staff but now we switch so it is better and now we work everywhere. I think it is a good thing as in one week I worked in all three units", "Very well led. They always check, very well. They encourage people to do what you can do and write it down", "I think it is better and better", "Yes, if we have a problem between us we will go and speak with the manager", "It is getting there now. When I first started it was a mess. Now allocations are being done, before I think things were ignored. Residents are being looked after well now" and "There is a culture change happening where they are trying to improve the service. Because there have been problems in the home and now they have a new manager things have been changing but it is not going to happen overnight. Things are improving and we are on the right track."

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care The care and treatment of service users did not meet their needs or reflect their preferences. Regulation 9

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 The registered person did not ensure care was provided in a safe way for service users. Regulation 12 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs The registered person did not ensure the nutritional and hydration needs of service users were met. Regulation 14 (1)

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 Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The registered person did not have a system in place to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those service) Regulation 17 (2) (a) The registered person did not have a system in place to maintain an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided. Regulation 17 (2) (c)

The enforcement action we took:

We have issued a warning notice telling the provider they must make the required improvements by 28 April 2017