Careconcepts Limited

Marion Lauder House

Inspection report

Marion Lauder House
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Ratings

Overall rating for this service	Inadequate
Is the service safe?	Requires improvement
Is the service effective?	Inadequate
Is the service caring?	Requires improvement
Is the service responsive?	Inadequate
Is the service well-led?	Requires improvement

Overall summary

The inspection was unannounced and took place on 18 May 2015. The inspection was carried out by three adult social care inspectors, an expert by experience and a specialist advisor. Experts by experience are people who have personal experience of using or caring for someone who use this type of care service. Specialist advisors have up-to date knowledge and experience in their specialist area. The specialist advisor was a registered general nurse.

Marion Lauder House is registered to provide accommodation for up to 79 people who require nursing and/or personal care. The home is separated into five units Maple, Cedar, Cherry which are the nursing units, Brookfield which is the residential unit and there is also a respite unit. The units are situated over two floors. All of the people residing at the home, and using the respite facility are living with dementia.

At the time of our inspection there were six people staying in the respite unit, 12 people in the residential

Summary of findings

unit and 38 people accommodated in the nursing units. People were supported on the respite unit by three care staff during the day and one at night. This was the same on the residential unit. The nursing units were located on the ground and first floors. The nursing units were supported by six care staff, two or three nurses during the day and one nurse at night. There was also a deputy manager and a general manager who had recently been employed by the home. The registered manager had left and the general manager had been recruited to take over this role.

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

The manager told us they were waiting for their Disclosure and Barring Service check to come back so they could submit their application to CQC to register. The Disclosure and Barring Service (DBS) helps employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups.

Prior to this inspection there had been an inspection carried out on 12 August 2014 where breaches in the Health and Social Care Act 2008 (Regulated Activities) 2010 were identified. The home sent us an action plan to tell us how they were going to improve. We had since then received a number of concerns from members of the public and health and social care professionals about the care and welfare of people residing at the home or using the respite service which we needed to look at during the inspection on 18 May 2015.

At the last inspection in August 2014 we found a breach of Regulation 13 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 because people were given medicine covertly without the correct safeguards being followed. At the inspection 18 May 2015 we found staff did not understand their responsibilities under the Deprivation of Liberty Safeguards (DoLS) and the correct processes were still not being followed. The Deprivation of Liberty Safeguards aim to make sure people in care homes are looked after in a way that does not inappropriately restrict their freedom. We found this was a breach of Regulation 13 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we followed up on action which was needed following the last inspection in August 2014 in relation to infection control. At the inspection on 18 May 2015 we found significant improvements had been made in relation to the cleanliness of the home and the décor in the communal areas of the downstairs nursing unit.

At the last inspection in August 2014 we found improvement was needed in relation to medicine management. At this inspection we found that medicines, including controlled drugs, were stored safely. We observed medicine being administered on two of the units and found most people received appropriate support to take their medicine. However on one unit we found the administration of medicine was impersonal and there was little or no verbal communication between the staff and the person being supported. We also found some medication was being given covertly without a proper assessment being done. This was a breach of Regulation 13 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last inspection in August 2014 we found support plans and clinical notes were out of date and did not always reflect the person's needs. At this inspection we found there was little improvement in the accuracy and continuity of clinical care records which meant some people were at risk of unsafe care and treatment. Care plans were still not person centred and assessments were not clear. This was a breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We also found there was a breach of Regulation 9 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because people did not experience person centred care specific to their needs.

Before the inspection we had received information of concern from visiting health and social care professionals and relatives of some people who used the service about the quality of support they received from some of the support staff and the qualified nurses. There were also concerns raised about whether there were enough staff to support the needs of people living at Marion Lauder House. We looked at staffing levels and training records

Summary of findings

and found improvement was needed. This was because people did not always receive care and support in a timely manner and clinical notes were not accurately maintained. This was a breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us more staff were needed and the manager told us they were recruiting. The manager told us they were planning to open a new nursing unit which would be staffed within the current staffing levels. This was a concern to us as the current staffing levels were not sufficient to support the needs of all the people who currently used the service.

We spent time observing how staff interacted with people who lived at the home. We found some staff interacted well and knew about the people they were supporting. Other staff we found did not engage well with the people they were meant to be supporting . We found some staff were not clear about the correct way to move or handle people and had little or no regard for the dignity of the person they were supporting. We did observe some staff defusing situations which may have become challenging and demonstrating good practice within some areas of the home. We found there was a breach of Regulation 10 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because people were not always respected or treated with dignity.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'. The service will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, it will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires improvement 

The service was not always safe.

There were not enough qualified staff to meet the needs of the people using the service.

People who used the service who had restrictions on their choices and personal freedom were not supported through the correct safeguarding processes.

Support was offered to ensure people received their medicines safely however this was not always carried out appropriately.

Is the service effective?

Inadequate 

We found the service was not always effective.

There were poor systems in place to monitor people's health and the nurses did not always make referrals to health and social care professionals when necessary.

We found the provider did not have suitable arrangements in place to protect people from the use of unlawful control or restraint.

We found significant improvements in the layout of the home had been made in the communal areas in the downstairs nursing unit. Consideration had been given to the impact of the environment for people who were living with dementia.

Is the service caring?

Requires improvement 

The service was not always caring.

We saw not everybody had their dignity respected.

Some care staff did engage on a personal level with the people they were supporting and listen to the views and preferences of the people they cared for. Others did not.

There was no person centred approach to the provision of care.

Is the service responsive?

Inadequate 

The service was not always responsive.

We saw some staff were skilled in defusing situations which may have presented as challenging. Others were not.

The care planning format did not provide a person centred plan about the person's individual needs and priorities to be addressed.

Summary of findings

Clinical notes were not always up to date or accurate. Information about care needs were not shared amongst the team. People did not always receive the correct level of support.

Is the service well-led?

Requires improvement 

The service was not always well led.

The registered manager had left and a new manager had recently been appointed. As a result there was a lack of leadership present within the home however the new manager had a clear vision of what improvement was needed and had begun to make changes.

There were no clear lines of accountability in place between nursing staff and care staff.

There were good quality assurance systems in place to drive continuous improvement but these had not been utilised effectively.

Marion Lauder House

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.'

The inspection was unannounced and took place on 18 May 2015. The inspection was carried out by three adult social care inspectors, an expert by experience and a specialist advisor. Experts by experience are people who have personal experience of using or caring for someone who use this type of care service. The expert had experience in dementia care. Specialist advisors have up-to date knowledge and experience in their specialist area. The specialist advisor was a registered general nurse.

We spent time speaking with eight people who lived at the home, in different parts of the service. We also spoke with eight staff including the manager and deputy manager, nurses, care staff and maintenance staff. We spoke with visiting relatives and looked around the home in all of the units including communal areas and in people's bedrooms where it was appropriate for us to do so.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

Before our inspection we reviewed all the information we held about the service. We considered information that had been shared with us by the local authority and looked at safeguarding alerts which had been made. We had asked the provider to complete a Provider Information Record (PIR), which told us key information about the service, what the service does well and improvements they plan to make. We used this to inform our planning. We also received feedback from the community nursing home team, social workers and commissioners about their views of the service.

We reviewed a range of records about people's care and how the home was managed. This included eight care plans, four of which we looked at in detail to ensure the correct support was being delivered in line with people's assessed need. We looked at food diaries, continence logs, daily incident logs and medication records for eight people residing in different parts of the home.

We looked at two records in relation to wound care and dressing's management. We also looked in detail at the information relating to capacity assessments and best interest decisions for people who were being deprived of their Liberty. We also looked at audits the home had completed.

Requires improvement

Is the service safe?

Our findings

Due to the nature of people's needs they were not always able to communicate with us verbally so were unable to tell us if they felt safe. We spoke with a relative in one of the nursing units who told us they had no issues or concerns about their relative and that the unit was settled. They told us sometimes the staffing levels were a bit low, particularly at weekends but felt confident their relative was being cared for properly.

At the last inspection in August 2014 we found the home was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This was because people were not protected from the risk of cross infection because the provider did not ensure appropriate standards of cleanliness and hygiene were maintained across the home.

At this inspection on 18 May 2015 we found significant improvements had been made in this area. The home had been redecorated and we found all areas of the home were clean and well maintained. We saw domestic staff were busy around the home ensuring people's bedrooms, bathrooms and toilets were kept clean. This meant the risk of cross infection had reduced and people were now better protected.

At the last inspection in August 2014 we found there was a breach of Regulation 13 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 in relation to medicine management. This was because information about the use of 'when required' medicines was brief and did not link to people's plan of care. At this inspection on 18 May 2015 we found improvements had been made as there was a proper medicine audit and clear records kept in relation to medicine administration. Medicine was stored appropriately and only administered by staff who were trained to do so. However when dispensing medication to individual residents we observed more support could have been offered to reassure people about their medicine.

For example we observed one person asking whether they were supposed to take the tablets. The nurse responded by saying, "Of course you do" rather than offering any assurances or engaging in meaningful conversation which would help the person understand what medicine they were taking and the reasons they needed them.

We had been made aware of ten recent safeguarding alerts, eight of which had been raised by the social work team in relation to the safety of some of the people living at the home. We had attended a strategy meeting with Manchester City Council to discuss these concerns further. One of the concerns was whether staff knew what to do to safeguard people form the risk of harm.

The staff we spoke with told us what they would do if they felt people were at risk. What they told us meant some staff understood their responsibilities in relation to safeguarding, others did not. The response from some staff was to, "Tell the nurse." We spoke with the manager about this and they told us they recognised the importance of increasing staff confidence to make decisions and escalate things themselves rather than rely on the nurses. This had been a particular problem on the residential unit when an incident had occurred which required medical intervention. A safeguarding alert had been raised by the North West Ambulance Service because they felt the staff had not responded in a timely manner to a medical emergency. The manager told us they were currently in the process of carrying out an investigation following on from recommendations from the safeguarding team. We found improvement was needed to ensure all staff were aware of their responsibilities to keep people safe.

We had received information of concern from external healthcare professionals that they felt the number of qualified staff on duty at night and the skill mix of staff may not be adequate to support the complex needs of some people living at Marion Lauder House. This was because Marion Lauder House provided nursing, residential and dementia care.

We looked at the staff rotas over the previous six months and saw staff were deployed to support the home in line with what the manager had said they needed. During the day there were two nurses employed across the home and up to 6 care staff. This reduced to one nurse at night. The home employed two Registered Mental Health Nurses and four Registered General Nurses. We spoke with four care staff and two nurses who told us this was not enough. We had been made aware of incidents which had occurred where the home had not escalated concerns or accessed emergency services in a timely manner. Given the size of the home and the number of nursing patients it would not be possible for a nurse to respond to everybody if more than one or two people needed support with a medical

Requires improvement

Is the service safe?

intervention. The care staff we spoke with told us they would refer any concerns they had to the nurses. Nurses were also responsible for carrying out audits and updating care plans. We looked at eight care plans, all of which were out of date. This, along with what nurses were telling us meant there were not enough staff available to support people effectively.

We found this to be a breach of Regulation 18 of The Health and social Care Act 2008 (Regulated Activities) Regulations 2014 because there were not sufficient numbers of suitably qualified, competent, skilled and experienced persons employed to meet the requirements of the people living at the home.

We spoke with the manager who showed us the advert they had recently placed for nurses. They said they wanted to increase the staffing levels during the night to two nurses which would mean the risk of people receiving unsafe care and treatment would be reduced.

The manager told us they were planning to open another part of the home as a general nursing unit to accommodate 12 more people requiring nursing care. They told us there were no plans to increase the staffing levels to support this unit as it would be staffed with existing staff within the home. This was a concern to us as it was clear through observations, speaking with staff and looking at records and care plans the capacity of the existing staff to effectively support people needed to be improved. The manager agreed the nurses currently employed by the home needed additional support and training therefore any plans to expand the home without additional resources to support people would jeopardise the effectiveness of the service provided and the safety of the people involved.

Inadequate

Is the service effective?

Our findings

People told us "Sometimes the food is all right, sometimes not." "The food is generally lukewarm, its ok I suppose." And "No we don't generally get offered drinks, I suppose we could ask, we never get coffee only tea."

At the last inspection in August 2014 we found the home to be in breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This was because people were not protected against the risks of inadequate nutrition and hydration. The home had a large dining area which was noisy and chaotic and staff were not able to properly support the number of people who needed support to eat. The home told us they were going to reconfigure the dining area to ensure people were properly supported in smaller groups.

At this inspection on 18 May 2015 we saw the dining experience for people in the downstairs nursing unit was significantly improved. One of the reasons for this was because the area had been made smaller and staff were available for people who needed support. We therefore conducted observations across other areas of the home during lunchtime to observe the experiences of people on the other units.

In order to experience the quality of the food offered to people at Marion Lauder House we spent time eating with the people who used the service and sampled a meal on the residential unit. We found the food was lukewarm and not very appetising. We used the Short Observational Framework for Inspection (SOFI) which is a specific way of observing care to help us understand the experience of people who cannot tell us about their care.

On the residential unit we observed that nobody was offered wipes to clean their hands before or after eating and the tables were bare with no condiments. We saw lunches were served already plated up as we were told people had been asked for their choices before hand. We found the portions were quite small and the food was not hot. Staff did not explain to people what they were eating and there was not much interaction between the staff and the people they were supporting. We found this was the same on the respite unit and one of the nursing units where staff did not interact with the people they were supporting. We found this was a breach of Regulation 10 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because people were not always respected or treated with dignity.

At the last inspection in 2014 we found the food and fluid charts had not been completed for those people who needed them. The manager told us since then they monitored the food and fluid intake of everybody. We checked care records and found there were still inconsistences although some improvement had been made. For example we looked at one person's nutritional care plan and saw the weight monitoring chart had been completed weekly and the person had begun to gain weight. We saw this had been monitored by the nurse and the records were up to date and accurate.

On the whole we found people were protected against the risk of insufficient nutrition and hydration because improvements had been made to the number of staff available to support people at mealtimes and to the monitoring of people's food and fluid intake.

The Care Quality Commission has a statutory duty to monitor the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) which apply to care homes. The Deprivation of Liberty Safeguards (DoLS) are part of the Mental Capacity Act 2005 (MCA). The aim is to make sure that people in care homes, hospitals and supported living who lack the capacity to make decisions for themselves are looked after in a way that does not inappropriately restrict their choices.

At the last inspection in August 2014 we found a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.This is because the registered person did not have suitable arrangements in place to protect service users against the risk of excessive and/or unlawful control or restraint.

At this inspection on 18 May 2015 we found the provider still did not have suitable arrangements in place to protect people from the use of unlawful control or restraint.

There were 15 people with a DoLS in place at the time of our visit. The manager told us this was because they lived in a care home and were unable to leave the home. They said they were in the process of making applications for everybody. We looked at the paperwork in place in relation to these DoLS and found there was no supporting evidence to outline why these restrictions were needed or how the

Is the service effective?

decision to restrict people's freedom had been reached. Some of the DoLS applications were incomplete and out of date. For example we saw one request had been made by the previous manager for an urgent authorisation because an individual "required 24/7 nursing care in a nursing home setting". The expiry date of the previous authorisation was 9 September 2014. The home was unable to locate the current authorisation and were therefore unsure whether it had been authorised. There had been no best interest meeting held with this person to support the application or to measure of the person's capacity to make their own choices. This meant the home could not be sure people were being supported in line with their wishes and in their best interests.

We found this was a breach of Regulation 11 of The Health and social Care Act 2008 (Regulated Activities) Regulations 2014 because care and treatment of service users was not provided with the consent of the relevant person.

We spoke with the deputy manager and a nurse about their understanding of the Mental Capacity Act 2005 and DoLS. What they told us meant they did not fully understand their responsibilities and the correct process to follow to ensure people were safeguarded.

We found this was a breach of Regulation 18 of The Health and social Care Act 2008 (Regulated Activities) Regulations 2014 because the provider did not ensure staff received appropriate guidance and training for them to undertake their duties in the correct way.

The deputy manager told us there had been no best interest meetings for any of the 15 people who were currently on DoLS. We saw people being reclined in chairs to restrict their movements, bedrails being used to keep people in bed, people subject to one to one support at all times and some people had their medicine covertly(hidden). Whilst we appreciated in some instances it may have been in the person's best interest to support them in this way we found the correct processes had still not been followed to reach any of the decisions. There was no record of best interest meetings for these people and no application made to DoLS to support the decision. This was a breach of Regulation 13 of the Health and social Care Act 2008 (Regulated Activities) Regulations 2014 because the registered person did not have suitable arrangements in place to protect service users from unlawful control and restraint or from having their liberty of movement restricted.

Before the inspection we had received information of concern that the home did not access emergency services in a timely manner or make the correct referrals to appropriate healthcare bodies when the need arose. We had looked into similar concerns at the last inspection in August 2014 and found improvements were needed to ensure the nurses had the correct information available to them to ensure people received effective care and treatment.

At the last inspection in August 2014 we also found the physical health element of the care plans lacked sufficient information to ensure that the health needs of the person were being accurately met. At this inspection on 18 May 2015 we found adequate improvements had not been made. We found wound care records were incomplete with no photographs taken by the home to record and measure the status of the wound. Reviews and updates were not done consistently by the nurses at the home and there was a reliance on outside agencies to update and record in care plans and assessments.

We noted clinical observations had not been done in December 2014 and January 2015 despite one person being 'very high risk' of developing pressure sores. We found there were two different repositioning charts in use for this person and their falls risk assessment had not been reviewed since March 2015. On one of the charts the person was deemed to be very high risk of developing a pressure sore and medium risk on the other. The weightings were different which created confusion regarding interventions needed for prevention. We found nurses did not question the introduction and use of two different assessments.

We found people were at risk of receiving inappropriate care and treatment because the provider did not maintain accurate, complete and contemporaneous records or assess, monitor and improve the quality and safety of the services provided. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We also noted clinical care and monitoring was not being routinely completed for all people. We observed creams were not used for people experiencing dry skin. We spoke to one of the nurses who told us they acknowledged that many residents, "probably" had dry skin, but they "do not have the time or motivation to assess their skin condition or request the care team/GP to prescribe any creams".

Inadequate

Is the service effective?

We asked the manager about any clinical training the nurses had recently undertaken. The manager told us the staff training was out of date but something which they were currently looking to address as a priority.

We found people were at risk of unsafe care and treatment because the provider had not ensured staff providing care and treatment had sufficient knowledge to do so safely. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires improvement

Is the service caring?

Our findings

People we spoke with who were able to tell us said they were generally happy with the care provided. One person said they, "Liked the members of staff" and felt they were "Well looked after."

Most relatives we spoke with on the day of our inspection were also positive about the care their relative received and we received some positive feedback about the caring attitude of the support staff. Comments included, "Care is second to none." And they "Couldn't wish for anything better."

However some family members said they felt the staff did not always demonstrate a caring approach to all of the people living in the home.

We found the atmosphere within the home was calm and relaxed and staff appeared busy throughout the day. Due to the nature of the service it was not always possible to obtain verbal feedback from some people who were living with dementia about their care. We therefore carried out a series of observations throughout the home to ascertain how caring the staff were towards the people they supported.

We found that the quality of care provided differed throughout the home and people were not always treated with dignity and respect. We found a lot of interactions were task orientated and staff did not always engage with people in a kind and caring manner.

We noted that although most members of staff were polite when addressing the people they supported some were not and most interactions took the form of instructions. For example at lunchtime we observed a nurse saying to one individual, prior to them being hoisted into a wheelchair, "Wake up. Sit up. I'm talking to you. I want you to stand up. Stand up straight!" Staff did not offer any assurances to the person being transferred and paid little regard to their dignity during the task.

We also carried out observations on two other units and found staff were supporting people without regard for their dignity. For example during one of our observations we noted one person was using the toilet. The door was open which meant people walking along the corridor could see into the toilet area. Staff appeared not to notice the person and the open door. This showed a lack of observation, respect and promotion of dignity and privacy for the residents.

We also observed two care assistants supporting a person to walk. The person being supported was off balance due to the way the staff were supporting them. The person looked upset and unsure of how to proceed. Staff did not assure the person and proceeded to manoeuvre the person through the door with one member of staff pushing from behind and one pulling from in front. This meant people were at risk of harm due to inappropriate moving and handling techniques being utilised by staff.

We noticed inconsistencies regarding how people were presented. Some people on the nursing units had long, dirty fingernails, dirty dentures and messy hair. Others however were having their nails done as an activity with one of the support staff. We saw another person had just had their hair done by the visiting hairdresser. We saw at lunchtime people were not supported to wash their hands prior to or after lunch and when people spilled food and soiled their clothes they were not helped to change. This told us not everybody was treated with respect and staff did not understand the impact this may have had on the people they were supporting.

During lunchtime in the respite unit we observed two people being supported to eat by two care assistants. The interaction between the care assistants and people being supported was limited with very little talking. One care assistant split some food on one person's hand and used their cloth to wipe it away without telling the person what they were doing. The care assistant did not realise the impact of their actions on the person as the person pulled their hand away in surprise. This told us staff were not considering the negative impact their actions may have on the person they were supporting and was not caring.

We also observed staff talking to other people whilst supporting a person to drink instead of concentrating on the person being supported. Staff supporting a person on a one to one paid no attention to the person they were supporting other than to nod their head without looking at them when the person spoke to them. This meant staff were not recognising the importance of individual care and attention when supporting people living with dementia in order to respect and promote their dignity, self-respect and independence.

Requires improvement

Is the service caring?

One family member told us that their relative had a preferred name which they had asked the staff to use on several occasions. They said they did not feel listened to as staff still called their relative by the formal name and not the preferred one. This meant the home was not respecting the wishes of the person they were caring for.

We found the above meant there was a breach of Regulation 10 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People using the service were not treated with dignity and respect by all staff.

The service followed The six steps programme for end of life care. The six steps end of life programme is a programme which aims to improve end of life care for people living in residential homes. We found the service had responded well to short term end of life care but was not in place as well as it should have been for all people. This meant people on The six steps programme did not always receive the stage of end of life care they had been assessed to receive.

For example the service had responded well recently for short term end of life care when a spouse came into the home for less than two weeks to be with the other spouse prior to their death. The family member praised the unit and felt supported by the staff at the unit.

However when we checked care records the death and dying care plan for one person was out of date. The end of life care plan review should have taken place in December 2014 and had not yet occurred. This meant that the person's views, needs and wishes regarding their end of life, along with any new support required, had not been identified, updated and recorded.

We found this to be a breach of Regulation 9 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service responsive?

Our findings

We found there were mixed responses regarding the responsiveness of the home. Some people on the residential unit spoke positively about their experiences, others did not.

One person told us "You do get fed up doing nothing. You like it or lump it." They went onto say staff talked to them "Now and again." People said they could spend time in their rooms but could become a bit isolated. Another person told us life at the home was, "The same as it ever was." They told us a musical entertainer had visited one of the units but he had not been "For a long time."

People we spoke with about choices available to them told us that they did not feel able to speak up for themselves or ask staff for anything. One person told us, "You haven't got much choice."

When prompted by staff to help them recall another person told us the home had asked someone from the British Legion to come in and talk to them. They said staff did this as they knew about their working life in the Navy. They told us they had very much enjoyed the visit.

In other areas of the home there was little sign of activities taking place at the time of our inspection and there was no schedule of activities. The manager told us there was no longer an activities co-ordinator and the role had become the responsibility of the senior carers. The manager explained they wanted to promote more meaningful activities for people to get involved in the day to day running of the home such as hovering, dusting and setting the table at mealtimes. We carried out a number of observations across the home at lunch time and throughout the day and did not see this practice being promoted.

We saw little sign of any personalised activity tailored to the preferences of individual residents. Individuals were not invited to participate in or assist in any small task related to the lunchtime process, which might have encouraged them to become more involved in daily proceedings.

In some care plans we looked at there was a "My life" sheet which was meant to outline hobbies and interests and information about a person other than their clinical needs.

All of the ones we looked at were incomplete. This meant there was little personalised information available for staff to better understand the needs and preferences of the people they were supporting.

We spoke to some of the care staff who were able to tell us about some of the people they supported. We found staff interacted well with the relatives of the people they supported and in some units the relatives helped staff by supporting the person they were visiting. For example at mealtimes relatives were available to support their family member to eat which meant staff had more time to respond to others who needed support.

A family member we spoke with told us there was a need for, "More activities." Another family member said their relative liked, "Cleaning tables" and "Windows and doors." The care plans did not make it clear what activities people enjoyed. One person's care records detailed six activities in a three month period. This meant hobbies and activities were not routinely planned to give people a quality of life and maintain their individual interests for as long as possible.

Overall we felt the level of care and support offered to people in different parts of the home

was not consistent and the information, knowledge and care planning and delivery of the

needs of people living with dementia was inadequate.

We found there were breaches of Regulation 10 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because people using the service were not treated with dignity and respect and their independence was not promoted or respected.

At the last inspection in August 2014 we found improvements were needed to the care plans and reviews of people who used the service. We found records were incomplete and did not accurately reflect the needs of the people requiring support.

During this inspection on 18 May 2015 we looked at eight care records all of which were out of date and contained information which was incomplete. We found there was old documentation held in the files which made it difficult to find the current paperwork. The lack of up to date, current information made it difficult to see how the provider was meeting the needs of people living at Marion Lauder House.

Inadequate

Is the service responsive?

We had received information of concern from visiting healthcare professionals about the lack of clinical knowledge to support people who were living with dementia.

We looked at three risk assessments to show how behaviours which presented as challenging were managed and how people were positively supported with their dementia care needs. We found incident reports were not completed although the evaluation sheets completed by staff on a daily basis recorded episodes of 'aggressive behaviours'. We found there was no analysis undertaken to identify trends or triggers as to why the person displayed challenging behaviour. We spoke to staff and they told us they knew people well so knew the triggers. We found new staff at the service and agency staff which were used regularly in the service would not know the triggers which meant staff would respond in an inconsistent manner which increased the risk to the people involved.

We found there were breaches of Regulation 9 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. There was no assessment of the needs and

preferences for care and treatment of some of the service users living at Marion Lauder House.

We also found records such as weight monitoring, personal cleansing and toileting charts were out of date. This placed people at risk of not receiving the care and support they needed because accurate records were not maintained.

We looked at the care records for one person who it was noted had sleep disturbance. We saw it had been noted that the person was awake for most of the night but staff went in to provide personal care when they were asleep and therefore woke them up. This meant the care provided to this person was not person centred because staff completed their duties regardless of the impact on the person they were supporting. This was a breach of Regulation 9 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at the care records of three people who required specific nursing care. We noted their care plans did not contain information which was up to date and their nursing care needs did not appear to be routinely assessed by the home. Information was not shared between the nurses and the care staff. For example we noted for one person their continence was being assessed. Nurses had carried out the assessment but it did not detail the frequency that the person should be supported to use the toilet. The care staff we spoke with did not know either but said it would "probably be after meals". This was a breach of Regulation 9 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found the clinical notes were not easily accessible within the files and were not kept in good order. Staff were not aware of the health care needs of some of the people they supported. We also found proper monitoring was not taking place which meant when people's needs changed staff were not always able to respond appropriately as the changing needs had not been identified.

It was recorded in one person's care plan they had been assessed as "very high risk" of developing a pressure sore. It was noted this should have been reviewed each month and this had not routinely been done. The last review was in February 2015. There was no review done in December 2014 or January 2015 despite the person being at "very high risk". We also noted due to their deteriorating health condition the GP visited weekly. This meant the home was not working collaboratively with external healthcare professionals to ensure the level of support the person was assessed as needing was based on up to date information.

In another care plan we found continence and nutritional assessments were up to date but a falls risk assessment had not been done since January 2015. This person had been assessed as 'extremely high risk' on one assessment form and 'medium risk' on a second form which meant the information available to staff about the level of support this person needed was conflicting.

We the above to be a breach of Regulation 9 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We had received a number of safeguarding notifications about incidents which had occurred at the home which had placed people at risk. We found the lack of proper care planning, auditing and review and the lack of communication between the nurses and care staff, as outlined above, did place people at risk. This was a breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last inspection in August 2014 we found the multi-function of the respite unit which provided long term support, assessment and respite was very conflicting. We

Inadequate

Is the service responsive?

had spoken with staff about whether consideration had been given to the appropriateness of respite placements being brought into someone's permanent home and also how this disruption may adversely affect someone's behaviour. At this inspection on 18 May 2015 we spent time on the respite unit to carry out observations. The Team Leader of the respite unit told us they "Had not had a safeguarding in ages." They went onto say that before the last inspection they would, "Take people without an assessment and have loads of problems but now, we do the assessment and get more details."

We saw assessments had taken place and where people wanted or needed to stay longer the correct processes had been followed to ensure decisions made were in their best interests. Overall we found improvements had been made in the respite unit of the home.

Requires improvement

Is the service well-led?

Our findings

Since the last inspection in August 2014 there had been changes to the management of the home and the layout of the service.

A new dining area had been introduced to improve the living environment for people on the downstairs nursing unit. The unit had been made smaller which made it feel more homely.

At the inspection in August 2014 we found strong leadership had not been visible or effective at all levels. At this inspection on 18 May 2015 we found some improvement had been made with the recruitment of a new manager.

Staff we spoke with acknowledged the service overall had, "Improved since last inspection." They said this was because the home was calmer and they got more support from the new manager.

Other staff we spoke with were less enthusiastic and felt the new manager was very strict where other managers had, "Been too soft and let staff do what they wanted."

Some staff said they were concerned that, "Different managers came and went and all had their own ideas which confused the staff."

We spoke with the new manager who was aware of the issues staff had raised. We were invited to attend the team meeting which was taking place on the same day as the inspection. The meeting had been arranged so the new manager could introduce themselves to staff whilst outlining changes which were planned to improve the service. This included timekeeping, staff accountability, record keeping and staff training. This meant we were assured that the manager had independently identified areas for improvement. This was because some of the areas being addressed were the same as what we had found during our inspection.

At the last inspection in August 2014 we found improvements were needed in relation to audits and reviews carried out by the registered manager. The deputy manager explained they were unable to carry out all the audits they were expected to do as they were not given any additional time since the registered manager had left. We spoke with the new manager who assured us this was an area that would be quickly addressed now they were in post.

At this inspection on 18 May 2015 we found there were still a number of gaps in the audits. There were no regular checking or cleaning of mattresses, beds, cushions, hoists and the weighing chair being done routinely. One of the nurses told us "The night staff are responsible for washing chairs and wheelchairs but probably don't do it." We found this was a breach of Regulation 17 of The health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The new manager had been in post since April 2015. The home also employed a deputy manager, team leaders and senior staff to support the management of the home.

We could see improvements had been made in some areas of the home and there was evidence the new manager was implementing organisational changes. We saw there was a more structured team in the downstairs nursing unit which had made a positive difference to the people who lived in that part of the home.

We saw evidence of some care staff having received supervision and care staff we spoke with confirmed they had found it useful. However this was not consistent throughout the home and the manager acknowledged it was not up to date on all of the units. The registered nurses confirmed they had received their clinical supervision from the nurse manager who had acted up.

However, we spoke at length to one of the nurses who told us they were unable to carry out their clinical tasks effectively due to the lack of time they had available to them. The nurse told us they were responsible for auditing records, care plans, risk assessments, infection prevention and control, medication charts and the cleanliness of residents' rooms but did not have enough time to carry out these tasks effectively. They went on to say they were unable to properly train care staff with some on the job training which would help support the nurses to ensure clinical care needs could be managed more effectively. This was a breach of Regulation 17 of The health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The new manager told us they intended to take a very 'hands-on' approach to managing the home and was able to talk to us openly about areas where improvement was needed.

Requires improvement

Is the service well-led?

At the last inspection In August 2014 we found where people had input from the community nursing home team (NHT) there was an over reliance on them to do and assess people's clinical care needs. We also found there was an over reliance on information from external agencies such as social workers and health care professionals and not much formal assessment being done within the home. We discussed this with the new manager who was receptive. They had also previously discussed staff accountability at the team meeting which told us they had already reached the same conclusion through their own observations. This assured us that although we had found breaches in The Health and Social care Act 2008 (Regulated Activities) Regulations 2014 some of the issues we had found during our inspection were already being addressed.

During the inspection we discussed with the manager incidents which had occurred such as poor moving and handling techniques utilised by some of the staff. The manager responded by immediately organising training for staff. We found the manager very clear about how they wanted to lead the service and very responsive to questions we asked and information we needed throughout the day.

We found strong leadership was needed to ensure staff were confident to respond to changes in conditions of the people they supported. Staff needed also to be able to analyse the changes and take responsibility for people's on going care. We found there was a sense of lethargy and lack of motivation in the qualified nurses which was exposing some residents to poor care. We spoke with the manager about our concerns and they assured us they knew what the problems were and had begun to address it through supervision and performance management.

Due to the on going issues at the home, which the provider had not rectified, we found the service to be in breach of Regulation 6 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the person responsible for supervising the management of the carrying on of the regulated activity did not have the necessary qualifications, skills and experience to properly supervise the management of the carrying on of the regulated activity which left people at risk of receiving unsafe care and treatment .