Galleon Care Homes Limited

Lindsay Hall

Inspection report

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Ratings

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

Overall summary

We inspected Lindsay Hall on the 18 and 20 March 2015. Lindsay Hall provides accommodation and nursing care for up to 38 people living with differing stages of dementia who have nursing needs, such as diabetes and strokes. There were 29 people living at the home on the days of our inspections.

Lindsay Hall Nursing Home is owned by Galleon Care Homes Limited and has two other homes in the South East. Accommodation was provided over three floors with a passenger lift that provided level access to all parts of the home. People spoke well of the home and visiting relatives confirmed they felt confident leaving their loved ones in the care of Lindsay Hall Nursing Home.

A manager was in post and was in the process of registering with the CQC. The manager is already the registered manager of the home situated next door to Lindsay Hall owned by Galleon Care. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like

Summary of findings

registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated regulations about how the service is run.

People and visitors spoke positively of the home and commented they felt safe. Our own observations and the records we looked at did not always reflect the positive comments some people had made.

People's safety was being compromised in a number of areas. Care plans did not reflect people's assessed level of care needs and care delivery was not person specific or holistic. We found that people with specific health problems such as diabetes did not have sufficient guidance in place for staff to deliver safe care. Risk assessments to promote peoples comfort, skin integrity and prevention of pressure damage had not identified when necessary equipment such as beds and chairs were not suitable for individual people. For example, taking in to consideration their height, and weight. This had resulted in potential risks to their safety and well -being. Staffing levels were stretched and staff were under pressure to deliver care in a timely fashion.

The provider was not meeting the requirements of the Mental Capacity Act (MCA) 2005. Mental capacity assessments were not completed in line with legal requirements. Staff were not following the principles of the MCA. We found there were restrictions imposed on people that did not consider their ability to make individual decisions for themselves as required under the MCA Code of Practice.

The delivery of care suited staff routine rather than individual choice. Care plans lacked sufficient information on people's likes, dislikes, what time they wanted to get up in the morning or go to bed. Information was not always readily available on people's life history and there was no evidence that people were involved in their care plan. The lack of meaningful activities at this time impacted negatively on people's well-being.

Whilst people and visitors were complimentary about the food at Lindsay Hall Nursing Home, the dining experience was not a social and enjoyable experience for people. People were not always supported to eat and drink enough to meet their needs.

Quality assurance systems were in place but had not identified the shortfalls we found in the care delivery. Staff had not all received essential training and specific in dementia and challenging behaviour to meet people's needs.

People we spoke with were very complimentary about the caring nature of the staff. People told us care staff were kind and compassionate. Staff interactions demonstrated they had built rapports with people and people responded to staff with smiles. However we also saw that many people were supported with little verbal interaction and many people spent time isolated in their room.

People's medicines were stored safely and in line with legal regulations. People received their medicines on time and from a registered nurse. However we found poor recording of topical creams, dietary supplements and as required medication.

Feedback had been sought from people, relatives and staff. 'Residents' and staff meetings were held on a regular basis which provided a forum for people to raise concerns and discuss ideas. Incidents and accidents were recorded, but not consistently investigated with a robust action plan to prevent a re-occurrence.

Staff told us they thought the home was well managed and the communication systems in place supported them to deliver good care, but felt that the lack of permanent staff had raised issues. Their comments included "We work well but need to build up the staff team, we can't do everything."

People had access to appropriate healthcare professionals. Staff told us how they would contact the GP if they had concerns about people's health. However care plans did not include all the information about people's health related needs.

People were protected, as far as possible, by a safe recruitment system. Each personnel file had a completed application form listing their work history as wells as their skills and qualifications. Nurses employed by Lindsay Hall Nursing Home and bank nurses all had registration with the nursing midwifery council (NMC) which was up to date

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010,

Summary of findings

which now correspond with the Regulations 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 this report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

Lindsay Hall Nursing Home was not safe. Risk assessments were devised and reviewed monthly. However, management of people's individual safety and skin integrity was poor and placed people at risk.

People were placed at risk from equipment not suitable for their needs and poor moving and handling techniques.

There were not enough staff to meet people's needs. People's needs were not taken into account when determining staffing levels.

People told us they were happy living in the home and they felt safe. Staff had received training in how to safeguard people from abuse and were clear about how to respond to allegations of abuse. Staff recruitment practices were safe.

Medicines were stored safely and people received their medicines when they needed them. However recording of topical creams, dietary supplements and as required medication was inconsistent.

Is the service effective?

Inadequate

Lindsay Hall Nursing Home was not effective. Meal times were observed to be a solitary and inefficient service with food being served to people who were in an inappropriate position or left with their meal untouched in front of them. Senior staff had no oversight of what people ate and drank. No guidance was available on how much people should be eating and drinking to remain healthy.

Not all staff received on-going professional development through regular supervisions, and essential training that was specific to the needs of people had not been undertaken. Lack of dementia care guidance and training was a particular concern.

Staff had some understanding of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. However, the use of mental capacity assessments for people who had limited capacity were not in place.

Is the service caring?

Requires Improvement

Lindsay Hall Nursing Home was not consistently caring. People and visitors were positive about the care received, but this was not supported by some of our observations.

Care mainly focused on getting the job done and did not take account of people's individual preferences or respect their dignity. People who remained in their bedroom received very little attention.

Summary of findings

Staff were not always seen to interact positively with people throughout our inspection. We saw staff undertake tasks and care without any interaction. However we also saw that some staff were very kind and thoughtful and when possible gave reassurance to the people they supported

Is the service responsive?

Requires Improvement

Lindsay Hall Nursing Home was not consistently responsive. Care plans did not always show the most up-to-date information on people's needs, preferences and risks to their care.

People told us that they were able to make everyday choices, but we did not see this happening during our visit. There were not enough meaningful activities for people to participate in as groups or individually to meet their social and welfare needs; so some people living at the home felt isolated. One person told us they were lonely in their room and another said "I miss meeting people, the days are long."

A complaints policy was in place and complaints were handled appropriately. People felt their complaint or concern would be resolved and investigated.

Is the service well-led?

Inadequate

Lindsay Hall Nursing Home was not well led. There was no registered manager in post. People were put at risk because systems for monitoring quality were not effective.

The delivery of care was not person focused and people were left for long periods of time with no interaction or mental stimulation.

The home had a vision and values statement, however staff were not clear on the home's direction. Staff however told us that they felt supported by the management and worked as a team.

People spoke positively of the care, however, commented that staffing levels could impact on the running of the home. People had an awareness of who the manager was and felt that the management team of the home were approachable.

Lindsay Hall

Detailed findings

Background to this inspection

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

On 1 April 2015 the Care Act 2014 came into force. To accommodate the introduction of this new Legislation there is a short transition period. Therefore within this inspection report two sets of Regulations are referred to. These are, The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. As from 01 April 2015, CQC will only inspect the service against the new Regulations - The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We visited the home on the 18 and 20 March 2015. This was an unannounced inspection. The inspection team consisted of two inspectors and an expert by experience who had experience of older people's care services. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of service.

During the inspection, we spoke with 15 people who lived at the home, eight visiting relatives, six care staff, two registered nurses the manager and the area manager for Galleon Care.

Before our inspection we reviewed the information we held about the home. We considered information which had been shared with us by the local authority and looked at safeguarding alerts that had been made and notifications which had been submitted. A notification is information about important events which the provider is required to tell us about by law. We also contacted the local authority to obtain their views about the care provided in the home.

We looked at areas of the building, including people's bedrooms, the kitchen, bathrooms, and communal areas. Some people were unable to speak with us. Therefore we used other methods to help us understand their experiences. We used the Short Observational Framework for Inspection (SOFI) during lunchtime. SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. We also used communication aids that people themselves used, to communicate with them.

During the inspection we reviewed the records of the home. These included staff training records and policies and procedures. We looked at nine care plans and risk assessments from Lindsay Hall along with other relevant documentation to support our findings. We also 'pathway tracked' people living at Lindsay Hall Nursing Home. This is when we looked at people's care documentation in depth and obtained their views on how they found living at Lindsay Hall Nursing Home. It is an important part of our inspection, as it allowed us to capture information about a sample of people receiving care.

Is the service safe?

Our findings

People told us they felt safe living at Lindsay Hall Nursing Home. Visiting relatives confirmed they felt confident in leaving their loved one in the care of Lindsay Hall Nursing Hall. One visiting relative told us, “I chose this home because it felt homely and its small, staff are really nice.” Another relative said, “I trust staff here.” One person told us, “I am safe here, plenty of people to help me.” However we found there were shortfalls which compromised people’s safety and placed people at risk from unsafe care.

Peoples’ risk assessments were not all accurate and some lacked sufficient guidance to keep people safe. Individual risk assessments were in place, which covered areas such as mobility, continence care, falls, nutrition, pressure damage and overall dependency. They looked at the identified risk and included a plan of action. However, some risk assessments did not include sufficient guidance for care staff to provide safe care and others were not being followed. For example, there was evidence of pressure damage for one person incurred by equipment not being suitable for that individual. Staff were aware of these issues and spoke about it but it was confirmed from discussion with senior staff that no preventative measures had been put in place to reduce the risk to this person, such as involving an occupational therapist or seeking advice from other professional experts. Assessments for this person had not looked at prevention from further skin damage.

Good skin care involves good management of incontinence and regular change of position. There was guidance for people in bed to receive two hourly position changes and the use of a pressure mattress. However for people sitting in chairs or wheelchairs there was no change of position or toilet breaks in their care directives for staff to follow. During the inspection, we observed people sitting in the communal lounges. We identified that throughout the inspection, five people had not been assisted to access the toilet or offered a change position in over 9 hours from 9 am until 6 pm. This increased the risk of skin breakdown through prolonged sitting in one position and not receiving regular continence care. We looked at these five people’s care plans for continence management which stated that regular checking of incontinence aids should be undertaken and barrier creams applied. These people were therefore at risk from pressure damage. There was no guidance in the care plan to ensure staff managed people’s skin integrity safely with regular checking and movement of position.

One person living with behaviours that challenged had a care plan that detailed ‘can be agitated and staff not to get near’, but there was no guidance on how to de-escalate or divert the agitation. There was a reference to sedation but no guidance as to triggers to identify how and when sedation may be necessary. We saw an incident report that stated an episode of verbal and physical abuse had occurred in February 2015 against a member of staff. However no action plan had been put in place to manage outbursts and the care plan had not reflected this incident.

The accident records identified that in February 2015, one person had fallen twice and the reason was they were unsteady on their feet. The action taken was to place an alarm mat in the bedroom for the night, however the records stated both falls occurred in the lounge and during the day. There was no action plan for keeping this person safe in the lounge during the day.

We saw that one person had sustained severe bruising to the face. It had been photographed, reported on and monitored but had not been investigated as to how it may have occurred. The manager confirmed that this will be fully investigated.

We observed two instances where people were being supported to move from a wheelchair to armchair with the support of hoisting equipment. The people were suspended and swaying, and not supported safely by the two staff members. There was little verbal support or reassurance from staff to the person being moved. This was not a safe or pleasant experience for them. We did however also see people moved with skill and expertise and so the skills in moving and handling people were varied.

We saw care staff move a person who had slipped in their armchair by means of using a 'drag' lift. A 'drag' lift (underarm lift) is any method of lifting people where staff place a hand or arm under the person's armpit. Use of this lift can result to damage to the spine, shoulders, wrist and knees of the carer and, for the person lifted, there is the potential of injury to the shoulder and soft tissues around the armpit. Staff stopped when they realised the inspectors were present and then used the appropriate equipment. We also observed one person moved in bed by staff using a

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'drag' lift so they could eat their meal. People were not protected from avoidable harm due to inappropriate moving and handling techniques. All of the above issues demonstrate that people were not protected against the risks of receiving care or treatment that is inappropriate or unsafe.

These issues were a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing comprised of six care staff on the day shift in addition to the registered nurse. The manager was supernumery to the staffing levels. Three waking staff provided support at night with on nurse. At the time of our inspection, Eleven people were fully dependant on staff and required two staff to support them for all of their personal care and mobility needs. A further 18 people required two staff to assist them with all personal hygiene needs and one staff members assistance with mobilising. We were told the provider used an informal staff ratio of 1 staff member to five people, this did not reflect the documented needs of people In addition to providing care and support for people, one person required 30 minute observations to keep them safe and care staff were also providing activities. The nurse administered medication three times a day and took responsibility for wound care but was not seen to be supervising care delivery or meal services.

Agency staff have been used regularly in the past few months due to staff leave, illness and resignations. On the day of our inspection there were three agency staff on duty. One told us, "We just get on with it, I have worked nights here before, but not days, I didn't have a hand over but staff are supportive." We looked at the staffing rota and saw that on one day the previous week there had been five agency staff on duty with one permanent staff member. This had not ensured that there was consistent care delivery, and people who live with dementia respond more positively to people they recognise. One staff member said, "People respond better when they recognise us, some refuse care from new faces. It can be challenging to be everywhere when we have lots of relief staff on."

Staff told us "Shifts can be hectic in the mornings and in the evenings, especially if any of the residents aren't well" and, "Sometimes there is not enough time to do everything as I would like to." One agency staff member said, "I was surprised as quite a few people were up, washed and dressed, the night staff tend to get people up." Care documentation did not support that this was people's choice. One staff member told us, "It's done to help us out in the morning, as we are very busy."

Personal emergency evacuation plans (PEEP's) were in place but staffing levels especially at night would not be able to respond to the actions detailed. This placed people at risk from failed emergency evacuations.

Accident and incident reports recorded a number of unwitnessed falls of people in communal areas, this indicated that staff were not present and people were not adequately supervised.

These issues were a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Whilst the provider had appropriate arrangements in place for the safe management of medicines. We saw that organisational procedures for 'as required' medication (PRN), nutritional supplements, drink thickeners and topical creams (creams and lotions for skin) were not always followed.

There were records of medicines received, disposed of, and administered. We observed the administration of the morning and lunchtime medicines and saw that staff administered medicines safely. Nurses who administered medicines carried out the necessary checks before giving them and ensured that the person took the medicines before signing the medication administration record (MAR) chart. The nurse ensured medication was swallowed before signing the MAR chart and ensured the trolley was locked when left.

However we also found that people were at risk of not receiving medicine as they required it, such as paracetamol (PRN Medicines) due to lack of guidance and risk assessments. We looked at eight people's care documentation that were prescribed PRN medication. PRN medicine should only be offered when symptoms are exhibited. Clear guidance and risk assessments must be

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available on when PRN medicine should be administered and the steps to take before administering it. Six people who received PRN did not have a PRN care plan detailing when the medicine should be administered.

Where people were prescribed topical medicines such as creams, records were incomplete. In one instance, staff were unable to provide any record that a cream was applied. This cream should have been applied twice a day and recorded. Staff could not demonstrate that the people's skin conditions had been treated as prescribed.

Where a person refused their medicine for more than two consecutive days, staff had not contacted the GP to establish any impact this may have on the person. This was contrary to the service's medication policy, which explained the GP should be contacted following three refusals. Staff inconsistently recorded the administration of prescribed drink thickeners. This made it difficult to track the amount of drink thickener held and impossible to establish if it was given to people appropriately, potentially placing people at risk of choking. For people prescribed food supplements there were incomplete records kept so we were not assured that people were receiving food supplements as required.

These issues were a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were protected, as far as possible, by a safe recruitment system. Staff told us they had an interview and before they started work, that the provider obtained references and carried out a criminal records check. We checked three staff records and saw that these were in place. Each file had a completed application form listing their work history as wells as their skills and qualifications. Nurses employed by the provider of Lindsay Hall Nursing Home and bank nurses all had registration with the nursing midwifery council (NMC) which was up to date.

Training schedules told us that staff had received safeguarding training on the 3 March 2015 and staff we spoke with confirmed this. Staff had a clear understanding of abuse and felt confident that any allegations made would be fully investigated to ensure people were protected. Safeguarding policies and procedures were in place and were up to date and appropriate. Staff had received training in safeguarding adults at risk and were able to tell us of the signs of abuse, we found safeguarding referrals were made to the local authority when required.

Inadequate

Is the service effective?

Our findings

People spoke positively about the home. Comments included, "I'm looked after." "The carers are very good." However, we found at Lindsay Hall Nursing Home did not consistently provide care that was effective.

Staff were not working within the principles of the Mental Capacity Act 2005 (MCA). Staff members told us, a majority of people would be unable to consent to care and treatment, and had a mental capacity assessment completed. However, in the mental capacity assessments we viewed, it was not clear what decision was being made. The MCA says that assessment of capacity must be decision specific. It must also be recorded how the decision of capacity was reached. We found mental capacity assessments did not record the steps taken to reach a decision about a person's capacity. We asked the staff to talk us through how they completed the mental capacity assessments. They were unable to tell us how they undertook the assessments and what steps they took. We were informed, "We were deciding on bed rails and acting in their best interest when giving care." This told us mental capacity assessments were not decision specific and were not recorded in line with legal requirements.

Training schedules showed us that no staff had received Deprivation of Liberty Safeguards (DoLS) training, or MCA training. Care staff had a basic understanding of mental capacity and informed us how they gained consent from people. One care staff told us, "We offer people choices and give them information to enable them to make a decision." Another member of staff told us, "We also monitor body language and facial expressions for signs of consent." However, the staff's, understanding of the MCA and completing mental capacity assessments was basic and not in line with legal requirements.

In March 2014, changes were made to the Deprivation Liberty Safeguards and what may constitute a deprivation of liberty. These safeguards protect the rights of people by ensuring that any restrictions to their freedom and liberty have been authorised by the local authority, to protect the person from harm. During the inspection, we were informed by the manager that two DoLS application had been made, however the management team were not clear on who was under a DoLS. Everyone at Lindsay Hall could be seen as needing a DoLS as there were key pads on most doors and lifts. There were some specific people that required an urgent DoLs as they were seen trying to open doors. However, when discussing DoLS with the management team, they were not aware of any DoLS applications being authorised, nor who they would be for, or the need to inform CQC. We saw people restricted from moving by tables in front of their chairs, poor positioning in recliner chairs and bedrails without a specific assessment undertaken.

There were no individual mental capacity assessments for people living at Lindsay Hall Nursing Home on how their freedom may be restricted or what least restrictive practice could be implemented. This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, this corresponds to Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Whilst people told us the food was 'nice', 'good and tasty', we observed that the lunchtime experience on the first day of the inspection process was not structured and was not a pleasurable experience or made to feel like an enjoyable event for people.

The main dining area and lounge was on the middle floor (ground) however there were only three tables available which meant that not everyone would be able to sit at a table to eat their meal if they wished to. Two people had been sat at a table all morning and they remained there for lunch. No-one sitting in the lounge or in their bedrooms were given the opportunity to choose where they had their lunch.

People were seated at dining tables which were uninviting as they had not been set for a meal, for example no condiments, glasses or napkins for people. There was no visual stimulus that would have promoted it as being a mealtime. People were not told what the meal was and one person said, "I'm not sure what I am eating. " A pictorial menu was on a notice board in the dining area but it was very small and staff did not show it to people during the morning. Seven people remained seated in the lounge area and either had small tables to eat their meal from, or received one to one support to eat from their recliner arm chair. Two people were assisted by staff still in a reclined position which meant that they were at risk from choking. One person in a recliner chair wasn't sitting up properly, the angle at which they were at the table, meant they couldn't fully see their plate. This person ended up using their fingers to eat and ate very little. The care plan for this

person did not say this was their preferred method of eating or that it was the best way for this person to eat independently. Staff didn't ask if they would like to change position or if they wanted anything else. One staff member said later they had assumed they were full. We observed one person at the dining table in a wheelchair. The wheelchair was at an angle as it did not fit under the table, this person struggled to eat their meal from that position and eventually was assisted by a staff member to finish their lunch which was no longer hot.

People that remained in their room received their food and staff did check intermittently that they were eating, but this was not consistent on all floors. We observed staff assisting people in bed to eat. The staff members stood and assisted over the bed rails. There was little interaction and it was not seen to be an enjoyable experience for people.

The meal was attractively presented by the cook, who was knowledgeable of people's specific dietetic requirements such as soft, fork masheable or pureed. Pureed food was attractively presented and recognisable as meat, vegetables and potato but prior to feeding people staff mixed the food together. People were then unable to identify the food they were eating. Much of the food was returned uneaten and poor appetite trends may not be picked up, as staff did not routinely record this unless it was someone identified at risk from malnutrition.

We looked at people's food and fluid records. The care plans directed staff to monitor people's food and fluid intake when it had been identified the person was at risk from dehydration and malnutrition. There were records for people at risk from dehydration and malnutrition that were incomplete and not totalled, and therefore would not be an effective way of monitoring their health. One person required 1500 mls a day to maintain their health but records stated their input was variable, for example, records showed the persons input of fluids on five consecutive days ranged between 200 mls to 600 mls. We also saw that 200 mls was taken in 24 hours and the following day there was no fluid chart in place. Staff had not identified this and not passed this concern on to senior staff. Output was not recorded and staff therefore would not know if this person was dehydrated. We also noted that for five of the 12 records looked at no-one received fluids after 5pm and received no drinks until 8am the following day. Food records for some people also demonstrated they ate very little and weight records showed weight loss for eight people, three people had been referred to a dietician. There were others who were considered stable but with a low body weight. The staff had not ensured that people received suitable and nutritious food and hydration which is adequate to sustain life and good health.

These issues were a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

All staff told us that they had completed training to make sure they had the skills and knowledge to provide the support individuals needed. Staff received an induction programme which lasted a month and on-going training support. Newly appointed staff shadowed other experienced members of staff until they and the service felt they were competent in their role. This was confirmed by a member of staff who said, "The induction process gave me the skills I needed to provide care for people. I was paired with others so I could learn, it was so good and all at my own pace. It made me feel confident." However the training records identified that staff training and training refreshers were out of date. We saw that training for some staff in safeguarding, dementia care and managing behaviours that challenge, had been due in 2001 but not undertaken by staff. We discussed this at the inspection with the manager and received an action plan detailing training dates that had been booked in March and April 2015 for urgent essential training. The lack of training for staff had not ensured that people received appropriate effective care.

Staff supervision was not up to date for all staff. Supervision helps staff identify gaps in their knowledge, which was supported if necessary by additional training. Staff said "Supervision is really helpful, it gives me the opportunity to discuss anything, and I used it when one of the resident's behaviour scared me. I was able to get further support to manage the situations that arose." However other staff said that they had not received regular supervision, "It's been a while I think, we have had staff changes and it's been a little bit up and down, because we have been filling in and so other things take a back seat."

Inadequate

Is the service effective?

Staff said that staff changes and high use of agency staff had impacted on their training and professional development. One staff member said, “I want to do my diploma in health and social care, but I have put it off because I would not have time to do it at present.”

The provider had not ensured that staff had received appropriate training, professional development and staff supervision to meet the needs of the people they cared for. This was a breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service caring?

Our findings

People were positive about the care they or their loved one received. Visitors told us, "They speak to residents, have a respectful approach, keep the place clean, and know how to calm them," and "My husband is a proud man so I'm grateful that he's always shaven and kept clean in his own clothes." However this was not fully supported by some of our observations

Some staff did interact with people in a caring manner, but we also observed instances when staff did not engage with people. Staff assisted people, but did not ensure comfort by verbal reassurance or display empathy with people's mental health needs. We saw one person being continually sent away by staff to walk around the main corridor area. This person then spent time alone and remained anxious and trying to leave the locked area. We saw other people being asked to wait when they called out.

Staff told us they promoted people's independence and respected their privacy and dignity. Staff knocked on bedroom doors and waited for a response before they entered. Staff also greeted people respectfully and used people's preferred names when supporting them. One staff member commented on how they encouraged people to be as independent as possible. However this was not supported by our observations. For example one person wanted to lift objects and books, but was asked to "Leave things alone." No explanation was given and this person became withdrawn and remained on their own for the rest of the morning. Another person was restless looking for a quiet place to sit, staff collected them four times in one hour and took them back to the main communal lounge where they remained restless and anxious. These people's individual needs were not considered or respected by staff at this time. We also saw that peoples clothing was not always appropriate. Some clothing was ill fitting and looked uncomfortable whilst others wore inappropriate foot wear. For example, one visitor commented that she wasn't aware her loved one wore ¾ length trousers but following discussion with staff the trousers had ridden up during the day to expose lower legs and had not been repositioned to be comfortable. We saw that people wore matching slipper socks that had been introduced by a staff member. However this was not seen as being their choice and lacked individual preference. The wearing of slipper socks instead of slippers or shoes whilst walking around the environment did not protect feet from injury or support/encourage walking. The rationale for introducing the use of slipper socks was not explored in individual peoples care plans.

Our SOFI identified that on two floors, verbal interaction was minimal and staff lacked empathy with the people they supported. We saw an example where a person was calling out constantly for over 15 minutes, but was ignored by staff as they were busy elsewhere. When asked staff said, "It's normal but we will spend time with them later when it's quieter, I will pop some music on for them." Eight people who had complex dementia health needs were in the lounge area. Seven people spent their time dozing or sitting in one place whilst staff helped one person with a puzzle. The environment and atmosphere was unstimulating. We saw staff were busy and there was currently no activity co-ordinator in post or staff lead in organising activities. The second day of the inspection was seen to be a more stimulating and enjoyable experience for people as staff had laid tables and 11 people were seen sitting and eating at a dining table.

Observations throughout the day identified that staff did not always offer people a choice or listen to what they wanted. People were placed in chairs for long periods without a change of position or being asked if they wanted to sit elsewhere. The television was on in the lounge but people were not asked if that was what they wanted to watch. One person was asking to return to their bedroom but staff told them to stay in the lounge. This had not fully enabled people to make everyday choices important to them and to meet their identified needs. One member of staff told us, "We try to ensure that people are given choice and make decisions for as long as they can but many can't, so we do it for them." This did not promote people's independence or autonomy.

During our inspection an external health professional visited the service to support people. . People were attended to in the corridor, in the lounge and in the dining area. Staff did not offer privacy screens for this support or devise an agreed protocol with the health professional to promote people's privacy and dignity.

People told us they were well cared for. One person told us, "They are very kind." Another person told us, "I'm very happy here." However documentation on when people received oral hygiene, bath or a shower recorded that often people would not receive a bath or a shower in 14 days.

Requires Improvement

Is the service caring?

One person had according to the documentation only received one bed bath in 14 days. We also saw that people could go five days without receiving oral hygiene. The manager informed us, "Care staff should be recording in people's daily notes when a bath or shower is offered and why oral hygiene was not given." The sample of daily notes we looked at did not always record when an individual received care or if personal care was offered. We could therefore not tell if people received regular support to bath or shower. Care staff commented that most people received a bed bath but could not confirm why people were not offered a regular bath or shower. This meant we could not be assured that people's personal hygiene needs were being met.

This had not ensured that people were treated with dignity and respect in ensuring their personal care needs were met consistently. These issues were a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Despite the above concerns, we did see staff interacting with people in a kind and compassionate way. When talking to people, staff maintained eye contact and knelt down next to the person. Staff had clearly developed rapports with people and people responded to staff with smiles. Staff we spoke with spoke positively of the home and confirmed they enjoyed their work.

People commented they could enjoy a laugh with staff. One staff member was observed sitting with visitors and their person they were visiting sharing news and stories. One visiting relative told us, "Staff bring in DVDs they think my loved one may enjoy. They brought in a football one the other week, they are very caring."

Requires Improvement

Is the service responsive?

Our findings

People commented they were well looked after by care staff and that the service listened to them. However, we found Lindsay Hall Nursing Home did not consistently provide care that was responsive to people's individuality and changing needs.

Communication and social well-being was an area that we identified as a concern, as there were people isolated in the lounge areas and bedrooms with little interaction. People that were mobile and able to communicate with words interacted with each other, visitors and staff. However, people who could not communicate with words were left for long periods of time without staff intervention. Staff were seen in the communal areas, but did not actively engage with people. We noticed one particular person who constantly wanted to be up and about and involved. This person approached care staff in a way that suggested they wanted some occupation, to be of use or at have some engagement. However this was not responded to and the person was consistently led back to the corridor and encouraged to continue walking. This happened over and over again with several different care staff having the same approach as opposed to identifying what this person actually needed.

Activities were not being undertaken as the activity co-ordinator has recently left and the provider was currently recruiting to the position. Care staff undertook an activity in the lounge after lunch if possible. However not everybody's social needs were being met. For example, there were only seven people in the communal area and there was no one to one with people in their rooms.

On the second floor people had high nursing needs and were on bed rest or remained in their room. We noted that apart from when care was being delivered, staff were rarely seen on this floor as they were assisting elsewhere. The manager had created a garden theme to the large landing which was an innovative idea but not used at all during the first day of the inspection and only used by two people on the second day.

We visited people in their bedrooms and observed some people lying in bed with nothing to visually engage with or listen to. There was little guidance in peoples care plans to guide staff in ensuring that their social needs were being met. One person was listening to music but it was the same song over and over again. The care plan contained no information that this was the person's preference. We observed that this person becoming distressed and calling for staff for assistance.

We observed in the lounge that people spent a considerable amount of time without staff being present. We sat in the lounge for 30 minutes and did not see a member of staff. People in the lounge had no access to call bells to summon assistance. One person's sitting position in the dining room meant they were unable to see the television or interact with other people. This person had no other form of stimulation such as a book. This person spent long periods of time dozing but enjoyed interaction when approached by staff.

People's care plans included risk assessments for skin damage, incontinence, falls, personal safety and mobility and nutrition. Records showed that people had regular access to healthcare professionals, such as GPs, chiropodists, opticians and dentists and had attended regular appointments about their health needs. However the care plans lacked details of how to manage and provide person specific care for their individual needs.

People's continence needs were not always managed effectively. Care plans identified when a person was incontinent, but there was no guidance for staff in promoting continence such as taking to the toilet on waking or prompting to use the bathroom throughout the day. We saw one person was known to only go to the bathroom in their room. During our inspection process this person was not offered to be taken to their room or prompted to go to the bathroom for up to ten hours. This was not identified by staff as problematic, but staff mentioned that the person would refuse drinks so as not to need to go to the bathroom. This was potentially a risk to the person's well-being, for example dehydration and urinary tract infections. Another person was sat in wet clothing at the dining table for over an hour. We asked staff to assist as the person was distressed and kept trying to stand up from their wheelchair. Staff passed the request to three different colleagues and the person waited 45 minutes before they received assistance. We asked staff about continence management and they could tell us who was incontinent and who required prompting and assistance. However there was no mention of promotion of

Requires Improvement

Is the service responsive?

continence to prevent incontinence. People's continence needs can be managed by regular prompting and responding to body language and timings for drinks and meals.

The evidence above demonstrates that delivery of care in Lindsay Hall at this time was seen as task based rather than responsive to individual needs. This meant that people had not received person centred care that reflected their individual needs and preferences. This was a breach of Regulation 9 of the Health and Social Care Act 2008, which corresponds to Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were supported to maintain relationships with people who were important to them. We observed people visiting throughout the day. Visitors told us they were always welcome at the home. They told us they were able to visit whenever they wished.

A complaints procedure was in place and displayed in the reception area of the home. However, this was not displayed elsewhere in the home or provided to people in an accessible format. Most people told us they felt confident in raising any concerns or making a complaint. One person told us, "I'm happy to complain if I need to. I know who the manager is, I sometimes see her." However, some people did not feel confident that their complaint or concern would be resolved. One person told us, "If I had concerns I couldn't raise them, it's just a waste of time, they ignore me." Staff explained that they knew that the person felt this way and spent time with them when they were not happy, and from reviewing the care plan we noted that it was documented with a plan of action detailed. The home had received one complaint since December 2014 which was still on-going, but documentation confirmed complaints were investigated and feedback was given to the complainant.

The manager had sent out satisfaction surveys in the latter part of 2014, and was in the process of collating them. One visitor said, "I have been asked to complete a survey, which I will be doing, but I do tell staff if I have a problem or want information about my husband."

Inadequate

Is the service well-led?

Our findings

People, friends and family and staff all described the management of the home to be approachable, open and supportive. People told us; "Very approachable," and "Nice and ever such a lot of help." A relative said; "The management have time for you, they will stop and talk and most importantly listen." A staff member commented; "The management are supportive, they come out onto the floor, they're not just stuck in their office."

There was no registered manager in post. The manager has been in post for a year and has recently submitted an application to the CQC that is being considered. The manager is already registered as manager of another home owned by Galleon Care.

Whilst there were quality assurance systems in place they had not identified that people's social and welfare needs were not being consistently met. We identified throughout the inspection that many people were unstimulated and isolated at times and that staff did not actively engage with them. Staff felt that low staffing levels stopped them giving the care they wanted to and said that this had been identified at meetings but not acted on. We also found that people's nutritional needs were not being effectively managed and monitored to ensure that people had enough to eat and drink. The care plan audits had not identified that people's specific health needs were not accurately reflected in their care plans, for example management of diabetes and continence. Medication audits had not identified the poor recording of topical applications and inconsistent recording of dietary supplements.

This meant that the people had not been protected against unsafe treatment by the quality assurance systems in place. This was a breach of Regulation 10 of the Health and Social Care Act 2008, which corresponds to Regulation 17 of the Health and Social Care Act 2014.

The culture and values of the home were not embedded into every day care practice. The manager told us, "The vision of the home is to put the person at the centre. This is their home. When I first started working here, the culture was not good, but I've been working on that and improving that." Staff were unclear when we discussed values and cultures with them. They felt values and cultures were about staff morale and supporting each other to achieve good care delivery. People were not put at the centre of the care delivery. Staff we spoke with did not have a strong understanding of the vision of the home and from observing staff interactions with people; it was clear that the vision of the home was not yet embedded into practice as care was task based rather than person centred. Staff however spoke positively of the culture and how they all worked together as a team, this was said by all staff we spoke with. They said they supported each other and helped out on other floors if they were busy. The staff talked about staff support but not about how to improve the lives of the people they supported and cared for.

We found that communication and leadership needed to be improved within the home. People and visitors had an awareness of the management team but felt that staff turnover and use of agency had unsettled the running of the home. The staff worked hard but shortcuts in care delivery were noted due to time constraints and staff shortages. This meant people did not receive the care they wanted and required. For example social interaction, mental stimulation and promotion of independence and mobility. We discussed with the manager that this is an area that needs to be improved.

The registered manager told us one of their core values was to have an open and transparent service. The provider sought feedback from people and those who mattered to them in order to enhance their service. Friends and relatives meetings were regularly held and surveys conducted that encouraged people to be involved and raise ideas that could be implemented into practice. People had meetings to discuss specific topics for example, meals and activities within the home. People and relatives told us they felt their views were respected and had noted positive changes based on their suggestions. One visitor said that the staff had changed their relative's room round at their suggestion. However these meetings had not been as regular over the past six months.

Staff meetings were regularly held to provide a forum for open communication. Staff told us they were encouraged and supported to question practice. If suggestions made could not be implemented, staff confirmed constructive feedback was provided. For example, one member of staff commented; "I raised a concern, the manager took my comments on board, spoke with staff and I've noticed change already." An area of continued concern that we were told was mentioned regularly at staff meetings was

Inadequate

Is the service well-led?

staffing levels and staff felt that this was not taken forward as pro-actively as it should be. They had been told that recruitment was on-going and care staff vacancies would be filled. One staff member said, “The high use of agency does affect the way we work, especially if the care staff are new to Lindsay Hall.

The management team took an active role within the running of the home and had good knowledge of the staff and the people. There were clear lines of responsibility and accountability within the management structure. The service had notified the Care Quality Commission (CQC) of all significant events which had occurred in line with their legal obligations.

Information following investigations were used to aid learning and drive quality across the service. Daily handovers and meetings were used to reflect on standard practice and challenge current procedures, for example, wound care. Documentation was improved following advice from the tissue viability nurse.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent Where people did not have the capacity to consent, the registered person had not acted in accordance with legal requirements. Regulation 11 (1) (3) (4) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider had not ensured the safety of service users by assessing the risks to the health and safety of service users of receiving the care or treatment and doing all that is reasonably practicable to mitigate any such risks. The provider had not ensured the proper and safe management of as required medicines, topical cream applications and dietary supplements and thickeners. Regulation 12 (1) (a) (b) (e) (g) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs The provider had not ensured that the nutritional and hydration needs of service users were met. Regulation 14 (1) (2) (a) (b) (4) (d) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation

This section is primarily information for the provider

Action we have told the provider to take

Accommodation for persons who require nursing or personal care

Diagnostic and screening procedures

Treatment of disease, disorder or injury

Regulation 17 HSCA (RA) Regulations 2014 Good governance

The provider had not ensured that service users were protected from unsafe care and treatment by the quality assurance systems in place.

Regulation 17 (1) (2) (a) (b) (c) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care The provider had not ensured that service users received person centred care that reflected their individual needs and preferences. Regulation 9 (1) (a) (b) (c) 3 (a) (h) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:
Warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect The provider had not ensured that service users were treated with dignity and had their privacy protected. Regulation 10 (1) (2) (a) (b) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:
Warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing The provider had not ensured that there were sufficient numbers of suitably qualified, competent, skilled and experienced persons deployed in the service to meet service user's needs. Staff had not received appropriate training, professional development and supervision. Regulation 18 (1) (2) (a) (b) (c) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Enforcement actions

The enforcement action we took:
Warning notice