

Methodist Homes Lauriston

Inspection report

40 The Green ,
St Leonards On Sea,
TN38 0SY
Tel: 01424447544
Website: www.example.com

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Ratings

Overall rating for this service

Inadequate



Is the service safe?

Inadequate



Is the service effective?

Requires Improvement



Is the service caring?

Requires Improvement



Is the service responsive?

Requires Improvement



Is the service well-led?

Inadequate



Overall summary

We inspected Lauriston on the 18 and 20 February 2015. Lauriston provides nursing and personal care for up to 60 people, some of whom lived with dementia. The home had been divided in to three units over two floors. The first floor unit provided nursing care and support for 25 people with a range of illnesses, such as Parkinson's disease, Multiple Sclerosis and strokes, some of whom were also receiving end of life care. The ground floor residential units were divided by a locked door and provided personal care and support for 15 people living with dementia and six people who were physically frail. Lauriston also provides short stay care known as respite care.

Accommodation and communal space was provided over the two floors with lift access that provided level access to all parts of the home. There were pleasant garden areas that were secure and safe for everyone.

Lauriston is part of a group of homes run Methodist Homes for the Aged(MHA). MHA is a charity providing care, accommodation and support services for more than 16,000 older people throughout Britain.

There has been no permanent manager in post since May 2014. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered

Summary of findings

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. There has been four 'stand-in' peripatetic managers, the latest has been in post since the 23 December 2014. We were informed that a manager had been recruited and would be commencing employment on the 7 March 2015.

At the last inspection in April 2014, we found that they had met all the essential standards inspected.

People spoke positively of the home and commented they felt safe at the home. 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. Staffing levels were insufficient to meet people's individual care and social needs. Staff were under pressure to deliver care in a timely fashion and was seen to be more task orientated than person specific.

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 readily available on people's preferences. End of life care lacked the holistic and inclusive approach.

Staff did not fully understand the principles of consent and therefore had not always respected people's right to refuse consent. Not all staff working had received training on the Mental Capacity Act 2005 (MCA) and mental capacity assessments were not consistently recorded in line with legal requirements. Deprivation of Liberty Safeguards (DoLS) had not been submitted for all that required them.

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 staff had built rapport 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.

Activities though provided for an hour to two hours daily did not reflect people's hobbies and interests. The dementia unit lacked the visual stimulation and dementia signage that enabled people who lived with dementia to remain independent.

Although a quality assurance framework was in place, it was ineffective. This was because it did not provide adequate oversight of the operation of the service.

Staff told us the home was not well managed at present, staff morale was low and many staff spoken with became tearful.

Training schedules confirmed staff members had received training in safeguarding adults at risk. Staff knew how to identify if people were at risk of abuse or harm and knew what to do to ensure they were protected.

Robust recruitment and selection procedures were in place and appropriate checks had been undertaken before staff began work.

People's medicines were stored safely and in line with legal regulations. People received their medicines on time and from appropriately trained senior care staff or a registered nurse.

Feedback was regularly sought from people, relatives and healthcare professionals.

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?

Lauriston was not safe. Care plans and risk assessments did not reflect people's changing needs or take account of incidents and accidents. Incidents and accidents were not always reported to the local safeguarding team when someone had sustained harm, such as unidentified bruising.

There were not enough suitably experienced or qualified staff to meet people's needs.

People were placed at risk from poor moving and handling techniques, continence management and lack of regular movement.

However, people told us they were happy living in the home and they felt safe and we found recruitment practices were safe.

Inadequate



Is the service effective?

Lauriston was not consistently effective. Some staff had not received training on the Mental Capacity Act 2005. Mental capacity assessments were not completed in line with legal requirements. DoLS had not been submitted for those deprived of their liberty.

Meal times for some people were observed to be a solitary and inefficient service with food being served to people who were asleep or in a poor position to eat. 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.

People spoke positively of care staff, but expressed some concern about lack of communication.

Staff received on-going professional development through regular supervisions, and training that was specific to the needs of people was available but not always put in to practice.

Requires Improvement



Is the service caring?

Lauriston was not consistently caring. People were positive about the care they 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 and did not always respect their dignity. People who remained in their bedroom received very little attention.

End of life care was not reflective of a caring and holistic approach.

Staff were seen to interact positively with people on a one to one basis throughout our inspection.

Requires Improvement



Summary of findings

Is the service responsive?

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

In addition, 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.

The delivery of care often suited staff routine, rather than people's individual preferences and choices.

Requires Improvement



Is the service well-led?

Lauriston was not well led. 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 but not everyone could tell us they had met the manager and were aware of them.

Inadequate



Lauriston

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 February 2015. This was an unannounced inspection. The inspection team consisted of an inspector and a specialist advisor with experience of caring for people with an acquired brain injury and people with complex nursing needs.

During the inspection, we spoke with 20 people who lived at the home, eight visiting relatives, six care staff, two registered nurses, two occupational therapist assistants, one occupational therapist, the cleaner, the peripatetic manager and a visiting GP.

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.

During the inspection we reviewed the records of the home. These included staff training records and policies and procedures. We looked at 12 care plans and risk assessments along with other relevant documentation to support our findings. We also 'pathway tracked' people living at Lauriston. This is when we looked at people's care documentation in depth and obtained their views on how they found living at Lauriston. 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. Comments included, “I feel safe here” and “I think I’m safe, I can tell someone if I feel unsure.” A visitor told us, “I think they have staffing problems because I see new faces a lot.” A relative told us, “I feel they are in safe hands most of the time, but I have concerns about staffing.” Although people told us they felt safe, we found examples of care practice which were not safe.

There were not sufficient numbers of suitably trained staff to keep people safe and meet their individual needs. Lauriston was divided into three units over two floors and there were two staff teams to cover 24 hour care. The ground floor accommodation was separated by a locked door and divided into two units, one for people who lived with dementia and required support and personal care, the other unit was for people who required personal care and support. On the day of our inspection, the day shift comprised of four care staff who provided care and support for 21 people, 15 of whom were living with dementia. We were told that three care staff provided support to those who lived with dementia and the fourth staff member offered support to those on the residential unit. During our inspections there were times the care staff were all on the dementia unit leaving people on the other side of the locked door without the support and supervision they required to keep them safe from harm, for example support with washing and with walking. Despite all four staff working on the dementia unit, we saw people trying to get out of various locked doors and becoming distressed and agitated. This, placing them at risk from falls and altercations with other people. There were also times when people were banging on walls as they could not find their way to their room or to a place they felt safe. We saw people entering other people’s rooms, which we were told by concerned visitors was a recurring problem which had caused unsettled behaviour resulting in people striking each other. This was unnoticed by staff until we alerted them as they were undertaking personal care with other people on the unit.

The incident and accident records identified a significant number of unwitnessed falls and unknown causes of severe bruising on the dementia unit. Trends and incidences were identified through audits but no action had been taken or management strategies put in place. We

asked for further information about certain recorded incidents which were not available. We have heard that they are now being investigated and a report will be sent to the CQC. The senior care staff administered medicines safely but was constantly interrupted and the medicine administrations took over two hours to complete. This potentially put people at risk of mistakes being made and of medicines not being given at the correct time. We were told by staff that 75% of the people who lived with dementia needed two staff to attend to their needs. The staffing tool used by the organisation to determine staffing levels had not been applied correctly to take this into consideration. The lack of sufficient staff placed people at risk from harm.

On the nursing floor there were 25 people supported and cared for by one registered nurse and four care staff. All 25 people had high dependency needs and needed two staff to meet their complex support needs. Some people did not receive personal care until the afternoon, which was not their personal preference. Personal care is washing, changing of clothing and oral care. We saw that only three people were assisted to get out of bed on the first day of our inspection. We asked staff if that was for people’s personal wishes or for medical reasons. Staff told us that it was for staffing reasons; they didn’t have time to get people up. One visitor told us that her mother was to be assisted to sit out in the lounge on certain days because she loved company. Staff had agreed to mark the days that her mother sat out on the calendar in her room for the relatives information, but this hadn’t happened in the past month and she wasn’t sure if her mother had been assisted to get out of bed at all. The visitor asked the nurse on duty who could not tell her as there were no records that showed information that her mother had sat out during the past two weeks.

We were told by another visitor that on many occasions whilst visiting her close relative she found them distressed and in discomfort because there hadn’t been staff available to move them safely to the toilet facility when they needed to go. This had impacted on this person’s health and mental well-being. We saw that one of the three people in the lounge had sat in a chair without a pressure relieving cushion for six hours without being moved or offered any personal care; this placed them at risk of pressure damage.

Is the service safe?

This person was not able to move themselves to relieve pressure. These examples evidence that the lack of sufficient staff had impacted on people's safety and safe care delivery.

There were only two registered nurses in post that were employed to work regular contracted hours. One nurse on day duty and one nurse on night duty. The nurse on day duty explained that when she was not on duty the shifts were covered by bank staff and agency staff. Feedback from staff and from people and families identified that this had impacted on communication, between staff, people and visitors and on care delivery. One visitor said, "I feel that my mother's care is compromised because she can't tell people what she likes or if she is uncomfortable, staff that are only here for one shift every so often won't know how to make sure she is ok." One staff member said, "It's hard, lack of staff and nurses mean we don't always know of changes, we don't have time to check care plans and rely on handovers, which doesn't really pick up important things." Another said, "We don't have time to give the care we want to, it's a rush and we can't get it done without something else giving and without a nurse that knows the residents, it's difficult." We spoke to another visitor who said, "Really concerned about the staffing levels, its rush, rush, and no time to talk." Visitors and staff comments supported the lack of sufficient staff to meet people's needs, one relative said, "I was concerned that mother should have two carers to move her but often had only one due to lack of staff. I have serious concerns about staffing levels," and "Feel my relative is unsafe as they have tables around them, which they could fall over, if they try to get up, I have concerns regarding staffing levels." Staff said, "There are not enough staff, really short and it does impact on care and of people's safety, I don't feel safe working here." People had personal emergency evacuation plans (PEEPs) which detailed their needs should there be a need to evacuate in an emergency. However we were not assured that staffing levels at present especially at night were suitable for safe evacuation procedures.

These issues were a breach of Regulation 22 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.

Risk assessments for health related needs were in place, such as skin integrity, nutrition, falls and dependency

levels. However not everyone's health and well-being was being protected and promoted. For example we found that one person with Parkinson's disease had a history of falls and needed staff to supervise them as their mobility had changed significantly. The moving and handling risk assessment for this person had not been updated to reflect the changes since 2006 and the reviews stated 'no change'. We noted that this person's repeated incidents and accidents had not been cross referenced alongside their risk assessments to prevent a re-occurrence of falls and maintain this person's safety.

The staff used a risk assessment tool to monitor people's skin integrity against changes in their health, such as weight loss. We found that whilst staff weighed people, weight loss for some people had not been identified and appropriate actions taken. The risk assessments had not been updated to reflect the weight loss and therefore precautions and guidance not always followed, this placed people at risk from skin damage such as pressure sores. 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 guidance for staff regarding change of position or toilet breaks in their care plans. During the inspection, we observed people sitting in the communal lounges. We identified that up to 14 people had not been assisted to access the toilet or offered a change of position in a six hour period. This increased the risk of skin breakdown through prolonged sitting in one position and not receiving regular continence care.

Care records did not consistently tell us when people were supported with their personal care. For example, people were not prompted or reminded to use the bathroom. Not all care records told us when people last received support to be comfortable or access the toilet. Records to monitor bowel movements were not consistently completed. Staff could not tell us if this was poor recording or a health issue for individuals.

We observed two transfers (people being supported to move from a wheelchair to armchair with the support of appropriate equipment). The transfers we observed showed that the person was suspended in a hoist and swaying, and not supported appropriately by staff. There was little verbal support or reassurance from staff to the

Is the service safe?

person being moved. This was not a safe or pleasant experience for them. However we did see one person moved with skill and expertise. The staff spoke to the person throughout and reassured them.

We saw care staff move people who had slipped in bed by pulling them straight from over raised bed rails placing themselves and the people at risk from injury. We also observed another person moved in bed by staff using a drag lift so they could eat their meal. A 'drag' 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. People were not protected from avoidable harm due to inappropriate moving and handling techniques.

There were people being supported who lived with behaviours that challenged others. Whilst staff had identified this, there was a lack of management strategies for staff to use to manage people's behaviour safely. This concern was heightened because of the high use of agency staff. One agency staff member told us that they had received a handover but not information about how to manage people that may present challenging situations. We saw that one person had unwitnessed bruises that staff told us they thought might have occurred through altercations with other people. This was not investigated, reported as a safeguarding or action taken to monitor situation. The planning and delivery of care had not ensured people's individual needs had been met and had not ensured their safety.

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

Safeguarding policies and procedures were up to date and appropriate for this type of home in that they corresponded with the Local Authority and national guidance. There were notices on staff notice boards to guide staff in whom to contact if they were concerned about anything and detailed the whistle blowing policy. 'Whistleblowing' is when a worker reports suspected wrongdoing at work. Officially this is called 'making a disclosure in the public interest.' Staff told us what they would do if they suspected that abuse was occurring at the

home. Staff confirmed they had received safeguarding training. They were able to tell us who they would report safeguarding concerns to outside of the home, such as the Local Authority or the Care Quality Commission. However not all that staff understood their own responsibilities to keep people safe from harm or abuse as unidentified bruising had not been reported to safeguarding. When we asked staff why unidentified bruising was not regarded as a safeguarding issue, were told by one staff member, "It must have happened when they walk around, just an accident."

The provider had appropriate arrangements in place for the safe management of medicines. There were records of medicines received, disposed of, and administered. We observed four medication rounds and saw that staff administered medicines safely. Senior care staff administered medicines on the residential unit. They had received training in medicine administration and passed competency tests. We observed that when disturbed, (as mentioned above) the care staff ensured the trolley was locked before leaving it. The senior care staff told us, "We know that we have to be mindful of times and if we have people that need strict four hourly medicines such as antibiotics, we document time given and then if necessary do an extra medicine four hours later." We confirmed this by checking the medication administration records (MAR) charts. Nurses and senior care staff who administered medicines carried out the necessary checks before giving them and ensured that the person took the medication before signing the MAR chart. All staff administering medicines ensured medication was swallowed before signing the MAR chart and ensured the trolley was locked when left.

Recruitment processes were safe. Staff files confirmed that a robust recruitment procedure was in place. Files contained evidence of disclosure and barring service (DBS) checks, references included two from previous employers and application forms. The Disclosure and Barring Service (DBS) helps employers make safer recruitment decisions. It also prevents unsuitable people from working with people who require support and care.

People were cared for in an environment that was safe. There were procedures in place for regular maintenance checks of equipment such as the lift, fire fighting equipment, lifting and moving and handling equipment (hoists). Hot water outlets were regularly checked to ensure temperatures remained within safe limits. Health and

Is the service safe?

safety checks had been undertaken to ensure safe management of food hygiene, hazardous substances, staff safety and welfare. Staff had received regular fire training which included using fire extinguishers and evacuation training.

Is the service effective?

Our findings

People told us they received effective care and their needs were met. One person said, “I haven’t been here long but my husband and I can stay together. We spend each day together but sleep on different wings because he needs a bit more support than me.” Another said, “I am very settled here, the food is good and I like the staff.” A relative told us, “I think there are some communication issues, I don’t get told when things happen and appointments are made.” Another relative said, “Very good, no complaints.” However, we found Lauriston did not consistently provide care that was effective.

CQC is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS).

DoLS form part of the Mental Capacity Act (MCA) 2005. It aims to make sure that people in care settings are looked after in a way that does not inappropriately restrict their freedom, in terms of where they live and any restrictive practices in place intended to keep people safe. Where restrictions are needed to help keep people safe, the principles of DoLS ensure that the least restrictive methods are used.

DoLS authorisations were in place for two people, but applications had not been submitted for the remaining people unable to consent to their care and treatment at Lauriston. Restrictive practices such as locked doors and bed rails were used. However assessments did not consider if people were able to consent to these measures or whether a less restrictive practice could be used, for example pressure mats or door monitoring alarms. We also observed that four people on the residential dementia unit were trying to get out of the locked doors on the unit. One person was banging on the door whilst others tried continuously to get out of the unit. This did not meet with the principles of DoLS.

Staff we spoke with had some knowledge of mental capacity and deprivation of liberty issues. Staff told us that many of the people supported would be unable to consent to care and treatment. The MCA requires that assessment of capacity must be decision specific and must also record how the decision of capacity was reached. We found

mental capacity assessments did not always record the steps taken to reach a decision about a person’s capacity. This did not meet with the principles of the Mental Capacity Act 2005 (MCA).

This is a breach of Regulation 18 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Whilst people were complimentary about the food and drink, we could not be assured that everyone had enough to eat and drink to sustain their health. Positive feedback included, “The food is lovely, no problems at all, too much sometimes.” Another person told us, “You have a choice; the second course is whatever you choose from the menu.” One staff member said, “We have had a change of chef so the food is different but there is enough of it for everyone.”

There was a choice of meals offered. Staff offered people living with dementia a visual choice of what was on offer by showing them the food plated up, so they could choose. People on other units were asked their preferences by staff in the morning. If people changed their mind or did not eat very much we were told an alternative would be offered. We saw that this occurred on the residential units but not on the nursing floor until we asked if there was an alternative as certain people had not eaten any of their meal. Staff said that some people on the nursing unit could not make a choice so they chose for them. We asked if they showed people the choices as they did on the residential unit and they said, “No, we know what they will eat.” Not many people could remember what they had asked for and we found that the meal experience on the first day on the nursing unit was a solitary experience. Three people sat in the dining area on separate tables and there was little interaction or stimulation. One person sat at a table for 15 minutes with their uncovered meal in front of them as they waited for assistance from staff. We saw poor techniques used by staff when they assisted people. For example, assisting people over raised bed rails whilst they were semi-reclined in a position which may potentially cause them to have swallowing difficulties. The residential unit’s meal times were more lively and inclusive; people seemed to enjoy the experience and staff sat with them at the table whilst they supported them.

Staff told us they monitored people's food and fluid intake and watched for any signs of weight loss and

Is the service effective?

malnourishment. However we saw that many records were incomplete and there were people whose fluid and food input was minimal and had not been identified by staff. No action had been taken or instructions given. For example, one person fluid records demonstrated variable amounts eaten and less than 400 mls recorded as being drunk four days in a row, 400 mls was not enough to maintain people's health and prevent dehydration. The guidelines for suggested fluid intake for this person's weight was 1200 mls. There was also no evidence recorded of food or drink offered or taken after 5pm. This was not isolated to one person or one unit but found across the home. Staff told us that they tried to offer drinks, but were sometimes so busy, it was difficult to keep track. The organisation catering procedure book stated that supper was served at 5 pm and then a further meal service offered later; in total four meal services offered in 24 hours. Staff told us this was not happening. Some people's records indicated that they had not eaten for up to 15 hours. The newly appointed chef was not aware of this fourth meal service being available. People were weighed monthly or more regularly if required. However we identified that some people's weights were unstable and showed significant weight loss. Staff were not aware of people's weight loss and had not followed up with an action plan or informed the GP or dietetic team. We were told that there might have been a problem with the weighing machine and this would be investigated. We asked senior staff if there was a written procedure to follow to ensure people were weighed consistently, for example at the same time of day and on the same flooring. Staff said there was no procedure to follow. One person was weighed weekly and records identified a 7 kg loss in a week, this person had not been reweighed and staff had not identified this as a possible error. We could not be assured that people received food and fluids that maintained their health and well-being.

This was 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.

Staff had received essential training in looking after people, for example in safeguarding, food hygiene, fire evacuation, health and safety, equality and diversity. Staff completed an induction when they started working at the service and 'shadowed' experienced members of staff until they were found competent to work unsupervised. Two members of staff shared their induction experience with us, "It was pretty good and I felt prepared to start working," another said, "Interesting and helpful." We saw that training for staff included specific training for supporting people who lived with dementia, managing behaviour that challenged, specialist feeding equipment. Staff also told us that they received teaching sessions about different illnesses such as Parkinson's disease, diabetes and strokes. They told us they had learnt many things to enhance their care delivery, but they did not have time on the shift to put their learning into practice. For example passive exercises to help prevent limb contractures following a stroke. Not all staff had received training in end of life care and syringe driver management and medication. A syringe driver is a battery operated medical device to administer medication slowly and consistently.

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. People we spoke with confirmed this. One person said, "I have regular chiropody and eye tests."

Staff received on-going support and professional development. Supervision schedules and staff confirmed they received regular supervision (every two months) and appreciated the opportunity to discuss their concerns. Nursing staff also confirmed they had received clinical training and support. Staff told us that they had raised concerns about staffing levels and use of agency staff, but they felt it had not been raised at senior management level as staffing levels had not increased.

Is the service caring?

Our findings

There was inconsistency in how people were cared for, supported and listened to and this had an effect on people's individual needs and wellbeing. As staff did not always focus on people's comfort, there was a risk of people receiving inappropriate care, treatment or support. We also observed people who found it difficult to initiate contact, were given very little time and attention throughout the day. People spoke positively of care staff, but visitors expressed some concern about lack of communication between staff and the people who lived at Lauriston. Comments included, "Staff try, they do care, but they are stretched to breaking, and it means people like mum get very little attention apart from the basics," and "I think that staff are kind, but I do wish they would chat to the residents, I visit my friend but spend time chatting to other people as staff don't have the time."

There were people at Lauriston receiving end of life care. This meant they had been seen by a doctor who agreed to withdraw active treatment and according to their care plan, were to receive 'tender loving care' (TLC). TLC is used in care to describe considerate and solicitous care. Documentation to support this decision was in place and followed NICE guidance. NICE guidelines are evidence-based recommendations for health and care in England. This meant that this care pathway had been discussed, documented and agreed by families and health professionals involved in their care. However we found concerns in respect of end of life symptom control and of aspects of care delivery. One person had been seen by the GP and all medication for their debilitating disease stopped as they were unable to swallow. A syringe driver for administering slow pain relief and to manage agitation, restlessness, nausea, vomiting and respiratory secretions had been prescribed, but not started. The person had not been monitored for pain or discomfort or any other symptom. This was despite documentation in daily records stating the person was restless and in need of specialised care at this time. We asked why there had been a three day delay in starting the end of line pathway and were told they were waiting for the hospice team as they could not start the syringe driver as they had not been trained. Training for this should have been instigated on receiving these instructions from the GP so the person received the comfort and relief from the medication when it was needed.

People in receipt of end of life care did not get personal care or any personal attention until 2 pm, which meant that they had not received the care they required as stated in their plan of care. We observed that staff completed care tasks but little time was spent reassuring and comforting them at this stage of their life. Mouth care and lip moisturiser had not been given despite people not being able to drink and eat. These people were isolated as staff only spent time with them to undertake care tasks. One person was not checked for four hours until they were due for a change of position. In six hours another person, who was not eating or drinking received just ten minutes of care. We spoke to staff about their understanding of end of life care. They demonstrated an awareness of what was expected but lacked empathy in the approach to the delivery of holistic care. One staff member said, "Time, we just don't have time, it's not right but what can we do." Not all staff had received training or guidance in end of life care. Staff had not ensured that people received quality holistic end of life care that met their individual needs.

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

People's care plans included information that demonstrated staff were aware of specific needs such as incontinence, mobility and nutritional support. However there were no plans in place to guide staff in managing incontinence or promoting continence, such as providing assistance taking people to the toilet on waking or prompting to use the bathroom throughout the day. Throughout our inspection we observed that people were not prompted or offered the opportunity to visit the bathroom. People who were not independently mobile were not taken regularly to bathrooms or to have their incontinence pads checked/changed. One visitor told us that their close relative needs to go to the toilet very regularly and this had been agreed but wasn't happening and they had found their relative regularly upset and tearful because staff had taken away the call bell. We asked staff about how they managed this care need and were told, "Realistically, we just don't have the time or staff to do this but I'm sure that no-one would take away the bell." We checked complaint records and found that this was currently being investigated by the provider. Mobility care plans lacked guidance for staff in maintaining what

Is the service caring?

mobility they had and encouraging retaining their mobility. For example, a mid-morning and afternoon stroll or gentle therapeutic exercises. We observed one person was served lunch while lying in a reclining chair. Although the person managed to eat, using a spoon, this was not an appropriate position in which to eat as food was dropped and the person was at risk from choking. The person's care plan stated this person was to sit upright so as to promote independence and prevent choking.

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

People's dignity and respect was not always promoted. People's preferences for personal care were recorded but not always followed. We looked at a sample of notes, which included documentation on when people received oral hygiene, bath or a shower. Documentation showed that often people would not receive a bath or a shower in eight days just an assisted wash. The care plan did not state that as a preference. One person had only received one shower in 10 days. We also saw that people could go eight days without receiving oral hygiene. The manager informed us if that if a person refused personal care it would be recorded in the daily notes. However we could not find records of this within the daily notes. We could therefore not tell if people received regular support to bath or shower or if they received oral hygiene. One visitor told us, "I don't like seeing my relative with hair that is not clean, I know it can be difficult at times." Staff admitted that showers sometimes didn't get done because of time restraints, and washes were more usual.

We spoke with one visitor who did not feel their close family members' care needs had been recognised. The person became very distressed during our inspection as they wanted to go to the toilet. The person would not push their call bell as they said "I am not allowed". The visitor told us staff had said, "They have pads so it doesn't really matter" but the visitor said this was a 'lack of dignity and not good.' The visitor also told us their relative had been very agitated on occasions because of this and had used a knife and a TV remote to bang on their table to attract attention for someone to assist them but these items had been taken away from them. We looked at this person's

care plan to see if these concerns were highlighted and management strategies put in place but could not find any reference or action plan to meet this person's needs and ensure that dignity and involvement was promoted.

We saw that people were not always offered choices of where and how they spent their time. During the morning, until after lunch, up to eight people who lived with dementia and were not independently mobile were supported in the dining area. After lunch everybody was moved to a lounge area, again no-one was offered a choice. Staff told us, "It is easier for us if they are all in one place." We asked people if they were able to choose the lifestyle they wanted. We were told by one person, "I am fairly happy, I don't think we get the opportunities we used to, but staff have changed, a lot of agency staff, so it's not been the best." Another person said, "There is an element of choice, but it can change, if staff go off sick or if we have staff we don't know." We spoke with one person who told us, "I used to get up and go out, but I don't like to bother staff when they are busy, so I stay in bed now." One person who had recently come to stay at the Lauriston said, "I am a lot younger than most, I feel I'm stuck here on the first floor, I only get out for a cigarette when staff are available, I have to keep asking and then waiting." Not everyone was treated with consideration. Communication and social well-being was an area that we identified as a concern as there were people isolated in their bedrooms and in the lounge areas with little interaction. We noted many people were in bed with no television or radio all day. The only respite from lying in their bed was meal times and when they received personal care. Staff performed care tasks but did not linger to chat. One person could communicate and was chatty when we spoke with them. We returned to this person throughout our inspection and saw that they received no social interaction. We observed staff waking this person for dinner by nudging them awake with very little verbal interaction. The staff member fed the person over the bedrail from a standing position and there was no eye contact or verbal interaction made throughout this procedure. It was a sad and solitary experience for the person. 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.

Care plans showed that family and person involvement had been sought where possible, and personal preferences had

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been recorded on admission to the home. These set out people's preferences within an activity plan based on the activities of their life before arriving in the home and when they reached the end of their life. We saw that people's food choices reflected their culture and religion choices. However these documents did not always take into account change for those who were living with dementia, as their condition progressed. One family told us, "It's really strange how a year with this illness can change their tastes and what they enjoy."

The manager told us that an advocate would be found if required to assist people in making decisions. They also told us they had information to give to people and families about how they could find one if it became necessary. This ensured people were aware of advocacy services which were available to them.

We did see some examples of good care. Some staff were knowledgeable about the individual personalities of the people they cared for and supported. Staff shared people's

personalities with us during the inspection and they talked about people with respect. There was some really positive moments when we saw staff and people interact with genuine affection and respect. We saw a member of staff sitting with a person in the residential lounge, holding their hand whilst reassuring them in a calm manner. One staff member was visibly upset that they could not give the support and care required. She said, "We care so much but just can't do it at the moment."

Care records were stored securely in the staff offices. Information was kept confidentially and there were policies and procedures to protect people's confidentiality. Staff had a good understanding of privacy and confidentiality and had received training.

Visitors were welcomed throughout our visit. Relatives told us they could visit at any time and they were always made to feel welcome. The manager told us, "There are no restrictions on visitors". A visitor said, "I come in each day and the staff always welcome me."

Is the service responsive?

Our findings

Whilst some people told us they were happy with the standard of care provided and that it met their individual needs, our observations identified that staff were not always responsive to individual needs.

We asked people and their relatives if they had been involved in the assessment of their needs. Some told us that they could not remember, whilst two visitors told us they had been. The care plans gave information about the person's family history, their preferences, relationships, family and key medical information. The information however was not always easy to locate. Staff told us they felt the care plans were detailed enough so that they could provide good quality care and know the person as an individual. However when we reviewed the care files we noted that not all contained up to date details to how to provide person specific care.

Care was not personalised to the individual. For example, people did not always get up when they wished. Care staff told us it was not uncommon for people to receive personal care just before lunchtime and sometimes after lunch. During the inspection we monitored how long it took for people to receive personal care. We found that people were still receiving assistance with washing and dressing at 2.30pm. Staff said that this was not unusual, "We are just so busy." People we spoke with confirmed they often had to wait for assistance in the morning. One person told us, "It varies and depends on who's on duty." Another person told us, "I have to wait but I'm not planning to go anywhere." A third person told us, "Yes I wait, but I rely on help so can't moan."

There were not appropriate arrangements to meet everyone's social and recreational needs.

Activities were scheduled once a day over seven days. Four of the seven days the activity was a worship service or fellowship meeting. Personal care however was not completed till lunch time or after and the daily activity was usually 11.30 am. This meant not everyone would be able to attend, even if they wanted to. We looked at people's individual care plans to see if people's wishes were reflected and acted on. The care plans reflected some people's specific need for social interaction, but these were not being met. On the dementia unit, a cinema screen had been erected in the dining room, and a film was being

shown, however people were sat in the same position, in the same dining chair where they had had breakfast. Activities offered were not people's individual interests and hobbies and therefore not meaningful for them. People told us they were bored, one person said, "I have little to do, I am not particularly religious so don't attend the prayer meetings." Another said, "It's a shame but there is nothing going on anymore, we used to have craft sessions." Records showed us that following fellowship meetings the lay person would visit people in their rooms. There was a lack of activities to stimulate memories or be beneficial for those people who lived with dementia. We saw people were restless and easily agitated as there was little to divert or engage them.

The home was well furnished and the communal areas had natural light, and were comfortable with garden areas for people to enjoy. However recent redecoration of the dementia unit had changed the décor, going from bright colours, individual coloured bedroom doors and dementia signage to bland colours and no signage. People were no longer able to identify their bedroom as signposting such as memorable pictures had been removed. Signage for communal rooms were missing, people could not identify toilets, lounge areas or the dining area. We saw people searching for their room and one person was looking for the bathroom. People wandered through corridors that held little interest to them or stimulation. We observed that dementia guidance, such as the department of Health's (DoH) Enhancing the Healing Environment (EHE) programme had not been used to achieve a dementia friendly environment.. One person was searching for their room, which had recently changed and when a staff member directed them to their door, it was locked, which caused the person anxiety and frustration. We were told that some people's doors had been locked to prevent specific people wandering in and moving the other people's properties. Whilst we saw that there were some activities on offer by the provider there was a need to give more opportunity for social interaction and individual activities for the people over the course of the day.

This was a breach of Regulation 9 of the Health and Social Care Act 2008.

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

Is the service responsive?

confident in raising any concerns or making a complaint. One person told us, "I'm happy to complain if I need to. I never know who is in charge though, changing all the time." However, some people did not feel confident that their complaint or concern would be resolved. One person told us, "They are not listening to our concerns." The home had received three formal complaints since September 2014, and documentation confirmed complaints were recorded, but there were no details of the investigation, outcome or action taken available. The peripatetic manager said "It was before I came here, I'm not sure where the paperwork

is." One complainant informed us that they were still waiting for a response and had not heard anything further from the management team. This is an area that needs improvement.

The provider had sent out satisfaction surveys in 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."

Is the service well-led?

Our findings

The previous manager had left the service in May 2014. There was no registered manager in post. There had been a number of peripatetic managers over the last six months. People said, "Very unsettling, you get used to one face, and then another change." A visitor said, "Four managers in the past few months, difficult to get to know what's actually happening." The CQC have been informed that a new permanent manager has been recruited and will start in April 2015.

There was not an effective quality assurance framework in place. The manager and provider regularly completed quality monitoring checks, however, these were not effective because they had not recognised or addressed many of the concerns identified during this inspection. These included insufficient staff deployed resulting in task led and impersonal care. The training provided had not ensured that people's end of life needs were met. Quality monitoring systems had not ensured that people were protected against risks relating to inappropriate or unsafe care and support or that it was delivered within the principles of the MCA 2005.

Accidents and incidents were recorded, but lacked management oversight to ensure that they formed part of the quality assurance systems in place. The manager had not recognised the need to inform appropriate agencies of some incidents when they were required to.

The provider had a vision and values statement. It explained the philosophy of Methodist Homes for the Aged, but was not specific as to what Lauriston provides for people. The statement did not correctly reflect the types of the service provided at Lauriston. People were not put at the centre of the care delivery. There was an element of task orientated care being delivered rather than individualised person specific care. 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 there was a negative culture within the home 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 units if they were busy, but felt there was no management structure. The staff talked about staff support but not about how to improve the lives of the people they supported and cared for. Although Lauriston specialised in the provision of dementia care, there were no established working links with specialist organisations or an active management plan to drive forward or improve the quality of the service provided.

We found that communication and leadership needed to be improved within the home. People had an awareness of the management team but were confused by the manager changes over the past few months. 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 end of life care and people were kept on bed rest when they should have been assisted to get up.

Systems had been introduced to seek the views of people, relatives and staff. Staff meetings had been held and we looked at a sample of minutes which confirmed this. These provided staff with a forum to air their views and provided opportunities for staff to contribute to the running of the home. However, we found concerns expressed to us by staff about staffing numbers and training had not been addressed. Staff told us that they had enjoyed working at Lauriston, but they did not always feel listened to and were considering alternative employment.

These issues were a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

Accommodation for persons who require nursing or personal care
Diagnostic and screening procedures
Treatment of disease, disorder or injury

Regulation

Regulation 9 HSCA (RA) Regulations 2014 Person-centred care

The registered provider had not taken steps to ensure that each service user was protected against the risks of receiving care that was inappropriate or unsafe by means of carrying out of an assessment of needs of each service user and the planning and delivery of individual needs.

Regulation 9 (1) (a) (b)

Regulated activity

Accommodation for persons who require nursing or personal care
Diagnostic and screening procedures
Treatment of disease, disorder or injury

Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

The registered person did not have effective systems in place to identify, assess and manage risks to the health, safety and welfare of service users and others.

Regulation 17 (a) (b)

Regulated activity

Accommodation for persons who require nursing or personal care
Diagnostic and screening procedures
Treatment of disease, disorder or injury

Regulation

Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs

The registered person did not have suitable arrangements in place for ensuring service users were protected against the risks of inadequate nutrition and hydration.

Regulation 14 (1) (2) (1)(a) 4 (a) (b) (d)

Regulated activity

Accommodation for persons who require nursing or personal care

Regulation

Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect

This section is primarily information for the provider

Action we have told the provider to take

Diagnostic and screening procedures
Treatment of disease, disorder or injury

The registered person had not ensured the dignity and privacy of the service users.

Regulation 10 (1)

Regulated activity

Accommodation for persons who require nursing or personal care
Diagnostic and screening procedures
Treatment of disease, disorder or injury

Regulation

Regulation 18 HSCA (RA) Regulations 2014 Staffing

The registered person did not have suitable systems in place to ensure that at all times there were sufficient numbers of suitably qualified, skilled and experienced persons employed to meet the needs of the service users.

Regulation 18 (1)

Regulated activity

Accommodation for persons who require nursing or personal care
Diagnostic and screening procedures
Treatment of disease, disorder or injury

Regulation

Regulation 11 HSCA (RA) Regulations 2014 Need for consent

The registered person did not have suitable arrangements in place for obtaining and acting in accordance with the consent of service users in relation to the care and treatment for them.

Regulation 11