Inspection Report

We are the regulator: *Our job is to check whether hospitals, care homes and care services are meeting essential standards.*

Lucerne House

Chudleigh Road, Alphington, Exeter, EX2 8TU

Tel: 01392422905

Date of Inspections: 03 March 2014
26 February 2014
24 February 2014

Date of Publication: May 2014

We inspected the following standards to check that action had been taken to meet them. This is what we found:

Care and welfare of people who use services	✖	Enforcement action taken
Safeguarding people who use services from abuse	✖	Action needed
Safety and suitability of premises	✖	Action needed
Safety, availability and suitability of equipment	✖	Action needed
Staffing	✖	Enforcement action taken
Assessing and monitoring the quality of service provision	✖	Enforcement action taken
Complaints	✖	Action needed
Records	✖	Action needed

Details about this location

Registered Provider	Barchester Healthcare Homes Limited
Registered Manager	Ms Samantha Foti
Overview of the service	Lucerne House is registered to provide accommodation for 75 people who require nursing and personal care. The home is situated in Exeter, Devon.
Type of service	Care home service with nursing
Regulated activities	Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury

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Summary of this inspection

Why we carried out this inspection

We carried out this inspection to check whether Lucerne House had taken action to meet the following essential standards:

- Care and welfare of people who use services
- Safeguarding people who use services from abuse
- Safety and suitability of premises
- Safety, availability and suitability of equipment
- Staffing
- Assessing and monitoring the quality of service provision
- Complaints
- Records

This was an unannounced inspection.

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 24 February 2014, 26 February 2014 and 3 March 2014, observed how people were being cared for and checked how people were cared for at each stage of their treatment and care. We talked with people who use the service, talked with carers and / or family members, talked with staff and reviewed information given to us by the provider.

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

We were supported on this inspection by an expert-by-experience. This is a person who has personal experience of using or caring for someone who uses this type of care service.

We talked with health and social care professionals that regularly visited the home.

What people told us and what we found

At the time of our inspection there were 68 people living at Lucerne House nursing home and the home employed over 100 staff. The service consisted of three units known as Shillingford unit, which provides care for people with dementia; Ide unit, which provides care for older people, and Alphinbrook unit, which provides care for younger people with physical disabilities.

At our previous inspection in August 2013, we identified five areas of non-compliance with the Care Quality Commission's Essential Standards of Quality and Safety. These were related to people's care and welfare, equipment, premises, staffing and managing complaints. The provider sent us an action plan outlining improvements being made to

become compliant. This inspection was undertaken to check the required improvements had been made.

We visited the home over three days and spent a day on each unit. We spoke with 27 people and relatives to gain their feedback about the service. We also received feedback directly from five relatives via our website. We looked at 14 people's care records. We spoke with 31 staff who worked at the home which included the registered manager, other senior staff, nurses and care workers, kitchen, housekeeping and maintenance staff.

Some people and relatives we spoke with were happy with the care and support they received. One person said, "When I want them, they are there." A relative said, "The care is excellent, they look after her really well". However, a number of people and relatives raised concerns with us about shortages of staff and about the lack of skills and experience of some staff. One person said, "The main issue here is not enough staff, they are understaffed quite a lot of the time". A relative said, "Staff are mostly friendly and hard -working but some appear very inexperienced". A second relative said, "They are going through a difficult time of being short staffed, particularly in the evening". A third relative we spoke with was really concerned the person wasn't getting enough to eat and drink.

Most of the staff we spoke with told us the home was short staffed on a regular basis. The registered manager confirmed they had reviewed staffing levels in relation to people's needs since the last inspection and had increased staffing levels. However, we saw that frequently, the recommended staffing levels required to meet people's needs were not being maintained due to staff absence. This meant people did not always receive the support and help they needed to maintain their health, safety and welfare.

We spoke with nine health care professionals who regularly visited the home to seek their feedback. Health professionals told us that the home contacted them appropriately for advice and support about people's care. However, several health professionals we spoke with raised concerns with us about the lack of knowledge and experience of some staff who worked at the home and about low staffing levels. One health professional said, "It depends on which staff are on duty, some are very experienced, others less so", another health professional said, "Some staff are struggling".

During our inspection, we found staffing levels were not sufficient to meet people's needs. On Ide unit, we found staff were not able to meet some people's basic care needs in a timely manner such as providing support for people who needed assistance with eating and drinking. People on Ide unit were not adequately supported to have regular meals, drinks and snacks. Also, eight care records we looked at about people's eating and drinking were so poorly documented that we could not tell whether those people were given enough to eat and drink. We found nutrition care plans in relation had not been followed and three people had lost weight. This meant the care needs of people who were at risk of malnutrition and dehydration were not being met, which put their health, welfare and safety at risk.

We immediately raised our concerns with the provider about the lack of support for people with eating and drinking on Ide unit and gave clear feedback about the areas for improvement. The examples of poor management of care and poor practice we found on Ide unit were promptly shared under a safeguarding process. A multi-disciplinary plan was drawn up by health and social care professionals to protect people's safety and well-being. This resulted in health professionals visiting the home as part of a safeguarding investigation and in a protection role.

We followed up equipment concerns raised at our previous inspection about damaged and soiled bed rail bumpers and crash mat equipment. We found a number of people's bed rails bumpers and crash mats were soiled and torn. These were unsightly and undignified for those people and represented an infection control risk. We also identified ongoing security risks related to the main entrance of the home. This was because the reception desk was often unmanned during the day and because the main entrance was left open early in morning and between five and eight o' clock at night. This meant visitors and others had unrestricted access to the home, which put vulnerable people at risk.

The home had a number of quality monitoring systems in place, but some of these were not effective. This was because they were not identifying the risks we highlighted during the inspection such as about adequate nutrition and hydration for people, concerns about low staffing levels, soiled and damaged equipment and t security risks. This meant prompt actions were not being taken to reduce those risks which put the health, welfare and safety of service users and others at increased risk.

We found the home had not made the required improvements and was not compliant with any of the eight standards we inspected.

You can see our judgements on the front page of this report.

What we have told the provider to do

We have asked the provider to send us a report by 20 May 2014, setting out the action they will take to meet the standards. We will check to make sure that this action is taken.

We have referred our findings to Local Authority: Commissioning and Local Authority: Safeguarding. We will check to make sure that action is taken to meet the essential standards.

We have taken enforcement action against Lucerne House to protect the health, safety and welfare of people using this service.

Where providers are not meeting essential standards, we have a range of enforcement powers we can use to protect the health, safety and welfare of people who use this service (and others, where appropriate). When we propose to take enforcement action, our decision is open to challenge by the provider through a variety of internal and external appeal processes. We will publish a further report on any action we take.

More information about the provider

Please see our website www.cqc.org.uk for more information, including our most recent judgements against the essential standards. You can contact us using the telephone number on the back of the report if you have additional questions.

There is a glossary at the back of this report which has definitions for words and phrases we use in the report.

Our judgements for each standard inspected

Care and welfare of people who use services ✖ Enforcement action taken

People should get safe and appropriate care that meets their needs and supports their rights

Our judgement

The provider was not meeting this standard.

People did not always experience care, treatment and support that met their needs and protected their rights. In particular, we identified significant concerns on Ide unit about the care and treatment of some people who were at risk of dehydration and malnutrition. This was because people were not adequately supported with eating and drinking which meant their safety and welfare was at risk.

We have judged that this has a major impact on people who use the service and have taken enforcement action against this provider. Please see the 'Enforcement action' section within this report.

Reasons for our judgement

At Lucerne House we spent a day on each of the three units, Shillingford, Alphinbrook and Ide. In total we spoke with 27 people and relatives and looked at 14 people's care records. Overall, we had mixed feedback from people and relatives about the care provided. Some people and relatives were very positive about the care received. One person said, "I haven't got any grumbles, they look after me well". Another person said, "They do everything they can do" and a third person said, "It's lovely, I would rather live here than anywhere else". However, a number of other relatives raised some concerns. One relative of a person on Shillingford unit was concerned about the person's safety because of lack of supervision by staff. Two relatives on Ide unit raised concerns with us about whether their relatives were getting enough to eat and drink.

We spoke with 31 staff who worked at Lucerne House which included the registered manager, nursing staff and care workers, as well at kitchen, cleaning and maintenance staff. We also sought feedback from nine health care professionals who regularly visited the home. These included the GP's, hospice community nurses, a speech and language therapist, a dietician and a tissue viability (pressure ulcer) specialist. Health professionals reported that staff at the home contacted them appropriately and reported concerns in a timely way. Some health professionals we spoke with also commented on the variety of skills and experience amongst staff and how that impacted on people's care. This included comments about the variability of staff skills in providing end of life care and in supporting people with nutrition and hydration.

We looked at 14 people's care records and saw an assessment of each person's care needs was carried out shortly before or just after they were admitted to the home. The home used a range of evidence based tools for assessing people's risks. For example, tools to identify people at risk of poor nutrition and dehydration, choking risks and people at risk of developing pressure ulcers. We found the home had comprehensive moving and handling plans for people, which included clear instructions, accompanied by photographs, about how to safely move and transfer people, such as from bed to wheelchair. Similarly, each person identified at risk of developing pressure ulcers had a care plan in place about how to care for the person and keep their skin in good condition.

We spoke with the tissue viability specialist who confirmed staff at the home contacted them appropriately to seek expert support and followed advice given. We found people at risk of developing pressure ulcers because of frailty or reduced mobility were nursed on the pressure relieving equipment specified in their care plan. We observed that staff repositioned vulnerable people every few hours, with the exception of one person. However, in some people's records we found gaps in documentation about repositioning. We could not tell whether this meant the care had not been carried out or whether these were lapses in record keeping.

Overall, we identified a lack of consistency in the quality of care provided for people at Lucerne House. For example, on Shillingford and Alphinbrook units we saw up to date care plans about how to meet people's needs and evidence of actions being taken to reduce risks. However, on Ide unit some care plans we looked at were not updated to reflect recent changes in people's condition and we found care plans which were not being followed. This meant people were at increased risk of not having their care needs met. We had previously raised these issues with the provider at our August 2013 inspection but the concerns remained.

On Shillingford unit, some people we met were not able to communicate with us because of their dementia. Instead, we carried out a structured observation of people in communal areas to see how well staff interacted and supported them. We observed most staff interacted well with people and treated them with caring and compassion. For example, making good eye contact and using touch to get their attention. Most staff we spoke with knew about people's interests, their likes and dislikes and about their care needs. Staff we spoke with on Shillingford unit, had a good knowledge about people's nutritional needs and about their food likes and dislikes and dietary restrictions such as for people with diabetes. Also about how to support people with choking risks who needed soft or pureed food. Staff used a variety of different ways to support people to eat and drink. For example, one person had an adapted plate and cutlery to help them eat independently, another person had 'finger food' they could manage easily. We observed how a care worker supported a person who was reluctant to drink to accept a cup of tea by patiently spending time with them and prompting them. However, we observed how three different staff supported another person to eat their soup, main course and pudding during lunch. This must have been very confusing for the person who had dementia.

On Alphinbrook unit, we spoke with eight people who told us they were well looked after well and spoke positively about how staff cared for them. During the day, we observed lots of positive interactions between staff and people which included lots of banter and laughter. However, on a couple of occasions we observed staff talking between themselves across people which was disrespectful towards those people. At lunchtime, we found people were supported and encouraged to eat and drink in an unhurried manner. We observed how one person's neck was supported by staff whilst they were eating to

reduce their choking risk, which was in accordance with the instructions in their care plan. Records were kept of people's food and drink intake and their weight was monitored and their nutritional care plans reviewed and updated as needed.
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On Alphinbrook, we saw how people who could not speak were being supported to communicate their needs and wishes. One person was working with a speech and language therapist to improve their ability to communicate via the use of an electronic tablet. Another person had a selection of words available to help them communicate their needs and wishes. However, when we spoke with this person they struggled to communicate with us that they were feeling cold. We realised this was because the selection of words available to them did not assist them with this. We observed several people on Alphinbrook spent a lot of time in their rooms. Four of the eight people we spoke with told us they got bored sometimes. We followed this up with an activity co-ordinator who told us how people's individual activities were recently discussed at a residents meeting. We were told about additional individual activities being arranged to meet the interests and preferences of those people.

On Ide unit, we saw a number of people were confined to their rooms because of their frailty and poor mobility. We looked at the care of eight people's on Ide unit who were assessed at high risk of malnutrition and dehydration. Those people relied on staff for assistance and prompting with eating and drinking. We observed the care and support offered to those people to eat and drink throughout the day, looked at care plans and daily records. Nutritional care plans included information about people's dietary needs, likes and dislikes, any dietary supplements prescribed and about importance of monitoring and recording food and drink. However, people's nutritional care plans did not give detailed information or guidance to staff about how much food and drink individual people needed to keep healthy. We found the information about people's individual calorie and fluid requirements were not detailed enough. Also, we observed staff were unable to spend the time people needed to support them to eat and drink regularly. We also found poor recording and monitoring of people's food and fluid intake. This meant a number of people on Ide were at risk of malnutrition and dehydration.

For example, we looked at the care of one person who was recently admitted to the home. The person had been assessed at high risk of malnutrition and dehydration. They also had swallowing difficulties, which meant they needed a pureed diet because of their choking risk, which they did not enjoy. The care plan showed the person had a poor appetite and needed a lot of encouragement and prompting to eat and drink. Their care plan instructed staff to offer the person regular snacks they liked and recommended how much fluid the person should drink each day to stay healthy. This person had a food and fluid chart that staff were instructed to complete to record all food and drink taken.

We looked at this person's food and fluid records over the previous eight days. The food/fluid charts we looked at were poorly completed, the entries made were confusing and there were large gaps between entries. They showed the person had drunk no fluids on two days and minimal amounts on other days, all much less than recommended in their care plan to keep them healthy. Also, we saw the person had eaten very little, or nothing at all some days. The records we looked at did not show the person was offered food, fluid or snacks regularly, as required by their care plan.

We observed this person on several occasions during the day we spent on Ide unit on 24 February. We observed the person was on their own each time we looked in on them. Although they had a drink in front of them, we did not see them drinking or see that staff

spent time prompting or encouraging them to eat and drink. At 1415 the person had a cup of soup in front of them but they weren't eating it. When we asked them if they needed help, they pointed to their dentures nearby to indicate to us they needed them to eat their lunch. We asked a staff member to help them. The staff member sat with the person for a couple of minutes and encouraged them to have a few sips of soup. Then they left again because they were assisting another person to eat lunch. This meant the person was not prompted or supported to try and eat anything else.

We looked at the person's daily progress and evaluation records between the 17 and 24 February 2014. These showed they were eating and drinking very little and frequently refused meals. The person was seen by their GP on 19 February who prescribed a fortified food supplement drink for the person. However, we could not see this was offered to the person twice daily, as instructed. Two staff we spoke with about this person who said they were concerned about this person because they were eating and drinking so little. When we left Ide unit at 18.50 the person's food and fluid chart had no entries about whether the person had eaten or drunk anything all day. This meant vital information about their poor fluid and food intake was not recorded or communicated between staff. The person's care plan also showed they needed to be weighed weekly, to monitor their weight. This was due on 24 February but was not carried out and this person still had not been weighed when we rechecked their weight chart on 26 February. This meant the weight monitoring instructions in the person's care plan were not followed and the person's health was at serious risk.

We saw a similar pattern of care for seven other people on Ide unit, who were at risk of malnutrition and dehydration. We found care records showed minimal food and fluids were recorded. We could not see that regular snacks or food supplement drinks were being offered regularly as instructed in those people's nutritional care plans. We found a lack of monitoring of food and fluids on the unit and weekly weight charts we looked at showed three people had recently lost weight and other people had gradually lost weight over time. Where staff were aware of people at risk, we did not see evidence that concerns were always reported or where they were, that robust action was taken in response. Care plans were not evaluated to see whether any changes were needed.

We also observed some people's water jugs had not been used and that a number of people were not offered a mid-morning drink. People's meals were delayed, because staff were occupied helping other people to eat. This meant some people had long gaps between meals, a concern we raised with the provider at our previous inspection. From our observations of people's care and support, we concluded, that staff on Ide unit were not able to spend enough time with each person who needed support with eating and drinking. This meant we could not be confident that eight people on Ide unit were getting enough to eat and drink.

Two relatives we spoke with expressed concerns about staff support for their relatives with eating and drinking. One said, "She does not eat enough to keep a fly alive, she loves ice cream but they don't remember to give it to her that often". They went on to say, "I feel really depressed about it, is it too much to ask that someone gives mum drinks?" A GP we spoke with commented they thought staff at the home could be more pro- active in encouraging people to eat and drink and use snacks more often in preference to food supplements to help people to gain weight.

We spoke with the chef who worked closely with each unit about people's nutritional needs. They told us about special diets prepared for people. For example, pureed food,

gluten free and reduced sugar foods. Also about methods used to increase calorie intake for people at risk of malnutrition such as by adding milk, cheese and cream to meals. They also told us about the availability of snacks such as yogurts and ice cream as well as food supplement drinks. At night, staff told us sandwiches, crisps and fruit were available in ward areas. However, these types of snacks would not have been suitable to offer most of the people we had concerns about on Ide unit, as many of them had choking risks.

We spoke with five staff on Ide unit about the care and support of people with their nutrition and hydration. Staff confirmed people often had their meals late because so many people needed support to eat and drink. The five staff we spoke with did not demonstrate they had enough knowledge about people's individual food and drink requirements or about how they would recognise if people were at risk and take appropriate action. We followed this up with the registered manager and asked about whether staff had received any training on nutrition and hydration over the past 12 months and were told they had not. This meant people were not adequately supported with their nutrition and hydration needs because staff lacked the knowledge and skills to do so.

We followed up our concerns with the registered manager and other senior staff about the poor quality of care and support for people's nutritional and hydration needs on Ide unit and about the poor documentation we found. None of the staff we spoke were able to explain why these issues were not being dealt with. We raised serious concerns about the care of welfare of eight people on Ide unit with the registered manager and asked them to review all of the people on that unit. We also informed the local authority safeguarding team about our concerns, which resulted in health professionals visiting the home as part of a safeguarding investigation and to help support improvements in care.

There were arrangements in place to deal with foreseeable emergencies although a GP we spoke with expressed some concerns about the arrangements. We asked staff about how emergencies such as sudden collapse were dealt with at the home. They told us in the event of a sudden collapse, staff would summon an ambulance by dialling 999 and that staff were trained to administer first aid whilst they waited for the ambulance to arrive. One GP we spoke with told us that recently they were called to deal with the emergency collapse of a person at the home. They commented that staff on duty did not seem very confident in managing the emergency resuscitation. We followed this up with the registered manager who confirmed that 94% of nursing staff were up to date with cardio-pulmonary resuscitation training. The GP told us they had written to the registered manager to request the provider purchase defibrillator resuscitation equipment. The registered manager told us this request was still being considered.

The Deprivation of Liberty Safeguards were only used when it was considered to be in the person's best interest. We were told that staff at the home had undertaken training on the Mental Capacity Act and Deprivation of Liberty safeguards. On Shillingford unit, staff told us about one person they had sought advice from the local authority deprivation of liberty team about. They told us they were advised the arrangements for managing the person safely did not represent a deprivation of their liberty. The home had also met with the family and other health care representatives to discuss how best to manage this person's needs. This showed the provider understood their responsibilities in relation to the Mental Capacity Act and Deprivation of Liberty safeguards and worked with the family and other agencies in the persons 'best interest'.

Safeguarding people who use services from abuse ✖ Action needed

People should be protected from abuse and staff should respect their human rights

Our judgement

The provider was not meeting this standard.

People who use the service were not protected from the risk of abuse because the provider had not taken reasonable steps to identify the possibility of abuse and prevent abuse from happening. This was because some people were at risk of dehydration and malnutrition because they were not getting enough to eat and drink to maintain their health.

We have judged that this has a moderate impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

People who used the service were not protected from the risk of abuse because the provider had not taken reasonable steps to identify the possibility of abuse and prevent abuse from happening.

All of the staff we spoke with confirmed they felt confident to raise concerns about suspected abuse and felt action would be taken in response to suspected abuse. The registered manager showed us training data which demonstrated staff undertook annual safeguarding training/updating. The provider had safeguarding policies and procedures in place. Individual safeguarding concerns were reported to the local authority safeguarding team and to the Care Quality Commission with evidence of actions taken to investigate concerns and reduce risks for people.

However, during the inspection, we had safeguarding concerns about whether eight people who lived on Ide unit were getting enough to eat and drink. We raised a safeguarding alert to the local authority about suspected neglect of those people. In response, a safeguarding strategy meeting was held on 05 March. This was attended by representatives from the safeguarding team, commissioners, the community healthcare team, CQC and the provider. The provider agreed to work in partnership with local teams to review the care of those people and others at Lucerne House. At the safeguarding meeting, the provider presented an action plan outlining immediate steps underway to improve people's care in relation to their nutrition and hydration. This included providing staff training.

On 06 March two safeguarding nurses visited Ide unit at the home to check on people's care and welfare. The visit confirmed the safeguarding concerns we raised about people on Ide unit were upheld by their visit. Since then, local healthcare staff have visited the home regularly to support staff and monitor people's ongoing care at the home to ensure

people's care is improved. The improvement plan will be co-ordinated through the local authority safeguarding process. Commissioners of the service have also met with senior managers and will work in partnership with the home to support all further actions required to ensure the improvements required are made and sustained.

Safety and suitability of premises ✖ Action needed

People should be cared for in safe and accessible surroundings that support their health and welfare

Our judgement

The provider was not meeting this standard.

People who used the service, staff and visitors were not fully protected against the risks of unsafe or unsuitable premises. This was because of ongoing security risks related to the main entrance to the home.

We have judged that this has a moderate impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

The provider had taken steps to improve the environment of the home. However, people who used the service were not fully protected because of ongoing security risks related to the main entrance to the home.

Most people and relatives we spoke with gave us positive feedback about the environment of the home. They told us the home was kept clean and in good repair. We saw that people were encouraged to bring familiar things such as pictures and furniture with them to the home so that each person's room was included things that were important to them. Several people mentioned how much they liked the gardens and looked forward to accessing the grounds in warmer weather. One relative told us they had to remind staff a couple of times before the curtain track in the person's room was repaired. On Shillingford unit, we followed up previous concerns raised about a broken commode disinfector which we found had been replaced. Also, we found additional storage had been arranged so that the unit was tidier and easier for people and staff to access all areas safely and unobstructed.

We also followed up previous concerns about water temperatures being too hot in some areas of the home. The estates manager told us all faulty blending valves had been replaced to ensure all hot water was temperature controlled. We saw that staff checked and recorded the water temperatures regularly, although we found some gaps in documentation. We checked the hot water temperatures in several rooms and found these were within a safe temperature range. This meant that people's risks of burns from hot water had been reduced.

We also followed up security concerns about the front and rear doors of the home. We found the rear door was securely locked but that risks relating to the main entrance remained. Following the last inspection in August 2013, the registered manager sent us an action plan about measures being taken to address the security risks we identified. This showed a receptionist checked people visiting the home between 09.00 and 17.00. Also

that the main entrance would be locked after 17.00 each evening when the receptionist finished for the day and would remain locked until 09.00 the next morning. The action plan showed that staff awareness had been raised about keeping the door closed and about plans underway to have the main entrance door alarmed.

However, each time we visited the home, we observed that visitors accessed the home regularly during day without any checks being made. This was because the receptionist had recently left and the reception area was only manned intermittently by other members of staff. One morning we visited the home at 0815 and were on site at 1900 on two evenings during the inspection. We were able to enter and leave the building unchallenged on all three occasions. One member of staff told us about an occasion where a member of the public accessed the home in an intoxicated state and fell asleep and how staff had difficulty getting the person to leave the home. This represented a security risk for vulnerable people who lived at the home and meant people remained at risk because visitors and other could access the home without the appropriate checks being made.

We followed up the security arrangements with the estates manager. They explained a number of options had been explored about how best to manage the security risks related to the front door. They told us a bid to install an electronic keypad had recently been submitted to the provider for approval. They also told us that staff were supposed to put down the latch so the door locked after visitors left but sometimes forgot to do so. They said the lock had recently been faulty and had now been replaced. We asked to see a copy of the risk assessment about this security risk but this was not provided, despite several reminders. We followed up our concerns about the ongoing security risks to the registered manager and asked about further actions planned. They told us funding to fit an electric keypad to the front door had now been approved and this work would go ahead in the next few weeks. This, when completed would ensure unauthorised visitors could not access the home because the door would be locked out of hours and staff would have to let visitors and relatives in. We were also told that plans to replace the receptionist were underway which would improve monitoring of visitors accessing the home during the day.

We found the home had effective systems in place to ensure the ongoing maintenance of the premises. Two staff worked on site undertaking maintenance, decorating and repairs, electrical testing and regular health and safety checks. We saw documentary evidence that water tests for legionella (a bacteria in hot water systems) had been carried out and was clear. Also, that checks of the emergency lighting, fire alarm system, and servicing of fire extinguishers were up to date. There was evidence that regular fire safety checks and fire drills took place. We were told about the contingency arrangements in place in case of any major loss of utilities. We looked at the storage arrangements for clinical waste and found storage bins used to store clinical waste were not securely locked, as they should be. The provider took immediate action to secure them.

We were told about new flooring to some areas and about about further improvements planned. For example, plans to replace the boiler and to decorate the lounge and dining area and improve the lighting on Shillingford unit. This showed ongoing investment by the provider to improve the environment of care for people.

Safety, availability and suitability of equipment ✖ Action needed

People should be safe from harm from unsafe or unsuitable equipment

Our judgement

The provider was not meeting this standard.

People were not protected from unsafe or unsuitable equipment. This was because some bed rail bumpers and crash rail equipment were torn and stained and because hoist slings were being shared between people. This was a health and safety and an infection control risk for people.

We have judged that this has a moderate impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

People were not protected from unsafe or unsuitable equipment.

At our previous inspection in August 2013 we found that a number of bed rail bumpers and 'crash mats' were damaged with tears and splits to the protective material. Some were also stained and dirty. Following the inspection, the registered manager sent an action plan which showed all damaged mattresses and bed bumpers had been replaced. We followed this up at this inspection and identified a number of further crash mattresses and rail bumpers on Shillingford and Ide units which were damaged and soiled. The damaged equipment posed a cross infection risk to people because they could not be effectively cleaned. It also meant the equipment was less effective in cushioning people from injury. We raised these concerns with the registered manager who told us they would arrange for the damaged equipment to be replaced, which they did.

There was not enough equipment to promote the independence and comfort of people who use the service. This was because we found hoist slings were shared between people, which was a cross infection and a health and safety risk.

We saw there was a variety of equipment available in all areas of the home to meet people's needs and to promote their independence and comfort. For example, pressure relieving equipment, electric beds, hoists and stand aids. Where people needed hoisting, we saw their care records included details about the size of hoist sling appropriate for their size and weight. We asked staff about whether they had enough equipment available and they confirmed they did. However, on Shillingford unit we found that hoist slings were shared between people. We saw large numbers of hoist slings were stored in communal bathroom areas. We asked staff whether each person who needed a sling for hoisting had their own sling and were told they did not. Instead, staff told us they obtained slings from the communal bathroom areas when a person needed hoisting. The use of communal slings represented a health and safety risk. This was because it increased the risk that the

hoist sling chosen might be the wrong size for the person's size and weight and because shared slings increased the risk of cross infection.

We found pressure relieving mattresses and cushions were in place for people who needed them. We checked the settings on some people's pressure relieving equipment and found they were at the correct setting for the person's weight. This demonstrated staff knew how to use the equipment correctly. We asked about equipment used for people who were unable to use a call bell. Where people were assessed as being at risk and were unable to use a call bell, we saw they had a pressure mats in place to alert staff if they got out of bed so they could offer assistance to the person. On one occasion on Alphinbrook, we found a member of staff was unfamiliar with specialist communication equipment used by a person. This meant they were unable to respond to the person's request to set it up in order to communicate with us, although another member of staff helped instead.

We spoke with the estates manager who showed us the arrangements in place for the servicing and maintenance of equipment in the home. We saw that specialist firms were used for undertaking servicing and maintenance of specialist medical equipment such as electric beds, lifting and pressure relieving equipment. The records showed regular repairs, checks and maintenance was undertaken. They told us how senior staff at the home met every few months and requested the purchase of new and replacement equipment to meet people's needs. This included ensuring that new equipment purchased such as beds and lifting equipment were suitable for the variety of people's weights and sizes. This meant the purchase of new equipment was appropriate for people's needs.

We noticed that the labels on several pressure relieving mattresses showed they were overdue for servicing and maintenance. We followed this up with the estates manager who explained this was hired equipment. They showed us documentation from the hire company which demonstrated the equipment servicing and maintenance records were up to date. We saw hoist equipment in a corridor which was awaiting repair. We followed up what action was being taken about this. They told us that some of the hoist equipment needed to be charged very regularly because of problems with the chargers. They confirmed that replacement charging equipment had been ordered to address this. This meant action was taken to ensure equipment used was fit for purpose.

Staffing ✖ Enforcement action taken

There should be enough members of staff to keep people safe and meet their health and welfare needs

Our judgement

The provider was not meeting this standard.

There were not enough qualified, skilled and experienced staff to meet people's needs. This meant people were not receiving the support and help they needed to maintain their health, safety and welfare.

We have judged that this has a major impact on people who use the service and have taken enforcement action against this provider. Please see the 'Enforcement action' section within this report.

Reasons for our judgement

There were not enough qualified, skilled and experienced staff to meet people's needs.

We followed up concerns identified at our previous inspection in August 2013 about low staffing levels. We received an action plan from the provider which showed they had reviewed staffing levels and skill mix and had increased staffing numbers. We asked the registered manager for an update about current staffing levels. They confirmed staffing levels were adequate for people's assessed dependency needs at the home. They confirmed additional staff had been recruited to replace staff that had left. The provider old us the home was almost up to full staffing levels and about ongoing staff recruitment to ensure there was enough staff to cover sickness and annual leave.

We asked the registered manager whether a dependency tool was used to assess the staffing levels and skill mix needed. They told us no dependency tool was used to assess this. Instead, they told us staff used the pre-admission assessment as a dependency guide, along with Barchester's care assessment tool. They also told us stff used their professional judgement and experience to assess the adequacy of staffing levels and skill mix requirements. They went on to explain the provider had a dependency tool which was being reviewed and updated and that Lucerne House would be a pilot site for using the revised tool.

People spoke highly about the staff who worked at Lucerne House but several also commented on low staffing levels. They described how staff worked "tirelessly" and were "always running around". One person said, "When I want them, they are there". A second person said, "there is just not enough staff". Other people told us about delays in responding to call bells, particularly at night. One said, "when you ring the bell, they (staff) arrive and say I'll be back, I recently waited half an hour for them to come back". Another person said, "The more people ring bells, the less chance you have of getting them

answered".

Several of the 15 relatives we spoke with also expressed concern about low staffing levels. One relative said, "The main issue here is not enough staff, they are understaffed quite a lot of the time". A second relative said, "They need to get the staffing situation sorted, staff come and go". A third said, "They are going through a difficult time of being short staffed, particularly in the evening. A fourth said, "Staff are always very busy and seem stressed out, I worry my mother will be seriously hurt by another patient as I can't always see or find staff". A fifth relative told us they thought Shillingford unit had "gone downhill" recently because experienced staff had left and how their relative was getting less one to one support than they had received previously.

Three of the nine health professionals, we spoke with told us about low staffing levels at the home. One told us they were recently called to see a person at the home because of concerns the person wasn't drinking enough. They said, "I think it's staffing, they don't always have enough staff to help people drink".

We spoke with 31 staff at the home during the three days we visited. Several new staff had recently started working at the home and told us they felt well supported by more experienced staff. People, relatives and staff told us about numerous changes in leadership and management over the last 12 months which meant they were feeling unsettled. For example, about numerous changes in managers at the home and about changes to the heads of unit posts in two of the three units.

We asked staff about the adequacy of staffing levels at the home and most staff we spoke with reported the home was short of staff regularly. Staff told us about shortages of staff each week due to high levels of staff sickness and holidays. We asked how often recommended staffing numbers were affected by staff absence. Responses varied from twice a week to every other day. One staff member said, "We are understaffed about 50% of the time, the sickness rate here is pretty high". Another member of staff said the unit was short staffed about three out of four days they worked each week. We asked staff about how gaps in staffing rotas were covered. Staff told us existing staff worked extra shifts, about staff being asked to go and help in other units to cover and how sometimes no replacement staff could be arranged, particularly at short notice.

We looked at the staffing rotas for each unit at Lucerne House over a four week period between 17 February and 16 March 2014. We found staffing gaps in the rotas for all three units over the period we looked at. These gaps confirmed all three units were regularly understaffed each week. They showed recommended staffing and skill mix numbers were regularly not being achieved because of staff sickness. We also saw examples of mistakes on the rota. For example, one member of staff discovered another member of staff was rostered to work on two units at the same time. This meant there was one less registered nurse on duty the next day than the home had previously realised.

During the first day of our visit, staffing was reduced on all three units because of staff sickness. As a result, on two of the three units, we saw the morning medicines were late being administered. For example, one person was given their early morning medication at 10.50. Their prescription chart showed this medication was prescribed for them four times a day. However, the late administration of this person's medication was not recorded as there was no place to record the time of administration on the medicine administration record (MAR). This meant there was an increased risk the person could be given their next dose too early because the late administration was not documented, which posed a risk to

their welfare and safety. We saw several similar risks for a number of other people in relation to delays in giving people their medicines.

Some people told us staff were too busy to spend enough time with them. One person said, "I am left on my own, no one talks to me" and another said, "It would make such a difference if the carers had time to talk to me in the morning; even if it was just about the weather". This showed that low staffing levels were having an impact on some people's emotional and psychological wellbeing. Two staff we spoke with told us that sometimes when the unit was short staffed, staff (who were supposed to provide one to one support for individuals) also looked after other people as well in communal areas. This was so that staff could catch up on their paperwork or have a meal break. This meant people, who were assessed as needing one to one care and support, were at increased risk because they may not get the one to one support they required.

On the 24 February we spent the day on Ide unit and saw how staffing shortages had an adverse impact on the health, safety and welfare of people and of staff. We looked at the level of needs and dependency of the people in Ide Unit. People on the unit had complex needs varying from dementia to physical disabilities and some needed palliative (end of life) care. The rota on Ide unit showed a total of seven staff should be on duty, two nurses and five care workers. Instead, five staff were on duty because of staff sickness. This meant there was only one nurse on duty instead of two until late afternoon and that five staff were caring for 25 people on the unit.

We observed the staff support given to people throughout the day on Ide unit and saw people were at risk because there were insufficient staff on duty to support their care needs. We saw several people, who were at risk of malnutrition and dehydration, were not supported to have lunch until 1430 and in the evening, two people still had not been assisted to have their supper when we left at 18.50. This meant those people were at risk of malnutrition and dehydration because there were long gaps between their meals. We also observed those people were not offered regular drinks or snack s which further increased their risks. Some staff we spoke with told us they did not have the time they needed to support each person who needed assistance with eating and drinking. Two members of staff told us they would like to be able to spend more time with people having end of life care. One said, "There isn't enough staff to sit with people". This meant people were at increased risk because there were not enough staff to support them with their care needs.

One health care professional we spoke with told us they were concerned about a recent weekend on Ide unit. This was because there was only one trained nurse on duty and three patients were receiving end of life care. Staff told us that people receiving end of life care required additional nursing time and their families often required support too. They said they felt the unit needed more staff in order to be able to sustain the end of life care provided. On the day we spent on Ide unit, eight people were receiving end of life care, three of whom had morphine pumps. Staff explained that, because the second nurse was off sick, they needed a senior care worker to assist the nurse to check the controlled drugs each time they changed a morphine pump. This meant that care worker was not available to provide personal care and support for other people during those periods.

We observed some people on Ide unit were not supported to get washed and dressed until lunchtime, which staff confirmed to us happened regularly. This meant some people did not receive personal care at a time convenient for them. During our visit to Ide unit, we observed nurse call bells flashing over people's door frequently throughout the day. We

asked about this and were told this meant a member of staff had been to see the person and silenced their bell but had not yet attended to their needs. This meant the flashing light represented people who were waiting for staff to return to provide their care.

We also found staffing shortages on Ide unit were having an adverse impact on the welfare of staff. The nurse on duty was due to finish at 14.00 but was still on duty five hours later. They told us this was because no replacement nurse had been found and instead the deputy manager came to work on the ward at 17.00 . The staff member told us they offered to stay because they needed to help the deputy manager with administering the medicines. One care worker we spoke with told us they had hurt their back over the weekend as they were so short staffed. They also told us that some staff took shortcuts, when the unit was short staffed, by undertaking moving and handling of people on their own, when two staff were needed to safely move people. This could put people and staff at increased risk of injury.

We reported these concerns to the registered manager who told us they would follow this up by carrying out some spot checks. We also saw staff meal breaks were delayed, staff had not had a lunch break by 14.45 because people still needed support to eat lunch. During the day, we also saw one care worker was spending time trying to cover staff shortages because of sickness absence for the next day. This meant the care worker was not available to provide care for people during this period.

Some relatives we spoke with raised concerns with us about the number of experienced staff that had left the home recently and that were replaced by inexperienced staff. One relative said, "Staff are mostly friendly and hard- working but some appear very inexperienced". Another relative said, "There are always new faces", and a third said, "Some staff skills better than others".

A range of health professionals we spoke with also commented on the variable skill levels of staff at the home. One said "It very much depends on who is on duty". Another said, "Some of the nursing staff are fabulous, others less so". A third health professional said, "Some staff seem much less knowledgeable than others, and some don't know about people's care needs or where things are kept". Two health professionals expressed concerns about the limited knowledge and experience of palliative care of some of the nursing staff. They said this meant nurses from the home frequently rang for advice. They said, whilst they welcomed the fact that the nurses recognised when they needed advice, they thought it showed some nurses lacked skills and confidence in providing end of life care. We followed this up with the registered manager who told us some staff from the home had recently attended some training at the hospice.

The concerns raised by people, relatives, staff and visiting health professionals about staff shortages and the impact on people's care and quality of life at this inspection were of a similar nature similar to those raised with us when we last inspected the home in August 2013. We found the actions taken to address low staffing levels were insufficient and that the provider was not safeguarding the health, safety and welfare of service users by ensuring sufficient numbers of suitably qualified, skilled and experienced staff were on duty at all times.

Assessing and monitoring the quality of service provision

✖ Enforcement action taken

The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care

Our judgement

The provider was not meeting this standard.

The provider had a range of systems in place to assess and monitor the quality of service that people received. However, some of these systems were not effective because they did not identify the failures in care, low staffing levels, equipment and security risks or examples of poor documentation found during the inspection.

We have judged that this has a moderate impact on people who use the service and have taken enforcement action against this provider. Please see the 'Enforcement action' section within this report.

Reasons for our judgement

People who used the service, their representatives and staff were asked for their views about their care and treatment. However, the feedback systems in place did not take account of day to day verbal complaints and comments made by people, relatives and staff to improve the service. This meant valuable information and concerns about people's care and about the impact of low staffing levels was not being identified.

A number of people, relatives and staff raised concerns with us about the number of changes in leadership and management of the home over the past nine months and the impact of this of the home. Some people and relatives we spoke raised concerns with us about high turnover of staff, low staffing levels and how differences in the skills and attitudes of staff impacted on people's care. One relative said, "Some staff are great, others less so".

One health professional who regularly visited Lucerne House said, "It lacks continuity of good leadership, it's a shame about all the management changes". Most staff we spoke with reported they felt supported by senior staff in the unit they worked in. One staff member we spoke with described about how each new manager brought a different leadership style. They said, "staff don't feel involved and valued, there is less discipline".

The provider had a range of audits and checking systems in place. These included monthly provider visits, audits of documentation and daily and monthly checks of bedrails. However, some of these systems were not fully effective because they did not identify, assess and manage some risks relating to the health, welfare and safety of service users. Also, we could not identify from our discussions with the registered manager and other senior staff how quality monitoring was being used to highlight and address when staff were not following the providers' policies and procedures. This meant there was a lack of

accountability for the poor standards of care and documentation we saw in some areas of the home, which were having an adverse impact on some people's care and treatment.

The provider undertook an annual survey of people and relatives. We looked at the most recent survey completed during September and October 2013, which was based on 37 responses from people. The survey covered topics such as staff and care, home comforts, choice, having a say and quality of life. The report showed, overall, high levels of satisfaction with the care and treatment provided at Lucerne House. The results showed most areas of the survey had improved scores compared to the previous year. However, scores had deteriorated a few areas. For example, in the number of people who reported that staff had time to talk to them and who reported they could choose what time they got up and went to bed.

An action plan, dated February 2014, was compiled by the registered manager in response to the survey findings. In relation to staff having time to talk to people, the action plan showed head of units were responsible for ensuring staff had allocated time and were encouraged to sit and chat with people. However, most staff we spoke with reported this was not happening in practice so further improvements in this area were needed.

We saw examples of some effective audits and checking systems. For example, cleaning schedules and monitoring of cleanliness, systems for ensuring regular servicing and maintenance was undertaken in relation to the premises, utilities, and equipment. However, other audits and checks failed to highlight problems and risks we identified during the inspection. For example, we looked at a documentation audit undertaken on 03 March 2014. We saw the audit tool looked at care plans and risks assessments but did not look at food and fluid or repositioning charts. Some aspects of essential documentation about people's care and well-being were not included in the audit tool and were therefore not checked. This meant the risks relating to poor documentation of service users food and fluid charts were not identified and did not prompt staff to identify and reduce those risks.

We also looked at records of daily checks and monthly audits of bedrails and bumpers on Shillingford and Ide units. These checks showed rail bumpers were reported as 'safe'. However, during this inspection we found a number of rail bumpers were torn, damaged and badly stained. We found staff did not accurately report on the condition of some of this equipment. This meant dirty and damaged equipment was not cleaned or replaced which increased the risk to people of cross infection.

We looked at the accident/incident system in place and found high levels of reporting by staff. However, we identified gaps in completing the documentation, which meant learning from incidents and opportunities to reduce risks were being missed.

We discussed the accident/ incident system with the deputy manager who told us they had just taken over responsibility for this and were still getting used to the electronic database system in use. They described how staff completed paper based accident/incident forms at the time of the incident which included details of any immediate actions taken. These were then signed by the head of unit and sent to the deputy manager who reviewed them and entered them onto a database, which was monitored by the provider.

We looked at the paper accident/incident forms completed during February 2014 which showed that although accidents and incidents were well reported, there a lack of detailed documentation about actions taken after the incident or accident to reduce risk of recurrence. We discussed this with the deputy manager who confirmed they were aware

some forms were poorly completed and regularly returned them to staff to request further details. This meant some information which could inform trends and identify further measures to reduce risks were not captured.

The database looked at trends and highlighted risks to prompt further actions. For example, about people reported as falling frequently. The deputy manager told us they followed up these with staff and discussed them with the registered manager to ensure they were satisfied all appropriate actions were being taken to reduce risks. Where safeguarding concerns were raised, for example, unexplained bruising, we saw these were followed up and appropriately investigated.

We followed up some equipment concerns raised with us following feedback received about an unexpected emergency. We asked to see the incident report about this and were told this was not reported as an incident as no concerns were raised at the time, although the home subsequently received a letter about this event. This meant an opportunity to review the event and identify learning for staff was missed. This was being followed up further.

We asked senior staff about training, supervision and appraisals and were told about the policies and procedures in place and the database system used for monitoring staff training, supervision and appraisals. However, information from the database about supervision and appraisals showed performance varied between units. For example, data from Alphinbrook unit showed lowest compliance with appraisals at 65% and Ide unit had lowest compliance with staff supervision at 57%. We also saw low staff compliance with attendance at clinical training for example, at drug competency and pharmacy update training. However, we could not identify from our discussion with senior staff how the training database system was being used to address variations in levels of supervision and appraisal between units or to address overdue training. This meant the database system was not being used effectively to address low supervision, training and appraisal rates in some units.

The home had a system in place for monitoring staff absence. The registered manager told us about actions being taken to address frequent staff absence amongst some staff. This included seeking support and advice from occupational health. The registered manager told us about a number of formal processes underway with some staff to reduce absence levels. This demonstrated policies and procedures on sickness and other absence were being followed and that positive action was being taken to reduce the impact of high levels of staff absence on people's care. However, we found high staff sickness continued and that low staffing levels meant people at Lucerne House were at increased risk of unsafe care and treatment.

We looked at the systems in place for statutory notifications to CQC and identified some gaps related to recent death notifications. These related to recent changes in the staff member responsible for submitting notifications and a misunderstanding about the need to notify deaths, even when the person did not die in the home. Following the inspection, we requested retrospective statutory notifications about the deaths of three people, which we have now received.

We asked about communication systems with staff. The registered manager told us about daily 10 minute meetings at 10 am attended by a representative from each department in the home. They explained these were a quick and effective way to raise awareness of day to day issues such as staff sickness and areas needing help, about repairs and

maintenance, planned activities and events. We attended this meeting on 26 February and heard staff being reminded about the importance of documenting food and fluid charts following feedback from the first day of the inspection.

Our discussions with staff during the inspection highlighted differences in how staff were involved in day to day decision making at the home. On Shillingford unit, staff reported they had regular opportunities to have their say at regular staff meetings. On Alphinbrook unit, we were told staff meetings were only held if there was a problem and other information was communicated through daily staff handover. On Ide unit, there was no evidence of any staff meetings in the past six months other than a meetings held by the registered manager when they first started.

Following the CQC inspection in August 2013, we received an action plan from the registered manager which included a range of quality monitoring systems being used to ensure the provider became compliant with the regulations and to monitor that compliance was sustained. For example, monitoring care plans monthly, reviewing staffing levels and skill mix on rotas and spot checks on care documentation. We looked at minutes of a meeting on 03 October 2013 and an unannounced inspection by the registered manager on the 12 January 2014. These showed the registered manager was aware of the some of the concerns we highlighted at this inspection such as about poor completion of food/fluid charts and about standards of personal care. This demonstrated the failings in care that we identified at our previous inspection and the breaches of the regulations have continued.

For example, we looked at minutes of a staff meeting held by the registered manager on Ide unit on 03 October 2013. These minutes showed the registered manager raised concerns about standards of personal care for people and highlighted the need for improved documentation of food and fluid charts. The minutes said, 'Fill them in, you are accountable'. Other issues discussed at the meeting included professional behaviour and concerns about high staff sickness levels. On the 12 January 2014, the registered manager carried out an audit of care practice at Lucerne House. The report showed once again, that the registered manager had to remind staff to complete food/fluid charts on time and to document records about mouth care. However, our inspection showed these problems and gaps in care continued. This meant that although systems were put in place to monitor compliance with the regulations, some staff were not implementing them.

We also found people and relative's complaints were not always fully investigated and resolved, to their satisfaction. This was because the complaint system at Lucerne House did not capture information about verbal complaints or comments. This meant opportunities to identify concerns about care were not captured. Also, that complaints about low staffing levels and inadequate staff support for people were not being identified, effectively investigated or resolved to the satisfaction of people and relatives.

The lack of effective quality monitoring systems in place at Lucerne House meant risks of inappropriate or unsafe care and treatment for people remained.

Complaints ✖ Action needed

People should have their complaints listened to and acted on properly

Our judgement

The provider was not meeting this standard.

The complaints system in place was not fully effective. This was because verbal complaints and comments received from relatives were not appropriately responded to.

We have judged that this has a moderate impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

People were made aware of the complaints system. We followed up whether out of date information about the regulator's role in relation to complaints in service user information had been updated since we last visited in August 2013 and found it had been. A welcome pack provided information to people about the provider's complaint policy and procedures. We also saw the information was on display in the front entrance of the home. This provided information about how people could raise complaints or concerns with the provider, commissioners and other agencies.

The home had a complaints policy, which outlined three internal stages in the complaints process and outlined timescales for investigation. These included local formal and informal processes and review of complaints by a regional representative of the provider. The policy included people and relatives rights to voice comments, suggestions and complaints.

People's complaints were not always fully investigated and resolved, where possible, to their satisfaction. This was because some relative's verbal complaints or comments were not captured and were not being resolved to their satisfaction.

We looked at the complaints file and saw two written complaints were received since we last inspected the home in August 2013, one of which was from a relative. We looked at both complaints and saw these had been fully investigated within the timescales and a written response had been sent in accordance with the policy. The response letter we looked at provided full information about the outcome of the investigation, offered apologies for areas where care provided had not reached the required standard and outlined actions being taken to improve care.

However, we saw some of the actions identified remained a concern during the inspection. For example, action to increase supervision and monitoring of care staff to ensure daily care records were completed. The response also referred the respondent to further information and contact details on display in the main entrance at Lucerne House about

how to raise their complaints or concerns with commissioners and other agencies, if they were dissatisfied with how their complaint was handled. This was unhelpful because it meant the complainant was provided with those external contact details in the response letter.

Prior to the inspection, two relatives contacted CQC to raise their concerns about low staffing levels and about experienced staff leaving. One relative told us they had raised their concerns directly with the registered manager. They said they were horrified to find their concerns had been fed back to staff in a way that suggested they had been complaining about staff, which they said was not the case. During the inspection we spoke with a third relative who expressed concerns about whether their relative was getting enough to eat and drink at the home. We asked them whether they had raised their concerns with staff at the home. They confirmed they had raised their concerns with senior staff on the unit several times. They described their frustration about the lack of sustained improvement in response to their repeated concerns. They said, "It's like beating your head against a brick wall, I keep banging on and then things go OK for a week or so". This meant some people's relatives were dissatisfied about how verbal feedback and complaints were investigated, dealt with and responded to by the provider.

We followed up the registered manager about how verbal complaints and concerns were dealt with . They confirmed these were normally dealt with by staff on each unit and that no log of verbal complaints was kept. This meant the information about verbal concerns raised at Lucerne House were not being captured so themes and trends were not identified. There was no evidence that verbal complaints were investigated and followed up to ensure they were fully addressed.

Records ✖ Action needed

People's personal records, including medical records, should be accurate and kept safe and confidential

Our judgement

The provider was not meeting this standard.

People were not protected from the risks of unsafe or inappropriate care and treatment because accurate and appropriate care records were not always being maintained. This meant some people were at risk of medication errors, malnutrition and dehydration because of inadequate documentation.

We have judged that this has a moderate impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

People were not protected against the risks of unsafe or inappropriate care and treatment because some care records were incomplete, inaccurate and were not fit for purpose, which was putting people's safety and welfare at risk.

We found the standard of documentation was inconsistent within the home. Some care records were well completed. However, other care records were so poorly completed; we could not tell whether from them whether or not people's care needs were being met.

We found gaps in daily records about people's care, particularly on Ide unit. For example, a number of people were confined to bed and needed to have regular changes of position to reduce their risk of developing pressure ulcers.These changes of position were recorded on a repositioning chart. People were supposed to have a change of position every few hours, however, we noticed gaps in some records of changes of position of between five and seven hours. We could not confirm whether these were lapses in care or in record keeping. However, we observed that people were repositioned regularly during our inspection.

We identified similar but more serious concerns in relation to records about people's food and fluid intake. We found the food/fluid charts used for recording were confusing and difficult to understand. We also found inconsistencies between staff about how they were completed. Staff frequently did not add up the total amount of fluids taken each day and did not report on urinary output, even when the person had a catheter. This meant vital information, which could highlight risks of dehydration and malnutrition for a person, and which should prompt staff to take further corrective action were not documented. These poor standards of record keeping meant people were at increased risk of unsafe and inappropriate care because of inadequate documentation.

Care records included a range of risk assessments and care plans. For most people, we saw these were reviewed and updated each month. However, we identified some care records on Ide unit which did not reflect concerns about poor nutrition and weight loss for eight people or about pressure damage for one person. This meant that concerns were not identified or and communicated within the staff team and prompt actions to address risks for people had not been taken.

We also followed up a documentation issue we raised during our last inspection in August 2013 in relation to the medicine administration records (MAR) sheets. Last time we visited the medicine administration record had insufficient space to record medication administration times. This meant delays in administering medication were not documented. We found this had not been addressed and meant people remained at risk of having their medicines more or less frequently than prescribed, particularly when there were delays due to staff shortages.

This section is primarily information for the provider

Action we have told the provider to take

Compliance actions

The table below shows the essential standards of quality and safety that **were not being met**. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activities	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	**Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010** **Safeguarding people who use services from abuse**
	How the regulation was not being met: People who use the service were not protected from the risk of abuse because the provider had not taken reasonable steps to identify the possibility of abuse and prevent abuse from happening. This was because some people were at risk of dehydration and malnutrition because they were not getting enough to eat and drink to maintain their health. This is a breach of regulation 1a.
Regulated activities	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	**Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010** **Safety and suitability of premises**
	How the regulation was not being met: People who used the service, staff and visitors were not fully protected against the risks of unsafe or unsuitable premises. This was because of ongoing security risks related to the main entrance to the home.

This section is primarily information for the provider

	This is a breach of regulation 15(b).
Regulated activities	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	**Regulation 16 HSCA 2008 (Regulated Activities) Regulations 2010** **Safety, availability and suitability of equipment**
	How the regulation was not being met: People were not protected from unsafe or unsuitable equipment. This was because some bed rail bumpers and crash rail equipment were torn and stained and because hoist slings were being shared between people. This was a health and safety and an infection control risk for people. This is a breach of regulation 16 (1) (a).
Regulated activities	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	**Regulation 19 HSCA 2008 (Regulated Activities) Regulations 2010** **Complaints**
	How the regulation was not being met: The complaints system in place was not fully effective. This was because verbal complaints and comments received from relatives were not appropriately responded to. This is a breach of regulation 19 (2) (c).
Regulated activities	Regulation
Accommodation for persons who require nursing or personal care	**Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010** **Records**
	How the regulation was not being met:

This section is primarily information for the provider

Treatment of disease, disorder or injury	People were not protected from the risks of unsafe or inappropriate care and treatment because accurate and appropriate care records were not always being maintained. This meant some people were at risk of medication errors, malnutrition and dehydration because of inadequate documentation. This is a breach of regulation of 20 (1) (a).

This report is requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider's report should be sent to us by 20 May 2014.

CQC should be informed when compliance actions are complete.

We will check to make sure that action has been taken to meet the standards and will report on our judgements.

This section is primarily information for the provider

✖ Enforcement action we have taken to protect the health, safety and welfare of people using this service

Enforcement actions we have taken

The table below shows enforcement action we have taken because the provider was not meeting the essential standards of quality and safety (or parts of the standards) as shown below.

We have served a warning notice to be met by 06 May 2014 This action has been taken in relation to:	
Regulated activities	Regulation or section of the Act
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	**Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010** **Care and welfare of people who use services** **How the regulation was not being met:** People did not always experience care, treatment and support that met their needs and protected their rights. In particular, we identified significant concerns on Ide unit about the care and treatment of some people who were at risk of dehydration and malnutrition. This was because people were not adequately supported with eating and drinking which meant their safety and welfare was at risk. This is a breach of regulation 9, (1), (b), (i), (ii).
We have served a warning notice to be met by 06 May 2014 This action has been taken in relation to:	
Regulated activities	Regulation or section of the Act

This section is primarily information for the provider

Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	**Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010** **Staffing** **How the regulation was not being met:** There were not enough qualified, skilled and experienced staff to meet people's needs. This meant people were not receiving the support and help they needed to maintain their health, safety and welfare. This is a breach of regulation 22.
We have served a warning notice to be met by 06 May 2014 This action has been taken in relation to:	
Regulated activities	Regulation or section of the Act
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	**Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010** **Assessing and monitoring the quality of service provision** **How the regulation was not being met:** The provider had a range of systems in place to assess and monitor the quality of service that people received. However, some of these systems were not effective because they did not identify the failures in care, low staffing levels, equipment and security risks or examples of poor documentation found during the inspection. This is a breach of regulation 10 (1), (a) and (b), 10 (2), (b) (i) and (iii), (c) (i).

For more information about the enforcement action we can take, please see our *Enforcement policy* on our website.

About CQC inspections

We are the regulator of health and social care in England.

All providers of regulated health and social care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The essential standards are described in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. We regulate against these standards, which we sometimes describe as "government standards".

We carry out unannounced inspections of all care homes, acute hospitals and domiciliary care services in England at least once a year to judge whether or not the essential standards are being met. We carry out inspections of other services less often. All of our inspections are unannounced unless there is a good reason to let the provider know we are coming.

There are 16 essential standards that relate most directly to the quality and safety of care and these are grouped into five key areas. When we inspect we could check all or part of any of the 16 standards at any time depending on the individual circumstances of the service. Because of this we often check different standards at different times.

When we inspect, we always visit and we do things like observe how people are cared for, and we talk to people who use the service, to their carers and to staff. We also review information we have gathered about the provider, check the service's records and check whether the right systems and processes are in place.

We focus on whether or not the provider is meeting the standards and we are guided by whether people are experiencing the outcomes they should be able to expect when the standards are being met. By outcomes we mean the impact care has on the health, safety and welfare of people who use the service, and the experience they have whilst receiving it.

Our inspectors judge if any action is required by the provider of the service to improve the standard of care being provided. Where providers are non-compliant with the regulations, we take enforcement action against them. If we require a service to take action, or if we take enforcement action, we re-inspect it before its next routine inspection was due. This could mean we re-inspect a service several times in one year. We also might decide to re-inspect a service if new concerns emerge about it before the next routine inspection.

In between inspections we continually monitor information we have about providers. The information comes from the public, the provider, other organisations, and from care workers.

You can tell us about your experience of this provider on our website.

How we define our judgements

The following pages show our findings and regulatory judgement for each essential standard or part of the standard that we inspected. Our judgements are based on the ongoing review and analysis of the information gathered by CQC about this provider and the evidence collected during this inspection.

We reach one of the following judgements for each essential standard inspected.

✓ **Met this standard**	This means that the standard was being met in that the provider was compliant with the regulation. If we find that standards were met, we take no regulatory action but we may make comments that may be useful to the provider and to the public about minor improvements that could be made.
✖ **Action needed**	This means that the standard was not being met in that the provider was non-compliant with the regulation. We may have set a compliance action requiring the provider to produce a report setting out how and by when changes will be made to make sure they comply with the standard. We monitor the implementation of action plans in these reports and, if necessary, take further action. We may have identified a breach of a regulation which is more serious, and we will make sure action is taken. We will report on this when it is complete.
✖ **Enforcement action taken**	If the breach of the regulation was more serious, or there have been several or continual breaches, we have a range of actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers include issuing a warning notice; restricting or suspending the services a provider can offer, or the number of people it can care for; issuing fines and formal cautions; in extreme cases, cancelling a provider or managers registration or prosecuting a manager or provider. These enforcement powers are set out in law and mean that we can take swift, targeted action where services are failing people.

How we define our judgements (continued)

Where we find non-compliance with a regulation (or part of a regulation), we state which part of the regulation has been breached. Only where there is non compliance with one or more of Regulations 9-24 of the Regulated Activity Regulations, will our report include a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation). This could be a minor, moderate or major impact.

Minor impact - people who use the service experienced poor care that had an impact on their health, safety or welfare or there was a risk of this happening. The impact was not significant and the matter could be managed or resolved quickly.

Moderate impact - people who use the service experienced poor care that had a significant effect on their health, safety or welfare or there was a risk of this happening. The matter may need to be resolved quickly.

Major impact - people who use the service experienced poor care that had a serious current or long term impact on their health, safety and welfare, or there was a risk of this happening. The matter needs to be resolved quickly

We decide the most appropriate action to take to ensure that the necessary changes are made. We always follow up to check whether action has been taken to meet the standards.

Glossary of terms we use in this report

Essential standard

The essential standards of quality and safety are described in our *Guidance about compliance: Essential standards of quality and safety*. They consist of a significant number of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. These regulations describe the essential standards of quality and safety that people who use health and adult social care services have a right to expect. A full list of the standards can be found within the *Guidance about compliance*. The 16 essential standards are:

Respecting and involving people who use services - Outcome 1 (Regulation 17)
Consent to care and treatment - Outcome 2 (Regulation 18)
Care and welfare of people who use services - Outcome 4 (Regulation 9)
Meeting Nutritional Needs - Outcome 5 (Regulation 14)
Cooperating with other providers - Outcome 6 (Regulation 24)
Safeguarding people who use services from abuse - Outcome 7 (Regulation 11)
Cleanliness and infection control - Outcome 8 (Regulation 12)
Management of medicines - Outcome 9 (Regulation 13)
Safety and suitability of premises - Outcome 10 (Regulation 15)
Safety, availability and suitability of equipment - Outcome 11 (Regulation 16)
Requirements relating to workers - Outcome 12 (Regulation 21)
Staffing - Outcome 13 (Regulation 22)
Supporting Staff - Outcome 14 (Regulation 23)
Assessing and monitoring the quality of service provision - Outcome 16 (Regulation 10)
Complaints - Outcome 17 (Regulation 19)
Records - Outcome 21 (Regulation 20)

Regulated activity

These are prescribed activities related to care and treatment that require registration with CQC. These are set out in legislation, and reflect the services provided.

Glossary of terms we use in this report (continued)

(Registered) Provider

There are several legal terms relating to the providers of services. These include registered person, service provider and registered manager. The term 'provider' means anyone with a legal responsibility for ensuring that the requirements of the law are carried out. On our website we often refer to providers as a 'service'.

Regulations

We regulate against the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009.

Responsive inspection

This is carried out at any time in relation to identified concerns.

Routine inspection

This is planned and could occur at any time. We sometimes describe this as a scheduled inspection.

Themed inspection

This is targeted to look at specific standards, sectors or types of care.

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