Rushcliffe Care Limited

Loudoun House Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on the 1 and 2 November 2016. The first day of our visit was unannounced. We returned announced to complete our inspection on the second day.

Loudoun House provides accommodation for up to 35 people who require personal care and support. There were 34 people using the service at the time of our inspection including people living with dementia.

The service had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Concerns had been raised with us prior to our visit regarding staffing numbers at the service. During our visit it was evident that there were insufficient numbers of staff on duty to meet the care and support needs of the people using the service and to keep them safe from avoidable harm.

There were systems in place to audit the medicines held at the service and appropriate records were being kept. However, people did not always receive their medicines as prescribed.

There were monitoring processes in place to monitor the quality and safety of the service. However these had not identified the shortfalls that we identified during our visit.

The provider's recruitment process had not been consistently followed, this was because up to date references had not always been collected.

People told us they were treated with respect by the staff team and they were kind and caring. Whilst this was observed, the actions of some staff members meant that people were not always treated in a caring or dignified manner.

People told us they felt safe living at Loudoun House Care Home. Relatives we spoke with agreed what they told us. The staff team were aware of their responsibilities for keeping people safe from harm and knew what to do if they felt someone was being abused. We did however observe practices that didn't always keep people safe from harm. This included two people being transferred in a wheelchair without the use of footplates.

Risks associated with people's care and support had been assessed. Where risks had been identified these had, where ever possible, been minimised to better protect people's health and welfare. We did note however that the staff team did not always follow the information contained in people's risk assessments or plans of care to keep people safe.

People were supported to maintain good health. They had access to relevant healthcare services such as doctors, community nurses and opticians and they received ongoing healthcare support.

People had been involved in making day to day decisions about their care and support. Where people lacked the capacity to make their own decisions, these had been made for them in their best interest and in consultation with others.

People's nutritional and dietary requirements had been assessed and a varied and balanced diet was being provided. For people assessed to be at risk of not getting the food and fluids they needed to keep them well, records were kept. We noted that these were not always completed accurately.

People's needs had been assessed before they moved into the service and plans of care had been developed from this. People's plans of care did not always include the actions the staff members should take to meet people's needs.

Observation records were not always completed accurately. This meant that staff could not demonstrate that they had observed people, as required within their plan of care or risk assessment, to keep them safe.

The staff members we spoke with felt supported by the management team. Though concerns were raised with regard to staff deployment. They were provided with opportunities to meet regularly with them to discuss how they were progressing within the staff team.

Staff meetings and meetings for the people using the service had been held. These meetings provided people with the opportunity to be involved in how the service was run.

We found the service was in breach of one of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

There were not enough staff deployed to meet people's needs and keep them safe.

The provider's recruitment process was not consistently followed.

People did not always receive their medicines as prescribed.

People told us they felt safe. The staff team were aware of their responsibilities for keeping people safe.

Risks associated with people's care and support had been assessed, though these had not always been followed by staff.

Is the service effective?

Good

The service was effective.

The staff team on the whole had the skills and knowledge they needed to meet the needs of those in their care.

Where people lacked the capacity to make decisions, these had been made for them in their best interest. Staff members had a basic understanding of the principles of the Mental Capacity Act 2005.

A balanced and varied diet was provided but records relating to nutrition and hydration were not always accurately completed.

People were supported to access healthcare services when they needed them.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People's care and support needs were not always met in a caring or dignified way.

People's privacy was respected.

The staff team knew the needs of the people they were supporting and they involved people in making day to day decisions about their care.

People's relatives were able to visit and were made welcome at all times.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People's plans of care did not always reflect the care and support they needed.

People's needs had been assessed before they moved into the service and they and their relatives had been involved in deciding what care and support they needed.

There was a formal complaints process in place and people knew what to do if they were concerned or unhappy about anything.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

Monitoring systems were in place to check the safety and quality of the service being provided however, had not identified areas requiring improvement.

Staff members we spoke with felt supported by the management team.

People had been given the opportunity to share their thoughts on how the service was run.

Loudoun House Care Home

Detailed findings

Background to this inspection

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

This inspection took place on 1 and 2 November 2016. The first day of our visit was unannounced. We returned announced the next day.

The inspection team consisted of two inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection visit the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the information within the PIR along with information we held about the service. This included notifications. Notifications tell us about important events which the service is required to tell us by law.

We contacted the commissioners of the service to obtain their views about the care provided. The commissioners had funding responsibility for some of the people using the service. We also contacted Healthwatch Leicestershire who are the local consumer champion for people using adult social care services to see if they had any feedback about the service.

At the time of our inspection there were 34 people using the service. We were able to speak with 10 people living there and four relatives of people living there. We also spoke with a senior manager, the registered manager, the quality manager, nine members of the staff team and a visiting professional.

We observed care and support being provided in the communal areas of the service. This was so that we could understand people's experiences. By observing the care received, we could determine whether or not they were comfortable with the support they were provided with. We also used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of

people who could not talk with us.

We reviewed a range of records about people's care and how the service was managed. This included four people's plans of care. We also looked at associated documents including risk assessments and medicine records. We looked at records of meetings, four staff recruitment and training files and the quality assurance audits that the senior manager and registered manager had completed.

Requires Improvement

Is the service safe?

Our findings

Prior to our inspection visit we received information of concern relating to the numbers of staff deployed on each shift and the adverse impact this had on the people using the service. Concerns were also raised with regard to how the staff team were deployed.

We asked the people using the service whether there were enough staff on duty to meet their needs. Eight of the 10 people we spoke with felt there were not. One person told us, "I don't think there is, [enough staff] they are often short staffed, sometimes I have to wait a long time for the bell to be answered." Another explained, "Night times is a bit awkward – they come a bit late."

Members of the staff team we spoke with felt that at times there were enough staff on duty to meet the needs of the people using the service, but at other times there were not. One staff member told us, "We should have extra staff to watch. Sometimes people are left at risk and have fallen. You can't keep an eye on everyone [because we are short staffed]." Another explained, "Staffing is a struggle. That means residents will be left."

We looked at the minutes of the last staff meeting held on 31 October 2016 and found that a member of staff had raised a concern regarding the numbers of staff on duty. The staff member stated that staff were regularly being left alone when two staff were required.

We discussed with the staff members the shift patterns they were required to work. Some felt these were unworkable whilst others felt they could cope with the shifts they worked. One staff member told us, "The shift patterns are really hard. You could be on a 14 hour shift and then an early the next day." Another told us, "I feel the manager is not looking at the shift patterns properly, I worked three nights, then a day off then a 14 hour shift, it's hard." Another stated, "I'm not bothered by the hours. I always think if they are short staffed I had better go in." We discussed these issues with the senior manager. They explained that the staff team had been given the opportunity to share their concerns but had not done so. A care team leader told us, "People have complained to me about shifts. I tell them to talk to [registered manager]. They don't talk to [registered manager]. I don't know why."

On the first day of our visit we witnessed an altercation between two of the people using the service. There were no staff members around to diffuse the situation. The two people were only kept safe because the quality manager happened to be in the vicinity and was able to divert their attention from one another.

We observed one of the people using the service requesting assistance to go to the toilet. They asked three times for help but had to wait more than 15 minutes before a member of staff arrived to assist them. One of the people using the service who should use their frame at all times was seen taking themselves out of the lounge without using it. A member of staff arrived at the doorway in time and reminded them the importance of using this. Another person required staff assistance to transfer from their chair to a wheelchair. Their plan of care stated that they were to be assisted by two members of staff. We observed a staff member doing this manoeuvre alone because the second staff member was assisting another person.

On the first day of our visit we observed staff practice in the downstairs lounge. We noted that the members of staff left the room for periods of time while they were assisting people. At 4pm they were out of the room for 11 minutes in total. During this time one person poured their drink on the floor and another person, who we were told were not to stand alone, attempted to do this.

One of the people using the service became extremely distressed during our visit. We went to see them as there were no staff members available. We stayed with them and calmed them before going to look for a member of staff. It was evident that the two staff who were working on the first floor were supporting another person with their personal care. We eventually found a member of the domestic team who spent time consoling them to alleviate their distress.

On both days of our visit, the activity coordinator worked over their hours to assist the staff team with their duties, including the lunch time meal.

Surveys had been sent to people's relatives to gain their views of the service being provided. Whilst it was evident that people were happy overall with the care their relatives received, concerns were raised about staffing levels. One comment stated, "The place seems to lack staff, sometimes I have to go in search of staff." Another person was unhappy regarding, "The number of staff available." We found no evidence to demonstrate that these concerns had been acted upon.

We asked the registered manager about how they decided what safe staffing levels were. We were told that people's dependencies were assessed using a dependency tool and staffing levels were determined by this. However, at the time of our visit there were five members of the staff team during the day supporting 34 people, some of who required the support of two staff members at times. This left three staff members to support 33 people. Three staff members were rostered on at night. The instances we identified during our visit showed that the deployment and numbers of staff was not sufficient to meet the needs of the people using the service

These matters constituted a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Staffing.

Concerns were raised prior to our inspection with regards to people not receiving medicines as and when required during the night time shift. This included paracetamol for pain relief. We were told that this was because no one working at night had been suitably trained for this task. We discussed this with the registered manager. They explained that a contingency plan was in place. A member of the senior team was on call and should be called if and when someone required any medicine at night. Not all staff were aware of this plan. On day two of our visit this plan was clearly displayed on the treatment room door. Training was also in the process of being arranged.

The care team leader explained that a person had asked for paracetamol the night prior to our inspection, 31 October 2016. This was prescribed to be given as and when required. The staff member told the person there had not been a four hour gap since their last paracetamol so they did not give it. However, when we checked the person's medication administration record (MAR) we noted that the person had not received any paracetamol on 31 October 2016. This showed us that this person had requested paracetamol and it had not been given. The person was offered paracetamol later but by that time it was not required.

We noted that one person had not received their medicine as prescribed. They had been prescribed a laxative to be taken twice a day. Their MAR chart stated it should be given twice a day and so did the pharmacy label on the bottle. This however had been changed to as and when required. There was no

record of who had made this decision and the lactulose had not been given. The registered manager contacted the person's GP and it was confirmed that it should be given twice a day. This was recommenced and a referral to the local safeguarding authority was made because the person had not received their medicine as prescribed.

People using the service told us that they received their medicines when they should. One person told us, "Yes they give me my medicine, and mostly on time." Another explained, "Yes, the staff give it to me [their medicines] I told her [staff member] to stop there and watch me take it as I dropped one last time, I found it on the floor, they're pretty good." What we found however, found was not compatible with what people said.

We looked at the way people's medicines had been managed. We found that medicines, including controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse), were stored securely and monitored regularly. Medication administration records (MAR) had been completed when people had received their medicines.

People who were able to speak with us told us they felt safe living at Loudoun House Care Home and felt safe with the care workers who supported them. One person told us, "Yes, I feel safe." Another explained, "Yes, I feel safe, we're more like friends." Relatives we spoke with agreed with what they told us. One explained, "Oh yes [relative] is very safe here."

Care workers we spoke with knew their responsibilities for keeping people safe from avoidable harm. The majority of the staff team had completed training in the safeguarding of adults. A staff member who had recently been employed told us that they had yet to complete safeguarding training, though this had been partly covered in their induction into the service. One staff member told us, "I would report it if I suspected someone was being abused. I can go to the Care Quality Commission (CQC) or social services." Another explained, "I would go to [registered manager] or a senior member of staff or head office. It is their [people using the service] home and our role is to protect them."

The registered manager was aware of their responsibilities for keeping people safe. They knew the procedure to follow when a safeguarding concern had been raised with them. This included referring it to the relevant safeguarding authorities and CQC.

The risks associated with people's care and support had been assessed. Risk assessments had been carried out and they had been reviewed on a monthly basis. Risks assessed included those associated with people's mobility and their nutrition and hydration. Regular reviews made sure that any changes in the risks presented to either the person using the service or the staff team, were identified and acted on.

During our visit we observed two people being assisted in wheelchairs without the use of foot plates. There was nothing within either their care plan documentation or associated risk assessments to state that this was acceptable practice. It is good custom and practice to use foot plates when assisting people. This minimises the risks of people falling from the wheelchair or damaging their feet.

We looked at the maintenance records kept. Regular safety checks had been carried out on the environment and the equipment used for people's care and support. Checks were also being carried out on the hot water in the home to ensure it was safe. We did note that in two people's bedrooms the temperature of the water was recorded over 54 degrees centigrade. It is recommended by the Health and Safety Executive that to avoid the risk of burns, hot water in people's bedrooms should be around 44 degrees centigrade. There was no evidence that any action had been taken regarding this. Fire safety checks and fire drills had been

carried out. However according to the records seen, checks on the fire panel which should have been completed daily to check it was in good working order, had not always been carried out. Records also showed that the emergency lighting had not been working for some considerable time. This meant that in the event of a power cut, not all of the emergency lighting would have worked effectively. We did note however that a contingency plan was in place and work to restore this had been arranged.

There were personal emergency evacuation plans in place in people's plans of care. These showed how each individual must be assisted in the event of an emergency. A business continuity plan was also in place. This covered emergencies and untoward events such as loss of amenities, flood or fire and provided the registered manager with a plan to follow should these instances ever occur.

We checked the recruitment files for three members of the staff team. A check with the Disclosure and Barring Scheme (DBS) had been made. A DBS check provides information as to whether someone is suitable to work at this type of service. References had also been obtained. We did note however that one of the files did not include up to date references. We discussed this with the registered manager who told us they would look into this.

Good

Is the service effective?

Our findings

Prior to our inspection visit we received information of concern regarding the lack of training around dementia awareness and behaviour that challenged. We discussed this with the registered manager who explained that whilst some staff had received training in dementia awareness others where in the process of completing this. Training records confirmed this. One staff member told us, "We are doing dementia training now." Another explained, "I've just completed dementia training, I also asked at the staff meeting if we could do training on challenging behaviour. The group operations manager said they are looking into it." The registered manager confirmed this was being looked into. This would provide the staff team with further knowledge and skills to support the people using the service.

People who were able to speak with us told us they were looked after well and felt the staff team had the skills and knowledge to properly meet their individual needs. One person told us, "Yes they're [staff team] not bad at all." Another said, "Yes it seems so." [That the staff team have the skills and knowledge they need]. The relatives we spoke with agreed with what they told us.

New members of staff had been provided with an induction into the service when they had first started work there. Training suitable to their roles had also been completed. Staff members we spoke with and training records seen confirmed this. One member of staff explained, "I have nearly finished my induction. We did four days training. It covered all of the basic training. It was very useful. I have worked in care before." Another told us, "I induct new staff. We observe day to day practice and sign people off. New staff do the care certificate and three shadow shifts." The Care Certificate is a national induction tool, the standards of which providers are expected to follow, to help ensure staff work to the expected requirements within the health and social care sector.

Training records showed us that specific training had been provided. This included moving and handling, nutrition and hydration and safeguarding adults. These sessions provided the staff team with the knowledge and understanding they needed to support the people using the service.

The staff members we spoke with felt supported by the management team. They explained that team meetings were held and supervision sessions were carried out. Supervision provides the staff team with the opportunity to meet with a member of the senior team to discuss their progress within the service. One staff member told us, "I can approach them [senior manager and registered manager] and they will listen." Another explained, "I have supervision every two or three months. I can talk to the registered manager or senior manager. They are approachable. The senior manager is here quite a bit."

Daily handovers were taking place between shifts. These provided the staff team with the opportunity to discuss the needs of the people using the service, discuss day to day issues that arose during their shift and encouraged open communication.

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

people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. The DoLS require providers to submit applications to a 'Supervisory Body' for authority to deprive someone of their liberty. At the time of our visit there were six authorised DoLS in place. We noted in the records we checked that people were receiving their care and support in line with the DoLs authorisation.

The registered manager had a good understanding of MCA and DoLS and was able to demonstrate when they had contacted the local authority for an authorisation under DoLS. Information on MCA and DoLS was displayed at the service for people's information. From the training records we looked at we could see that the majority of the staff team had completed this training and for those who hadn't, this had been booked. One staff member told us, "I am looking forward to doing MCA training. It is next after dementia training." Another explained, "I have heard of DoLS. I am not too sure about it." Another said, "I've not had training on MCA yet but we touched on it during our induction. Once this training was completed the staff team would be provided with the information they needed in order to work within the principles of the MCA.

Mental capacity assessments had been carried out when people had been assessed as lacking the capacity to make a decision about their care or support. For example when deciding whether to take their medicines or being supported with personal care. This assessment ensured that any decisions were made in people's best interest.

People using the service told us the meals served at Loudoun House Care Home were good. Their relatives agreed with what they told us. One person told us, "Its ok, [the food] not too bad at all." Another explained, "Its lovely, had my dinner, it was lovely." Four weekly menus were devised based on what people liked and choices were offered at each mealtime. The cook had access to information about people's dietary needs. They were knowledgeable about the requirements for people who required a soft or fork mashable diet and for people with diabetes. People were shown the menu each day so that they could make a choice of what they wanted. A pictorial menu and board were also in place to support people to make their choice and this had been updated on both days of our visit.

At lunch time people were assisted to the dining tables. Tables were set with table cloths, condiments and napkins. A choice of drink was offered. People's meals were taken to them on a tray with a jug of gravy. People were reminded of what they had for lunch and were offered more drinks throughout the meal time. People were asked if they wanted extra gravy and this was added for them. People asked for alternatives to the pudding they had ordered and this was accommodated.

For people who had been assessed to be at risk of dehydration or malnutrition, monitoring charts were used to document their food and fluid intake. Staff completed these charts after meals. This relied on the staff team remembering what people had eaten. We heard one staff member say to another, "What did [person using the service] have." The other staff member replied, "I am not sure. I think [person using the service] had omelette and cheesecake. I am not sure if they ate it. I think 25% of omelette and not much cheesecake." This meant that records of what had been eaten were made on the basis of information that

may not have always been accurate. The records were therefore not always a reliable.

People using the service had access to the relevant health professionals such as doctors, chiropodists and community nurses. This was evidenced through talking to them and their relatives and checking their records. One person told us, "Yes, they [doctor] come here." A relative told us, "Yes they can see there GP and they always contact me to tell me they need to be seen by the GP."

Requires Improvement

Is the service caring?

Our findings

People who were able to speak with us told us that the staff team at Loudoun House Care Home were kind and caring and treated them with respect. Visiting relatives agreed with what they told us. One person told us, "They treat everyone with dignity and respect." Another explained, "They seem kind enough." A relative told us, "Excellent, very caring [staff members], approachable." Another stated, "Lovely, can't fault them [staff team]."

A commented received after our visit read, "The staff at Loudoun house cared for my relative as if they were their own. We could not have had better carers. Any concerns we had were dealt with promptly and quietly, ensuring that [relative] would not become anxious. I can honestly say I don't think we could have found better care. The manager was helpful from the start and all the staff became like family, not only to [relative] but to us on our daily visits. Nothing was too much trouble."

We observed the staff team interacting with the people using the service. The majority of the time this was good. The staff interacted with people in a respectful way. They spoke in a cheery manner and we observed pleasant conversations throughout. We did however observe one occasion when a person had tried to speak with a member of staff and asked them what they were doing. The staff member did not respond. Another person also tried to talk to the staff member but they were focused on the person they were assisting and again did not respond.

We observed the staff supporting the people using the service. At times people were assisted in a caring way, at other times they were not. We observed a member of staff assisting one of the people using the service with a drink. Rather than getting down to their eye level they stood over them holding the beaker to their mouth so that they could take a drink. At one point another member of staff came in the room to ask their colleague a question. Rather than stopping the support they were offering, they continued whilst answering the staff member. This resulted in them spilling some of the drink down the person's top. Another person was given a drink which they did not touch. None of the staff team offered to help the person with their drink. The person was given another drink but again this was untouched and again no support was offered.

Whilst in one of the lounges we heard a member of staff comment, "It will soon be toileting time." We also heard another member of staff loudly discussing taking people to the toilet. This was neither dignified nor respectful.

On the first day of our visit we observed one member of staff supporting two people to eat their meal at the same time. They placed themselves in between the two people and then proceeded to alternatively give them food. This did not promote either person's dignity. We also noted another person who was assisted with their meal being left to help themselves on a number of occasions. Each time they picked up their food with their fingers. This included sponge and custard and Ice cream. The person was prompted to use a spoon. They declined and so the staff team left them eating large lumps of ice-cream with their fingers. This person was not supported in a dignified way. We discussed these issues with the registered manager and lunchtime on the second day of our visit was a much better dining experience.

For people who were unable to move around independently, assistance was provided by the staff team with the support of a hoist or a rotunda. The staff team explained what they were doing each time and put the person they were supporting at ease.

We saw that whenever possible, people had been involved in making day to day decisions about their care and support. We observed the staff team offering choices and supporting people to make decisions about their care throughout the day. One staff member told us, "I give people a choice including whether they would like me to help them." Another explained, "I ask people what they want to wear or if they want assistance." One of the people using the service told us, "I can choose if I want a shower or a wash, so yes I have choice." The staff team respected the choices that people made.

Staff members gave us examples of how they promoted people's privacy and dignity whilst supporting them. One staff member explained, "I make sure I cover people with a blanket over their legs in the lounge. I ask people to do things for themselves." Another told us, "I always knock on people's door." A third stated, "I greet people and say good morning. I explain what I am doing. It is important to close the door to maintain privacy." We observed one person who was assisted to walk instead of using a stand aid. They were encouraged to walk which they did. However, their top had ridden up and was over their stomach displaying this area to the room. The staff members who supported them did not adjust their clothing. This was not dignified for the person involved.

People using the service had been involved in making day to day decisions about their care and support whenever possible. One person told us, "I was involved [in making decisions about their care]." Another explained, "Yes [involved in making decisions] and I'm happy with the care I receive here, they are lovely."

We looked at people's plans of care to see if they included details about their personal preferences or their likes or dislikes. We saw that they did. For example one person's plan told the reader that they liked their door leaving open at night. Another person's plan explained that they liked to drink black coffee with no sugar. The staff members we spoke with knew people's likes and dislikes and preferences. For instance one staff member told us, "[Person using the service] likes church services." Another staff member explained, "We talk to them [people using the service] and their families and we find out what they like."

Requires Improvement

Is the service responsive?

Our findings

People who were able to speak with us told us that they had been involved in deciding what care and support they needed. One person told us, "I was involved." Relatives confirmed that they had also been involved in this process. One relative told us, "Yes, we told them [staff team] what they [their relative] liked doing."

The registered manager explained that people's care and support needs were assessed prior to them moving into the service. By carrying out this assessment the registered manager could be confident that people's needs could be met by the staff team working at the service. From the initial assessment, a plan of care had then been developed.

The plans of care we looked at covered areas such as, communication, nutrition, mobility, behaviour and personal care. These had been reviewed on a monthly basis. However, not all of them showed evidence that they had been reviewed with the people themselves or with someone who knew them well.

A document entitled 'getting to know me' was included in people's plans of care. This document gave the reader information about the person's past history and their likes and dislikes. The activity coordinator had also commenced a 'getting to know me' collage in people's bedrooms. This provided little snippets of people's history and what they liked to do. For example one person's stated that they had a dog called [name] and liked to go to church. This provided the staff team with information with which they could start a conversation. We observed one member of staff having a discussion with one of the people using the service. They used the information they knew about them as prompts, they said to the person, 'You were in the RAF' and 'you have two children, what are there names'. This enabled the staff team to provide more person centred care.

We looked at four people's plans of care in detail to determine whether they reflected the care and support they were receiving. We found that whilst some areas within them showed what support was to be provided, other areas were not so clear. For example, one person had a plan of care for the behaviour they displayed. This told the staff team to record any triggers or distraction techniques that they identified rather than informing them of the triggers to look out for that may result in certain behaviours and showing the distraction techniques that best worked for the person. Because the person had communication difficulties the staff team may struggle to identify what was wrong because nothing had been recorded in their plan of care.

Nutritional screening tools had been completed to determine whether people were at risk of malnutrition and these had been reviewed on a monthly basis. In one of the files we checked we noted that the person had been identified at risk. They had been weighed on a monthly basis and we noted that in April 2016 they had lost 4.2 kgs. Their plan of care stated that a GP should be contacted if there was more than a 2kg loss. There were no recorded actions within the plan of care or the monthly review that this had been carried out. Their plan of care for cognition identified that they needed support when they became anxious or screamed, there was no detail about how to do this or ways to try and distract them. Their behaviour plan however did

describe to approach them in a calm and caring manner when supporting them and reassure them that the support would only be for a short time only.

One of the people using the service was at risk of absconding. The registered manager explained that this person was on hourly observations unless they became agitated when these should be increased to 30 minutes or 15 minutes. We checked the records held for this person and noted that hourly observations had not always been recorded as being completed. The day prior to our visit this person had tried to leave the building eight times. On the first day of our visit this person was very agitated and tried to leave the building on two occasions whilst we were there. The registered manager explained that their observations had increased to 30 minutes the previous evening. However, neither their care plan nor their risk assessment had been updated and not all of the staff members we spoke with were aware of this. We checked the observation records and these showed us that staff members were still only recording that they were observing hourly. When we asked one of the staff members how often the person should be observed they told us, "I don't know, Maybe every hour. We have been told to watch where [person using the service] is going. There is nothing officially to say that we must watch at certain times." Another explained, "[Person using the service] should have a 1:1. We are short of staff. We keep an eye on her. I would need to check the care plan to see how often we have to observe." The staff team were not all aware of the support this person required because pertinent information had not been effectively passed on.

The plan of care for one person stated that 30 minute observations were to be completed when they were in bed. This was because their initial assessment, care plan and risk assessment assessed them as at high risk of falls, having fallen from their bed at home and suffering a fracture. We checked the observation records and found that these had not been not consistently recorded.

During our visit we observed the staff team supporting people. It was evident that they were completing the care and support tasks required of them, however there seemed little time left for them to interact and socialise with the people using the service. People were therefore often left to their own devices in one of the lounges. People were offered opportunities to be involved in activities they enjoyed. The things people liked to do had been explored when they had first moved into the service. An activity coordinator was employed for 20 hours a week and they provided both group activities and one to one sessions. On the day of our visit people enjoyed a game of skittles and one to one conversations. The activity coordinator offered activities that people were interested in. They were very knowledgeable with regard to people's history and were able to have meaningful conversations with them.

We checked the activities board and found a number of activities that were offered. These included pet therapy, theme days, pedicures, reminiscence chats, gentle exercise and gardening. One of the people using the service told us, "I like gardening and I go out to the garden." Another explained, "I mainly do puzzles."

People we spoke with and their relatives knew how to make a complaint if they needed to. A formal complaints process was in place and this was displayed for people's information. One person told us, "Yes I know how to make a complaint, but so far I have not needed to." Another told us, "No, nothing to complain about, I like here and don't want to leave." A relative told us, "Yes I would ask in the office." Another explained, "Oh yes, [knows how to make a complaint] and I would make a complaint if necessary."

People using the service and their relatives told us that there were no restrictions on visiting times. One person told us, "I have nieces and nephews, they come and visit." Another stated, "I get a visit from my friend once or twice a week." Relatives told us that they were always made welcome by the staff team.

Requires Improvement

Is the service well-led?

Our findings

There were systems in place to regularly monitor the quality and safety of the service being provided. The senior manager monitored the service on a four weekly basis and was in the process of carrying out observations of practice, supervisions and staff interviews to establish the issues raised around staffing.

The registered manager was monitoring the service being provided. Regular audits were being carried out. These included looking at the medicines held and corresponding records, people's plans of care, incidents and accidents that happened at the service and staffing levels. Health and safety checks and checks on the environment had also been completed. Whilst these monitoring systems were in place, these hadn't been effective in picking up the issues identified during this inspection. For example, staffing numbers were insufficient to meet the needs of the people currently using the service and to keep them safe. There was no monitoring of whether the staff team practiced dignity in care. Monitoring had not identified that observation records were not being accurately or consistently completed when people were at risk of falling or absconding and medicines prescribed had not always been given.

People who were able to speak with us and their relatives felt that the service was well managed and the registered manager was approachable. One person explained, "Yes, it's [registered manager] and yes I can speak to her." Another told us, "Yes, it's a woman, can't remember her name though." A relative told us, "Oh yes, [registered manager] and [name] is the deputy, oh gosh yes they are approachable."

A healthcare professional visiting at the time of our visit told us that the service was well led. They told us that the staff team worked well with them to ensure the people using the service were properly supported. They explained, "They [staff team] are really helpful and approachable. I am really impressed by the level of care. They work really well with us."

Staff members we spoke with told us they felt supported by the registered manager. One staff member told us, "The manager is approachable and I feel she would find time to listen to what we've got to say." Another explained, "I can go to the care team leader, or my manager. They are approachable, I have no concerns, It is so much better than the other home I worked at."

Staff meetings had taken place. These provided the staff team with the opportunity to be involved in how the service was run. One staff member told us, "We have staff meetings and people are able to put their views across." We looked at minutes of the last team meeting. The staff team were reminded about the whistleblowing policy and recent concerns shared with the CQC around staffing. Topics discussed included the complaints procedure, staffing rotas and the implications of not adhering to the European Union time directive. (The European Union time directive ensures that people do not work over a certain number of hours over a period of time). This showed us that the management team were being open and transparent with regards to current issues within the service. It wasn't evident however that comments made by the staff team were taken seriously or acted upon. This included a comment a staff member made about the current staffing levels not being sufficient.

Meetings had been arranged for the people using the service and their relatives; however these had been poorly attended of late. The senior manager had recently written to the people using the service and/or their relatives asking for suggestions for improving communication between all parties. This showed us that they were positively seeking people's thoughts of the service being provided.

Surveys had also been used to gather people's thoughts of the service being provided at Loudoun House Care Home. Following the return of the most recent surveys, a 'You Said….We Did' action plan had been developed and this was displayed for people's information. One of the comments in the 'You said' section stated 'could be more activities'. The response in the 'We did' section stated, 'We have been focusing on activities over the last few months. We have a four weekly planner and every day we ask people what they would like to do. This showed us that the management team took people's views and suggestions on board. It wasn't evident however that all the comments made by people's relatives were taken seriously. This included comments regarding staff deployment.

The registered manager and management team understood their legal responsibility for notifying the Care Quality Commission of deaths, incidents and injuries that occurred or affected people using the service.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were insufficient numbers of staff to support the people using the service and keep them safe from harm.