Four Seasons (No 7) Limited

Morecambe Bay Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

Morecambe Bay Care Home consists of four self-contained areas, catering for a range of people with differing abilities. The service caters for people with disabilities, older people with nursing care needs and older people with residential care needs. At the time of the inspection there were 70 people who lived at Morecambe Bay Care Home.

We carried out a focussed inspection of this service on 01 and 08 September 2016. The first day was unannounced. At this inspection a breach of legal requirements was found. We found people did not always receive their medicines safely. We took enforcement action as a result of our findings and served a warning notice to the registered provider. This required the registered provider to reach the requirements of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 by the 05 December 2016.

After the focussed inspection, the registered provider wrote to us to say what they would do to meet legal requirements in relation to the breach. They provided us with an action plan which indicated legal requirements would be met by 31 January 2017.

We undertook this comprehensive inspection on the 02 and 03 May 2017 and the first day was unannounced. We carried out this inspection to check that they had followed their plan and to confirm they now met legal requirements. This report only covers our findings in relation to those requirements. You can read the report from our last focussed inspection, by selecting the 'all reports' link for Morecambe Bay Care Home on our website at www.cqc.org.uk.

There was a manager in place who was registered with the Care Quality Commission. 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.

During this inspection we found people who used the service were not fully protected against the risks associated with the administration, use and management of medicines. People did not always receive their medicines and creams at the times they needed them or in a safe way. This was a breach of Regulation 12 of

the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Safe care and treatment).

Risks to people who lived at the home were not consistently managed. We found risks were not always assessed and people were placed at risk of avoidable harm. We also found care and treatment was not always delivered in a way which minimised risk. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Safe care and treatment).

People were not assured they would receive care and support from staff who had received appropriate training and development. Staff told us they needed training to enable them to respond to peoples' needs. We observed staff were sometimes unable to offer support due to lack of training. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Staffing).

People told us they sometimes had to wait for staff to help them. One person told us, "I wish they would come quicker." We observed staff were not always effectively deployed. We found people were left unsupported in a lounge, with no access to call bells and no staff present to ask for help. In addition staff and visitors told us they felt leadership on one of the units at the home was poor. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Staffing).

Person centred care was not always delivered. We observed one person at the home did not have their verbal request for a specific meal met. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Person – centred care).

We found people were not protected from abuse and improper treatment. Systems in place were not consistently operated to ensure investigations were carried out and people were protected from abuse and avoidable harm. We found a person was being unlawfully deprived of their liberty. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Safeguarding service users from abuse and proper treatment).

We found quality monitoring systems were not always operated effectively to ensure risks were identified and mitigated, documentation was up to date and accurate and the quality of the service improved. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Good governance).

We viewed care documentation and found this was not always accurate, complete and reflective of peoples' needs. We noted gaps in records and one person did not have a care plan in place to address their needs. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Good governance).

Under Section 28 of the Health and Social Care Act 2008 we varied condition 2 of the service providers registration. Full information about CQC's regulatory response can be found at the back of the full version of the report.

We observed the lunchtime meal being provided. We saw this was not a positive experience for everyone who lived at the home. We observed one person being helped to eat and saw staff left them on two occasions to support another person. This meant the person's meal was interrupted. People who lived at the home gave us mixed feedback regarding the quality of the food provided. One person told us they did not enjoy the meals provided. A further person described the food as, "nice."

People and visitors told us staff were caring. One visitor commented, "They treat [my family member] with

respect and they are caring." We observed staff as they supported people. We saw some positive interactions between people who lived at the home and staff. However, we also saw staff did not always promote interaction between themselves and people who lived at Morecambe Bay Care Home.

We reviewed staff files and found there were processes that ensured staff were suitably recruited. Staff we spoke with confirmed checks had been carried out prior to starting work at the home.

During the inspection we saw people took part in group activities which were meaningful to them. We observed people enjoyed the activities provided and were smiling and laughing as they took part. We saw a board was displayed within the home advertising the activities programme in place.

We viewed documentation which showed people were supported to see other health professionals if the need arose. We saw referrals were made to doctors and specialist health teams if this was required.

There was a complaints policy in place to enable complaints to be made if this was required. We viewed the homes complaint file and saw if a complaint was made, this was responded to.

People could access advocacy services if this was required. The clinical manager informed us this would be arranged at peoples' request.

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

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

During the inspection we became aware of specific incidents at the home. We are considering our response to these.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not always safe.

People could not be assured they would receive their medicines safely.

People told us they considered more staff were required and some staff voiced their concerns regarding the number of staff available to meet peoples' needs. We saw staff were not always effectively deployed.

People did not always receive care and treatment in a way that minimised risk.

Policies and processes were in place to raise safeguarding concerns if the need arose. However, these were not consistently followed.

There were recruitment processes in place, which were followed in practice to ensure staff were appropriately recruited.

Is the service effective?

Requires Improvement

The service was not always effective

Some people did not like the food provided and equipment was not always provided to support people to eat. People could not be assured they would be helped to eat without interruption.

Staff had not received sufficient training to enable them to support people effectively.

People could not be assured their rights would be upheld and protected. Deprivation of Liberty applications were not consistently made.

Referrals were made to other health professionals to ensure care and treatment met peoples' individual needs.

Is the service caring?

Requires Improvement

The service was not always caring.

People told us they considered permanent staff knew their preferences and needs, however they had less confidence in the agency staff who attended the home.

Some staff were caring. We saw some staff were kind when interacting with people who lived at the home and people told us staff were caring.

People's privacy and dignity were respected.

Is the service responsive?

Requires Improvement

The service was not always effective.

People did not always receive care and support which met their individual needs and preferences.

Care documentation we viewed was not always up to date or accurate

There was programme of activities made available to people who lived at the home.

There was a complaints policy to enable peoples' complaints to be addressed.

Is the service well-led?

Inadequate

The service was not always well-led.

Quality assurance systems were not always in place and operated effectively to ensure areas of improvement were identified and actioned.

Some people, relatives and staff expressed concerns with the leadership at Morecambe Bay Care Home.

The registered manager consulted with people they supported and relatives for their input on how the service could continually improve.

Morecambe Bay 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.

The inspection team consisted of two adult social care 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. The expert by experience who attended the inspection had experience of dementia and older peoples' care. The inspection team also consisted of two pharmacist inspectors.

Prior to our inspection we reviewed all the information we held about the service. This included notifications the registered provider had sent us and their action plan from the last inspection. We also reviewed information provided by the safeguarding authorities. This enabled us to plan our inspection effectively. We noted concerns had been raised regarding the availability of staff at Morecambe Bay Care Home. Therefore, we included this within our inspection.

As part of the inspection visit we walked around the home and spent time in each of the self-contained areas where people lived. This enabled us to observe the care and support people experienced and the interactions between staff and people who lived at Morecambe Bay Care Home.

We spoke with eleven people who lived at the home and eight relatives. We spoke with a range of staff at the home. This included the regional manager, the clinical manager and the registered manager. We also spoke with two resident experience leads and twenty one staff who worked at the home. This included qualified nurses, care staff and the chef.

During the inspection visit we viewed a range of documentation. This included seven care records and a sample of medicine administration records (MARs). We also looked at quality audits, staff duty rotas, records

of staff hours worked and two staff personnel files.

Inadequate

Our findings

At the focussed inspection carried out in September 2016 we found medicines were not managed safely and people were at risk of harm. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Safe care and treatment). We took enforcement action and issued a warning notice telling the provider they must by complaint with the regulations, by December 2016. Following the inspection we received an action plan from the registered provider telling us how they would comply with the regulation. This indicated the registered provider would be compliant with the regulation by 31 January 2017.

A pharmacist and a second medicines inspector visited the service on 02 May 2017 to ensure improvements had been made and medicines were handled safely. We looked at how medicines were managed for 21 of the 70 people who lived at the home and found concerns about some aspect of medicines handling for each of those people.

Medicines were not obtained safely. We found on the day of the inspection nine people's records showed that they were out of stock of one or more of their medicines, creams or nutritional supplements. The managers from the home checked the stock of medicines for all the people in the home and they found four more people did not have stock of all of their medicines. We looked at records about medicines for the previous four weeks and saw a further three people had not been able to have all their prescribed doses of medicines because there was no stock. One person was unable to have a prescribed laxative for 23 days because the staff were "unable to locate", the medication which was out of stock.

Records about medicines were not well maintained. We found there were gaps in recording and missing signatures, so it was not possible to tell if medicines had been given. When the stock and the records were looked at and compared we found that some medication had been signed for and not given. For other medicines there was less medication in the home than was expected. This meant medicines could not be accounted for fully. One person missed having several doses of their medicine because the records were inaccurate. The records about the application of creams and the use of thickeners were inaccurate or incomplete. Records did not show creams were applied as prescribed or that thickeners had been used safely. Thickeners are used to enable people to drink fluids safely where they have difficulties in swallowing. A system was in place to record the time people were given doses of Paracetamol to ensure a safe time interval between doses. However, these records were not kept well and they could not show there was always a safe time interval between doses.

People were not always given their medicines safely. Arrangements had been made to ensure some medicines which needed to be given at specific times with regard to food were given safely. However, we saw some people were given their medicines at the wrong times. Three people were prescribed medication to be taken 30 - 60 minutes before food. Records showed this was given with food. Another person was prescribed an antibiotic that we saw was given with their lunch. The prescription directed the antibiotic should be given on an empty stomach. If medicines are not given at the right times they may not be effective. People missed having doses of their medication because they were asleep or they refused their medicines. Arrangements had not been made to offer their medication at a different time.

People were prescribed medicines to be given "when required". The information recorded to guide staff to give these medicines safely and consistently was not personalised and for some people this information was missing. This meant that people may not have been given their medicines at the times they needed them. Some medicines were prescribed with a choice of dose and there was no information to guide staff when to give the upper or lower doses. This meant people may not have been given the right dose of their medication.

One person was prescribed a thickener to be added to their drinks to prevent them choking. The care staff who made the drinks were not making them thick enough. This meant this person was at risk of choking.

There were homely remedies kept in the home. For example, medicines for simple ailments such as pain, constipation or indigestion. Most people had authorisation from the GP in place to administer these medicines. We saw one person's records showed they were allergic to one of the homely remedies but no special measures had been put in place to ensure that they were not given this medication. If they had been given the medication this may have put their health at risk of harm.

Most medicines were stored securely in very clean, dedicated medication rooms. However, waste medication was not stored securely, in line with current regulations and best practice guidelines.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Safe care and treatment).

During the inspection we viewed a person's care records and noted there had been numerous incidents of behaviours which may challenge the service. Documents viewed recorded the person had displayed these behaviours towards people who lived at the home, staff and a visitor to the home. We spoke with staff who also described the behaviours. They told us the person sometimes tried to pull wires from the television and they were concerned they would hurt themselves. The care records viewed did not contain a risk assessment to assess the risks the person presented, or the risks presented to other people. In addition, documentation did not contain instruction for staff on how risks were to managed. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Safe care and treatment).

We spoke with ten people who lived at Morecambe Bay Care Home to see if there were enough staff on duty. We received mixed feedback. Four people raised no concerns. One person commented, "I have a bell to ring and staff come if I need them." However, six people told us they were dissatisfied with the response they received if they required help. Comments we received included, "That bells mine. If I ring it they come eventually." And, "I wish they would come quicker." Also, "I get bored waiting for someone to come and help me."

We spoke with eight relatives to gain their views on staffing levels at the home. We received mixed feedback.

Four relatives commented, "It seems a lot better now." And, "There's always been plenty." And, "I know they use agency and they've had them in this weekend." In addition, "The staffing's fine." However, four other relatives voiced concerns with the availability of staff to support their family members. One relative told us if people displayed behaviours which may challenge, they considered more staff were required. A further relative described seeing a person wait for assistance. They told us, "I don't feel there's enough staff." Another relative told us, "They need more staff to keep people safe."

We spoke with staff and received mixed feedback about staffing levels at the home. Twelve staff members told us they had no concerns. However, eight staff told us they fell the staffing levels could be improved. One staff member described the staffing provision as, "unsafe." They told us they did not have enough time to support people, because one person required additional support. A further staff member said, "Sometimes people do have to wait if we're busy elsewhere. That's not comfortable to me." They said additional staff would allow them to spend more time with people who lived at the home. Another two staff told us extra staff were required to support someone who lived at the home with individual support.

We viewed the care records of a person who lived at the home. We saw a health professional had advised they would benefit from individual support. The care records recorded they had displayed behaviours which may challenge. We discussed this with the clinical manager who informed us they were unaware of the health professional's advice. During the inspection we observed the person on numerous occasions and saw they did not receive individual support. In addition we saw the person had been assessed at being at high risk of falls and required supervision when mobilising. We reviewed the person's care records and saw they had been found on the floor on five occasions. During the inspection we observed them walking around the home with no staff present. This placed the person at risk of injury and showed staff had not followed the management plans and professional guidance.

We observed staff interactions with people who lived at the home. We found staff were not effectively deployed. This had a negative impact on people who lived at the home and placed them at risk of avoidable harm. We saw two staff sitting in the dining room that were completing care records. We noted four people who resided at the home were in a lounge with no staff present. We asked a staff member how the lounge was monitored to ensure people did not require help and support. The staff member said, "We pop in occasionally." We saw people who lived at the home were in another lounge. Six people were in wheelchairs and one person requested help from an inspector to go to the bathroom. There were no staff in the lounge. We noted two staff were in the dining room and two staff were talking at the top of a corridor. We found people in the lounge did not have call bells within arm's reach as these were fixed to the walls. The lack of staff presence and accessible call bells meant people were unable to summon assistance if this was required and placed people at risk of avoidable harm. Prior to the inspection concluding, we were informed by the regional manager a system had been introduced to minimise risk. We were told staff had been informed to visit the lounge on a regular basis to ensure people did not need assistance. In addition, more call bells were being purchased.

We observed a lunchtime meal being provided to people who lived at the home. We saw a staff member helping a person to eat their meal. This was the only staff member in the dining room. We saw the staff member left them to speak to another person who lived at the home as the person had communicated with them. The staff member returned to the person they were helping eat their meal. We observed the staff member leave the person again and helped a further person to get a drink. The staff member then returned and continued to help the first person with their meal. This demonstrated staff deployment was not sufficient as the person had their meal interrupted on two occasions.

In addition we saw documentation which recorded staffing was insufficient. We viewed a person's fluid

charts and noted gaps. The care records we viewed recorded the fluid charts were not completed due to being short staffed. We discussed this with the registered manager who could not explain this entry in the record. They told us they used an assessment tool to calculate the numbers of staff required to meet people's needs and staffing was provided to the numbers calculated by the assessment tool.

The above instances, demonstrated that staffing was insufficient and staff were not effectively deployed to meet the needs of people who lived at the home. This placed people who lived at Morecambe Bay Care Home at risk of avoidable harm. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Staffing).

We spoke with staff about safeguarding. They told us they had received training to deal with safeguarding matters. We asked staff to give examples of abuse and they were able to describe the types of abuse that may occur. Staff also demonstrated an understanding of signs and symptoms of abuse and explained how they would report these. They said they would immediately report any concerns they had to the registered provider, the manager, or to the local safeguarding authorities if this was required. One staff member told us, "I would report to the safeguarding authorities." Staff told us they could access the local authority safeguarding telephone number in order to report concerns. During the inspection, we saw contact details for the local authority were displayed within the home.

However, we found safeguarding referrals were not always made as required. We viewed the care records of a person who lived at the home. These recorded numerous incidents where they had presented behaviours which may challenge towards other people who lived at Morecambe Bay Care Home. We spoke with a staff member who told us they had witnessed some of these incidents. They told us they had not recorded these on the home's internal reporting system and had not raised them with the Lancashire Safeguarding Authorities. They told us they had reported them to whoever was in charge of the unit that day. We discussed safeguarding referrals with the registered manager and the clinical manager. The clinical manager told us they were unaware of all the incidents. This showed staff had not followed procedures to report safeguarding concerns which left people at risk of avoidable harm.

In addition we saw in a further person's care record, a bruise had been noted by staff. There was no evidence to show this had been investigated by the management of Morecambe Bay Care Home or raised with the Lancashire Safeguarding Authorities.

We viewed the Safeguarding Policy for Morecambe Bay Care Home. We saw this instructed staff to record incidents using the homes' internal reporting system and all cases of abuse, suspected abuse or mistreatment were required to be reported to the Home Manager or On Call Manager on the day it was noted. In addition the policy instructed staff should work in partnership with other agencies to protect people at risk of abuse.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Safeguarding service users from abuse and proper treatment) as systems and processes in place had not been effectively operated to investigate allegations of abuse and prevent abuse of people who lived at the home.

We looked at staff files to check suitable recruitment processes were in place. We reviewed documentation which showed appropriate recruitment checks were carried out before a person started to work at the service. Staff we spoke with told us they had completed a disclosure and barring service (DBS) check prior to being employed. This is a check which helped ensure suitable people were employed to provide care and support. We saw records of the checks were kept and references were sought for each new employee.

We looked at a range of health and safety documentation. We found agreements and checks were in place to ensure equipment and services were maintained safely. We noted window restrictors were fitted and water temperatures were monitored to minimise the risk of scalds. This helped ensure peoples' safety and security.

We spoke with staff and asked them to explain the procedure they would follow in the event of a fire. Staff we spoke with were able to explain the procedure. They were knowledgeable of the support people would require to enable them to evacuate the home. Staff explained each person had a 'Personal Emergency Evacuation Plan' (PEEP) and we saw documentation which evidenced this.

Requires Improvement

Our findings

We spoke with people who lived at Morecambe Bay Care Home to gain their views on the care provided. One person told us, "The care's fine. I'm happy." A second person said, "I'm well looked after." Relatives we spoke with voiced no concerns with the care and support provided.

The 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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We saw documentation which showed if people were unable to consent to care and support, mental capacity assessments were carried out. During the inspection visit we saw people were asked to consent to care and support before this was given. For example, we saw people were asked if they wanted to take part in activities and where they wanted to spend their time. Staff we spoke with demonstrated an awareness of the importance of gaining people's consent and told us they had received training in this area. They told us they would report any concerns immediately, to the registered manager or registered provider to ensure peoples' rights were protected.

However, we found peoples' rights were not consistently protected and upheld. We found applications to restrict peoples' liberty were not always submitted to the local authority if these were required. We observed one person banging a door saying, "Will you let me out." We saw staff intervened and distracted the person who became calmer because of the staff intervention. We asked a staff member why the person could not leave the area of the home in which they lived. Staff told us the person would be at risk of harm as they were living with dementia. We viewed the person's care record and saw they had attempted to leave the home on a previous occasion in 2016. We could see no evidence a Deprivation of Liberty application had been submitted to the local authorities for authorisation. We were informed by the regional manager an application was being completed during the inspection process.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Safeguarding service users from abuse and proper treatment) as applications to lawfully deprive people of their liberty were not consistently made.

We spoke with staff to check they received sufficient training to enable them to deliver safe and effective care. Staff explained they had received training in areas such as safeguarding, dementia awareness and moving and handling. However, some staff told us they required training in the management of behaviours which may challenge. One staff member said they felt, 'helpless' as they were unsure how to respond to such behaviours.

During the inspection we saw staff were unable to support a person effectively. We noted the person was displaying behaviours which may challenge. We observed a staff member approached the person and offered them a cup of tea. The person refused support from staff. We saw the staff member said, "I can't do this." They then walked away from the person. We spoke with the clinical manager and the regional manager. We were informed staff had not received training in behaviours which may challenge and this would now be arranged.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Staffing). Staff had not received suitable and sufficient training and development to enable staff to support people who displayed behaviours which may challenge. This placed people who lived at the home and others at risk of avoidable harm.

Staff we spoke with told us they received an induction prior to starting to work with people who received care and support. In addition we saw evidence that staff received supervisions with the registered manager. These were one to one meetings where staff discussed their performance and any training needs. We saw documentation which showed these took place.

Care files we viewed contained contact details of people who were important to those who received care and support from Morecambe Bay Care Home. We saw details of doctors and relatives were recorded to enable contact to be made. Staff we spoke with told us if they were concerned about a person's wellbeing, they would contact their line manager and other health professionals as required.

We saw documentation which showed people were referred to other health professionals if the need arose. For example, we saw evidence of involvement with doctors and district nurses were recorded in the care records.

We asked people who lived at the home for their opinions of the food provided. We received mixed feedback. One person told us, "It's very nice." A further person said they felt the food provision could be improved. Relatives we spoke with also gave mixed feedback. One relative said, "The quality that comes out of the kitchen isn't great." A further visitor said, "[Family member] loves her food." One relative commented they felt the portions could be larger.

We observed the lunchtime meal being served and saw this was not a positive experience for some people who lived at the home.

We saw a staff member helping a person to eat their meal. We observed the staff member leave the person on two occasions to support other people who lived at the home. We noted one person requested a hot ham sandwich and this was not provided. The meal on the day of the inspection was corned beef hash. We saw this was watery and the portions were small. We observed one person was unable to eat this without spilling it on the tablecloth. There was no plate guard on the plate to assist the person to eat independently. We observed hot and cold drinks were provided throughout the meal.

We found a menu was in place. We spoke with catering staff who confirmed they had sufficient resources

available to offer people a nutritious meal and alternatives were available if people requested them. However, we saw this was not the case when one person requested a hot ham sandwich as an alternative.

We viewed documentation which evidenced peoples' weight was monitored to ensure their dietary needs and preferences were considered as part of the care planning process. Staff we spoke with told us they would refer any weight loss to a health professional for further advice.

Requires Improvement

Our findings

People who lived at the home told us they considered staff were caring. Comments we received included, "The staff who are on are lovely. The regular night staff are good. Very caring, very helpful." And, "The way I find it, they're respectful. We have a bit of banter, but it's never gone over the top, we have a laugh together." All the relatives we spoke with told us they considered staff to be respectful. One relative told us, "They're polite. They say [my family member's] name and wait for a response."

We observed occasions when some staff were caring. We observed staff talking with people respectfully and offering help. We saw staff were patient when they interacted with people and helped them in a gentle way. Staff did not rush people and were thoughtful when they spoke with them. We observed a staff member supporting a person who was upset. They spoke with them to try and find out what was upsetting them. We saw they gave them a hug and this was welcomed by the person who hugged them back. We observed a person being helped to walk. We saw a staff member offered encouragement and praise. This was accepted by the person who smiled in response to staff and said, "Thank you." We also observed one person who became distressed. Staff spoke with them gently about people who were important to them. This distracted the person who became calmer and appeared happier.

However, we saw further occasions where staff were not caring. We saw one person said, "help me" to a staff member who was walking by them. The staff member said, "You'll be alright" as they carried on walking. This did not demonstrate a caring approach.

We also observed a staff member sitting next to a person who lived at the home. We observed the staff member was reading a magazine and continued to do so for 15 minutes. There was no interaction between the staff member and the person who sat looking around the room. This was further evidence of a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation (Staffing) as staff were not effectively deployed.

Staff spoke kindly and respectfully about people who lived at the home. Staff told us they cared for people and wanted to do their best for them. One staff member said, "If you don't have the care and compassionate side you shouldn't be in this job." A further staff member said, "I enjoy my job. It's good to help people."

We asked people who lived at the home if they felt staff understood them and their individual needs. People told us the permanent staff at the home did. We were told, "Staff know me fine." And, "Staff know how to help me." Also, "They seem to know me, they know my routine." However, two people told us they had less

confidence in the agency staff who attended the home. One person described the agency staff as "rubbish."

We asked three people if they were involved in their care planning. Comments we received included, "Oh yes. Staff do talk to me about what I need and we sort it out." And, "I talk to staff about the help I need and they follow what I say." Also, "If anything changes I talk to staff about it." This demonstrated people were given the opportunity to influence their care.

During the inspection visit we noted staff took care to respect people's privacy and uphold their dignity. For example, we observed bathroom doors were closed when personal care was delivered. We saw staff knocking on people's doors prior to entering their rooms. People who lived at Morecambe Bay Care Home told us their dignity was protected. One person commented, "They're spot on with that. I don't feel embarrassed with staff."

We found care records were stored securely. This helped ensure private information was only available to authorised people. We noted if staff needed to discuss people's needs or wishes, this was done in a private area to ensure details could not be overheard. This helped ensure individual personal details remained private and people's dignity was protected.

We discussed the provision of advocacy services with the clinical manager. They informed us advocacy support was arranged at people's request.

Requires Improvement

Our findings

People who lived at Morecambe Bay Care Home voiced no concerns regarding the care provided. One person told us, "If I'm not well, they arrange for me to see a doctor." Relatives we spoke with told us they had no concerns with the care provided. One relative commented, "The care is fine."

However, we found care was not always provided in response to people's individual needs and preferences. We saw one person required specific care whilst they were in bed and receiving nutritional support. During the inspection we saw the specific care was not provided. We saw the person was not positioned in a way which met their needs. This placed them at risk of avoidable harm.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Safe care and treatment) as care and treatment was not provided to meet individual needs and placed the person at risk of avoidable harm.

We discussed our concerns with the regional manager and prior to the inspection concluding were provided with information on how the persons' needs were to be met.

In addition, we saw one person who lived at the home requested a hot ham sandwich at lunchtime. They requested this on three occasions. We observed staff told the person this could not be provided. We spoke with the staff member who told us they were unable to provide the persons choice and they had not contacted the catering staff to request this. Staff told us they had not asked the kitchen staff to make this as the person had agreed to have a ham sandwich cold. We spoke with the person who told us they would have preferred their sandwich hot. We viewed the person's care plan and saw recorded they preferred gammon.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Person – centred care) as person centred care had not been provided which reflected the person's preferences.

We discussed this with the regional manager and prior to the inspection concluding were provided with information on how the person's preferences were to be met.

Care documentation we viewed was not always up to date or accurate. In one care record we saw a falls risk assessment had not been updated following a fall. In another care record we noted a weight assessment tool had been calculated incorrectly. We viewed a further care record and saw gaps in the recording of a

person's fluid output. In a fourth care record we found weight records were incomplete as weight assessments had not been fully recorded. In addition, we viewed a fifth care record which did not contain a person centred plan to inform staff how a person was to be supported.

We spoke with the management team at Morecambe Bay regarding the gaps in the records we had identified. Prior to the inspection concluding, we were informed a person centred care plan had been developed to ensure staff had guidance to follow on how the person's needs should be met.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Good governance) as care records not consistently accurate and up to date.

People told us activities were available if they wanted to participate. One person we spoke with told us they were supported to attend activities of their choice. They told us they liked to attend art sessions and staff reminded them of these. A further person said they went swimming. Relatives we spoke with also said activities took place.

We saw an activities programme was displayed advertising the activities available. These included, 'Animal Safari' and 'knit and natter.' During the inspection we saw two activities taking place. We saw people attended an 'Animal Safari' where they could stroke and watch a variety of small animals. We saw this was enjoyed by people who lived at the home. We saw people laughing and smiling and chatting with each other. We also observed group of people engaging in group activity where they threw a ball to each other. This resulted in laughter and clapping by the people who attended.

We found there was a complaints procedure which described the response people could expect if they made a complaint. We spoke with one person who lived at the home who told us they had complained but this had not been resolved. They told us they had complained about the staffing provision at the home. A further person told us they had complained and they were happy with the response. Relatives we spoke with told us they had discussed concerns with the management of Morecambe Bay Care Home and these were responded to.

Inadequate

Our findings

We asked people their opinion of the leadership at Morecambe Bay Care Home. We received mixed feedback. One person described the home as, "chaotic." A further person said, "Everyone's so busy. They don't know what they're doing." Two other people we spoke with said they considered the home was well run. Relatives we spoke with also gave mixed feedback. Four relatives we spoke with told us they were satisfied with the management of the home. However, two relatives told they were concerned with the management of one area of the home. We were told, "[Unit manager] doesn't instruct or guide staff." And, "[Unit manager] doesn't know anything."

We spoke with staff to ascertain their views on the leadership at the home. Staff gave conflicting feedback. Some staff said they were happy with the support they received from the clinical manager and the registered manager. Other staff told us they considered the clinical manager and registered manager did not understand the challenges they experienced and concerns they had. Two staff members said they were concerned that if they complained, there would be repercussions towards them. Three staff members voiced concerns regarding the leadership of one area of the home. They told us there had been a change in the unit manager and they felt since the change they received no direction, support or guidance. We raised our concerns with the management team who told us they would review the management arrangements in place on one unit at the home.

Staff we spoke with told us some checks were carried out to ensure improvements were identified. They confirmed checks on medicines, and the environment took place. They also told us the clinical manager worked alongside them and would inform them if an improvement was required in their working practice.

We asked the regional manager, clinical manager and registered manager what audits were carried out to ensure a high quality of care was achieved. We were told environmental and equipment audits were carried out and we saw evidence of this. In addition we were informed checks were carried out on medicines. We saw documentation which evidenced this.

We asked if care records audits were carried out. We were told these were checked to ensure they were accurate. In addition we were told the registered manager checked care records to ensure care reviews were carried out in a timely way. We saw documentation which evidenced this. However, we found the audit system had not identified the shortfalls in the records we viewed.

We spoke with a member of staff who carried out care records audits. They told us they completed audits on

the care records to ensure they were accurate. We asked if the daily entries were viewed to ensure the care plans and risk assessments met peoples' needs, if falls risk assessments were checked to ensure they were updated after falls and that weight records were complete. The staff member told us they did not check these when completing care records audits.

We viewed a care record which recorded numerous incidents of behaviours which may challenge. In addition, care records documented the person had been found on the floor on five occasions. On speaking with a staff member we were told they had witnessed some incidents of behaviours which may challenge but had not reported them on the homes internal reporting system. They told us they were unaware they should have done this.

We asked the clinical manager if they were aware of the incidents. They told us they were not aware of all the incidents. We asked the regional manager, registered manager and clinical manager if they were aware of the occasions the person had been found on the floor. They confirmed they were not.

We viewed the homes Incident Reporting and Investigation Policy. This instructed staff should report the incidents on the homes internal reporting system. Before the inspection concluded we were informed by the regional manager the occasions when the person had been found on the floor had not been reported to senior management. This was as no significant injuries had occurred.

These were breaches of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Good governance) as systems to assess, monitor and mitigate risk were not consistently effective. In addition due to the failure to operate an effective system, shortfalls had not been identified and improvements had not been made to practice. Documentation was inaccurate and incomplete.

Before the inspection concluded, we were informed by the regional manager that additional measures had been implemented to ensure the homes internal reporting system was effectively utilised.

We asked staff if staff meetings were held. Staff told us these took place. We viewed documentation which evidenced this. We saw areas such as training, staffing and documentation were discussed. In addition we saw 'managers meetings' were held. We noted actions had been noted. For example, that staff were to ensure care records were updated, and update the care plan matrix. In addition, we saw recruitment was discussed following an 'open day' being held to recruit new staff to Morecambe Bay Care Home.

We saw evidence staff were able to access surveys. These were completed by staff and analysed to identify areas of concern. The regional manager explained the human resource team visited the home periodically. This was to enable staff to voice any concerns without addressing the managers if they wished to do so.

We saw documentation which demonstrated people who lived at the home were invited to attend 'residents and relatives meetings.' We viewed minutes of the last meeting. This showed discussions had taken place regarding the laundry provision at the home and the timeliness of staff in answering the phone. This demonstrated the registered provider actively sought peoples' views.

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care People did not always receive person centred care which met their preferences. Regulation 9(1) (c) (3) (i) Person Centred Care.

The enforcement action we took:

Under Section 28 of the Health and Social Care Act 2008 we varied condition 2 of the service providers registration. They are no longer authorised to carry on regulated activities from Morecambe Bay Care Home, Gleaneagles Drive, Off St Andrews Grove, Morecambe, Lancashire. LA4 5BN.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were not protected from avoidable harm as risks were not always assessed and reasonably practicable steps were not always taken to mitigate risks. Regulation 12 (1) (2) (b) People were not protected from avoidable harm as people did not receive their medicines safely. Regulation 12 (1) (2) (g)

The enforcement action we took:

Under Section 28 of the Health and Social Care Act 2008 we varied condition 2 of the service providers registration. They are no longer authorised to carry on regulated activities from Morecambe Bay Care Home, Gleaneagles Drive, Off St Andrews Grove, Morecambe, Lancashire. LA4 5BN

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment People were not protected from abuse and improper treatment. Systems and processes to prevent abuse of people who lived at the home were not implemented effectively. Regulation 13 (1) (2) (3). People were not always lawfully deprived of their liberty. Regulation 13 (1) (5) (7) (b).

The enforcement action we took:

Under Section 28 of the Health and Social Care Act 2008 we varied condition 2 of the service providers registration. They are no longer authorised to carry on regulated activities from Morecambe Bay Care Home, Gleaneagles Drive, Off St Andrews Grove, Morecambe, Lancashire. LA4 5BN

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The systems in place were not effectively operated to assess, monitor and mitigate the risk to people, and others who may be at risk from the regulated activity and to improve practice. Documentation was not always accurate, complete and up to date Regulation 17 (1), (2), (a), (b), (c), (f).

The enforcement action we took:

Under Section 28 of the Health and Social Care Act 2008 we varied condition 2 of the service providers registration. They are no longer authorised to carry on regulated activities from Morecambe Bay Care Home, Gleaneagles Drive, Off St Andrews Grove, Morecambe, Lancashire. LA4 5BN

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing Staff were not effectively deployed to meet people's needs and leadership was not consistently provided to staff. Staff did not always receive appropriate training to enable them to carry out the role for which they were employed.

Regulation 18 (1) (2) (a).

The enforcement action we took:

Under Section 28 of the Health and Social Care Act 2008 we varied condition 2 of the service providers registration. They are no longer authorised to carry on regulated activities from Morecambe Bay Care Home, Gleaneagles Drive, Off St Andrews Grove, Morecambe, Lancashire. LA4 5BN