Indigo Care Services Limited

Castleford Lodge

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

The service was inspected on 7 and 8 December 2016 and was unannounced. The inspection was prompted in part by notification of an incident following which a service user sustained a serious injury. This incident is subject to a criminal investigation and as a result this inspection did not examine the circumstances of the incident. However, the information shared with CQC about the incident indicated potential concerns about the risk of unsafe management of medicines.

Castleford Lodge provides accommodation and nursing care for up to 61 older people, some of whom may be living with dementia and other mental illnesses. There were 43 people living at the home on the days of our inspection. The accommodation is arranged over two floors with the dementia nursing unit on the ground floor and the nursing and residential unit on the second floor. There is a passenger lift operating between the two floors.

There was a registered manager who had been registered since October 2016 but they were absent from the service at the time of our inspection. 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.

People at the service were not protected from harm by other people living at Castleford Lodge. We found staff on the dementia unit were not always observing or responding to incidents between people using the service. This meant there was an under recording of incidents which were not always fully investigated to implement actions to prevent a reoccurrence.

Moving and handling risk assessments and care plans were not completed adequately and we saw poor moving and handling practice during our inspection. Risks around the use of assistive equipment such as wheelchairs, bathing equipment, shower chairs and specialist seating systems were not always recorded to ensure identified risks were reduced to the lowest possible level. There was no robust system in place to ensure faulty equipment was removed from use.

We found areas of the home were not always thoroughly clean to ensure the risk of infection was minimised such as faeces on mattresses, bed rail bumpers and carpets. Not all areas had liquid soap or personal protective equipment to ensure good practice was followed.

We found decision specific capacity assessments had been carried out for people living in the dementia unit which were compliant with the Mental Capacity Act 2005. In contrast, we found capacity assessments on the nursing unit which were not decision specific.

Deprivation of Liberty Safeguards had been appropriately applied for and authorisations were in place or awaiting authorisation by the relevant body. However, we found one person's conditions attached to their

authorisation had not yet been incorporated into their care plan. Staff were not aware who had a Lasting Power of Attorney for health and welfare decisions to ensure consent obtained from family members was lawful. We also found a lack of recorded consent in people's care files to evidence they had consented to care and treatment.

Not everyone was provided with a meal on the day of our inspection and there was a lack of system in place to ensure people received adequate nutrition and hydration. In addition, people's weights had not been consistently recorded to ensure those at risk of weight loss were adequately monitored.
We observed some staff were kind and caring when they were supporting people with care. They treated people with dignity and respect. However, we observed some people were ignored by staff and they did not have their care needs met or were left to wait.

Some records contained person centred information detailing people's preferences and choices. However, other records lacked detail and were incomplete in this area. We found care plans did not always evidence people's care needs and daily records for several people did not evidence care had been provided such as oral care or foot care.

Not all complaints had been recorded in line with the registered provider's procedures, which meant there was no opportunity to learn from the experience or for management to recognise there was an issue with care delivery.

We found there had been a lack of leadership at the home. Not every area of care had been audited to determine the quality of the service provided. Where audits had been completed and actions identified, these had not been undertaken. For example, there had been ongoing issues with the management of medicines which had been identified at management audits but improvements had not been sustained. Staff were assessed as competent to manage medicines but still made errors which demonstrated a lack of robustness in the systems used at the home.

The registered provider had failed to effectively assess and monitor the quality of the service provided to people and as a result any improvements that had been made were not sustained. Records relating to people who used the service and staff employed were not accurate enough to withstand scrutiny and systems and processes were not robust enough to ensure full compliance with the regulations.

We found the service was in breach of several regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

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 safe.

The management of medicines was not safe. People did not receive medicines in line with their prescribed needs. Medicines were not stored in accordance with manufacturer's directions and there were inadequate checks to ensure medicines were managed safely.

There were not enough staff to meet the needs of the people who lived at Castleford Lodge.

Risk assessments were not in place to ensure risks were reduced and people were protected from harm.

The environment was not thoroughly clean, and not all equipment was well maintained and we there was no systematic and robust way of ensuring actions had been completed around maintenance issues.

Is the service effective?

Inadequate

The service was not effective.

The home did not ensure people's nutritional and hydration needs were met consistently.

Mental capacity assessments on the downstairs unit were decision specific, but there was a lack of decision specific capacity assessments on the nursing/residential unit.

Staff had not always been proactive in following up issues in relation to blood sugar monitoring with the GP.

We saw evidence staff were appropriately referring on to speech and language therapy, dieticians and other health professionals when the need arose.

Is the service caring?

Inadequate

The service was not always caring.

We saw some staff were kind and compassionate when dealing with people at the service.

We saw staff did not always reassure people who were anxious or support people requiring assistance.

People's privacy and dignity was not always respected.

Is the service responsive?

Inadequate

The service was not responsive.

There was missing and out of date information in people's care files which could have a detrimental impact on their care if followed. Records of daily care provision were incomplete and did not evidence care had been provided such as personal care.

The activities coordinators were effective in their roles. However, outside of these activities staff did not have time or the ability to engage people in meaningful occupation.

Complaints were not always recognised, recorded and dealt with appropriately to ensure lessons were learnt and mistakes were not repeated

Is the service well-led?

Inadequate

The service was not well-led.

We found a lack of governance, management and leadership at the home.

Many of the management audits had not been robust and had not identified issues at the home around medicines management, infection control, moving and handling and safe care and treatment.

The registered provider had completed a detailed audit and actions had been completed. However, improvements had not been sustained to ensure improvements in the quality of the service provision and the same issues as found by the audit had recurred.

Castleford Lodge

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 three adult social care inspectors and specialist pharmacist inspector. The inspection was prompted in part by notification of an incident following which a service user sustained a serious injury. This incident is subject to a criminal investigation and as a result this inspection did not examine the circumstances of the incident. However, the information shared with CQC about the incident indicated potential concerns about the management of risk of unsafe management of medicines. This inspection examined those risks.

Prior to the inspection we reviewed all the information we had about the service including statutory notifications and other intelligence. We contacted the local authority commissioning and contracts department, safeguarding, infection control, the fire and police service, environmental health, the Clinical Commissioning Group, and Healthwatch to assist us in planning the inspection. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. We reviewed all the information we had been provided with from third parties to fully inform our approach to inspecting this service.

The registered provided had not been asked to complete 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 used a number of different methods to help us understand the experiences of people who lived in the home. We observed care in both units and observed the lunch and teatime experience.

We interviewed the area manager, the deputy manager, the cook, the laundress, one of the cleaning staff, an activities coordinator, two nurses, and two care assistants. We spoke with five relatives and six people who lived at Castleford Lodge. We looked at nine Medicines Administration Records (MARs).

We reviewed the management records at the service and records of maintenance and safety checks.

Inadequate

Is the service safe?

Our findings

People who were able to express their views, told us they felt safe at Castleford Lodge. One person said, "I feel safe here." All the relatives we spoke with during our inspection told us in their opinion their relatives were safe.

We asked staff about their understanding of safeguarding and they demonstrated they understood the signs of abuse and knew the procedure to follow to report any incidents. This included how to whistleblow if they were concerned about a colleague's practice. However, we saw evidence of poor practice during our inspection and a number of unreported incidents, which meant although staff had been trained to recognise abuse, in practice they were not following guidance.

We asked people and relatives at the home whether there were enough staff to care for them. One relative said, "Not at lunchtime. They are serving and trying to feed people." Another relative told us they visited every lunchtime to ensure their relation ate their meal as they took a long time to eat. They said, "Staff wouldn't have the time it takes to feed [relation]." A further relative told us "People are settled when the activity ladies are doing things but the girls are run ragged." One person who lived at the home told us, "There is not enough staff. It's not the staff fault. There isn't enough to go around. I started ordering some tea yesterday and it came an hour and a half later." Another person said, "They need more staff. There are not enough people on."

The area manager told us they used a dependency tool based on the continuing health care decision support tool. However, it was difficult to see how this had been used to work out the actual number of staff required based on people's support needs at the time of our inspection.. We observed people at the service who required intense support to ensure they and other people were safe from unpredictable and often very challenging behaviours. Staff also told us there were insufficient staff and that was the reason why paperwork was not always completed correctly. Our observations concluded there were not enough staff on the days of our inspection and the staff were not deployed effectively. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

As part of our inspection process we checked to see whether medicines were ordered, stored and administered safely. We looked at nine Medicines Administration Records (MARs) and spoke with two nurses and the senior carer responsible for medicines, as well as the area manager. Medicines were stored in treatment rooms and access was restricted to authorised staff. Unwanted medicines were disposed of in accordance with waste regulations. Controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse) were stored in controlled drugs cupboards, access to them was restricted and the keys held securely. However, staff did not regularly carry out balance checks of controlled drugs in accordance with the registered provider's policy.

Room temperatures where medicines were stored were recorded daily and were within safe limits. We checked medicines which required cold storage and found gaps in records on the downstairs unit. On both units temperatures had been recorded which were outside of the recommended range and this had not

been escalated in accordance with the registered provider's policy. This meant we could not be sure medicines stored in both fridges were safe for use. On the upstairs unit the same temperatures had been recorded every day for two months which suggested staff did not understand how to reset the thermometer correctly between readings. In addition, the thermometer showed a minimum temperature of zero degrees Celsius on the day of our inspection. We raised this with the nurse on duty who made arrangements for the insulin and other medicines to be replaced immediately. Storing medicines outside of the recommended temperature range may reduce their effectiveness.

On the day of our inspection, we were concerned about the length of time the morning medicines round took on the downstairs unit. At 12pm four people had still not received their morning medicines. One person had been given paracetamol at lunch time but the MAR had been signed for the morning dose. This increases the risk of the person receiving another dose of paracetamol without leaving a safe gap between doses.

Staff did not routinely reconcile people's medicines when they moved between care settings. For example, one person had been recently discharged from hospital. Staff had not followed the home's policy and obtained a copy of the person's discharge letter to check they were giving the right medicines. This person had been given a medicine since 4 November 2016; we spoke with their GP who told us this medicine should have been stopped.

There was a lack of written guidance to enable staff to safely administer medicines which were prescribed to be given only 'as and when' people required them. For example, one person was prescribed a medicine for agitation, however there was no information to guide staff what signs or symptoms the person might display to indicate this medicine should be used. In addition, staff did not record the reasons for administration or the outcome after giving the medicine, so it was not possible to tell whether medicines had had the desired effect. Where one or two tablets had been prescribed, staff did not always record the number of tablets they had given which meant records did not accurately reflect the treatment people had received. We also found staff did not routinely record the time 'when required' medicines had been given which increased the risk of people receiving medicines without a safe gap between the doses.

We found gaps in four of the nine administration records we reviewed where staff had not signed or recorded the reasons for not administering medicines. We checked stock balances of medicines and found they were not always correct compared with the amount of remaining stock shown on people's MARs. We also found staff had signed to say they had given medicines to two people, but we found they were still in the blisters in the medicines trolley on the day of our inspection. In addition, topical application records were not properly completed for one person on the downstairs unit who was prescribed a pain relief patch. This increased the risk of skin irritation and sensitisation because staff could not be sure they had properly rotated the site of application in accordance with the manufacturer's instructions.

There were not always sufficient quantities of medicines to meet the needs of people living at the service. For example, one person had not received any of their medicines on 1 or 2 December 2016 because they had not been obtained in time. Staff had identified these medicines were missing on 25 November 2016 but had not acted to ensure a supply was obtained in good time.
We checked records for one person who needed their fluids thickened to reduce the risk of them choking. Staff did not always record the use of fluid thickeners on the MAR and there was no written guidance specifying how many scoops of thickener should be added to the person's drinks to achieve the right consistency. An entry had been made in the person's diet care plan on 12 February 2016 stating one scoop was being used, however the label on the thickener stated two scoops should be used. This increases the risk of the person choking because fluids are not thickened to the correct consistency. In addition, we found

18 unopened tins of this thickener in the medicines room, five tins of which had been dispensed in August 2016. This suggested the thickener was not being used as it had been prescribed.

We looked at how the service managed risk to ensure people living at Castleford Lodge were safe. We found standardised risk assessments such as Waterlow scale, which is a tool to assist staff to assess the risk of a person developing a pressure ulcer and 'MUST' (Malnutrition Universal Screening Tool) which is a five-step screening tool to identify adults, who are malnourished and are at risk of malnutrition. These had not always been completed fully. We found incomplete moving and handling risk assessments and care plans in people's files which meant staff did not have clear guidelines to follow. We observed staff supporting people to manoeuvre using an underarm technique which is not in line with good practice. We observed one person was manually assisted using an underarm lift into an armchair by two carers before the third staff member returned from collecting a standaid from the upstairs unit. Underarm lifting can lead to soft tissue damage and pain for the person being assisted in addition to injury to staff. We brought this to the attention of the area manager.

We found there was a lack of risk assessments around the use of assistive equipment such as the bath hoist, wheelchairs and commodes in all the files we looked at and their moving and handling care plans did not specify which equipment such as a shower chair was to be used for which person. This posed a risk that inappropriate equipment could be used in the care of people at the service which could lead to unavoidable harm.

The examples above evidence the service was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Safe care and treatment.

We looked to see how the service protected people from harm. This included harm from people with behaviours that challenged others or themselves. We found there were insufficient numbers of staff on the downstairs dementia unit to protect people. We observed incidents between people using the service. Staff did not respond to these promptly to prevent an escalation of the situation and in some instances staff were not in the vicinity to intervene. This meant there was a significant under recording of incidents. We observed a near miss when one person climbed over the decorator's platform holding the door open to the laundry and kitchen area. This person was only prevented from falling from the platform by the quick actions of the laundry staff as there were no care staff in any of the communal areas at this point. These examples demonstrated a breach in Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found not every person had a Personal Emergency Evacuation Plan (PEEP) in place to enable staff to assist people to evacuate the building if necessary. Those that were in place had not been updated since the nursing and residential unit had moved upstairs and the dementia unit downstairs, although the area manager was aware of this and had requested these were updated. This had not been done by the time of the inspection.

We had major concerns in relation to cleanliness at the home. The home employed three cleaning staff who were responsible for the general cleaning. We were told by the housekeeper that care staff were responsible for cleaning spillages such as bodily fluids, cleaning mattresses and making people's beds. We found the environment odorous, bedroom carpets were stained and in need of cleaning, mattresses were unclean and odorous, and there were dried faeces on one door handle and on bed rail bumpers. We found not every bedroom or communal facility had personal protective equipment (PPE), soap or paper towels. At one point there was no toilet paper in the visitors' toilet. We observed one person spitting during our inspection and no staff attended to this, which posed a risk to other people at the service due to poor infection control.

The examples above provide further evidence the service was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Safe care and treatment.

We looked at the records for two recently recruited staff. We found recruitment practices were not robust and gaps in employment history had not been explored for one person, their application form only stated year of previous employment and not the exact dates. Each person had undergone a Disclosure and Barring Service (DBS) before they started work at the home but we saw no evidence issues arising from DBS checks had been explored for one person. There was a lack of evidence of robust interviewing to ensure candidates were recruited with appropriate values and behaviours. This evidenced a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service effective?

Our findings

As part of our inspection process we checked to see whether people had their nutritional and hydration needs met. We asked people at the service about the food and drink they were offered. The responses were mixed with some people telling us they were enjoying what they were eating whilst others complained. For example, on the first day of inspection one person declined to eat their cooked breakfast (toast, bacon and tomatoes) and told us, "The way it looks now I wouldn't serve it to the dog. I want it served up nicely." The deputy manager offered to take the plate away and get it re-served but this person said, "I've got passed caring. Just looking at that has put me off." We spoke with this person at lunchtime and they told us how much they had enjoyed their lunch.

We observed the lunchtime experience on both units. On the nursing unit, tables were set with placemats and cutlery but no condiments. The menu for the day was sandwiches, Cornish pasty, salad, soup and rice pudding but when the trolley arrived the menu did not match what people were offered. Lunch consisted of sandwiches, quiche, beans, soup with mousse and blackberry crumble for dessert. Staff told us people chose in the morning what they wanted for lunch. One person struggled to understand what was on offer and staff did not offer an alternate form of communication to assist with their choice such as a picture menu. However, apart from this, we observed staff were kind and courteous to people, and asked if they had enough to eat.

On the dementia unit, the menu matched what people were offered and we saw staff appropriately prompt and support people to eat their meals. However, not everyone on the unit received their lunch and staff could not tell us who had eaten and who had not. We also found not everyone at the service was offered a drink and people were not offered a snack with their morning drink. This demonstrated ineffective systems for ensuring nutritional and hydration needs were met.

We found not every person had their weight recorded weekly or monthly and when we questioned the reason for this the deputy manager told us there had been a problem with the weighing scales. This meant staff at the service had not adequately monitored those people at risk of compromised nutrition consistently. We found in two care plans where a dietician had visited that new care plans had not been written to incorporate new guidance to encourage nutritional intake.

As part of our inspection process we looked to see how the service was supporting staff to develop knowledge and skills to provide a high quality service. The registered provider utilised a blended learning system for all staff and training was a mixture of e-learning and classroom based training. Staff we spoke with told us they had received sufficient training to enable them to perform in their role. The deputy manager told us the registered nurses had the opportunity to attend the Royal College of Nursing seminars and they had recently attended one in relation to delivering person centred care. They were also in the process of obtaining a National Vocation Qualification. We were told new staff received an induction into the service and the deputy manager told us they shadowed more experienced staff for three days. There was a new member of staff during our inspection who was shadowing other staff and they were supernumerary to the staff working that day. This meant they had the opportunity to learn from other more experienced staff.

The deputy manager told us staff received six supervisions each year. They told us they had undertaken some supervisions since the registered manager had been absent from the service. However, these had not been recorded on the supervision matrix, which showed staff supervisions were not up to date. The new staff we spoke with told us they had not received supervision. Staff had not received an annual appraisal to support their development and identify gaps in their knowledge and future training requirements. The registered provider assessed nursing staff competencies in relation to bladder, bowel and continence care, communication, food and drink, medication, personal hygiene, pressure care, prevention and management of pain and record keeping. All the nursing staff except three who administered medicines had been assessed as competent, but we found errors in the management of medicines, which demonstrated these competency assessments were not effective. In addition, a member of staff who had not had their competency checked was observed to be administering medicines. Staff had received moving and handling training but were observed not to be practising safe handling techniques. This demonstrated there was a gap between theoretical based training and the practice carried out at the home. This further demonstrated a breach in Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. The Deprivation of Liberty Safeguards (DoLS) are part of the Mental Capacity Act (MCA) 2005. They aim to make sure that people in care homes, hospitals and supported living are looked after in a way that does not inappropriately restrict their freedom.

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. We found decision specific capacity assessments in the files we looked at on the downstairs unit, and these were completed in detail, although some of these lacked information on who had been consulted in relation to determining what was in the best interest of the person. On the upstairs unit, we found capacity assessments in place which were not specific and recorded "Refer to separate MCA assessment." One of these lacked information on how the person had been supported to make the decision for themselves and we found a person had been deemed to lack capacity to make basic decisions around personal care and mobility, when our discussions with the person on the days of our inspection indicated they had capacity to make these simple decisions. This demonstrated the person undertaking these assessments did not understand the principles of the Mental Capacity Act and their role in supporting people to make decisions for themselves.

We found the service had appropriately referred to the local authority for all the people requiring a Deprivation of Liberty Safeguard, although due to a backlog of assessments by the local authority, there were very few authorisations in place. However, we found in one of the files we reviewed which had an authorisation in place, that the conditions attached to the DoLS had not been transferred into their plan of care.

Some people were being given their medicines covertly disguised in food or drink. We checked care records and found appropriate assessments had been undertaken and decisions made in accordance with The Mental Capacity Act 2005 for those people on the downstairs unit. However, on the upstairs unit we found one person's capacity assessment and best interest decision record lacked clarity. This person on occasions refused some of their medicines and at other times consented. Although various people including GP and pharmacist, social worker and continuing health care nurse had been involved at some stage in the decision making there was no plan in place to draw all the information together to provide clear guidelines for staff to follow in relation to each medicine or intervention when the person was declining and what staff needed to do to reduce the risks to this person. We found a capacity assessment in place which stated they lacked capacity in relation to their medicines, but their care plan had not been updated and still stated they had capacity in relation to their medication and clinical interventions.

The service did not have a record of who had a Lasting Power of Attorney (LPA) for health and welfare decisions and staff we spoke with were not able to tell us this information. This meant they were unable to advise who could consent on behalf of a person living at the home. In addition, not all consent forms had been completed in the files we looked at to evidence people had consented to care. This demonstrated a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found evidence staff were liaising with other health professionals in relation to people's health and wellbeing such as speech and language therapy, social work staff, district nurses and dieticians. However, the timeliness of following up issues had been of concern, particularly in relation to those people with diabetes. We found in two people's care plans, staff had contacted the diabetic clinic but struggled to speak with the diabetic nurse on several occasions, but often left it days in between before recording they had attempted further contact. We also found issues with communication of information with GP surgeries in relation to blood sugar monitoring and following up information. This meant people were at risk of unsafe care and treatment provision due to the lack of effective communication.

Inadequate

Is the service caring?

Our findings

People we spoke with told us the care staff were caring. One person told us, "I've been happy with what they have done for me." We observed care interactions between people and staff. We saw some staff were attentive, polite and sensitive to people's needs but we also saw staff ignore some people, particularly those who were difficult to engage. We observed staff on occasions talking to each other rather than engaging with people using the service. We observed one person coughing and shouting to staff to bring them a drink. The staff continued to talk to each other and did not bring the person a drink. On another occasion we saw a member of care staff stroking a person's hand and ensuring they had their cup of tea in a place they could reach safely.

We saw some people were appropriately supported with their lunch when required and this was done in a caring and dignified way but we also found other people who were not supported in a way that respected their dignity. For example, we observed one person was left with soup around their mouth and another with porridge on their trousers. Staff were observed to involve some people in their care providing information and explanation for example, when assisting to transfer people, but at other times we saw care being provided without any communication with the person. We observed people in the downstairs unit were supported without consultation, food was just placed in front of them; people were brought into the communal area with no discussion or communication. At other times, we saw staff show people two different types of juice on offer to aid their choice.

We observed staff knocking on people's doors before entering to ensure their privacy and we saw staff protect a person's modesty whilst they were hoisted by covering their knees with their skirt. On another occasion we saw one person being hoisted who was resisting care but no reassurance was offered to this person even when they told staff the hoist was hurting their leg. Staff were not always present to protect people's dignity and one person was seen on several occasions walking around the downstairs unit bare below the waist. This demonstrated a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw one member of staff encouraging a person to eat independently. Other staff told us they promoted independence during personal care by encouraging people to do as much as they could for themselves but helping them with the parts they required support. We observed two people who had difficulty communicating their wishes verbally although were able to understand what was being said. Both were seen to be frustrated that they could not be understood, but there had been no attempt to provide communication aids to reduce their frustrations.

Records were kept confidentially in the nurses' station and care was taken by staff not to leave information in communal areas. However, we did observe staff talk about what a person was wearing across a communal area which was indiscreet.

The service supported people to maintain their religious preferences and there were regular visits from local services. There was a section for people's religious preferences in the preadmission assessment and care

plan, but this was not always completed, therefore it was not possible to be certain that every person's spiritual or religious preferences had been discussed and acknowledged.

The deputy manager told us people at the service had the use of formal advocacy if required to support them to make decisions, if they were unable to make these independently.

Inadequate

Is the service responsive?

Our findings

We reviewed seven people's care files as part of our inspection. We found in two of the care files we reviewed the preadmission assessment had not been thorough and did not evidence the assessor had spoken with the prospective resident, relative or hospital staff. This meant there was a lack of information to ensure the home could meet the needs of the person and to gain essential information to identify risk and implement an effective plan of care.

We found files contained separate sections for each support needs such as continence, medication, mental state and cognition, mobility and dexterity. Each section contained a care plan which was underpinned by a risk assessment. We found the care plans we reviewed were not fully completed and some contained conflicting information and did not contain evidence there had been a discussion with the person receiving support or their relative. Some care plans did reference choice and preferences. For example, in one care file we saw a record of what time a person wanted to go to bed and get up and on waking up they liked to have a cup of tea. However, not all the life histories had been completed to provide staff with the information required to engage with people and provide care in line with past wishes and interests. The lack of collaboration with the relevant people to ensure care and treatment was planned to reflect the needs and preferences of the person demonstrated a breach in Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Person Centred Care.

We found care plans in place to guide staff how to manage behaviours that challenged did not contain the detail to enable staff to support people. We also found staff were not always recording people's behaviours in ABC (Antecedent, Behaviour, Consequences) charts, which are designed to enable staff to understand challenging behaviour and develop suitable responses but also to inform professionals about the extent of people's behaviours.

We found incomplete short term care plans in place for people who were either new or on a temporary stay at the home and a full care plan had not been completed within seven days in line with company policy in two of the care plans we reviewed. This meant there was a serious risk of inappropriate care delivery based on inadequate information. We also found records of daily care provision were incomplete and did not evidence care had been provided such as oral care or foot care. Body maps had not always been completed when a person had sustained an injury.

The examples of incomplete and inaccurate records demonstrated a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We noted from the care records that staff carried out an evaluation each month and these evaluations contained a statement "that the care plan was to be discussed with the resident and next of kin and written agreement obtained." This section had not been completed and therefore, there was no evidence people or their relatives had been involved with the review of their plan of care.

The registered provider operated "Resident of the day" with the aim of a "top to toe" review of a person's

care needs. This looked at a person's care records, preferences, medication, bedroom environment, activities, and sought feedback from the person and their relatives. Although an attempt had been made to initiate these reviews, they had not been completed fully or effectively. Staff told us they were time consuming and they did not have time to complete. In addition, the registered manager had told the area manager these were being completed but they had not been aware these were not being completed fully.

We saw very positive interactions between the activities coordinators and people at the service. This included friendly chatter whilst they made cards with two people at the home and also engaged people to sing to guitar music. A pantomime was held on the afternoon of our second day of inspection and people told us they had enjoyed this. We spoke with one of the activities coordinators who was very enthusiastic and knowledgeable about people's individual needs, social history and interests. They showed us activities which had been undertaken and there was evidence of relatives' involvement in these, such as creating a sea of poppies for remembrance day. However, outside of these planned activities we saw very little interaction between staff and people using the service, and lost opportunities for engagement.

Staff told us people had a choice about what time they got up in the morning and what time they chose to go to bed. We saw these choices respected during our inspection and those people who did not want to get up were still in bed. Other people told us they preferred to get up early and were able to do so, with one person telling us they were able to get up at their chosen time of 5.30am. Staff told us people were normally offered a bath once a week but people could have more if they required this.

Not all complaints had been recorded in line with the registered provider's procedures, which meant opportunities to learn from the experience were missed and this also meant management were not able to recognise there was an issue with care delivery. This evidenced a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

There was a registered manager in place who had been registered since October 2016 but had been working at the service as a manager since June 2016. They were not present at the time of the inspection and have since resigned from their post. The home was supported by an area manager whose responsibility was to have an overview of the service and a deputy manager. In the absence of the registered manager a peripatetic manager had been brought in to offer support to the service.

We spoke with the deputy manager who said, "I love my residents." Their vision for the service was to ensure people were well cared for up to the end of their lives and to deliver a high standard of care.

We found the systems in place to protect people from harm were not robust. In particular this affected the following areas: infection control practices, safe management of medicines, safe care and treatment and protecting people from harm from others who presented with behaviours that were challenging other people.

The registered provider had undertaken a Quality Monitoring check on 7 and 8 June 2016.This had been a thorough audit of the service provided in line with the Care Quality Commission key lines of enquiry and regulatory framework. This audit identified many of the issues we found at our inspection in relation to medicines management, audits, care planning and documentation, consent, lack of snacks, cleanliness and infection control, and documentation of challenging behaviours. An action plan had been completed which confirmed all issues had been addressed. However, we found issues in the same areas of service provision at our inspection which showed a systemic failure to sustain improvements required to ensure a safe, high quality service.

We found individual audits had not been carried out robustly such as medicines and care plan audits. The latest medicines audits had been carried out in October 2016. The audit identified a number of shortfalls in medicines management, some of which we also found during this inspection. An action plan had not been put in place to address all of the shortfalls. There was also no identified person or completion date specified for those actions, and the action plan had not been reviewed by the manager. This meant the management team had not acted to adequately mitigate known risks arising from poor medicines management at the home.

Records and care plans for people using the service were incomplete which demonstrated there was no systematic approach to effectively auditing care records. There was a system in place "Resident of the day" but this had not been completed in the detail required by the registered provider and staff told us they did not have the time to complete this lengthy process. Staff, people living at the home and their relatives all told us there were not enough staff to meet the needs of the people at the home, and it was not clear from our discussions with the area manager how the service had worked out safe staffing levels from their dependency tool.

Mattress audits were incomplete which posed risks to people at the service. The area manager told us the

mattress audit was the responsibility of the nurse on each floor. The nurses told us it was the care staff responsibility. We checked the audit records and noted the last recorded audit on the upstairs unit was 6 October 2016 and only confirmed the mattresses in six rooms had been checked. The downstairs mattresses had been checked on 5 December 2016.

We found poor infection control practices and faulty equipment in use during our inspection. These issues should have been identified as part of the manager's daily walkaround. The area manager told us the manager completed a daily check around the building and this included checking four bedrooms per floor each day. We noted this check had only been completed five days out of the previous ten days. There was a lack of robust systems in place to catalogue assistive equipment and to ensure it was safe and maintained. As a result we found a faulty shower chair in use at the service which posed a risk to people at the service.

We saw recorded information to evidence hoists and slings had been checked to meet Lifting Operations and Lifting Equipment Regulations 1998 (LOLER). However, there was no systematic way of cross referencing this check with slings in use for individual people as the serial number of the sling was not recorded in people's care plan. We also found the LOLER testing of the passenger lift was six weeks out of date but had been booked in for the following week.

We reviewed the minutes of a relatives' meeting from September 2016. The minutes did not detail the exact date of the meeting, or which relatives had attended. It was not clear from the minutes who would be addressing actions as a result of relatives' comments. Apart from the residents' meeting there was a lack of evidence that feedback was being sought, monitored or analysed for concerns which may require further action. In addition not all complaints and comments were being noted or escalated, which would have given the registered provider the opportunity to improve outcomes for people living at Castleford Lodge.

Staff meetings are an important part of the registered provider's responsibility in monitoring the service and coming to an informed view as to the standard of care and support for people using the service. We saw staff meeting minutes dated 28 July 2016 which looked at issues with staff behaviours and complaints. There was no list of the names of staff who were present at the meeting or actions to be completed from the meeting. We also saw minutes from a meeting with staff on 23 November 2016 held as a result of a recent Clinical Commissioning Group visit and infection control audit. There was no action plan detailed on these minutes to clarify who was responsible for each area requiring action, and we found many of the items discussed were still an issue at our inspection which demonstrated there was a disparity between identifying issues and ensuring issues were resolved. We reviewed the minutes of the registered nurses meeting held on 24 November 2016 which reflected on issues relating to a specific incident. Staff told us they had raised concerns with the registered manager but in their perception their concerns had not been listened to. We were not provided with any evidence during our inspection that staff had raised concerns and this was not documented on minutes of staff meetings.

We found the purpose of the monitoring of people's needs was not always clear. For example, we found a complete and contemporaneous record of people's daily fluid intakes had been recorded onto a chart providing an overview for management. Where records showed a low daily intake, there was no evidence that actions resulted to address these shortfalls. The area manager told us the registered manager's responsibility was to ensure all audits were forwarded to head office on the 5th of each month but we did not see the evidence to support whether this was happening or not or whether any concerns had been raised by head office.

The above examples demonstrated the registered provider had failed to effectively assess and monitor the quality of the service provided to people. Records relating to people who used the service and staff

employed were not accurate enough to withstand scrutiny and systems and processes were not robust enough to ensure full compliance with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This evidenced a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.