Millreed Lodge Care Limited

Millreed Lodge Care Home

Inspection report

373 Rochdale Road
Walsden
Todmorden
Lancashire
OL14 6RH

Tel: 01706814918
Website: www.sagecare.co.uk/millreedlodge

Date of inspection visit:
13 June 2018

Date of publication:
30 July 2018

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

This inspection took place on 13 June 2018 and was unannounced.

At our last inspection on 3 May 2016 we rated the service as 'Good' and there were no regulatory breaches.

Millreed Lodge is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The home provides nursing and personal care for up to 36 older people who may be living with dementia. Accommodation is provided on two floors with lift access between floors. There are communal areas on the ground floors, including lounges and a dining room. There were 27 people in the home when we inspected.

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

We found standards had declined in some areas since our last inspection in 2016 and at this inspection we identified several regulatory breaches.

Medicines management was not safe which meant people were at risk of not receiving their medicines when they needed them.

Staff had received training in safeguarding and understood the reporting systems. Safeguarding incidents were reported to the local authority safeguarding team. We found risks to people were not always properly assessed or managed well, particularly in relation to fire safety. Following the inspection we referred our concerns to the fire authority.

We found there were not enough staff to keep people safe and meet their needs. We saw people were left unattended for long periods of time and had to find staff to assist with a person who was walking about and at risk of falling. Staff recruitment procedures were not always robust as checks had not been made to establish employment history or ensure appropriate references had been obtained.

Staff induction was not thorough and did not prepare staff for their roles. Staff were up to date with most of their training and specialised training for conditions such as epilepsy and diabetes, had been booked.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible; the policies and systems in the service did not support this practice.

People's care records were not personalised and did not reflect people's needs or preferences. There was not enough detail to guide staff about the care and support people required. People's nutritional needs were met, although the completion and monitoring of food and fluid charts was poor. People had access to healthcare services and systems were in place to manage complaints.

People and relatives told us there were few activities which our observations confirmed. People and relatives told us staff were kind and caring. We saw some caring interactions but also practices which showed a lack of respect for people.

The provider's systems and processes did not enable them to effectively assess, monitor and improve the service. They did not monitor and mitigate risk effectively.

We found shortfalls in the care and service provided to people. We identified six breaches in regulations – staffing, safe care and treatment, recruitment person-centred care, consent and good governance. The Care Quality Commission is considering the appropriate regulatory response to resolve the problems we found. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

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.

Medicines management was not safe and effective, which meant we could not be assured people received their medicines as prescribed.

Staffing levels were insufficient to meet people's needs in a timely manner. Staff recruitment checks were not always thorough.

Risks to people's health, safety and welfare were not assessed and mitigated. Safeguarding incidents were recognised, dealt with and reported appropriately.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff induction was not thorough. Staff received ongoing training and supervision.

The service was not meeting the requirements of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS).

People's nutritional needs were met. People had access to healthcare professionals.

Is the service caring?

Requires Improvement

The service was not always caring.

People told us the staff were friendly and caring and we saw this in some of our observations. However, we also found people were not always treated with respect and their dignity was not maintained.

Is the service responsive?

Requires Improvement

The service was not responsive.

Care records were not accurate or up to date and did not reflect people's preferences.

Activities were limited and there was little to interest or occupy people.

People knew how to raise any concerns and complaints procedure was in place.

Is the service well-led?

Inadequate

The service was not well-led.

Leadership and management of the service needed to improve.

The provider did not have effective systems and processes in place to assess, monitor and improve the service or assess, monitor and mitigate risk.

Millreed Lodge 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 checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 13 June 2018 and was unannounced. Two inspectors and an expert by experience with experience of services for older people attended. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we reviewed the information we held about the home. This included looking at information we had received about the service and statutory notifications we had received from the home. We also contacted the local authority commissioning and safeguarding teams and Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

We asked the provider 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. The provider returned the PIR and we took this into account when we made judgements in this report.

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

We spoke with eight people who were using the service, three relatives, one nurse, two care staff, the cook and the registered manager. We also spoke with a visiting healthcare professional.

We looked at four people's care records, four staff files, medicine records and the training matrix as well as records relating to the management of the service. We looked round the building and saw people's bedrooms and communal areas.

Inadequate

Is the service safe?

Our findings

We found medicines were not managed safely. We looked at the medicines with the registered manager who was also the nurse on duty on the day of the inspection.

We checked six people's medicine administration records (MARs). The records did not always show that medicines had been given as prescribed. For example, three people's morning medicines had not been signed as given, although these medicines had been administered. The registered manager told us they had forgotten to sign the MARs and then signed them in our presence. However, they also signed for a medicine they had not administered, which had been given by the night nurse.

People were prescribed medicines to be given "when required", however there was not always information recorded to guide nurses in how to administer medicines prescribed in this way. We found where people were prescribed a variable dose, the actual dose administered was not recorded. Where medicines required a time gap between doses the actual time of administration was not recorded on the MAR. This meant that people prescribed medicines in this way were at risk of not being given them safely or consistently.

We found people were not always given their medicines as prescribed. One person told us they were prescribed medicines which had to be given at the same time each day to manage their medical condition. They said, "Some staff don't give me it when I need it and they tell me I don't need it at exactly the same time but I know I do to keep my (condition) level." We reported this to the registered manager. Another person was prescribed a medicine for the treatment of diabetes to be given daily with breakfast. We saw this medicine was administered 90 minutes after the person had eaten their breakfast. The registered manager told us the person refused their medicines and said they had to "get it down any which way we can". The MAR did not show that this medicine had been offered earlier or that it had been refused by the person.

The registered manager told us one person had their medicines given covertly (hidden in food or drink). A mental capacity assessment and best interest decision was recorded. The medicine care plan gave instructions on how each medicine should be administered covertly, however there was no evidence to show a pharmacist had been involved in these instructions. This is important as the therapeutic effect of a medicine can be altered if it is crushed or dissolved which may present a risk to the person if this is not done correctly.

The systems for recording changes to prescribed medicines were not safe. The dose of one person's medicine had changed following a GP visit and the new dose was printed on the MAR. There was a handwritten note with the MAR which gave the wrong information and if followed by the nurses would have meant the person would have received double the dose prescribed. The registered manager had not identified this and told us this was an error. We saw another person was prescribed a medicine which required regular blood tests to determine the dose to be administered. We saw the results of the most recent blood test which confirmed the dose that was being administered from 6 June 2018. However, when we asked to see the previous blood test results to check the dose before 6 June 2018, the registered manager told us they did not keep these and confirmed there was no record to evidence the prescribed

dose. This meant we could not be assured the correct dose had been given prior to 6 June 2018.

The systems for recording how to apply creams and documenting when creams had been applied were not robust. We saw care staff signed MARs for any topical creams they applied. These forms were poorly completed and showed creams were not being applied consistently or in accordance with the MAR. We saw one person had a prescribed ointment in their bedroom yet this was not on the MAR. The registered manager told us this had been discontinued 'a while ago'.

We saw safety lancets, used to obtain blood samples for blood sugar monitoring, were stored in an open box on a shelf in the dining room. This meant they were accessible to people in the home, visitors and staff unauthorised to use them

We found there were not effective systems in place to assess, monitor and manage risks to people and keep them safe. Risk assessments were in place for areas such as choking, the use of bed rails, skin care and falls, however these were not always up to date.

For example, one person needed to have thickener added to their drinks to minimise the risk of choking. We saw the correct amount of thickener to be used was on the handover sheet and diet sheet but the safe swallowing advice sheet had not been updated to show the correct amount. If drinks are not correctly thickened they may cause choking.

We found bed rails fitted to one person's bed were not appropriate for the type of bed the person was using and had not been fitted correctly. We raised this with the registered manager who took immediate action to replace the bed rails. We saw two other people's beds had mattresses which were too big for the divan base. The mattresses hung over the end of the beds which meant if a person was to sit on it they would fall as there was no base to support their weight. Some wardrobes were secured to the wall, however others were not and we found they could easily be pulled off balance raising the potential risk of injuring someone.

We had concerns about fire safety which we raised with the fire authority following the inspection. Care files included personal emergency evacuation plans (PEEPs). However, the PEEPs for two people included instructions for staff to use moving and handling equipment including the hoist and stand aid to assist people to evacuate and for two staff to be engaged in the manoeuvre. The use of such equipment would not be possible or appropriate in an emergency.

We looked at the fire safety policy which the registered manager had signed to say they had reviewed in May 2018. The policy required the names of staff who had responsibility for fire safety; this had not been completed. We asked the registered manager about this and they said they had only skimmed through the policy and had not noticed this.

We saw fire risk assessments were in place for individual people based on the number of the room they occupied. However, seven of these risk assessments were for the previous occupant of the room. There were no fire risk assessments available for the current occupants. We saw Yale locks were fitted to bedroom doors with individual keys hung on hooks outside the doors. There was no reference to this in the home's fire risk assessment.

We asked to see records of fire drills that had taken place in the last two years. The registered manager provided us with a list of 13 staff who they said had taken part in a fire drill on 9 April 2018. There was no detail about the drill, such as the time it was carried out, the fire point actuated or the staff response. The registered manager told us there were no other records of drills as they had all been archived. The registered

manager told us two fire sledges had been purchased in the two weeks prior to the inspection. They confirmed staff had not received any training in how to use the sledges although they said they were hoping to arrange this soon.

We saw accidents were recorded and a monthly analysis was completed. However, this was not robust. For example, one accident form said staff had failed to apply the brakes on a person's bed when they fell from it. This had not been listed as a contributory factor to the accident on the analysis. We also found the analysis did not include all accidents. For example, an analysis had not been completed for fourteen accidents that happened in February 2018 and although we saw records of four accidents in March 2018 only one had been recorded on the analysis.

We concluded people were not receiving safe care and treatment in relation to the management of risks, fire safety, accidents and medicines. This was a breach of the Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us there were very busy times when they struggled to meet people's needs, particularly when supporting people to get up and have breakfast and during the evening time.

Our observations found there were not enough staff. We noted periods in excess of an hour during the morning when staff were not available in the lounge. On three occasions we had to attend to a person who was walking very unsteadily and was at risk of falling as no staff were present in the lounge. We supported the person until staff were available.

We saw people did not always receive the support they needed to eat their meals. One person's care records said they liked to sit in the dining room for breakfast and needed staff supervision and occasional prompting to eat their food. We saw this person sitting in the lounge with an untouched bowl of porridge and cup of tea in front of them for over an hour and a half with no staff intervention. No staff were in the lounge during this time. When staff noticed the person had not eaten they asked if they wanted something else and provided them with toast and a cup of tea. Staff did not stay to support the person. At lunchtime the person again sat with most of their meal in front of them for an hour and twenty minutes. Again, no staff were in attendance. We concluded there were insufficient staff deployed to meet people's needs and keep them safe. This was a breach of the Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at four staff recruitment files. All had completed application forms and references and criminal record checks had been obtained before new staff commenced in post. However, for one of these staff members there was conflicting information about their employment history and we could not determine the last employer. We also found the references for this staff member were not from any previous employers. The registered manager said they would look into this but could offer no explanations. This was a breach of the Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw safeguarding incidents had been recorded and reported to the local authority safeguarding team. Staff knew what to do if they suspected abuse. They told us they would always report their concerns to the registered manager or person in charge. One staff member told us they would not hesitate to contact the local authority safeguarding team if they thought their concerns were not being taken seriously.

We saw up to date records relating to checks of the safety of the premises, for example in relation to operation of equipment, gas safety, water storage and fire alarm testing. The registered manager was not able to locate the electrical wiring certificate at the inspection but sent it to us subsequently.

Requires Improvement

Is the service effective?

Our findings

The registered manager told us all new staff received an induction. We looked at the induction records for four staff who had started their employment in the last seven months. The induction for one staff member had been signed as completed over one day, another staff member's induction lasted two days, the third staff member's induction was not dated and the fourth staff member's induction record had not been fully completed. There was little evidence to show these staff had completed an induction that equipped them with the skills, knowledge and competency to fulfil their roles. There was no evidence in the staff files we reviewed or on the training matrix to show new staff had completed the Care Certificate. Although the PIR completed by the provider prior to the inspection stated all new staff completed the Care Certificate through a 12 week induction programme. This was a breach of the Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us they received plenty of training. They said the majority of this was through 'Social Care TV' with practical training such as moving and handling done face to face. The training matrix showed the majority of staff were up to date with training the provider deemed as mandatory such as safeguarding and moving and handling. Dates were booked for those who still required updates. The matrix showed specialist training had been booked for the next couple of months topics such as stroke awareness, epilepsy and diabetes.

The registered manager told us staff received supervision six times a year. They said these were either face to face or observational supervisions. We saw observation supervision records for three staff which were well completed. However, two face to face supervision records we were shown were identical and the only issue discussed was the use of social media. Staff said they received supervision approximately every three months. They said it gave them opportunity to discuss anything and said they could say anything they wanted to.

People told us they liked the food and were given a choice. Comments included; "The food's good and there's plenty of choice"; "I like the food but there's not much choice of what I like" and "The food is sometimes very good and sometimes not so good. I tell them if I don't like it and they will replace it and there's always a choice and a menu."

We spoke with the cook who was aware of people's dietary requirements. They used cream and butter to fortify meals for people at risk of weight loss. We saw people had a choice of toast, cereal or eggs at breakfast. At lunchtime the choice was scampi with chips and side salad or home-made chicken soup. There was a choice of desserts. People were asked for their choices approximately an hour before the meal was served.

We saw drinks and biscuits were served to people in one of the lounges in the late morning. We asked one of the care staff why people in the television lounge had not been offered the same. They were not aware of this and told us it was usually the kitchen staff who served drinks in the television lounge. The member of staff then served drinks and biscuits.

The cook told us the tea time meal for the people who needed a soft diet would be chicken soup. However, we saw people were served blended mashed potato with cheese and blended baked beans. One of the care staff told us there was not enough chicken soup left from lunchtime.

Care records indicated appropriate referrals to healthcare professionals such as the GP, district nurse and chiropodist had been made. We saw the speech and language therapist (SALT) had been involved where people had difficulty eating and their advice had been included in care records. We spoke with a healthcare professional who visited the home regularly. They spoke positively about the home and had no concerns. They said the home was always clean and staff were friendly and knew what they were doing.

The Mental Capacity Act 2005 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 application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

The registered manager kept a record of when DoLS had been applied for, the authorisation date, expiry date and details of any conditions. However, we saw applications made by the service were not always followed up. For example, for applications made in February and May 2017 there was no record of response or follow up. One person's DoLS had expired in March 2017. Yet there was no information about this on the registered manager's DoLS record and therefore we were unable to establish if a further application had been made.

We saw records of best interest meetings being held but where the record asked for details of the people involved in the decision, this had not been completed. One record relating to the use of bedrails said the person's family had been consulted and were in agreement but did not detail which family member or whether they were the person appointed to make decisions on behalf of the person concerned.

Another record of a best interest meeting did not detail anybody other than the registered manager having been involved in the decision. The DoLS authorisation for this person showed a family member had been named as a relevant person for decision making and also a named advocate. We saw the person named as an advocate on the DoLS was named as an independent mental capacity assessor (IMCA) in the person's care records. When we asked the registered manager if the person was an advocate or an IMCA, they said they didn't know.

We heard and saw staff explained what they were doing and checked to ensure people understood and agreed before proceeding. However, we found the recording of people's consent was lacking. For example, care records showed one person's relative had enduring power of attorney (EPA) and the relative had signed consent forms for the person's care and treatment. However, documents showed the EPA was for property and affairs and not for health and welfare. When we asked the registered manager if the relative had the legal authority for health and welfare they said they did not know. Another person's care file had no consent records. This was a breach of the Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Our tour of the home found only minimal dementia-friendly adaptation to the premises and little evidence

to show people had been involved in decisions about the environment. We saw people's bedroom doors had their names on and a picture of something that was meaningful to them. For example, one person had some images of music which their care records showed they liked. There were signs on doors to indicate bathrooms and toilets but this was in words and there were no pictures. There was no signage to assist independently mobile people with orientation, for example to show which direction they should walk in to find the quiet room, dining room lounge or bathrooms. We saw access to outside space was limited to a balcony from one of the lounges. One person told us they preferred a bath but said they could not have one as they could not get in or out. We found there was only one bath in use which had a chair hoist. The other assisted bath was in a bathroom that was being used as a storage area. There were two separate shower rooms.

Requires Improvement

Is the service caring?

Our findings

People praised the staff who they described as kind and caring. Comments included; "I like it here they always help me and I can press the bell and they come. I never have to ask they always know what I need"; "I get on well with all the staff and we are like family but if I'm not happy with something I will say" and "I am happy with it here. It's very clean and staff are very nice."

A relative told us, "I find the staff are wonderful. I am here every day and they are always really good at everything (family member) needs".

We saw staff were kind and caring during their interventions with people. We observed staff were very busy however they displayed a good relationship with each person showing consideration, compassion and humour. We saw people who needed help with their meals were given the time they needed by staff who chatted with them while providing support. We saw throughout the day staff checked people were all right; asking them if they were comfortable or if there was anything else they needed.

However, we also observed some staff practices which demonstrated a lack of respect for people. For example, we saw some staff knocked on bedroom doors before entering but also saw other staff walked straight in without knocking. We sat with people in the television lounge from 9.30am until 11.30am. During this time we saw staff supported people into the room but did not speak with any of the other people who were already in the lounge. One person was sat with their breakfast untouched for over one and a half hours before staff noticed and asked if they would like something else.

Most people looked clean, comfortable and well groomed, although we saw some people had long nails which were not clean.

Care files included an 'activities of daily living assessment.' We saw the information on these was personalised and included some details of personal preference. Life histories and 'resident's background' documents were in place which helped staff to get to know and understand the people they were supporting. These were developed with information from the person or, where appropriate, their families.

Requires Improvement

Is the service responsive?

Our findings

We found staff had not always been responsive to or were clear about people's needs. The registered manager told us nine people stayed in bed all the time and was not able to explain fully the reasons why. There was also a lack of detail in the care records. For example, one person's care plan said they were nursed in bed due to 'general deterioration'. However, it stated elsewhere in the care notes the person was nursed in bed because it was unsafe for them to sit in a chair. We asked the registered manager if an assessment of this person's seating needs had ever been requested. The registered manager said it had not. This meant the person did not have any opportunity to get out of bed, but the decision had not been assessed through a formal assessment and care planning process.

Another person's care records had advice from the community matron in January 2018 which stated the person was to have 1.5 to 2 litres of fluid daily. There was no reference to this in the person's care plans. Staff told us the person was not on any food or fluid charts so it was unclear how staff were monitoring this person's daily fluid intake.

We found people's preferences were not always respected. One person told us, "I would like more showers but they are short of staff and really I'd like a good bath as I prefer that to showers but they say I can't as I can't get in and out. I have a calendar there that says when I last showered and it says February so it's been four months. Mind you they will say I refused but I don't always."

Another person's care plan said they preferred to have blankets rather than a duvet. However, when we met this person in their room, we saw they had a duvet on their bed.

Care records did not always evidence that appropriate care had been given. We found food and fluid charts were poorly completed and there was no evidence to show that these were reviewed by senior staff to ensure people were receiving sufficient to eat and drink. For example, one person's care plan showed they needed to drink more fluids as their urine was concentrated. We saw fluid charts for this person showed very little input. For example, on 10 June 2018 their daily fluid intake was 400mls; on 11 June 2018 it was 800mls and on 12 June 2018 it was 550mls.

We looked at the fluid charts for another person. The fluid intake was usually between 1,100mls and 1,250mls daily. However, on 6 June 2018 their daily fluid intake was 650mls and there was no drink recorded between 11.45 and 20.30. On 7 June 2018 it was 800mls with no drink recorded between 12.15 and 20.40 and on 12 June 2018 the fluid intake was 575mls with only four drinks recorded between 07.15 and 22.00hrs.

Care plans were reviewed monthly or when people's needs changed, however we found the care plans were not updated accordingly. For example, one person's mobility needs had changed, yet this was not reflected in their care plan.

We found people's wishes with regard to end of life care were not always fully recorded. In two people's care records we saw this information had been completed but in a third person's file there was no

documentation relating to this matter.

People told us there was a lack of activities. Comments included; "No one comes in to do activities I'm in bed all day" and "No activities really other than nails and feet and that's nice." A relative told us, "Well no, I don't really see many activities. (Family member) was a big tennis fan so I take (them) home to watch tennis and I bring sudoku in and we do that together. I don't think they have the time really to do things with them as they are all so busy but it's done (family member) good coming here".

We saw newspapers were available for people in the lounges but other than that there was little for people to engage with. In one lounge two televisions were placed back to back so that people at either end of the room could see them. However, for most of the morning only one television was playing. We asked two people if they had been asked what they wanted to watch and they said they had not. We asked these two people what they usually did with their time. One said, "We sit here looking at each other all day most days." Both people told us they liked it when entertainers came in and one said they went out with their family.

The registered manager told us an activity co-ordinator worked between 10am and 4pm on weekdays. On the day of our inspection, this person was working as one of the care staff during the morning and was therefore not able to engage people in activities. The activity programme for the day said games would be held in the morning between 8am and 10am. This did not take place.

We asked the activity co-ordinator if they took people out. They told us they tried to take people to a local 'Dementia Café' held on the first Saturday of every month. However, they could only take one person on each occasion. They told us they would like to take people out more often but staffing did not allow for this. The activity co-ordinator told us people enjoyed engaging in various activities and had recently made decorations and had a party for the royal wedding.

They told us they tried to spend time with everyone living at the home including doing one to one activity with people in their rooms but this was not always possible due to demands on their time. We saw the activity record for one person who stayed in their bedroom did not have any entry for over three weeks. The social care plan for another person who stayed in bed all the time stated they had a daily one to one session; the last record of this taking place was on 24 May 2018.

We concluded people did not receive care that was personalised or responsive to their needs. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager told us the complaints procedure was usually displayed in the entrance but had been taken down while they redecorated. People and relatives told us if they had any concerns they would speak with the registered manager. The registered manager told us they had not received any complaints since the last inspection.

Inadequate

Is the service well-led?

Our findings

At this inspection we found shortfalls in the delivery of care as evidenced by the regulatory breaches cited in this report. Governance systems were not effective as issues had not been identified or addressed through quality audits. We concluded the service was not well-led.

Prior to the inspection the local authority and clinical commissioning group (CCG) had shared information with us about a visit they had made to the service four weeks before our inspection. We found issues they had identified and raised with the registered manager and area manager had not been resolved. For example, food and fluid charts not completed correctly or totalled, ineffective audit systems including poor accident and incident analysis and a lack of recording of consent.

A large number of policies and procedures were in place to advise and support staff. The registered manager had signed to say they had reviewed all of the policies over two days. However, when we asked them about this they said they had 'skimmed over' the policies rather than completing a full review.

Audits were in place to measure the safety and quality of the service. However, we found variations in how effective these were in identifying issues and making improvements. An infection control audit had taken place shortly before our inspection and there was an action plan to address the issues identified. Yet other audits we reviewed were not robust. For example, the audit of accidents did not include all the accidents that had occurred. We saw care plan audits were in place but where there were actions these had not always been followed up. For example, a care plan audit undertaken three weeks prior to our inspection said all identified actions needed to be completed within two weeks. We did not see any evidence of any actions being completed. Medicines were audited on a monthly basis but we were unable to see how any issues identified were communicated to relevant staff.

Environmental issues had not been identified and addressed until we brought them to the attention of the registered manager. For example, unsafe bed rails, mattresses too big for bed bases and some wardrobes not secured to the wall. Although the maintenance person carried out regular environmental checks these issues had not been identified.

We asked people and relatives if they were asked their views about how the home was run. Comments included; "I can't say I have ever been asked really"; "I know the manager and I wouldn't hesitate to ask her anything but I've never been asked about (family member) or (their) care really since (family member) arrived"; "I've not been asked on my opinion for how it should be run" and "I don't get asked about how it should be run but I know it's a good home as I've seen not so good with my (family member)".

People we spoke with were not aware of any residents meetings. One person said, "No, we don't have meetings and I've never even met the owner and I've been here years." The registered manager told us residents and relatives meetings were held monthly and advertised in the home's newsletter, a copy of which was available in the home. The records showed a meeting had been held on 28 March 2018 and stated no-one had attended. The registered manager was resigned to the fact that no-one had attended and

could not tell us of any action they had taken to try to involve people and their relatives in meetings or look at different ways of engagement.

The registered manager told us the views of people who used the service and their relatives were sought through questionnaires on an annual basis. We saw the results of the questionnaires had been collated and a summary of responses developed. However, only positive comments had been included on the overview and no reference had been made to how less than positive feedback was to be addressed.

We concluded the above evidence demonstrated a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The home had a registered manager who had been in post for many years. People and relatives we spoke with all knew the registered manager and spoke positively about her. One person said, "The manager is good and she will always sort things out." One relative said, "I know the manager and I wouldn't hesitate to ask her anything." Another relative said, "I like the manager and all the staff and they are good at keeping me informed."

On the day of the inspection the registered manager was also the nurse on duty from 8am until 2pm. We observed they were very busy throughout the day. Although there was an administrator working they were located in an office on the top floor away from the registered manager. A new office was being created on the ground floor for the registered manager. There were a number of staff vacancies they were trying to fill which included a deputy manager, a nurse for days and care staff for both days and nights. Agency staff were used currently to fill the nurse and care staff roles.

Staff told us they could go to the registered manager with any issues or problems and said the registered manager always tried to respond but was often very busy. One staff member said they took part in staff meetings where they were able to make suggestions in relation to the running of the home. We saw separate meetings had been organised for staff, one for nurses and another for housekeeping staff both in February 2018. The meeting records stated no staff had attended either meeting. Twelve staff had attended a general meeting on 29 May 2018.