Barchester Healthcare Homes Limited

The Wingfield

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We carried out an unannounced comprehensive inspection of this service on 1 November and 2 November 2016. At the comprehensive inspection we identified six breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We issued the provider with six requirements stating they must take action.

After the comprehensive inspection, the provider wrote to us to say what they would do to meet the legal requirements in relation to the breaches. We undertook this focused inspection on the 6 and 7 June 2017 to check that they had followed their plan and to confirm that they now met legal requirements. We had also received complaints about the service provided on five different occasions since the last inspection.

This report only covers our findings in relation to those requirements. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for 'The Wingfield' on our website at www.cqc.org.uk'

The Wingfield had not had a stable management team since the registered manager left in 2015. A new manager had recently been appointed and had submitted an application to the Care Quality Commission (CQC) to become the 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.

At our focused inspection on the 6 and 7 June 2017, we found that the provider had not followed their plan which they told us would be completed by the 30th March 2017. This meant not all legal requirements had been met.

The service used a DICE tool (a dependency assessment tool) to work out staffing levels. All staff we spoke with told us the tool did not reflect the needs of people living with dementia. We observed many people in Memory Lane stayed in bed and staff told us they were not able to get people up due to staffing levels. Relatives told us they had also raised concerns about staffing levels.

The service was not consistently meeting the requirements of the Mental Capacity Act 2005 (MCA). The service had liaised with Wiltshire Deprivation of Liberty safeguards team and had received advice on the implementation of the MCA. We saw evidence that mental capacity assessments had been completed for some people who lacked capacity to consent to care and treatment at The Wingfield. However, we found many people still did not have a capacity assessment in place. Staff showed a good understanding of the MCA and we saw staff giving people choice and asking for permission before providing support.

People were given a visual choice of two meals and if they didn't like what was on offer, they could ask for an alternative. Pureed food was presented well and appeared appetising. We found though that people were

not always encouraged to eat and drink sufficiently. We observed food taken away from people without staff encouraging them to eat. We observed people with prescribed build up drinks next to them, untouched. Where people were prescribed thickeners we found an increased risk to people due to conflicting information available and the knowledge of the staff.

We found the service had started to implement a system of reviewing and updating all care plans. However care plans we looked at, were not person centred and information within the plans was contradictory. People were not supported to follow their interests and take part in social activities.

Complaints received had not been investigated and responded to in a timely way.

Staff told us they did not always feel supported by management, but were hoping the new manager would make positive changes to the service.

Staff had received additional training in dignity and respect since our last inspection. The service no longer used agency staff to provide care, which meant more continuity in care. We observed staff knocking on doors before entering people's bedrooms. People told us staff were caring and we observed positive interactions between people and staff.

We found repeated breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

We found that action had not been taken to improve the safety of the service.

Staffing levels did not reflect the needs of people who may be living with dementia.

Staff and relatives had raised concerns regarding staffing levels with management, which was not acted on.

Staff were only able to provide basic care and we observed care was rushed, which meant staff did not have time to spend with people.

Is the service effective?

Requires Improvement

We found that action had not been taken to improve the effectiveness of the service.

The service was not consistently meeting the requirements of the Mental Capacity Act 2005.

People were not encouraged to have sufficient food and drink.

Is the service caring?

Requires Improvement

We found that action had been taken to improve the caring nature of the service.

Staff knocked before entering people's bedrooms and treated people with dignity and respect. Staff have had additional dignity and respect training since our last inspection.

People told us staff were caring and we observed positive interactions between people and staff.

This meant that the provider was now meeting legal requirements.

While improvements had been made we have not revised the rating for this key question; to improve the rating to 'Good' would

require a longer term track record of consistent good practice.

We will review our rating for caring at the next comprehensive inspection.

Is the service responsive?

Requires Improvement

We found that action had not been taken to improve the responsiveness of the service.

We found the service had started to implement a system of reviewing and updating all care plans. However care plans we looked at, were not person centred and information within the plans were contradictory.

People were not supported to follow their interests and take part in social activities.

Is the service well-led?

Requires Improvement

We found that sufficient action had not been taken to improve the well-led of the service.

Complaints received had not been investigated and responded to in a timely way.

The service did not have a registered manager in post, however a new manager had been appointed, who had applied to be registered with the CQC.

Staff told us they did not always feel supported by management, but was hoping the new manager would make positive changes to the service.

The Wingfield

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 was 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.

We undertook a focused inspection of The Wingfield on 6 and 7 June 2017. This inspection was completed to check that improvements to meet legal requirements planned by the provider after our comprehensive inspection on 1 and 2 November 2016 had been made. We had also received further information of concern since our last inspection with regards to staffing levels.

We inspected the service against all five questions we ask about services: is the service safe, is the service effective, is the service caring, is the service responsive and is the service well-led. This is because the service was not meeting some legal requirements in relation to those questions.

The inspection was undertaken by one inspector, a bank inspector, specialist nurse adviser and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before our inspection we reviewed the information we held about the home, this included the provider's action plan, which set out the action they would take to meet legal requirements.

We used a number of different methods to help us understand the experiences of people who use the service. This included talking with eight people and nine visiting relatives about their views on the quality of the care and support being provided.

We looked at documents that related to people's care and support and the management of the service. We reviewed a range of records, which included 15 care and support plans, daily records, staff duty rosters, complaints, staff meeting minutes and relatives' meetings minutes. We looked around the premises and observed care practices.

We spoke with the manager, operations manager, five registered nurses, seven care staff, staff from the catering department and the activities coordinator. We received feedback from one health and social care professional who worked alongside the service.

Requires Improvement

Is the service safe?

Our findings

At the last comprehensive inspection in November 2016 we identified that the service was not meeting Regulation 18 (1) of the Health and Social Care Act (2008) (Regulated Activities) Regulations 2014. This was because sufficient numbers of staff were not deployed fully to meet people's needs for person centred care. Following that inspection we issued a requirement notice. The provider developed an action plan to address the shortfalls, which they submitted to us following the inspection.

During this inspection we found that some actions from the provider's plan had been implemented. However, staffing levels remained a concern. On the first day of our visit we saw there were five care assistants and one nurse on duty in the morning on the first floor of Memory Lane. They were supporting 22 people living there. In the afternoon, the number of care assistants reduced to four. The unit manager said that this was the normal number of care assistants on duty, but there were occasions when staff phoned in sick at short notice, which meant they couldn't always arrange cover. At night there were normally two care assistants and one nurse on duty. On the ground floor of Memory Lane there were 25 people living there, who were supported by four care assistants and one nurse in the morning and then this reduced to three care assistants and a nurse in the afternoon.

All staff we spoke with commented about staffing levels. One said "They're not good. It's put me off caring for life. It's unusual to have five (care assistants) in the morning. It's usually four. It's hard going, we can't get everyone up." They mentioned that sometimes at weekends the staffing levels had dropped below four staff. Two other staff members we spoke with confirmed this. We saw two relatives' meetings were held on the 5 April 2017 and reviewed the minutes. During both meetings relatives expressed anxiety around staffing levels, many were concerned that a reduction in the hostesses' hours were impacting on care staff.

A care assistant working on Memory Lane said "The floor needs more staff. DICE (a dependency assessment tool used to work out staffing levels) doesn't work for this floor. Things are not being done; we used to have six or five care assistants and two nurses. People could have a shower or bath if needed; now it's just the essentials. We just get done what needs to be done." They felt that staff morale had been affected due to staffing levels and added "We want to be able to give them more time." They confirmed that on the 27th May 2017 only two care assistants arrived in the morning. They said that another care assistant was called in to raise the level to three. They added "We have often started the day with three. They try and ring around but many are now saying no and won't come in. The more we jump in the more they expect it. I'm hoping the new manager will see what we see and do something about it." We checked the staffing rotas, which confirmed that on 27th and 28th May 2017 there were two care assistants on the roster and on the 1st June there were three.

Another care assistant, who had worked on both floors of Memory Lane, said "There's not always four on. They try to call someone in to help. You can't give the same care at the same quality." They described the atmosphere on Memory Lane as "Tense" saying staff were "Under pressure, stressed and frustrated." They added "New staff come but they don't stay. You can't do the job without the staff. When you have a lot of doubles (people who require two staff to support them) like we do, you just start at one end and go around,

you can't give the time you want to people."

Comments from another Care Assistant working on the first floor of Memory Lane regarding staffing included "I really don't think there are enough of us, physically not enough time. We tried explaining (to management) that it's not about numbers of residents up here," "care is minimal; we get what needs to be done, but no more."

On the second day of our visit we inspected The Lodge. There were 27 people living there. The nurse on duty informed us that there were normally five care assistants and one nurse on duty during the day and one nurse and two care assistants at night. Duty rotas seen confirmed these levels.

We observed during our two days inspection that many people on Memory Lane remained in bed. This had been a concern at our previous inspection. We saw however that for some people referrals had been made for assessment of specialist chairs, to enable people to sit out of bed. Staff told us they did not have a sufficient number of staff on duty to enable them to get people up. One member of staff said "It's hard going, we can't get everyone up." Another staff member confirmed this and told us they rotated who they were getting up that morning. They said "People stay two days in bed and the third we get them out". Other comments included "DICE does not enable us to support people living with dementia. The demand is great" and "We are allocated 15 minutes per person for personal care. It can take up to 45 minutes with some people".

Staff also told us that staffing levels had an impact on people receiving their meals in a timely way, especially breakfast. They said they were responsible for providing personal care, getting people up as well as serving breakfast and supporting people to eat where needed. We observed a person sitting in the dining room with a bowl of porridge in front of them at 10.10am. It wasn't until 10.40am that a staff member approached the person and asked if they needed support. The staff member did not ask to reheat the porridge or offered an alternative. Another person's relative visited at 12.15 and we observed the person still had their apron on from breakfast with the relative picking breakfast cereal off the person's apron and bed. Lunch was due to start at 12.30pm. We observed one person was given a glass of prescribed Fortisip (build up drink). By the time breakfast was finished they had not taken a sip so it was moved with them to the lounge. We noted that at 11:40 the person still had the drink next to them.

Speaking with people they told us they felt safe, however did not feel well supported. They said that there were not always staff available when needed and they did not have time to support them in the way they liked. People said "They [carers] do their best but there isn't enough of them", "They [carers] do what they can but appears they need more" and "Staff are not always available. When I want someone, I stand at my door and call and sometimes I have to wait a very long time". We observed on the afternoon of the second day of our inspection a person was sat in the lounge in Memory Lane at 2.30pm. We checked at 15.20 and the person was still sat in the same position, with only interaction when staff brought in a cup of tea. At 15.50 the person was still sat in the same position on their own. We spoke to the visiting relative of this person in the morning who said "Mum is usually left in the lounge with the television on". They also said that at times when they visited in the morning, their family member's breakfast was just "sitting" there.

Accommodation at The Lodge is arranged over three floors. During the day, one care assistant was allocated to work on the ground floor where there were eight people living; two on the first floor where there were eleven and one on the second where there were eight. The remaining care assistant was allocated to provide extra support where needed across the three floors. During the inspection we saw that staff supported each other to provide assistance throughout The Lodge. A care assistant confirmed the staffing levels and said that they felt there was enough staff to meet people's needs. There was also only one stand

aid at the Lodge, which meant staff were rushing from floor to floor when a person needed support with standing. One relative told us this meant people had to wait a long time, for example when they wanted to use the toilet.

We raised the concerns about staffing levels with the manager and operations manager who told us they were reviewing the use of the DICE tool. They said that staffing levels had never been at the level some relatives and staff had suggested. We saw though, this was contradictory to the provider's action plan they sent us in November 2015 that the staffing level on the first floor of Memory Lane and The Lodge was six care staff and one registered nurse in the morning and five care staff and one nurse in the afternoon. The management team told us they had now raised the staffing issue with the regional manager and they had agreed to increase staffing until further reviews had been completed.

This remained a breach of Regulation 18 (1) of the Health and Social Care Act (2008) (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service effective?

Our findings

At the last comprehensive inspection in November 2016 we identified that the service was not meeting Regulation 11(1) (2) (3) of the Health and Social Care Act (2008) (Regulated Activities) Regulations 2014. This was because the requirements set out in the Mental Capacity Act 2005 (MCA) were not always followed when people lacked the capacity to give consent to living and receiving care at the home. People living with dementia were not always supported to make choices. Following that inspection we issued a requirement notice. The provider developed an action plan to address the shortfalls, which they submitted to us following the inspection.

At this inspection we found the provider had taken action to meet shortfalls in relation to the requirements of Regulation 11 described above.

We looked at how the provider was meeting the requirements of the Mental Capacity Act 2005 (MCA) and the associated Deprivation of Liberty Safeguards (DoLS). The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and be as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

Checking whether the service was working within the principles of the MCA, we found mental capacity assessments were not all completed where people lacked capacity to consent to care and treatment at The Wingfield. A senior member of staff told us they were in the process of updating and completing mental capacity assessments, but this was a slow process. Where people had been identified as being deprived of their liberty, the service had made DoLS applications to the supervisory body and was awaiting assessment for the majority of applications. Four applications had been authorised.

One person's care plan stated that they lacked capacity to make decisions about their care and welfare. This was supported by a mental capacity assessment. Evidence in the care plan indicated that the person's next of kin, general practitioner and members of the care team at The Wingfield had been involved in decisions relating to their care and welfare. The relative of a person who lacked capacity confirmed that they were involved in decisions regarding their relative stating "I'm always asked and made aware of things."

Some people had given others lasting power of attorney (LPA) in relation to either their finances or their health and welfare. This gave them the power to take decisions on behalf of the person if they lacked mental capacity. The service had obtained details of LPAs where people had them, however this was not consistently recorded in people's care records. We saw that relatives were signing consent forms, for example for the use of bed rails, however it was not recorded if the relative had the legal power to do so. We also found that where people were unable to consent to a flu vaccination associated mental capacity

assessments were not in place.

We asked a senior care assistant what they would do if a person refused the support they were offered. They replied "Normally go away and try again later." They were aware of issues regarding capacity and consent saying "If they don't have capacity, you need to talk to the family, the team and the GP." We observed staff asking for permission before supporting people.

At the last comprehensive inspection in November 2016 we identified that the service was not meeting Regulation 12 of the Health and Social Care Act (2008) (Regulated Activities) Regulations 2014. This was because people were not always supported to eat sufficient food and records did not accurately reflect what people had or had not eaten. This meant people were not always receiving care in a safe way to prevent risks to avoidable harm. Following that inspection we issued a requirement notice. The provider developed an action plan to address the shortfalls, which they submitted to us following the inspection.

During this inspection we found some action had been taken, for example the implementation of the dining champion. We were told that "The champion attends the nutrition meeting and shares good practice and understands the personal requirements of the residents". However we found similar concerns raised at our previous comprehensive inspection.

We observed a person who appeared frail, was living with dementia and unable to verbally communicate, had their breakfast on a tray in front of them, which they had not eaten. A carer eventually removed the breakfast and reported to another carer that the person had not eaten it. This also happened at lunch time when they had not eaten their soup or their main meal. At no time did a carer sit with the person to encourage them or support them to eat their food, or offer an alternative meal. The unit manager said that this was because the person would not accept a carer supporting them to eat. The person's care plan stated that they required assistance with choosing an appropriate diet and encouragement to eat. A care assistant stated that they felt the person required assistance to eat but that staff were "too rushed."

We found people were not always supported to have their prescribed build up drinks. For example, we observed one person was given a glass of Fortisip (build up drink). By the time breakfast was finished they had not taken a sip so it was moved with them to the lounge. At 11:40 the person still had the drink next to them. We observed another person with a drink of Ensure with them at the dining table. Another person came and sat next to them, taking the drink and was about to take a sip when we had to intervene and called the hostess, who took the drink away. We did not observe the drink being replaced, which meant the person who was prescribed the build-up drink, did not have it as prescribed.

Staff told us meal times were busy and many people needed support with eating. For example, staff were responsible for delivering breakfast and supporting people to eat. A hostess was available at lunchtime to support with the delivering of food in the dining room, however staff were responsible for delivering food and supporting people in their rooms. Staff told us hostesses were not available over weekends. A relative said "More carers are needed at lunchtime, especially as many must help with feeding residents".

Speaking with the chef, they told us that the nurses informed them about people who were losing weight. They said that they provided snacks and finger foods between meals. Also fruit smoothies and bananas were provided. Cream and butter was added to mashed potatoes to increase the calorific value. Whilst on Memory Lane we witnessed staff offering drinks and biscuits between meal times, but no evidence of finger foods, fruit or smoothies. A member of staff said "There's not always finger food available." We observed there were no snacks around for people to help themselves. The dining champion told us there was no reason why snacks could not be left out as the person who used to take all the snacks on Memory Lane was

no longer resident there. Food and fluid charts had been completed and checked by staff to ensure that appropriate action was taken when people did not meet their required target for fluid intake.

People were shown two choices of main meals that had been plated up, in order for them to choose which one they would like. Meals were well presented and appeared appetizing. Pureed food was presented well with each component served individually. However, we found where people were on a pureed diet, the information was not always recorded correctly and speaking with catering staff, they were not aware that there were different textures in a pureed diet. For example in people's care plans it stated the recommendation was for a B or C texture, which referred to a thick or thin puree. This meant that people were not receiving the correct textured diet as recommended by the speech and language therapist.

Where people were prescribed thickeners (to reduce the risk of choking when drinking) we found an increased risk to people due to conflicting information available and the knowledge of the staff. For example one person's care plan stated 1 scoop of 'Nutralis Clear' (a brand of thickener) to 200mls of fluid. The fluid chart stated 2 scoops per 200mls, but did not state the brand of thickener. Different brands of thickener require differing amounts to be added to achieve the same consistency. We asked a care assistant who said they thought it was 3 to 3 1/2 scoops of 'Thick and Easy' in beakers of juice and tea; but added that they would always check with the nurse or senior carer first.

Another carer stated 1 scoop of 'Nutralis Clear' in 200ml. The nurse stated 3 to 4 scoops of 'Nutralis' after reading the instructions on the container. We looked at the records of another person who required the use of thickeners in their drinks. Their care plan said that they needed 'Stage one fluids' using 'Nutralis', but did not state the amount to be used. The fluid chart recorded 2 scoops of Nutralis and a care assistant told us they used 1 scoop per 200mls. The lack of clear guidance and information for staff left the people at higher risk of choking when drinking. We raised this with the nurse and management of our findings who told us they would correct this immediately.

Another person had a tissue viability assessment that indicated that they were at high risk of developing pressure ulcers. Their care plan stated that they required 'an air mattress on setting 3-4.' Neither the type of mattress or inflation pump was stated. The inflation pressure setting for pressure relief air mattresses is dictated by a person's weight. We visited the person in their room. We found that they had been supplied with an air mattress, which had been set at an inflation pressure of 4. The label on the inflation pump indicated that this equated to someone who weighed 70kgs. The person's records indicated that they weighed 53kgs, meaning a setting of 3 would have been more appropriate. Records indicated that the inflation pressure had been checked daily, but staff had not altered the pressure to the correct setting. This increased the risk that the person would develop pressure ulcers.

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

Requires Improvement

Is the service caring?

Our findings

At the last comprehensive inspection in November 2016 we identified that the service was not meeting Regulation 10 of the Health and Social Care Act (2008) (Regulated Activities) Regulations 2014.This was because people's privacy and dignity was not always respected. On Memory Lane we observed staff consistently entering people's rooms without knocking or seeking permission to enter. Following that inspection we issued a requirement notice. The provider developed an action plan to address the shortfalls, which they submitted to us following the inspection.

During this inspection we found that the provider had followed the action plan they had written to meet shortfalls in relation to the requirements of Regulation 10 described above.

Staff spoke positively about the people they were supporting. Staff told us the service no longer used agency staff as carers (only in emergencies), which meant people were receiving more continuity in care. The unit manager said that there had been an increase in the number of registered nurses employed in the home, stating that there were now seven available for day duty and six for night duty. This had been an improvement since our last inspection as the provider had been using large numbers of agency staff, which was impacting on the care people received.

All the people we spoke with in Memory Lane and The Lodge said that the staff were caring and tried to support them the way they liked. A visiting relative told us their family member had been a lot happier since moving to the home. He told us the person liked to look out of the window and look at the world go by. He said he had always found the person by the window whenever he visited. He said, "she is obviously well cared for because she is always well dressed and her hair always looks nice". Another relative commented "The staff in the Lodge are wonderful and caring but under far too much pressure."

One person said "I cannot fault the carers. If I were to set up my own home, I would not hesitate to offer them a job. The carers are not the problem; it is the attitude of the management". Another person told us the care they received was "Marvellous" and said the staff were very "good."

People received care and support from staff who had got to know them well. The relationships between staff and people receiving support demonstrated dignity and respect at all times. We observed staff supporting a person to the toilet. The carer supported the person in to the bathroom and after a couple of minutes left the person alone to ensure their privacy. They returned shortly after to support the person back to the lounge. This promoted the person's independence and respected their dignity.

We spoke with the relative of a person who was receiving end of life care. They said that they were happy with the level of care that had been provided and that they always found their relative comfortable and pain free when they visited. They said "it's been very good, that side of things."

Requires Improvement

Is the service responsive?

Our findings

At the last comprehensive inspection in November 2016 we identified that the service was not meeting Regulation 9 of the Health and Social Care Act (2008) (Regulated Activities) Regulations 2014. This was because care plans were regularly reviewed, but the quality of information within the plans was variable. For some people we saw their care plans stated they needed support with personal care, however it did not state how the person would like to receive their personal care. Some care plans were comprehensive and detailed; others were not and contained conflicting information. Following that inspection we issued a requirement notice. The provider developed an action plan to address the shortfalls, which they submitted to us following the inspection.

People had care plans in place, which were based on assessments of their personal needs. These included communication, personal hygiene, elimination and continence, mobility and moving and handling, tissue viability, nutrition, breathing, pain, sleeping, mental health and cognition, cultural, spiritual and social values and hopes and concerns for the future.

Speaking with a senior member of staff they told us they were in the process of reviewing and updating each care plan. They told us this had been a slow process as staff were not allocated time for the completion of the care plans, but had to fit it in around their caring duties. We saw some care plans had been updated, but found some still contained contradictory information. For example on one person's tissue viability care plan it stated the person should be repositioned 3 – 4 hourly. An entry on the care plan on 17 December 2016 stated repositioning 2 – 3 hourly and another entry 21 April 2017 noted a grade two pressure ulcer. There was no evidence to show the repositioning guidance had been reviewed following the grade two pressure ulcer. This could cause confusion for staff, which meant the person was not repositioned when needed.

The homes policy was that care plans relating to individual needs were to be reviewed each month. We found that this was mainly the case, although there were some exceptions. For example; one person's care plan for tissue viability, who lived in The Lodge, had not been reviewed since 16th April 2017. A visiting health care professional told us they visited the home to complete funded nursing assessments, however the care plans did not always give them the information needed. For example they were looking at a person's mobility care plan, but could not identify if the person was able to walk or if they stayed in bed.

We also found gaps in recording, for example bed rail checks and repositioning charts. We found where a person had been assessed as at risk from falling out of bed, bedrails were being used. The care plan stated monthly inspections of the bedrails were required however records indicated that these had only been checked three times this year so far in January, March and May. There was a 'Bedrail Safety Record' in the persons room, which recorded that 2-4 hourly checks were being carried out, although the frequency of the checks required had not been stated in the care plan or on the chart.

A relative described the activity staff as "exceptionally good" but added "unfortunately they have all left, except for one". Another relative told us "There is a lack of stimulation". They said it would be beneficial for

example if there were more stimulating pictures on the wall. A member of staff confirmed that three members of the activity staff had all left at the same time. There was currently one activity coordinator who was employed for 12 hours a week, for both The Lodge and Memory Lane. Further replacements had been recruited but had yet to start. They stated that care assistants were allocated to help with group activities, but that this did not always happen. Another staff member said "Before the activity staff left it was good; now they are few and far between."

We found people were still left in their rooms for long periods of time, with the only interaction being when staff provided care. People were not supported to follow their interests for example for one person we found it stated in their pre-admission assessment that they enjoyed collecting stamps, reading crime and fiction and watching the news and antiques road show. This was not reflected within their subsequent care plan. They were now restricted to bed and could not leave their room. The last recorded activities visit was 4 months ago in February. Other options had not been considered for this person for example talking books. We found people were still at risk of social isolation and there continued to be a risk to their emotional well-being. The manager told us they had recruited another activities coordinator who were due to start working with the service soon.

This remained a breach of Regulation 9 of the Health and Social Care Act (2008) (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service well-led?

Our findings

At the last comprehensive inspection in November 2016 we identified that the service was not meeting Regulation 17 of the Health and Social Care Act (2008) (Regulated Activities) Regulations 2014. This was because there has not been consistent leadership and consequently the service remaining in breach since the last comprehensive inspection in October 2015. We saw that complaints and concerns were recorded, however found this was not always investigated and responded to in a timely way. Following that inspection we issued a requirement notice. The provider developed an action plan to address the shortfalls, which they submitted to us following the inspection.

We looked at the complaints records and saw that the service had received four written complaints in March 2017. We found that for one of the complaints the relative wrote a second letter of complaint as they had not received a response within the 28 days as per stated by the provider's complaints policy. For another complaint, we saw the initial response of receiving the complaint was sent to the person within the first week, however a response to the outcome of the investigation of the complaint was not sent within 28 days. There was also no response to inform the person that there would be a delay in sending an outcome to the investigation.

This remained a breach of Regulation 17 of the Health and Social Care Act (2008) (Regulated Activities) Regulations 2014.

Since the last inspection, a new manager had been appointed at the service. The manager had submitted an application to the Care Quality Commission (CQC) to apply to become the registered manager. A registered manager is a person who has registered with the CQC 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 and associated Regulations about how the service is run.

Staff told us their morale had been low due to many changes in the management structure. They had not had stable management since 2015. Some staff said they felt positive about having a new manager in post and were hopeful that they would be able to turn the service around. Comments from staff included: "Things have been much calmer since the new manager started" and "Things are picking up. The new manager is liked by staff, he appears calm. He's had a meeting with staff. There was a period of disruption due to management upheaval but it's settling now." Some staff though felt morale was still low commenting "It's not a happy place at the moment." And "There have been lots of changes. It's tense at the moment." The manager said they were realistic that changes wouldn't happen imminently, but that they were looking around the service and listening to staff to prioritise where to start.

A visitor whose mother lived on Memory Lane said that following the change of manager, they felt the home had "turned the corner" adding they were "positive about the future as things were more settled."

The manager told us they had recruited a new deputy manager who would be joining the service soon. The manager was currently supported by a regional manager and was in the process of completing their

induction at the time of our inspection. The manager told us their ethos was "Life is about living" and they wanted to change the culture within the home.

A relative commented "Someone needs to pull up their boot straps and whip this place back into shape like it was when we first came. Many have paid their life savings to live here and it needs to be made a comfortable home again.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care Care plans were reviewed, but the quality of information within the plans was variable and contradictory. Care plans were not person centred and people were not supported to follow their interests.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance We saw that complaints and concerns were recorded, however found this was not always investigated and responded to in a timely way.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were not always supported to eat sufficient food and records did not always reflect what people had or had not eaten. This meant people were not always receiving care in a safe way to prevent risks to avoidable harm.

The enforcement action we took:

Warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Sufficient numbers of staff were not deployed fully to meet people's needs for person centred care.

The enforcement action we took:

Warning notice