Indigo Care Services (2) Limited

Lofthouse Grange and Lodge

Inspection report

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13 June 2018

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on 6, 12 and 13 June 2018 and was unannounced. This was the first inspection undertaken since the service was registered in December 2017. The inspection was prompted in part by notifications sent to us that raised concerns about people's care.

Lofthouse Grange and 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. Lofthouse Grange and Lodge accommodates up to 88 people over two communities, referred to as 'The Lodge', which accommodates people living with a dementia related condition and 'The Grange', which accommodates people requiring residential care. There were 72 people living in the home when we inspected.

At this inspection we found four breaches of the Regulations of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. 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 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.

There was a registered manager in post at the time of the 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.

There were not enough staff to meet people's needs effectively. There was a high turnover of staff and staffing levels were impacted due to sickness and absence. People, their relatives and staff told us they had concerns with staffing levels. There was a high number of agency staff used with the service, and people, their relatives and staff told us they had concerns about continuity of care and competence of agency staff.

Systems and processes around medicines management were not safe. Specifically, we found concerns with the safe storage, administration practice and documentation of some medicines.

Safeguarding referrals were not always made appropriately and there were a high level of falls and incidents which had not been managed effectively. This meant appropriate action had not been taken to manage known risks effectively and reduce the possibility of their recurrence

We found concerns over the cleanliness of the service through our observations and what staff told us. We found malodorous water jugs and dirty fridges. Wheelchairs and pressure mats were often unclean. Automatic hand gel and soap dispensers across the service were not working which put people at risk of cross contamination. Cleaning rotas were sometimes incomplete and had not been reviewed.

The inadequacy of the governance arrangements meant shortfalls were not identified and subsequently preventative action was not taken to mitigate risks. The shortfalls we identified during our inspection had either not been highlighted by the providers internal quality assurance processes, or had been identified with action taken but these actions were not sustained.

People, their relatives and staff told us they thought that permanent staff received good training. However, they said that agency staff were not always sufficiently skilled to meet people's needs.

Staff gave mixed feedback on their levels of support through supervisions and appraisals. Staff were recruited safely, with appropriate identity checks and references undertaken.
The service was compliant with and acted under the principles of the Mental Capacity Act (2005).

We observed mealtimes and these were pleasant experiences, however, recording of people's dietary needs was not always up to date.

People told us staff were kind caring and compassionate, however due to other factors the service was not always able to deliver a wholly caring service. Staff were able to describe how they would protect people's dignity and privacy, as well as promote their independence.

People were assessed appropriately before using the service. Some care plans we reviewed contained good person-centred plans specific to their needs, however in other care plans the quality of information recorded was not always consistent.

Whilst activities were provided by the service and people enjoyed these, some people felt they could do more. Staff said they could not always give people the stimulation they felt they needed. Recording of activities was not always consistent.
There was a complaints process and policy in place. People and relatives were aware of the process but gave mixed feedback about it. Complaints we reviewed were responded to in line with the policy.

Staff told us they were not confident in the leadership of the service and that morale was low. People and their relatives gave mixed feedback on the management of the service.

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?

Inadequate

The service was not safe.

There were not enough staff to meet people's needs. People received poor continuity of care and we observed people had to wait for basic care and support.

Medicine were not managed safely, which meant we could not be assured people received their medicines in a timely and safe way.

Safeguarding referrals were not always made in a timely way. Falls and incidents were not always managed effectively.

The service was not cleaned and maintained to a high standard.

Is the service effective?

Requires Improvement

The service was not always effective.

People told us that while permanent staff were trained well, agency staff were not always wholly competent to meet their needs. Staff gave mixed feedback around support through supervisions.

Records around dietary preferences were not up to date, however, the lunchtime experiences we observed were positive.

People told us they were able to access healthcare professionals where necessary. The service was compliant with the principles of the Mental Capacity Act (2005)

Is the service caring?

Requires Improvement

The service was not always caring.

While staff were often kind, caring and compassionate, due to other issues they were not always able to deliver a wholly caring service.

Staff supported people to maintain their independence and this was emphasised in people's care plans. Staff told us how they

respected people's dignity and privacy but we observed that people's dignity and privacy was not always respected.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans contained person- centred plans with reference to national guidance, however some plans did not contain an appropriate level of detail to ensure staff could meet their needs in line with their preferences.

People and staff were complimentary about activities staff but they also told us they felt that activities provision could be improved. Records around what activities people participated in were not always complete.

There was a complaints process in place and people and their relatives knew how to make a complaint.

Is the service well-led?

Inadequate

The service was not well-led.

The provider had systems in place to monitor and improve the service, however these were not effective in identifying the concerns we found or driving improvement. We found audits that did not identify how to make improvements, and records that were incomplete or not stored appropriately.

The leadership and culture of the service was not positive. Staff gave negative feedback about morale and management of the service.

People and their relatives we spoke with gave mixed feedback about the management of the service.

Lofthouse Grange and 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.

This inspection took place on 6, 12 and 13 June 2018 and was unannounced. This inspection was conducted by two adult social care inspectors and two experts-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.

Prior to the inspection the Commission had received a number of concerns. These related to recent safeguarding incidents at the service.

Before the inspection we reviewed the information we held about the service. This included looking at information we had received about the service such as statutory notifications. Statutory notification are changes, events or incidents the provider is legally obliged to tell us about within required timescales. We also contacted the local authority for feedback.

Prior to our inspection, the provider had been asked to complete a Provider Information Return (PIR). This is a form that asks the registered provider to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection we spoke with 14 people who used the service, nine relatives of people who used the service and 15 staff. These included the registered manager, deputy managers, senior carers, carers, a chef and a domestic member of staff.

During our inspection we used a method called Short Observational Framework (2) for Inspection (SOFI 2).

This involved observing staff interactions with people in their care. SOFI (2) is a specific way of observing care to help us understand the experience of people who could not talk with us. We looked at care plans and associated records for nine people, records relating to staff recruitment, training and support, records of accidents and incidents, policies and procedures and quality assurance. We observed care, support and activities being delivered in communal areas as well as a lunchtime experience.

Inadequate

Is the service safe?

Our findings

People using the service, their relatives and staff told us there were not enough staff deployed effectively to meet people's needs.

Staff we spoke with highlighted staffing levels as a serious concern. Staff comments included, "Staffing is not enough. Since the registered manager has come in, staff (have) left from their attitude and the way they do things. People are not working their notice. Since June 2017, loads have left. I've never seen as many leave.", "There are not enough staff. Lots of residents are not really suited here. There are high challenge residents, we need training. We have regular agency. Lots of staff leave. It's difficult for residents, some don't recognise agency", "There are only two staff on the ground floor, not three as we've been told. They used to have a floating member of staff but now they don't. Sometimes there is only one staff on each floor, this is unsafe. One person may often need three staff as she is hard to support. Staff morale is at rock bottom."

Relatives we spoke with highlighted concerns with staffing. Comments included, "[Name] was left needing the toilet and could not wait. It is undignified for them. I have seen it happen with another person too. It is very upsetting. There just aren't enough staff.", "We think they need another staff member in the afternoon, they seem run off their feet and sometimes you hear them say to people 'I can't take you down, I am on my own.' One service user said, "I sometimes wonder if there is anyone working in this building, it happens on a daily basis." Another service user said, "There aren't many staff around which means I have to wait for assistance."

There was a high turnover of staff. Between February and April 2018 in The Lodge there was a 29% turnover of staff. There was a high level of agency staff used on a regular basis, which was as high as 45%. In The Lodge there were 900 vacant hours in February, this had reduced to 700 in April. Agency staff as a percentage varied by week. On The Lodge, this was between 17% and 47%. The registered manager said, "The average across the service is 35-40% agency, on nights this is around 50-60%." During our inspection we observed people waiting for care and support. One person required 'one to one' observation whenever they were not in their room due to a safeguarding incident, however on two occasions during the inspection we observed them unattended. People were waiting for care in the communal areas and in their rooms. We also saw that from time to time the communal areas of the units were not be supervised by staff who were busy supporting people in their rooms. Call bells were continuously sounding throughout both units on all three days of our inspection.

Staff were often required to carry out an additional number of domestic tasks which we saw took them away from providing care for people. This included making beds, cleaning tasks during the day and night, plating up meals for people, washing pots and serving breakfasts. We also looked at the service's dependency tool for The Grange, a dementia unit where people required the most support. The dependency tool was used to calculate the level of need for each person and show how many staff were needed to support people on each community. It gave them a green (meaning low dependency) amber (meaning moderate dependency) and red (meaning high dependency) rating. Nobody was judged to be at high dependency and of 47 people only nine were recorded as moderate dependency. This meant that according to the service's calculations,

enough staff were provided, despite our observations and concerns raised to us about staffing levels and people's support needs.

We concluded the above evidence demonstrated a breach of Regulation 18 (Staffing) of the Health and Social Care Act (2008) Regulations 2014 (Regulated Activities).

Medicines management was not always safe. We observed medicines administration. One person was handed their medicine, staff did not witness them take their medicine however, they recorded they had. Another person's medicine was dispensed into a pot and left in the medicines trolley by staff. This meant staff may not know who the medicine was for and is not considered good practice.

We found medicines storage was not always safe. Medicines in stock, and those that were to be disposed of as they were no longer required were intended to be stored in lockable cupboards, however, we found they were unlocked. This meant that medicines could be accessed and ingested by vulnerable people who were living with dementia

We also found that medicines no longer required or refused were not correctly entered onto the service's medicines returns record while awaiting disposal. These included sedatives which required secure storage which subsequently put people at risk.

We found systems and processes for providing 'as and when required' (PRN) medicines were not robust as we found incidents where appropriate guidance was not in place. For example, we found one instance where the recorded reason for the medicine being given was 'pain'. NICE (National Institute for Health and Care Excellence) guidance (Managing Medicines in Care Homes, 2014) states that PRN protocols should record in detail why people need the medicine.

The service was not always maintained to a high standard of cleanliness. We found equipment people used such as protective mats and wheelchairs were not clean, and were often stained or in poor repair. One relative we spoke with said, "We saw staff stand and walk on the mats and we haven't seen them cleaned". One member of staff said, "This place used to be spotless, it looks run down. It used to be kept clean. With agency on nights, our staff used to gut the place but agency don't. There aren't enough domestic staff. We are a dementia unit, two people across the whole service isn't enough." We saw in a staff supervision meeting one staff member said, 'I'm fed up of not having enough cleaners'. We found that cleaning rotas were not always completed, and that wheelchairs were absent from cleaning schedules. During our inspection we found a heavily soiled bathroom, when we raised this with the domestic member of staff they said they had not been able to clean people's toilets despite having been on shift for two hours.

Fridges, kitchen cupboards and work surfaces were not clean. Fridges contained items such as jam, sauces and cream which had not been labelled to show when they had been opened. This meant people were at risk of eating food which was not safe to eat. Plastic containers used to store cereals on the top floor of The Lodge were dirty and stained. One did not have a lid. Plastic jugs used for water and juice on the top floor of The Lodge were stained and malodorous. We found that all dishwashers and sterilizers at the service were broken and had not been working for two weeks. This meant staff had to clean these items by hand at mealtimes and were not able to sterilize them.

We found that automatic gel dispensers across the service were not working. We observed people using the toilets and going to their lunch, however, they would have been unable to wash their hands with soap as the dispensers were not functioning. When we raised this with the service they told us that maintenance staff were aware, however, there had been no action taken in the interim to provide people with access to anti-

bacterial products in communal bathrooms. This meant people were at high risk of cross contamination due to the inadequate actions of the provider.

Personal protective equipment (PPE) such as gloves and disposable aprons were available, however, this was kept in a locked box on each floor. Staff told us if the person who had the key was unavailable, this caused a delay in staff accessing PPE in order to respond to accidents and cleaning tasks. One relative said, "All gloves are locked in a cupboard and when staff need them they have to wait until they can get the key and then get the gloves." One member of staff said, "Management took the keys away, you can't get gloves if you have an emergency if you can't get the key." We saw in a staff supervision meeting from January 2018 one member of staff said, that they had a problem with 'not having PPE to hand.' The registered manager told us they would alter this practice to make it easier for staff to access PPE.

During our tour of the premises we were able to access an unlocked laundry room and an unlocked sluice. This placed people at risk of harm as they were able to access areas and products that were not safe. We found that shower rooms which were being used as storage areas were not locked and there was no signage to indicate that this was the case. In one communal bathroom on The Lodge we found a red bag inside a laundry basket and contained clothing. Red bags indicated their contents were soiled, it was unclear why or how long this had been there. This meant that people were able to access this.

We concluded the above evidence demonstrated a breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act (2008) Regulations 2014 (Regulated Activities)

People were not always protected from harm. There were a high number of falls and incidents recorded. There were 42 falls recorded on The Lodge unit since February 2018. These had not been referred to the falls team, despite one person falling 12 times in six months. The action stated on the falls management audit for all falls was 'refer to falls team by 20 June 2018'. In March according to the internal key performance indicator report falls had increased by 209% on the previous month, the action recorded was 'step mats in place'.

We saw one example of a large skin tear that was not investigated appropriately or raised with safeguarding despite the severity of the wound and a lack of explanation as to why this had occurred. There were also 13 safeguarding referrals made since February 2018 on The Lodge.

We concluded the above evidence demonstrated a breach of Regulation 13 (Safeguarding Service users from Abuse or Harm) of the Health and Social Care Act (2008) Regulations 2014 (Regulated Activities).

Staff received training in safeguarding vulnerable adults and were able to describe how they would identify and raise potential abuse. One member of staff said, "You report it, it sets the ball in motion. If you see it, you report it. It could be people having a fight with each other or if you saw a member of staff verbally abuse someone."

The service conducted a range of health and safety checks, such as gas safety and electrical safety checks, however, we noted that some of these checks such as the LOLER (Lifting operations and lifting equipment regulations 1998) and electrical safety checks had not been completed in a timely way. The electrical safety check was due to expire on 22 April 2018 however, this had not been completed until after that date. We were assured the check had been completed before we concluded our inspection. Load bearing equipment such as bath lifts and hoists displayed out of date certificates of inspection which showed they were due for re-inspection on 14 May 2018. Although we were provided with evidence the checks had been carried out, equipment still displayed out of date information.

We reviewed risk assessments, both for the service as a whole and for individual people. There was a fire safety risk assessment in place and associated fire safety checks were carried out. However, we found a fire door on the top floor which was designed to close automatically was not working. We raised this with the registered manager who told us this would be reported to maintenance staff. There was a business continuity plan in place which provided a scheme of delegation and actions for staff in the event of a serious disruption to the business such as a natural disaster or power cut. There were also individualised risk assessments such as moving and handling and mobility risk assessments for people.

Staff were recruited safely. We reviewed five recruitment files. They included an application, interview notes, professional references, relevant qualifications, and a valid DBS (Disclosure and Barring Service). The DBS is a national agency which uses the police national database to help employers make safer recruitment choices.

Requires Improvement

Is the service effective?

Our findings

We received mixed comments about the training and competency of staff. For example, one relative we spoke with said, "Definitely the permanent staff but not some of the agency staff. We have had some problems with them, for instance one brought our relatives pudding in before their dinner, a permanent staff member came in straight away and was upset about it because they had done it to someone else." Another relative said, "Staff training seems fine but I wonder if the agency staff have the level of expertise." One senior member of staff we spoke with said, "The training is good for us, don't think agency do the same. I feel some agency staff don't have the right training." Another member of staff said, "Yes training is okay, we need more on the new electronic care plans." We reviewed the files the service held for agency staff. These included a photograph of the staff member, DBS information and their induction to the service. This included fire safety, call bell systems, accidents and incidents, and a record of what qualifications they had. It was clear that agency staff had received training and were qualified to practise health and social care.

Permanent staff received a comprehensive induction to the service and completed training the service considered mandatory. This included basic first aid, fire safety and safeguarding adults. One member of staff said, "For my induction I did shadowing shifts where I followed the guidance of experienced staff and had my medicines competencies observed, it was good." The service monitored compliance with training needs with the aid of a training matrix.

Some staff told us they received supervision meetings where staff held recorded discussions with managers about their performance and needs and annual appraisals of their performance, however, others did not. One senior member of staff said, "Supervisions are every couple of months, they let you know when training is due. There aren't many spot checks. It depends who does the supervision. Staff are happy to chat with senior staff but not the registered manager." Another staff member said, "I have lots of one to ones and observations." We also spoke with two members of staff who said they had either not had supervisions or had not had one for a long period of time.

The Mental Capacity Act (MCA) 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 make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). There were policies and procedures in place for completing mental capacity assessments. Mental capacity assessments we reviewed were completed adequately and best interest decisions were made with the input of a multi-disciplinary team. Applications were made for DoLS where necessary. These were tracked and followed up by the registered manager.

When people had a lasting power of attorney (LPA) appointed on their behalf this was documented clearly.

An LPA is a legal agreement that lets people appoint others to help them make decisions on their behalf over a specific area such as finances.

We observed two lunches at the service; on The Lodge and another on The Grange. Staff were helpful and encouraging, food appeared to be of good quality and well presented. However, one person on The Grange had to remind staff they were allergic to eggs as they did not know. We spoke to the chef who was knowledgeable around people's dietary preferences and needs. For example, if people required pureed food due to swallowing difficulties. Vegetarian and food for religious diets were available upon request. However, records around people's dietary needs were not always up to date. The kitchen had a record book which recorded each person's dietary needs. This was last reviewed in April 2018 and did not accurately reflect people's needs as we saw one person who was provided with pureed food as per prescription during lunch yet the record book stated they did not have special requirements. This information was held in their care plan. When we asked staff how the chef knew who required specialised diets, they replied, "They just know." This placed people at risk as staff may not know what support people needed to eat. The registered manager told us they would update the document immediately.

The Lodge side of the service was designed for people living with dementia related conditions. Corridors were brightly lit and doors were painted in distinctive colours. Communal rooms were signed clearly and the decoration was generally pleasant with plenty of pictures on the walls.

People told us they had good access to healthcare professionals and staff were prompt in getting help if needed. A GP visited every Thursday to hold a clinic. Visits conducted by health professionals were recorded in people's care plans detailing why the referral had been made and what the outcomes were.

Requires Improvement

Is the service caring?

Our findings

People and relatives told us staff were kind and caring in their experience. However, staff were not supported by the provider to deliver a wholly caring service. Due to shortfalls we found in staffing, governance and cleanliness, people did not always receive a consistent quality of care. For example, one member of staff said, "I feel very rushed around, I can't always speak to residents."

During our inspection we observed staff treated people in a way that respected their privacy and dignity, for example staff knocked on doors and asked to enter before going into people's rooms. However, people's dignity and privacy was compromised by other factors. For example, we observed people using communal bathrooms that did not have soap. A relative told us they had to wait too long for assistance for their family member to go to the toilet which had resulted in an accident related to their continence. We found five pairs of glasses during our inspection which no staff we spoke with could tell us who they belonged to across the medication room, laundry and kitchenette. We also found a set of false teeth in the laundry and staff did not know who they belonged to. One member of staff said, "If someone had an accident for example, we would take them to their own room, shut doors and help them to calm down. I love helping people one to one with privacy but it's about finding the time."

Although people praised permanent staff they raised concerns over continuity of care. One relative said, "Staff deserve medals. They are always nice and polite." One person we spoke with said, "They are very caring, more like friends." However, because staff often changed and agency staff were often employed, people did not receive good continuity of care. One person said, "[Agency staff] are kind but I cannot understand them." One relative we spoke with said, "The large number of agency staff particularly on the dementia unit is a concern because the necessity to anticipate needs and continuity is important. Agency staff have no idea how to interact with people because they do not know them." Another relative said, "I've noticed the number of agency staff. They don't know people. I know all the staff, but they aren't helped when other staff don't know people like they do." Another relative said, "Regular staff here are good but they keep leaving as they are unhappy with the management."

Staff told us they gave people as much independence as they could by helping them make decisions for themselves. One person we spoke with said, "They encourage me to independent." One member of staff said, "We always offer choices, selections of clothes, we help people choose their own gels and perfumes."

During lunch observations we saw staff helping people who were living with dementia related conditions choose what they wanted to eat by offering up plated options for them to pick. We saw care plans which instructed staff to think about independence. One care plan we reviewed said, "Respect [Name's] wishes and choices. Try and assist them to be involved socially."

The service understood the role of advocates in people's lives and this was evidenced in documentation, for example involvement in best interest's decisions. Advocates are individuals nominated to make important decisions on behalf of vulnerable people.

Requires Improvement

Is the service responsive?

Our findings

People were assessed appropriately before using the service. This included obtaining information about their medical history, social and professional network, communication needs and spiritual or cultural needs.

Care plans varied in the quality of information provided. We reviewed five people's care plans. In one care plan we reviewed, the person required high levels of support from staff but there was no information relating to their interests and activities. We saw 'N/A' was recorded for their interests and in another care plan we reviewed there were no likes or dislikes recorded for the person. We raised this with the registered manager who told us they would revisit this care plan. In others, there was good person-centred information, for example; "[Name] likes to walk around the unit and talk about weddings and photos they have." In another person's communication care plan however it guided staff to 'Show [Name] patience and understanding' which was generic. Care plans were stored electronically. Staff accessed care plans by using mobile phones and inputting daily notes.

All care plans had photographs of the person available to make identification simple. Care plans included personalised risk assessments and used national guidance to inform them, for example the Cornell depression scale, Malnutrition Universal Screening Tool and Waterlow skin assessment tool. There were individualised care plans specific to people's needs, for example inappropriate behaviour care plans. Due to the electronic nature of the care plans, they automatically flagged when they were due for review to ensure they remained relevant to people's needs.
Care plans contained sections on people's wishes in respect of end of life care. Where appropriate, 'do not attempt cardiopulmonary resuscitation' orders were in place in people's care plans. Care plans also recorded people's religious and cultural wishes sensitively.

There were activities taking place, for example we observed a fruit tasting and crafts morning which people seemed to enjoy. People were complimentary about the activities staff; however, people felt they wanted to do more. One person said, "The home is okay but there isn't much to do." Another person said they loved gardening but desperately needed to be taken out more or speak to people on their level. Another person said, "Activities are good, we had a donkey visit." One senior member of staff said, "The two activities coordinators job share, but they also do care work. They always think of things to do, for example, we had a Grease day to celebrate the movie, we have had some training on activities but we don't get to use it." Another member of staff said, "It is a big home for two part-time staff. We don't want one floor to have no activities because of this." Another member of staff said, "The activities girls are brilliant, love the residents and love making them feel special. They don't always have time for one to one though."

Recording of activities was variable. Care staff were directed to record all 'interactions' and activities electronically. One person had 10 'interactions' recorded between 1 June and 12 June 2018, whereas another person had only two recorded within the same timeframe. There was also a function for staff to record how much time people spent outside, however, it was evident this was not used in the five care plans we reviewed. One member of staff said, "It's hard to log them (activities), sometimes it isn't logged."

There was a complaints process in place. We reviewed the complaints file and found that formal complaints were responded to in line with the provider's complaints policy. People gave mixed comments about the service's responsiveness to complaints. One person said, "I would just say, can I have a quiet word? And ask could you do something that way, I feel comfortable doing that." Relatives told us they were aware of the complaints policy.

Inadequate

Is the service well-led?

Our findings

Although there were quality assurance processes in place, they were not always robust in identifying and addressing shortfalls in practice.

We found audits that were incomplete or did not take place. A medicines audit in March 2018 which looked at a sample of medicines care plans and MARs gave a score of 25% compliance overall with standards and that of five people sampled five did not have correct PRN protocols in place, however, there were no actions generated as a result. The medicines audit for April was also incomplete and a compliance score was not given, and where faults were identified such as PRN protocols there were no actions. This meant the audit was ineffective in monitoring and driving improvement, as PRN protocols had been identified as failing to meet standards yet there was no evidence of action taken or improvements made. A tissue viability audit conducted on 6 June 2018 showed that of 72 points available the service scored 12 for compliance, showing that body maps and the malnutrition universal screening tools had not been updated as required. However, there was no date for these actions to be completed and this was not added to the service's comprehensive action plan.

The falls audit showed a number of falls which had occurred over a six-month period, including one person who had fallen 12 times in six months, however, the action for each person was 'refer to falls team by 20 June 2018.' It was unclear why these referrals had not been made earlier, and no additional actions evident to address the root cause of falls. One senior staff member said, "With falls it's distressing, one lady had lots of falls, she has equipment in place. We encourage her to use the equipment. We've had telecare out but not the falls team." This meant that although an audit had taken place and falls were recorded, actions taken were ineffective and showed the service failed to gain professional advice and guidance in a timely way. Subsequently people were at risk of not receiving help to reduce the risk of falls.

Other records we found were not always completed properly. We found that domestic cleaning tasks were not always checked regularly and that these tasks did not include cleaning equipment such as floor mats and wheelchairs. We found gaps in cleaning schedules and rotas. We found an error in weight recording which showed a person had lost over 10kg in a week and this had not been identified or acted upon until we discussed with the registered manager why this had happened and they told us it was an error of recording. Weekly handover sheets did not contain required information about people which included their date of birth, medical condition and next of kin. Despite checks being in place for these documents we saw no actions had been taken to address this.

Records were stored inappropriately. The service used a store room which was full of boxes of records which were not archived or labelled in an organised fashion. The registered manager informed us the documents went back 'years' and was due to a performance issue that they were taking action on. However, we remained concerned that action had not been taken in the interim to address this. After we raised this with the provider's improvement team by the end of the inspection these documents had been removed and stored in a more appropriate way.

The registered manager, deputy and senior staff conducted daily walk arounds, however, it was unclear from the records what actions were taken when incidences of non-compliance were found. For example, we reviewed all daily walk arounds between 4 and 25 May 2018 and saw that in nine of them there were multiple rooms, sometimes as high as 13 rooms, found without fresh water jugs in them. It was not recorded what action was taken, or if this had been identified as a recurring theme. Walk arounds did not identify cleaning issues we found during our inspection, indicating that this was not effectively implemented.

The provider had recently brought in an improvement team to tackle issues they had found from their own internal quality monitoring processes. This had resulted in a comprehensive action plan with over 200 items on it at the time of the inspection. Some issues identified had been completed and sustained, such as improving mandatory training rates to over 90%, however other improvements signed off as completed had not been sustained. This included an up to date dietary list which was inaccurate at the time of the inspection, safeguarding monitoring compliance, and cleanliness and infection control which we identified as requiring improvement. It was clear that improvements made were therefore not sustained. The registered manager added some of these issues to the comprehensive action plan. Staff we spoke with did not know who the improvement team where.

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

All staff we spoke with were not confident in the leadership of the service. Some staff told us they felt the management team were unapproachable. Comments included, "I can't speak to them, I don't I feel I can go to the registered manager.", "I think the registered manager is approachable, but carers prefer to come to me rather than the registered manager.", "I feel I can approach management, before as a carer I didn't. They (carers) feel that way."

We saw staff meetings took place where discussions were held about updates and issues related to people using the service, however these were not well attended by staff. Two staff members we spoke with said, "Staff meetings are a waste of time", while another said they had been unable to attend but that minutes were provided.

Staff commented that morale was low. Comments included, "I wouldn't recommend the service and wouldn't have my family here. I'm only staying for the residents.", "I'm happy to do the work, just not like it was, morale is so low. I can't fault staff, they work hard, we get put down by management."

People and relatives of people using the service gave very mixed feedback about the leadership of the service. Positive comments included, "There's never an uproar and things tick over", "It's run like a well-oiled machine, no one is running about not knowing what they are doing and no one is failing.", "The staff who have been here a while are good, it's well managed in that sense." Negative comments from people included, "I don't know who the manager is", "I can talk to the manager but there are no actions." One relative said, "The management are not approachable, it isn't well run, the manager never comes out of their room and does not know the residents." Another relative said, "Managers never do what they say."

We looked at notifiable incidents and found that not all notifiable incidents were reported in a timely way. We have referred to this in the safe domain.

The service sent an annual survey to people however at the time of the inspection, the data was unavailable and had not been analysed.

The service had some links to other organisations, for example the service made use of its links to other services operated by the provider. One member of staff said, "We had high tea together with people from two nearby services we are very close."

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 12 HSCA RA Regulations 2014 Safe care and treatment Medicines management was not always safe which meant that people were at risk of not receiving their medicine as prescribed. The service was not maintained to a high standard of cleanliness which left people at risk of cross contamination.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Incidents were not always safeguarded appropriately. There were a high number of falls which were not referred to the falls team.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Quality assurance processes were not effective in identifying concerns or driving sustained improvement.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were not enough staff deployed effectively to meet people's needs.