HC-One Oval Limited

Godden Lodge Care Home

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

About the service:
Godden Lodge Care Home provides accommodation, personal care and nursing care for up to 133 older people. Some people have dementia related needs and some people require palliative and end of life care. The service consists of four houses: Victoria House, Cephas House, Boyce House and Murrelle House.

People's experience of using this service:
Not all people felt well cared for or treated with dignity and respect. Staff routines and preferences took priority over consistent care and meeting people's preferences and wishes.
People were not routinely supported to take part in social activities, relevant to their interests, preferences or needs. There were insufficient activity coordinators available to facilitate activities.

People's comments about staffing levels were variable. The service did not always ensure there were enough staff with the right skills and experience to support people. This was because there was high agency usage across the service. Staff did not always have the time to give people the care and support they needed. Staff regularly felt stretched, and the focus was on completing tasks rather than on providing person-centred care and support.

Information about risks to people's safety was not consistently identified and recorded. Some staff practices placed people at potential risk of harm. Medicine practices did not ensure the service followed relevant national guidelines. People did not always receive their medicines as prescribed.

People were not always protected by the service's prevention and control of infection procedures as the premises were not as clean and hygienic as they should be.

Staff training was not designed around the care and support needs of people who use the service. Training was not embedded in staff's everyday practice. Staff supervision and support was not consistent, and improvements were required.

• Care records were not always accurate, up-to-date or followed by staff. People were not always involved in decisions about their care and support. People's end of life care needs were not clearly documented.

People stated they were safe and supported to eat and drink enough. People's healthcare needs were monitored, and they received access to healthcare services. Consent to care was always sought and people's capacity to make decisions assessed.

People, relatives and staff did not feel the service was always well-led. Governance and performance management arrangements were not always reliable or effective.
Rating at last inspection:
Following the last inspection, the rating of the service was 'Good' (Last report published October 2017).

Why we inspected:
This was a planned inspection based on the rating at the last inspection of 'Good'.

Follow up:
We will continue to monitor intelligence we receive about the service until we return to visit as outlined in our inspection programme and schedule. If any concerning information is received we may inspect sooner.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

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

The service was not always safe

Details are in our Safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective

Details are in our Effective findings below.

Is the service caring?

Requires Improvement

The service was not always caring

Details are in our Caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive

Details are in our Responsive findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led

Details are in our Well-Led findings below.

Godden Lodge Care Home

Detailed findings

Background to this inspection

The inspection:
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) 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 Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Inspection team:
The inspection team consisted of four inspectors on two days [Two Inspector's, Assistant Inspector and Bank Inspector]. The inspection team was accompanied by two experts by experience on the first day of inspection. An expert by experience is a person who has personal experience of using or caring for someone who uses care services. In this instance, services for older people and people living with dementia.

Service and service type:
Godden Lodge Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. At this inspection 107 people were living there.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection:
This inspection took place on the 3 and 4 April 2019 and was unannounced.

What we did:
Before the inspection, we reviewed information we had received about the service since the last inspection. This included details about incidents the provider must let us know about, such as abuse. We also sought feedback from the local authority and other professionals involved with the service.

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.

During our inspection visit, we spoke with 20 people using the service, 14 relatives and 16 members of staff [house managers, qualified nurses, senior care staff and care staff]. We also spoke with the registered manager and Area Quality Director. We observed the support provided throughout the service. We looked at records in relation to people who used the service including 18 care plans and 30 medication administration records. We looked at records relating to staff recruitment, training and systems for monitoring quality.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm

Some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed. Regulations may or may not have been met.

Assessing risk, safety monitoring and management; Using medicines safely; Learning lessons when things go wrong

• Not all risks for people were identified. On Murrelle House, one person had bedrails in place to prevent them from falling out of bed. No risk assessment was completed to assess the potential risks posed by having this equipment in place. On Cephas House one person's care plan referred to them living with a mental health condition. The care plan stated they were at risk of committing suicide. Potential risks, for example, ligature points had not been considered. Ligature points refers to anything which could be used for hanging or strangulation.

• Where risk assessments were in place, these did not clearly identify how risks to people's safety and wellbeing were to be reduced and the actions required to keep people safe.

• Not all staff were aware or understood risks posed to people using the service. On Boyce House, one person had an alarmed floor mat positioned by their bed as they were at high risk of falls. The equipment was in place to maintain the person's safety and to alert staff at the earliest opportunity to the person getting out of bed. This was not plugged in and when discussed with a member of staff they were unaware of this or that the person was at high risk of falls. This was also noted for one person living on Victoria House.

• Suitable arrangements were not in place to ensure the proper and safe use of medicines. There were unexplained gaps on Medication Administration Records [MAR]. This was a recording issue as we found the medication had been dispensed.

• One relative on Cephas House raised concerns that their family member did not always receive their time critical medicine when they should. They told us, "They [qualified nurse] often seem to be late with bringing their [relative] tablets, their Parkinson's medicine has to be given at the right time, they've been late quite often."

• The MAR forms for three people detailed they were prescribed a PRN 'when required' medication for 'aggression and agitation'. Medicines with a 'when required' dose are offered to people outside the normal medicine round. The MAR forms recorded occasions whereby this medication was administered. The rationale for this decision by staff was not recorded on the reverse of the MAR form and provided no evidence to indicate the person had been anxious or distressed at these times.

• Where people were prescribed a topical cream to be administered each day, records to confirm this had been applied, were not routinely completed. Handwritten MAR forms were not double signed to ensure these records were accurate and recording errors minimised.

• Safety concerns were not consistently identified and improvements and learning from events were not always made when things went wrong.

People's care and support needs were not provided in a safe way and risks to people were not recorded to

evidence how risks were to be reduced. Medication practices and procedures were not always followed. This demonstrated a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
• People's comments about staffing levels were variable across the service. One person on Cephas House told us, "The staff are kind but they're always busy and need to get to the next thing. When I press the buzzer [call alarm] I sometimes wait a long time before anyone [staff] comes, especially if there's only two staff on. I don't like sitting on a dirty pad but don't have a lot of choice. There does seem to be a lot of agency staff, particularly at weekends." One person on Murrelle House told us, "I don't get a shower as often as I'd like, they [staff] don't have time to do many." On Victoria House one person told us, "Only bugbear is the buzzer [call alarm]. It takes ages for them [staff] to come, depends how many staff are on. Longest wait is over an hour in the mornings, it frustrates me. I wait until the second shift comes on, they are better than the night staff. They are so short staffed, they [staff] cannot do what you want, they cannot sit and chat, they are so busy."
• Relatives repeated what people told us. On Boyce House one relative told us, "They are short of staff, mornings are worst, they have lots of agency staff. Staff used to go around and talk to them [people using the service] but you rarely see them sit and talk to them now."
• Observations demonstrated there was high usage of agency staff deployed at Godden Lodge Care Home. People using the service, relatives and staff confirmed this could have a detrimental impact on the quality of care provided and received. A permanent member of staff told us, "It puts more pressure on us when there are agency staff. They [agency staff] don't know what to do to support them [people using the service]." The Area Quality Director confirmed arrangements were in place to recruit more staff. It was envisaged this would in time lessen the number of agency staff used.
• Suitable arrangements were not in place to ensure there were enough staff to give people the care and support they need. Staff did not have the time to sit and talk with people. Staff regularly felt stretched and under pressure, with the focus on completing tasks and paperwork, rather than providing person-centred care and support.
• Staff told us this impacted on the quality of care people received. People may receive personal care later than they wished resulting in some people remaining incontinent and soiled. Not all people received regular baths or showers. Some people were left in bed and not supported to sit in a comfortable chair within their bedroom or enabled to sit within the communal lounge. On the first day of inspection, staff on Cephas House were not able to support two people to sit in the communal lounge. A staff member told us, "There were two resident's today who wanted to get up, but we couldn't get them up. One was okay about it, one wasn't speaking to us. I explained it to them, but they kept saying, "It's not good enough. It's really hard, we just do the best we can. We definitely need more staff because of the needs of the people, especially those cared for in bed. You feel like you're rushing them."

Effective arrangements were not in place to make sure there were enough staff to support people to stay safe and meet their needs. This demonstrated a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• Staff had been recruited safely to ensure they were suitable to work with the people they supported.
• Staff's protected characteristics under the Equalities Act 2010, such as age, disability, gender, religion and ethnicity were identified as part of the recruitment process.

Preventing and controlling infection
• Malodours relating to urine and faeces were observed during both days of inspection on Victoria, Boyce and Murrelle house.

• The level of cleanliness within the service required improvement. This demonstrated the service did not always meet current national guidance and standards in relation to infection control.
• One person's bedroom on Victoria House was unclean. Stains were observed on the person's wardrobe doors and on a poster attached to their bed. The skirting boards were stained, and their bedroom floor was sticky when walked upon. The person had a trolley placed beside them but this to was dirty and heavily stained. The person's bedrail covers were also stained with food and drink debris. This was discussed with the Area Quality Director and immediate steps were taken to deploy a housekeeper.
• A used pair of gloves and an apron were discarded on the floor of one person's en-suite facility on Victoria House. It was evident that the person using the service had been supported by staff to have their personal care needs met but staff had failed to follow safe infection control practices and procedures to dispose of these items.

Systems and processes to safeguard people from the risk of abuse
• People told us they felt safe. One person told us, "It's alright, I think I'm safe here, I don't feel worried." A second person told us, "I spend most of my days here in the lounge and I feel quite safe here." Most relatives told us they felt their member of family was safe living at Godden Lodge. Comments included, "I know they're [family member] safe here, night and day. I'm here almost every day and have never had cause to worry about the way they're looked after" and, "I know [relative] is safe here. I was worried to leave them at first but now I come in a couple of times a week and don't have any concerns at all for their safety."
• Staff had attained up-to-date safeguarding training. Staff demonstrated a good understanding of what to do to make sure people were protected from harm or abuse. Staff confirmed they would escalate concerns to a senior member of staff and external agencies, such as the Local Authority or Care Quality Commission.
• Where there was an allegation of abuse, the Local Authority and Care Quality Commission were notified without delay.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence

The effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent. Regulations may or may not have been met.

Staff support: induction, training, skills and experience
• Staff received mandatory training in a variety of subjects, however improvements were required to ensure staff received appropriate training relating to the specialist needs of the people they supported.
• Not all training completed was embedded in staff's practice. For example, although staff had received manual handling training, we observed an incident on Boyce House whereby two members of staff performed an unsafe manual handling practice. One person's care plan referred to them having a medical condition which could result with them experiencing seizures. Staff's knowledge and understanding of the actions to be taken if the person became unwell was poor and staff confirmed they had not received training relating to this.
• Evidence was not available to show newly employed staff had received a robust induction. The registered manager stated that induction documents were retained by the employee.
• Staff told us they did not always feel listened to, valued or supported by the senior management team or by the registered provider. Most staff stated they felt supported by their individual 'house' managers. Comments included, "I get support [name of house manager], outside of this house, no" and, "Support from my manager, yes, 100%. I sometimes feel supported by the organisation, they want a million and one things done all at once, it's not realistic." One member of staff advised that care provided to people was task focused and not person-centred. They told us, "That's not right, the managers seem not to know, or care what is happening, they are not listening."
• Staff had not received regular supervision and where areas for improvement were recorded, there was little or no evidence to show these had been followed up for action.

Not all staff received appropriate training, induction or supervision to fulfil the requirements of their role. This demonstrated a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
• People's needs were assessed prior to admission to ensure the person's needs could be met. The assessment included information relating to their physical, mental health and social needs.
• People's protected characteristics under the Equalities Act 2010, such as age, disability, gender, religion and ethnicity were identified as part of their need's assessment.

Supporting people to eat and drink enough to maintain a balanced diet
• We asked people about the food they received at Godden Lodge Care Home. People's comments were variable and included, "Food is alright. I like plain food, they [staff] have always got alternatives like ham,

egg and chips available. They will find you something", "Get enough fruit and vegetables, get enough drinks" and, "The food is boring, tasteless and tough, it is dull and repetitive. Breakfast is okay, but lunch and supper could be improved."
• People had access to enough food and drink throughout the day. Meals were nicely presented and the overall dining experience for people was generally positive.
• Where people were at risk of poor nutrition, their needs were assessed, and appropriate healthcare professionals were consulted for support and advice.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
• The service worked with other organisations to ensure they delivered joined-up care and support. People had access to healthcare services when they needed it and confirmed their healthcare needs were met. One relative told us their family had recently experienced a fall, but staff had sought medical advice and interventions in a timely manner. They told us, "All was well thankfully." Another relative confirmed their family member's medical condition of diabetes was monitored.
• One healthcare professional told us, "I find communication to be good at Godden Lodge. They [staff] always contact us if they have any concerns."
• The service was part of the 'Red Bag Care Home Scheme'. This is a national initiative. The aim is to promote and improve communication and relationships between the care service, ambulance crews and NHS Hospital; enabling relevant healthcare information about a person to be shared.

Adapting service, design, decoration to meet people's needs
• Godden Lodge Care Home is a purpose-built care home consisting of four individual houses. People had access to a small garden and this was adjacent to each house.
• There were enough dining and communal lounge areas for people to use and choose from within the service. People had personalised rooms which supported their individual needs and preferences.
• Improvements to the service were required to make this more 'dementia friendly'. There was a lack of visual clues and prompts, including accent colours, signs using both pictures and texts to promote people's orientation.

We recommend the service consider national guidance to develop a more supportive environment for people living with dementia.

Ensuring consent to care and treatment in line with law and guidance

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 as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met.

• Staffs understanding of MCA and DoLS and how this impacted on people using the service was variable.

• People's capacity to make decisions had been assessed and these were individual to the person.
• Where people were deprived of their liberty, applications had been made to the Local Authority for DoLS assessments to be considered for approval and authorisation.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect

People did not always feel well-supported, cared for or treated with dignity and respect. Regulations may or may not have been met.

Ensuring people are well treated and supported; respecting equality and diversity; Respecting and promoting people's privacy, dignity and independence

• People's comments about the care and support they received was variable. Though some people and their relatives felt the care and support provided was good, others did not. Positive comments included, "The staff are nice here, they're lovely, but they never seem to have time to chat", "The staff are kind but they're always busy and need to get to the next thing. Sometimes staff will sit and rub some hand cream in for me which is nice" and, "Staff are lovely, can honestly say there is no one I don't like, they've always got a joke."

• People did not always feel they were treated with care and kindness or feel listened too. This was attributed to inadequate staffing levels at the service, staff regularly being moved between the individual house's, high usage of agency staff and staff not having the time to spend with them. One member of staff told us, "There is no time to support people properly. Agency staff need significant support. There is no teamwork or communication because we [permanent staff] are directing agency staff on things they should be doing far better than they do." Another staff member told us, "Some of the agency staff are doing their best but just don't know the needs of residents. We [permanent staff] have no real chance to provide care as we, and they [people who use the service], would like and need. It is heart-breaking to hear residents apologise for asking for help because they know we are so busy."

• People and those acting on their behalf told us they did not always receive proper personal care, regular baths or showers. Information available suggested people's comments were accurate. People's comments included, "I need help when I have a shower, if they can fit me in. It's usually only once a week so I have to make do with a wash" and, "I only get a shower once a week which I am not happy with, but don't seem to be able to change."

• Many interactions by staff were task and routine led. This referred specifically to staff providing drinks, supporting people to eat their meals and assisting people with their personal care and comfort needs. There was an over reliance on the television despite many people being either asleep or disengaged with their surroundings and not watching the television. Staff did not sit and talk with people for a meaningful length of time.

• Though people received support with their personal care in private and staff were discreet when asking people if they required support to have their comfort needs met, they were not always treated with respect and dignity. For example, one person on Boyce House was observed on many occasions to walk in and out of people's bedrooms uninvited. Staff failed to manage this to ensure others privacy and dignity were respected and maintained.

• Where positive interactions took place, support provided by staff was caring, kind and compassionate. During these exchanges people were noted to have a good rapport with staff and there was good humour and banter.

Supporting people to express their views and be involved in making decisions about their care
• People and their relatives were given the opportunity to provide feedback about the service through the completion of annual questionnaires and by leaving comments on an external website.
• Most relatives confirmed they had been involved in the pre-admission assessment process prior to their family member being admitted to the service.
• Most people and their relatives could not remember having seen a plan setting out the person's care needs. One person told us, "Social services did an assessment at home with me and my family member, but I don't know what the staff have written down." Care reviews were intermittent.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs

People's needs were not always met. Regulations may or may not have been met.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control
• People's care records did not fully reflect or accurately detail people's care and support needs or provide enough guidance for staff as to how people's needs were to be met and risks mitigated. For example, discrepancies were found for one person relating to their dietary needs which could result with them being given incorrect drinks in a form they were unable to consume safely.
• Records monitoring people's food and fluid intake and repositioning charts for people at risk of developing pressure ulcers required significant improvement. Although this was records based and there was no impact noted for people using the service, it was difficult to determine if people were receiving appropriate care.
• People received limited opportunity to participate in meaningful social activities. Throughout the inspection there was an over reliance on the television and music. Records to evidence activities provided were poor and concurred with our observations during both days of inspection. The Area Quality Director confirmed this was due to there being only two out of four activity coordinators in post, but steps were being taken to rectify this. One person told us, "I used to go shopping with the activity lady, she has gone so it does not happen. I am going to a dental appointment next week and that is as much excitement as I get." This person stated they felt isolated on occasions.
• One relative on Cephas House told us, "There's nothing laid on that interests [relative] so they stay mainly in their room and does puzzles and things, or 'people watches' through their window." One relative on Victoria House told us, "On Christmas morning I was here for five hours and there were three members of staff on. No Christmas music played, one member of staff had antlers on, the atmosphere was rank and only got better when relatives started to arrive."
• The service understood people's information and communication needs. These were recorded in care plans. However, we did not see enough evidence of how the Accessible Information Standard has been applied. For example, the activity programme and menu was not in an easy read or large print format.

Improving care quality in response to complaints or concerns
• Arrangements were in place to record, investigate and respond to any complaints raised with the service. Each complaint had been responded to and investigated in an open and transparent way. However, there was a lack of evidence to demonstrate lessons learned and learning outcomes.
• People did not always feel their concerns were listened to, taken seriously or addressed by the management team. One person told us when they attended 'house' meetings, "They [staff] don't listen to me." Another person told us, "If I see anything that worries me I speak up, [name of registered manager] is almost always around and things get sorted out."
• A record of compliments was maintained to evidence the service's achievements.

End of life care and support
• Staff told us there were people using the service that were assessed as requiring end of life care. Although

there was no evidence to suggest people were not receiving appropriate care, no information was recorded relating to their pain management arrangements and how the person's end of life care symptoms were to be managed to maintain the person's quality of life as much as possible.

Requires Improvement

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture

There were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care. Some regulations were not met.

Planning and promoting person-centred, high-quality care and support with openness; and how the provider understands and acts on their duty of candour responsibility

- The registered provider's quality monitoring arrangements were not robust or effective to ensure the delivery of high quality and person-centred care for people using the service.
- Areas which needed improvement included, care planning and risk management arrangements, medicines management, staff training, induction and supervision, infection control practices and ensuring there were enough staff on duty with the right experience and competence to support people to stay safe. Though many audits and checks were in place and completed at regular intervals, these checks failed to effectively monitor how the above improvements were to be made to ensure positive outcomes for people living at Godden Lodge Care Home.
- For example, an internal audit completed by the registered provider in March 2019 stated staff on Boyce House did not understand the risks posed to people or respond effectively to people's care and support needs. The example cited within the report referred to people not receiving food of the correct texture. No information was recorded detailing the actions to be taken by staff to monitor this and subsequently reduce the risk to people's safety and wellbeing. The audit also highlighted improvements were required to people's care plans as these were not as accurate or person-centred as they should be. Improvements were also required to demonstrate people's involvement in planning their own care. The above was not an exhaustive list; however, the inspection showed these and other issues remained outstanding and had not been addressed.
- Not all staff felt listened to, valued or supported by the registered manager or other senior team members.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- A new manager was appointed and registered with the Care Quality Commission in March 2019. The registered manager had previously been the deputy manager at Godden Lodge Care Home. Although the registered manager was aware of their role and responsibilities, they had received little support from the organisation, to make the required improvements.
- Our findings detailed within this report, demonstrated not all 'house' manager's, qualified nurses and senior members of staff were effective role models. Although a member of the senior management team was based on Boyce House and Cephas House, our findings suggested their presence was not effective for identifying, capturing and managing areas for improvement.

Engaging and involving people using the service, the public and staff, fully considering their equality

characteristics
• Arrangements were in place for gathering people's views of the service they received and those of people acting on their behalf. Actions taken by the service following the previous satisfaction survey in July 2018 were recorded in response to people's comments. However, there was evidence to show not all actions had been maintained, for example, in relation to staffing levels, agency staff usage, infection control and activities.
• People and those acting on their behalf had also completed a further review of the service in 2019. It was not clear if this information was to be used as part of the registered provider's own quality assurance procedures as the form related to an external website. Many comments were positive.
• Staff employed at the service had completed a satisfaction survey in September 2018. An analysis of the results had been collated. Where there were areas for improvement highlighted, no action plan was completed detailing what was being done to address these. For example, 33 out of 52 members of staff stated they did not feel valued.
• Staff meetings were held to enable the management team and staff the opportunity to express their views and opinions on the day-to-day running of the service. Where issues were raised, an action plan had not always been completed detailing how these were to be monitored and addressed.
• Relatives meetings were held for family members to feel involved and to provide on-going support and information. Where issues were raised, an action plan had not always been completed detailing how these were to be monitored and addressed.

Effective arrangements were not in place to ensure compliance with regulatory requirements and to monitor the service. This demonstrated a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Continuous learning and improving care; Working in partnership with others
• Once the registered provider was aware of the lack of effective quality monitoring at Godden Lodge Care Home, arrangements were put in place to deploy the Area Quality Director to the service to provide immediate support to the registered manager and senior management team.
• The Area Quality Director confirmed further additional senior management presence to be increased within Godden Lodge Care Home.
• Recruitment of new staff at all levels was underway to reduce the use of agency staff and to provide consistency for people living at the service.
• Godden Lodge Care Home was benefitting from the 'Prosper Project' to ensure the service could proactively enhance people's lives. This is a local initiative across Essex to reduce the number of falls, pressure ulcers and urinary tract infections. They are also working closely with Essex Quality Team to support continuous quality improvement in the service.

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 Not all risks for people were identified and recorded to mitigate risks to people's safety and wellbeing. Improvements were required to ensure the safe management of medicines.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Effective arrangements were not in place to assess, monitor and improve the quality and safety of the service provided for people using the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Suitable arrangements were not in place to ensure there were sufficient competent, skilled and experienced staff to meet people's needs. Improvements were required to ensure staff were suitably trained, received a robust induction and regular supervision.