Mrs Lorraine Wakerley

The Lodge

Inspection report

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Date of inspection visit:
07 November 2018
13 November 2018

Date of publication:
21 December 2018

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

This inspection took place on 7 and 13 November 2018 and was unannounced.

We previously inspected this service in October 2017, under a different provider registration name. In October 2018, the provider de-registered the previous company and registered as a sole provider. The same provider is operating this service.

The Lodge is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The Lodge accommodates up to 20 people in one adapted building. At the time of our inspection there were 16 people using the service, some of whom were living with dementia.

There was a registered manager in post. 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 this inspection in November 2018, we found four breaches of regulation in relation to safe care and treatment, governance, person-centred care and consent procedures. We also found one breach of registration regulations as the service had not reported a safeguarding incident to the CQC as required by law.

Auditing processes had failed to identify all of the concerns that we found during this inspection. Senior staff's work had not been checked adequately to ensure they were competent in their role.

Risks in relation to people's care was not always sufficiently detailed to ensure people were cared for in a safe way. There was not always accurate guidance in place for staff about how to manage or reduce risk.

The management of people's medicines was not always safe. We found discrepancies which indicated people may not have received their medicines as intended. Some medicines had not been obtained in time and so had not been available to give to people. Audits were in place to enable staff to monitor medicine administration but we considered the audits to be ineffective at identifying and promptly resolving the issues that we identified.

Documentation procedures did not enable staff to have effective oversight of people's care. This placed people at risk of harm.

Staff knew how to recognise abuse or potential abuse and how to respond and report these concerns

appropriately. However, the service had not reported one safeguarding incident to the CQC as required by law.

Staffing levels had been increased by the provider, however, they were unable to demonstrate how they had assessed people's needs in determining the number of staff needed, as the dependency tool had not been recently completed. Staff did not have defined roles and responsibilities.

Staff received supervision and training relevant to their role, however, training in end of life care and behaviour that may challenge others had not been undertaken to ensure staff had the skills to support people effectively.

Care plans were not always accurately detailed, or sufficient to ensure people's needs and preferences were documented. End of life care plans were not always detailed.

The previous registered manager had applied for Deprivation of Liberty Safeguards when people who lacked capacity to consent, had their liberty restricted. However, it was not always possible to determine if or how people had consented to their care where they had not been given information in a format they could understand. This did not support the principles of the Mental Capacity Act 2005.

The provider was not aware of the Accessible Information Standard which ensures that people with a disability or sensory loss can access and understand information they are given.

The dining experience was not conducive to an enjoyable mealtime and opportunity for social interactions, and we have made a recommendation about this.

There was a complaints procedure in place. Complaints were logged and actions taken documented.

Safe recruitment procedures were in place, and staff had undergone recruitment checks before they started work to ensure they were suitable for the role. We did however find one DBS check had not been renewed or reviewed over a number of years, and some photographic identification was not suitable.

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 consistently safe.

Medicines were not managed safely. Some medicines had not been obtained in time and had not been available to give to people.

Risks associated with people's care were not always accurate and lacked clear guidance for staff.

The provider was unable to demonstrate how they had calculated staffing levels to ensure people's needs were met at all times.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff had not received training in all areas relevant to their role, such as end of life care and behaviour that may challenge. Staff received supervision and appraisal sessions.

Recording of food and fluids was not always accurate to ensure people received adequate nutrition.

Deprivation of Liberty Safeguards had been applied for when people who lacked capacity to consent had their liberty restricted. However, the service was not following the principles of the Mental Capacity Act 2005.

Is the service caring?

Requires Improvement

The service was not consistently caring.

We found that people's communication needs had not been considered in line with legislation.

There were no restrictions on visiting times, ensuring people could spend time with their relatives when they wanted to.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Care plans were not always accurate and did not always contain clear guidance for staff.

There was a complaints procedure in place.

There was an activity co-ordinator in post and people participated in activities on offer.

Is the service well-led?

Requires Improvement

The service was not well-led.

The provider had failed to adhere to their regulatory responsibilities and ensure compliance with the fundamental standards and regulations.

Quality assurance systems were not effective in identifying the concerns we found during this inspection.

The registered manager had implemented new processes which would improve care delivery and support staff. However, they will require an appropriate level of support to ensure improvements can be made and sustained.

The 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 7 and 13 November 2018 and was unannounced. The inspection team consisted of three inspectors, one of whom specialised in medicines, 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.

As part of our inspection planning we reviewed all the information we held about the service. This included previous inspection reports and any notifications sent to us by the service including safeguarding incidents or serious injuries. This helped us determine if there were any particular areas to look at during the inspection. We spoke with the local authority safeguarding and quality team prior to the inspection.

At the time of inspection there were 16 people living at the service. To help us assess how people's care needs were being met we reviewed five people's care records and other information, including risk assessments and medicines records. We reviewed three staff recruitment files, maintenance files and a selection of records which monitored the safety and quality of the service.

During the inspection we spoke with eight people who lived at the service, and one relative, the registered manager, deputy manager, registered provider, and four members of care and catering staff.

Requires Improvement

Is the service safe?

Our findings

During this inspection we looked at how the service managed people's medicines, and found that this was not always managed safely.

Oral medicines were stored securely for the protection of people who used the service and at correct temperatures. Medicines prescribed for external application such as creams and ointments were held within a medicine trolley located in a corridor. We noted the key was in the medicine trolley door whilst unattended with the risk that people living at the service could have accessed these medicines and caused themselves accidental harm.

We looked at people's medicine administration records (MAR) and noted gaps and discrepancies which indicated people may not have received their oral medicines as intended. We noted some medicines that had not been accurately transcribed on the MAR charts which could have led to error. We saw that some medicines had not been obtained in time and had not been available to give to people to ensure that their treatments were continuous.

When people were prescribed medicines on a when-required basis, there was some written information in place. However, for some medicines prescribed in this way there was a lack of written information needed to ensure the medicines were given consistently and appropriately.
In addition, some information was available for medicines which were no longer prescribed with the potential for misleading staff and error.

For a person with limited mental capacity to make decisions about their treatment and who would refuse their medicines, there were records of their mental capacity and best interest decisions in place. This decision instructed staff to give the person their medicines crushed and hidden in food or drink (covertly). The service had consulted with the pharmacist about giving the person their medicines in this way but we noted members of staff were not always following this advice for one of the medicines when they gave them to the person. We asked two members of staff about this and were told differing strategies about how these medicines should be given to them. We noted there was a lack of clear written information for staff about this.

We noted that for people who regularly refused their medicines or were regularly asleep at their scheduled medicine times there was a lack of clear documentation showing staff had referred this to their GP for further advice.

People's care records contained risk assessments covering areas such as moving and handling, falls, malnutrition, and risks relating to the development of pressure ulcers. However, we found that some guidance in place did not always provide staff with all the information they needed to ensure risks were mitigated as far as possible.

For example, one person experienced periods where they would strike out at staff which placed them at risk

of harm, and we were told that one staff member had to attend hospital following an injury. The person's care plan included some strategies which would help to manage the situation. However, a staff member told us that if staff failed to de-escalate situations, the sight of the senior staff members uniform had been effective in calming the person. We found this information was not included in the person's risk assessment. We saw behaviour charts which showed the person had punched and scratched a staff member, yet these specific behaviours were not detailed in the risk assessment so staff were aware of potential harm.

Another person had displayed behaviours which put staff and others at potential risk. There had been three incidents since June 2018. We asked the registered manager if there was a risk assessment in relation to these concerns. They told us that a risk assessment had not been completed in relation to this. This meant that no action had been taken to mitigate potential risks both to staff and others living in the service. The registered manager sent us a risk assessment following the inspection visit. It did not however detail specific incidents which had taken place so staff were aware of potential harm.

Information about people's diabetes and how this should be managed was referred to in risk assessments. However, information relating to what specific monitoring was required was not available to staff so they knew what signs to look out for. Where reference was made to people having diabetes, there was no information on what their target blood sugar levels should be, what action staff should take if they became too high or low, or the associated symptoms of this. One care plan said to check blood sugar levels 'only if concerned'. However, there was no guidance for staff on what symptoms to be aware of which would warrant a check on blood sugar levels.

Mobility plans were not always accurately detailed. For example, one plan said that the person required two staff and a walking frame to mobilise, and that they may need the hoist for transfers. It provided no further information on what circumstances a hoist would be required, and how staff would determine this. Additionally it did not give information on what type of sling was used with the hoist, and a staff member told us it was a specific toileting sling, but this was not documented. This meant there was a risk that staff might use the incorrect sling when moving the person which placed them risk of potential harm.

The service was using an electronic system to record people's continence management, which should highlight any concerns in relation to constipation or urinary retention. However, we found that staff were recording this in several different areas of the system, which meant that nobody had oversight of any concerns, or whether further action needed to be taken. Staff found it difficult to find information, and in one case, failed to find the information we requested. The deputy manager was not clear on who was supposed to oversee this and suggested either the senior staff or 'head of senior care'. This lack of oversight presented a serious risk of harm and did not enable concerns about people's health to be quickly identified.

Records for one person showed they had only opened their bowels three times and only had a record of a urine output on seven occasions in 13 days. There was no guidance in the care plan as to the person's usual bowel habits and when to be concerned and what action to take. We raised our concerns with staff so they could follow up with health professionals if necessary.

Records for another person noted that they experienced continence difficulties and pain but gave no information as to when to consult health professionals for advice.

We found some environmental risks which the provider had not identified in the building. For example, we found in the main kitchen there was a large urn of hot water. The kitchen door was not locked, and therefore people could walk in and potentially burn themselves. A staff member told us that only one person would be able to walk into kitchen independently and they had never done so, and said that staff were always around.

However, we found this was not the case at all times. The risk associated with this had not been assessed. Following the inspection the registered manager confirmed a lock had been put onto the kitchen door.

One bathroom was found to have a skylight which was leaking. The maintenance person had looked at this and concluded that it needed to be re-felted. There was no date planned for this. This bathroom had a toilet as well, so people were regularly using this. There was a risk assessment on the door stating not to use the bathroom if it was raining. However, people may not read this and walk in unaware. This posed a risk of injury to people living in the service, and to visitors.

All of the above constitutes a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked people their views on the staffing levels. One person told us, "They [management] seem to have changed the system. Sometimes there are a lot of staff and at other times there are not enough. But I'm happy. Anything you ask for its there, I'm never refused anything." Another said, "No I don't see a staff member regularly. No there aren't always people around, they could do with more staff." A third told us, "I don't really know if there's enough staff. Sometimes I wait for help. The other night between 11pm and midnight I had to wait."

The service had a dependency tool to determine how many staff were needed. However, this had not been completed since October 2017. The registered manager told us that there had been a period of staff sickness this year and some staff had left which meant that staffing levels had not always been sufficient. They told us more staff had been recruited and staffing levels had improved. The provider had agreed to add extra hours to each shift as required during busier times between 8am until 1pm, and 5pm until 9pm. Rotas seen confirmed this. However, the service was unable to demonstrate how they had assessed people's needs in determining the number of staff needed, as the dependency tool had not been recently completed. This was particularly important as there were eight people who required two staff to assist them when moving, and people who experienced behaviour which challenged.

Accidents and accidents were being logged. Details of incidents were comprehensively completed.

Some people living in the service required a hoist to be moved safely, and we saw these had been serviced periodically to ensure they were safe to use. We were told that hoist slings had been serviced by an accredited LOLER (Lifting Operations and Lifting Equipment Regulations) company but the date these needed to be re-serviced was October 2018, which had passed. The registered manager made arrangements following the inspection for this to take place in November 2018.

There was a fire risk assessment in place which had been completed in September 2018. Two actions were identified relating to a carbon monoxide detector and a fire door which needed to be replaced. The registered manager told us they had only recently received the risk assessment from the company, and would prioritise the actions to be completed.

People's records included personal emergency evacuation plans (PEEP's) which outlined what help people needed in the event of an emergency. However, we found that one person's PEEP's made no reference to their behaviours which included hitting out and scratching. The PEEP's stated they, "May become agitated", but no other information on specific behaviours and how this might affect prompt evacuation in the event of an emergency.

Systems were in place to reduce the risk of legionella in the water systems, and there was a risk assessment

in place but this required updating, as the names listed as the site appointed responsible person and their deputy, were staff that no longer worked at the service. One of the ways to reduce the risk of legionella is the effective control of hot and cold water temperatures. At the time of our visit we saw that hot and cold water temperatures were being checked, but that some cold water temperatures were higher than the recommended 20 degrees. The registered manager told us that running the taps for two minutes corrected the issue, however this was not documented. De-scaling of taps and shower heads was undertaken periodically as required.

Staff were recruited safely; checks had been carried out with the Disclosure and Barring Service (DBS). The DBS identifies people who are barred from working with children and vulnerable adults and informs the service provider of any criminal convictions noted against the applicant. We did however find in one case that the one form of photo ID on file was not of a suitable standard as to confirm the person's identity. Additionally, one DBS check had not been renewed or reviewed over a number of years, which is good practice to ensure staff continue to be suitable to work with vulnerable adults. The registered manager told us they would update this and look into the DBS periodic update service.

Staff received safeguarding training and were able to tell us the action they would take if they came across different types of abuse. One staff member told us, "We can come across all types of abuse; financial, physical, emotional, psychological. I would document concerns, complete a body may if needed, and raise any concerns directly with [manager]." Another said, "I would report concerns to the safeguarding team, I have their contact details, I can also go online." This meant that staff were aware of the correct procedures to follow if they were concerned about people.

Infection control procedures were being followed and we observed that most areas of the service were clean and fresh on the day of the inspection. There were adequate supplies of personal protective equipment, such as aprons and gloves, and we observed staff used these appropriately.

Following the inspection, the registered manager took a 'lessons learned' approach to rectify several areas of concern we identified. However, the service had not independently identified the areas requiring improvement which placed people at risk of harm.

Requires Improvement

Is the service effective?

Our findings

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 decision 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 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). The MCA DoLS requires providers to submit applications to a 'Supervisory Body' for authority to restrict people's liberty.

There were three DoLS applications made by the service, none had yet been authorised by the local authority. Where people had DoLS applications awaiting authorisation, there was no reference to this in people's care plans so staff knew how people's liberty was being restricted, and how to support people with this aspect of their care.

We checked whether the service was working within the principles of the MCA, and found that this needed to be improved. We found that people had not always consented to their care.

We asked the manager about a DoLS application for one person. A mental capacity assessment (MCA) was carried out and noted that the person lacked capacity in relation to personal care, medicines, sharing information and the environment. When we asked for the MCA assessments relating to this and the DoLS application the registered manager showed us a paper copy of consent for photographs and information sharing signed by the person's relative. It was not noted in the record that this person's relative had the necessary legal authority to do so. The service were unable to find records of an MCA assessment, involving appropriate professionals and/or relatives.

A second person who had severe communication difficulties, and was not able to communicate verbally, had a record of consent to aspects of their care in their care plan. It was not clear how this informed consent had been obtained and staff were not able to tell us about any particular action they had taken to ensure the person had fully understood what they were consenting to. In addition, it appeared from the person's records that a representative from the local authority had consented, on behalf of the person, to the sharing of information and the use of photographs. It was not recorded who this person was or why they had been involved and staff were unable to tell us. These actions meant that we could not be sure that this person had been able to give informed consent to their care and treatment. There was also a written record of the person signing and consenting to information sharing. This had been signed by them in May 2018 but it was not clear how staff had ensured the person understood what they were consenting to and signing for.

Where people had legal representatives in place, such as a Lasting Power of Attorney (LPA), it was not always clear what authority they held as this was not always documented. For example, we were told that one

relative held LPA for finances and health and welfare. When we spoke to the relative, they told us they only had authority to deal with their relatives finances. It is important that the provider is clear on what type of LPA is held, and that the provider has seen the LPA documentation so that they know what decisions the attorney can make.

The above constitutes a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's care plans included their nutrition and fluid needs. These plans outlined people's preferences in terms of food likes and dislikes, and how calorie intake should be increased where needed. Included was a chart that showed weight changes over the year. Where people had lost weight appropriate referrals had been made. There was a detailed information folder in the kitchen with information about people's dietary requirements, and when we spoke with the chef they were able to tell us who required diabetic diets, soft diets, and pureed food. They were aware of certain foods which were not safe to be pureed.

However, improvement was needed in the way staff recorded people's food and fluid intake. For example, one person required three milkshakes per day to increase their weight. However, staff were not clear where this should be recorded; in the fluid chart or on the nutrition chart. It was therefore difficult to ascertain that the person was receiving three milkshakes per day. Additionally, staff often wrote, 'declined a drink when offered', but it was not clear if this was the milkshake being offered or regular fluids. We did however see that the person was gaining weight.

Following the inspection, the registered manager sent us information which will improve the recording and monitoring of food and fluids. They implemented a 'daily action plans for seniors' which will now mean that staff members will be allocated to check nutrition and hydration records are recorded correctly.

We asked people about the food provided in the service. One person told us, "There's a good choice of food and plenty to eat. I had chicken and chips today which was good. We have a trolley with drinks and snacks in the morning and afternoon." Another said, "The food's very nice. I had stew today with mash and ice cream afterwards." A third told us, "The food's very good. There's always enough, yes. I had mince and vegetables today."

The majority of people chose to eat in their rooms. One person ate alone in the dining room, and we saw staff checked on them at regular intervals. We saw no interaction between two people who ate in the lounge and who were left with their food by staff. Lunchtime was a subdued affair, and not a noticeably enjoyable experience for people.

We recommend that the service explores current best practice guidance to ensure that mealtime experiences are an opportunity to support and promote independence, in addition to creating a positive mealtime experience, particularly for those with specialist needs including dementia.

People's needs were assessed with input from members of the multi-disciplinary team involved in people's care. However, we could not be assured that people's choices were always known. For example, people told us they had not been involved when their care plans had been reviewed. Additionally, people did not always have access to information in formats they could read and understand.

We found that the work being undertaken by one staff member was not being checked sufficiently to ensure their competence, and errors were found with medicines, which included leaving some people without medicines over several days and failing to pick up these issues during the auditing process. The staff

member concerned was also overseeing the work of other staff.

Providers should have a systematic approach to determine the range of skills required in order to meet the needs of people using the service. They should consider the different levels of skills and competence required to meet those needs, including leadership requirements. We found that staff did not have defined roles and responsibilities and their work was not being checked sufficiently to identify where staff had made errors.

When new staff started working in the service they received an induction and worked alongside experienced members of staff whilst getting to know people and learning about how people wanted to be supported. Staff received training that helped them develop the knowledge and skills needed to support people. Records showed that staff had received training in safeguarding adults, dementia care, first aid, manual handling, medicines, and the Mental Capacity Act 2005. The registered manager kept a matrix which showed when staff had received training and where some staff were overdue refresher training. Staff had also recently attended training in dementia care which included a 'virtual experience'. This helped staff to understand more fully some of the day to day challenges people might experience when living with dementia.

Some people living in the service experienced behaviours and periods of distress that challenged staff. The registered manager told us that there were a number of staff who had received training in this area, however they had since left the service. Therefore staff currently working with people had no specific training in this area. Additionally staff had not received training in end of life care. This meant that staff may not be equipped with the necessary skills to support people effectively. The registered manager told us following the inspection that they would arrange both of the training sessions as a priority.

Staff were provided with one to one supervision meetings. Supervision provides staff with a forum to discuss the way they worked, identify training needs, and receive feedback on their practice. The registered manager kept a log of when supervision sessions were last held and when they were next due. We saw some were slightly overdue but the registered manager had planned to arrange these in the next month or so. Supervision records we reviewed were not always sufficiently detailed. Training needs were discussed, however, more detail was required in relation to the staff members role and responsibilities, particularly for senior staff. This was evident given the issues we found during this inspection in relation to a lack of defined roles.

The service worked together with other organisations. This included GP's, dieticians, physiotherapists and social workers. People told us they saw other professionals as required. One person said, "Chiropodist comes every eight weeks or so. If I need a doctor the staff sort it but I haven't needed anyone lately." Another said, "Yes they [staff] send for the GP or you can see them when they come." A third told us, "You just tell the carer and the boss phones for a GP to come."

The electronic care planning system was able to create a summary of key information about people's care. This information could be shared when a person is transferred between services or was admitted to hospital. Sharing this information with other professionals less familiar with the person would help them to deliver more effective care which was in line with people's preferences.

The provider had given some consideration to maximising the suitability of the premises for the benefit of people living in the service and those living with dementia, though further improvement was needed. We found there to be uneven flooring in the main corridor leading to people's bedrooms which could present an additional challenge to people whose mobility was already impaired.

Photographs and people's artwork were displayed on the hallway walls. The doors to people's bedrooms had photographs which would help people to recognise their room more easily. New sensory boxes were in people's rooms and in communal areas. The registered manager told us they were also planning to acquire more sensory items for people to interact with.

Requires Improvement

Is the service caring?

Our findings

At this inspection we found that people did not always receive a caring service.

The registered manager was not aware of the Accessible Information Standard (AIS). The AIS is a framework put in place from August 2016 making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given. This includes receiving information and correspondence in formats people can read and understand. We found that people's communication needs had not been considered in line with legislation. For example, for one person who had severe communication difficulties, they had not received any information in a format they could understand.

We found correspondence of an official nature had been received for one person. The letter had been opened, but was then just placed in their care file. Staff had not sought advice about the letter, or considered whether other professionals should be contacted to support the person to deal with the content. This did not demonstrate a caring approach to people's care.

We asked people if they were involved in their care plans. One person said, "Originally yes but not now." Another told us, "No, we just get on with things." A third person said, "No." When we spoke to a senior staff member they told us that people were involved, but there was nothing to evidence this. This did not demonstrate that the service was gaining people's views about the care they were receiving, and if they were satisfied. However, the detail held in some care plans reflected people's preferences well, and therefore the service needed to ensure that when care plans were reviewed that people signed to show their involvement.

'Residents meetings' were held to obtain people's views about their care, and we saw that the last residents meeting was in July 2018, but no one attended. The registered manager told us that this has been a recurring theme, so instead they spoke to people individually using questionnaires and addressed any concerns or changes. As an example, they told us that one person had asked for curry to be put on the menu and the chef now makes sure that this is available for them.

Care plans contained information to guide staff and help them offer care which eased people's distress and confusion. For example, one person's care plan documented how staff should give clear and simple instructions to prevent them becoming confused. Another stated, 'The news can upset me. Offer comfort and tell me it's happening somewhere else and I'm safe'.

We asked people their views on the staff and if they were caring. One person said, "The staff are okay, very good, kind and considerate. They listen to me I guess." Another said, "They're kind and compassionate mostly. If I wasn't well they would listen." And a third told us, "Top hole! I can't grumble. The staff can't be everywhere, as I say they do their best."

We observed some kind interactions during the inspection. For example, we observed staff and saw them

being kind and considerate with people. Where one person was very disengaged and their body language was very negative, we saw a staff member getting down to their level, having a joke with them and completely changing their mood. One staff member was very patient with another person who couldn't decide what pudding they wanted and they got quite distressed. The staff member gave them a piece of all three and they were seen laughing about this with the staff member.

People told us that staff tried to increase their independence. One person told us, "It's difficult now I can't walk but they [staff] do encourage me to go out." Another said, "Oh yes. I go out into town when I want and I'm left to it in my room." And a third told us, "Yes, I try to do a few things." People also told us that their privacy and dignity was upheld, and we saw that when staff were attending to people's personal care needs they ensured doors were closed and spoke with people in a hushed tone to protect people's privacy. One person told us, "The staff are caring and respectful. They [staff] listen and do what's needed." Another said, "I sit where I want. The staff wash and dress me, they're respectful and kind."

Requires Improvement

Is the service responsive?

Our findings

People's care plans were evaluated monthly and some contained very specific details about people's care needs and preferences. This information helped to guide staff and help enable them to provide individualised care. Where electronic records were completed as required the system worked well, but it was not streamlined to make it easy for staff to find the information they needed or for anyone to get an overview of particular aspects of people's care. There were ways to use the system to ensure an overview but this was not being done and management were also unclear on how to do this which presented a risk. Staff were unable to easily find out, for example, when a person last had a bath.

Care plans were not always accurate or sufficiently detailed. Risks associated with people's continence management were not clearly recorded within people's care plans. For example, the care plan for one person said they experienced continence difficulties and pain but gave no baseline as to when to consult other professionals for advice. Systems were not in place to promptly flag up possible concerns and instead relied on individual staff to notice possible problems.

Care plans concerning people's health conditions, such as diabetes, needed to include more detail. Where reference was made to people having diabetes, there was no information on what their target blood sugar levels should be, what action staff should take if they became too high or low, or the associated symptoms of this.

Given there were several new staff working in the service, the accuracy of detail relating to people's care needs was even more important to ensure staff had clear guidance about how to meet those needs. Without this information, people were at risk of receiving care that was inappropriate or did not meet their individual needs. We asked people if they felt service met their needs. One person told us, "The GP said I should rest, but the staff get me up early. The carers want me up around 9 or 10 o'clock." Another said, "Not really. I'd like to walk more." Others felt their needs were met. One person said, "The staff look after me pretty well." Another said, "Yes. I'm warm, comfortable, I can please myself, I have good food, clean clothes and everywhere's clean. I can't ask for more."

Care plans included people's personal histories. These varied, with most being filled out comprehensively with lots of specific detail about a person's life before they came to live at the service. However, this was not the case for all care plans and we saw one which had no history and just stated. 'No history has been obtained due to my lack of speech'. One member of staff told us that the person had relatives but this was not recorded in the plan and there was no record of staff trying to contact them for more information even though the person had lived at the service for a number of years.

The person's care plan was similarly blank in other areas such as religious or spiritual needs, and their end of life wishes. Other areas of this person's plan documented very specific wishes. For example, that they wished to be checked every two hours during the night and that they did not wish to donate their body to medical science. However, it was not clear how this information had been established given their severe communication difficulties and staff confirmed that no specialist advocacy had been put in place for this

person. This meant there was a risk that this person was receiving care which was not in line with their particular preferences.

People's care plans held limited information on their end of life wishes and planning. Often the wording used within these were standardised for each person.

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

The registered manager told us that end of life care plans were an area to be improved upon. However they showed us a care plan for one person whose health had deteriorated. It described the person's wishes and preferences in detail, including their spiritual needs, which we saw had been met.

Following the inspection the registered manager informed us that they had removed all the extra charts from the electronic system which now included only one section, therefore making the auditing process easier to follow. They also informed us that they intended to create new care plans for each person which will contain accurate and current information.

We asked people if they were able to follow their hobbies and interests and received mixed views. One person told us, "I haven't done much. We did some exercises yesterday." Another said, "There's dominoes, I don't do that sort of thing." And a third told us, "I have problems sitting at a table. Sometimes we have ball games and skittles I love games like that." A fourth told us, " I just stay in here [bedroom]."

The service had an activity co-ordinator who worked full time Monday to Friday. At the weekends staff delivered activities as time allowed. We spoke with the activity co-ordinator and found they had some good ideas about how they wanted to improve the range of activities provided. They told us about an exercise session they had held the previous day. We were shown resident's artwork which would eventually be made into Christmas decorations and new sensory boxes were in people's rooms. One person who was living with dementia had been given a doll which had proved a calming influence. They told us about two people who didn't like water, which at times made it difficult for care staff to perform personal care. The activity co-ordinator told us they planned to begin some water exercises to try to improve things. They told us, "Activity is important for people. I have lots of ideas, it will take time, but I'll get there." We observed them interacting with people positively, encouraging participation.

There was a schedule of activities on display in the hallway that people could attend if they wished. Though some feedback indicated not all people's needs were being met, the activity co-ordinator was aware that progress needed to be made, and had suitable ideas on how to improve this.

The provider had systems in place for managing complaints. We asked people if they would make a complaint if they needed to. One person said, "The staff usually listen but I don't bother to complain." Another said, "I would speak with one of the regular staff. With recent changes there are new people [staff] here." And a third told us, "The staff could listen a bit more."

We reviewed the log of complaints and found that these had been recorded appropriately, detailed the nature of the complaint and what action was taken in response to concerns raised.

Requires Improvement

Is the service well-led?

Our findings

In October 2018, this service was registered under a new provider. It was previously registered as a company. A director who was also the nominated individual for the company registered as a sole provider under a new registration. This means that the same individual is responsible for the management and oversight of the service. The inspection history of the registered provider was considered when inspecting this service. Historically we have not seen evidence of adequate leadership in place to ensure improvements are made and sustained. This inspection in November 2018 identified that the service needs to make further improvements to ensure people receive safe and effective care.

Auditing systems and processes had failed to identify areas of people's care that placed them at risk of harm. We found four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, and one breach of the Care Quality Commission (Registration) Regulations 2009.

The previous registered manager had left the service in July 2018. A manager was appointed soon after this and is now registered with the CQC. They were supported by a deputy manager and, 'Head of senior care'. However, we found that the work completed by one staff member had not been checked adequately and errors they had made were not identified by the registered manager.

There was a lack of defined roles and responsibilities for staff working in the service, and work was not being checked sufficiently to identify where staff had made errors. As a result, accountability amongst the staff team was poor.

Auditing processes were in place and included various aspects of people's care, such as falls, care plans, night shift audit, laundry, equipment safety checks, and people's weights. Audits were also in place to enable staff to monitor medicine administration but we considered the audits to be ineffective at identifying and promptly resolving the issues that we identified. Other auditing processes had also failed to identify issues that we found during this inspection, such as inaccuracies and poor recording in care plans, no oversight of risks associated with the management of people's continence, environmental risks, and gaps in staff training.

There was no accessible information provision which marginalises people. There was no provision for easy read or foreign language in relation to 'resident guides', statement of purpose, or complaints procedures, even though these were clearly required for some people living in the service. This meant there was a risk that people's rights might not be upheld.

Staffing levels had been increased at busier times of the day, however, how the service had determined the number of staff required to keep people safe and meet their needs was unclear. Further, there were people with very complex dependency needs which would require additional staff input at certain times. Therefore a robust calculation of staffing levels was required to ensure staffing levels were adequate, and this had not been completed since October 2017. Additionally, the service had not recognised the experience for people living in the service.

All of the above constitutes a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found that whilst safeguarding referrals had been made to the local authority appropriately, the necessary statutory notifications had not always been made to us as required by law.

This meant that the provider was in breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

Incidents and accidents were being logged on two different forms which made oversight of these more difficult. Details of incidents were however comprehensively completed.

Following this inspection, the registered manager was pro-active in sending us updates on the work they were completing to make the improvements promptly. They informed us that the provider had agreed for an extra staff member to assist with gathering information and creating new care plans. They had also created a form outlining responsibilities for senior staff so roles were clearer.

Staff told us that the registered manager was supportive and that they had confidence in their ability. One staff member said, "[Registered manager] is really good. Very approachable." Another said, "I am supported by [registered manager] I cannot fault them." A third said, "Things are getting better now, the culture is more like a team."

We saw that the new registered manager had implemented a new 'on call' system. This supports staff out of hours. They had also implemented protocols for certain situations that staff may come across, such as falls, fractures, and sepsis. This gave staff clearer guidance of what action they should take to ensure correct procedures were followed. The registered manager was open and transparent throughout and following the inspection, sending information as requested to assist us. However, going forward they will require appropriate support both from their management team and the registered provider if improvements are to be made and sustained.

Questionnaires were issued to people, visitors, and professionals periodically to gain feedback about how they felt the service was performing.

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 18 Registration Regulations 2009 Notifications of other incidents The provider had not always notified us without delay of events which had happened in the service. 18 (1) (2) (e)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care Care plans were not always accurate and did not always contain clear guidance for staff. 9 (1) (3) (a) (b) (d)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had not ensured that people consented to the care and support that they received. They had not followed the principles of the MCA 2005. Regulation 11 (1) (3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Medicines were not managed safely. Some medicines had not been obtained in time and

had not been available to give to people.

Risks associated with people's care were not always accurate and lacked clear guidance for staff. Systems to record potential risks were not robust.

12 (1) (2) (a) (b) (f) (g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes did not enable the provider to identify where quality and/or safety were being compromised 17 (1) (2) (a) (b)