National Schizophrenia Fellowship

Thistley Lodge

Inspection report

40 Warwick New Road
Leamington Spa
Warwickshire
CV32 6AA

Tel: 01926435045
Website: www.rethink.org

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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

The inspection visit took place on 4, 7 and 11 December 2018. The first day of our inspection visit was unannounced. Thistley Lodge is a residential care home which provides care and nursing support to people with mental health conditions. 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.

Thistley Lodge is registered to provide care for up to eight people. At the time of our inspection there were five people living at the home. The inspection was prompted by the notification of an incident following an investigation by the provider and safeguarding authorities. This incident is subject to a police investigation and as a result at this inspection we did not examine the circumstances of the incident. However, the information shared with CQC about the incident, indicated potential concerns about the management of risk and people's safety.

Our inspection looked at whether people's care was managed safely and that staff had the right level of competency and skill. When the investigation is concluded we will consider any further action we may take.

At our previous inspection in December 2017 we had rated the home as 'Good' overall, with 'Requires Improvement' in Well Led. This was because the provider's audit system was not effective and there was a lack of audits and checks for us to review. In some cases, audits were not made available to us. In addition, there was no registered manager at the home. At this inspection we found there had been significant changes in how the home was run which had adversely affected the quality of care people received. We have rated the home 'Inadequate' in Safe, and Well Led, and 'Requires Improvement' in Effective, Caring and Responsive. This meant the service was rated 'Inadequate' overall.

There was a registered manager employed at the home at the time of our inspection visit who was registered with CQC to manage two care homes owned by the provider. However, the registered manager was also overseeing two additional homes for the provider, and so only spent up to two days per week at the home. 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.

Although people told us they enjoyed living at Thistley Lodge, senior staff were not always trained and supported in how to recognise and report safeguarding concerns. The provider did not always report and act on safeguarding concerns to ensure people were always cared for safely and risks to people were effectively managed.

Staff with the required skills and competencies were not always available to respond to people's health needs and keep people and staff safe. Risks to people were not always properly assessed. Care plans did not provide sufficient information for staff to support people safely and minimise risks to their health and wellbeing.

Some care plans and risk assessments contained important health information and advice, which was not followed, to ensure staff provided consistent support that met people's changing needs. People did not always receive support to maintain their health, where it was required.

Care plans were not effectively reviewed to ensure staff had the necessary and up to date information to support people as their needs changed. People's care records did not always describe to staff how to support people with their communication needs.

People were not supported in line with the requirements of the Mental Capacity Act 2005 (MCA). Mental capacity assessments were not completed and best interest's decisions were not recorded for scrutiny and oversight. Legal advocacy arrangements were not checked to ensure people's rights were protected under the MCA.

Staff did not have all the skills they needed to support people safely and effectively. The provider had ineffective systems to monitor staff training had been completed.

Systems to assess the quality of the service provided were not always effective because improvements had not been identified, sustained and fully implemented. Some risks associated with the management of medicines and people's care and treatment had not been identified because effective checks were not undertaken. Accidents, incidents and safeguarding concerns were not always learned from to prevent further incidents from happening.

There was a lack of management oversight by the provider and registered manager to check delegated duties had been carried out effectively. Checks were not regularly reviewed or records completed that showed what, if any, improvements had been made.

The provider's governance and oversight lacked close scrutiny. The registered manager accepted their lack of support and regular attendance at the home had impacted on the focus and improvements that were required. Several shortfalls in how people were protected from abuse were identified by the provider, yet the culture at the home continued to put people at risk, which meant the service people received fell below the provider's expected standards. The provider's representative, Associate Director for Nursing, Safety and Clinical Services agreed that the levels of care and support people received was not what the organisation wanted.

Care records were kept securely in the registered manager's office. However, at the time of our visit we received information that suggested people's personal details may have been shared inappropriately. The provider is investigating this incident and had agreed to tell us the outcome of their investigation and findings.

We found six breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special Measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action.

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 skilled and competent staff to support people safely, and meet their health needs. There was a lack of leadership at the home, to support staff to make safe decisions. People did not always receive their medicines safely to ensure their health was maintained. Where people were identified as being at risk of harm, measures were not always taken to keep people safe. Safeguarding procedures were not always followed to investigate any concerns and to protect people from harm.

Is the service effective?

Requires Improvement

The service was not consistently Effective.

The provider and registered manager were not following the principles of the Mental Capacity Act 2005. Staff did not always have the relevant training, skills and support to provide people with effective care. People were not always supported to maintain their health and referred to external healthcare professionals when a need was identified. People did not receive treatment from trained and competent staff, as required.

Is the service caring?

Requires Improvement

The service was not consistently Caring.

Staff treated people with kindness in their everyday interactions. Permanent staff knew people well. However, people were not always supported by staff to make their own choices about how they lived their daily lives. The provider did not support their staff in a caring way, which always supported their wellbeing and safety. The provider was not confident people always had their private information kept in a secure way.

Is the service responsive?

Requires Improvement

The service was not consistently Responsive.

People were involved in planning how they were cared for and

supported. There was a range of activities on offer to support people with physical and mental stimulation that met their preferences. People knew how to make a complaint and provide feedback to staff and the registered manager. However, care plans were not up to date and effectively reviewed to ensure care and treatment met people's needs. People's care records did not always describe to staff how people should be supported with their communication needs in line with Accessible Communication Standards.

Is the service well-led?

Inadequate

The service was not Well Led.

People and staff told us the registered manager and service manager were approachable, however, there was a lack of leadership support within the home and the organisation. Lessons were not learnt from the analysis of accidents, incidents and safeguarding concerns. The provider's management systems were ineffective in identifying where improvements were needed. The provider did not always act to improve, where a need was identified. The registered manager and provider did not fully understand their legal obligations, and were not meeting the Regulations.

Thistley 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 comprehensive inspection visit took place on 4, 7 and 11 December 2018. The first day of our inspection visit was unannounced and was completed by an inspector and an assistant inspector. Two inspectors returned announced on the second day to continue gathering information and to speak with the registered manager. On the third day of our inspection visit we met with the provider's representative and a member of the quality assurance team. This visit was conducted by two inspectors, and a pharmacy inspector who looked at medicines management.

The inspection visit was prompted by the notification of an incident. This incident is subject to a police investigation and as a result, for the inspection, we did not examine the circumstances of the incident. However, the information shared with CQC about the incident, indicated potential concerns about the management of risk and the safety of people who lived at Thistley Lodge. Therefore, we looked to see that people's care was managed safely and that staff had the right level of competency and skill. We will consider any further action we may take.

Before the inspection visit we looked at our own systems to see if we had received any concerns or compliments about Thistley Lodge. We analysed information on statutory notifications we had received from the provider. A statutory notification is information about important events which the provider is required to send us by law. We looked at information we had received from other agencies, including commissioners of services. Commissioners are professionals who may place people at the home, and fund people's care. We considered this information when planning our inspection of the home.

The provider had not been asked to return an updated Provider Information Return since our previous

inspection. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. During our inspection visit we gave the registered manager and provider an opportunity to give us this information and tell us about their service.

During our visit, we observed how care and support was delivered in communal areas of the home, to gain people's experiences of living at Thistley Lodge. We spoke with three people who lived at the home. However, we were unable to speak with people in detail, as they did not feel they wanted to share their experiences with us. We spoke with the registered manager, three care staff, an agency nurse, a service manager, the nominated individual (who was the Associate Director for Nursing, Safety and Clinical Services) and the Head of Quality Assurance.

We looked at three people's care records to see how they were cared for and supported. We looked at other records related to people's care such as medicine records, daily logs, incident records and risk assessments.

We reviewed records of the checks the registered manager and the provider made to assure themselves people received a quality service. We also looked at recruitment and supervision procedures for members of staff to check that safe recruitment procedures were in operation, and staff received appropriate support to continue their professional development.

Inadequate

Our findings

At our previous inspection in December 2017 we found the home was rated 'Good' in Safe. At this inspection visit we found significant improvements were needed to ensure people were cared for safely. We have rated Safe as 'Inadequate.'

In November 2018 we were made aware of an investigation the provider had completed into incidents that occurred at the home. When the investigation was shared with us we found four incidents, which should have been notified to CQC, had not been sent to us in accordance with the provider's responsibilities. This meant the incidents were not considered by CQC at the time they occurred, to ensure people were safeguarded and cared for safely at Thistley Lodge.

We asked the registered manager what training they had in recognising abuse and effectively operating the provider's safeguarding procedures. The registered manager told us they had only received online training for safeguarding concerns at the level of a care worker. They had not received training in how, as a registered manager, they should respond to safeguarding concerns.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, safeguarding service users from abuse and improper treatment.

Risk assessment procedures were inadequate and failed to identify and manage all the risks to people and staff at Thistley Lodge. People who lived at the home were diagnosed with a range of mental and physical health conditions. Where people displayed behaviours that put themselves, staff, or members of the public at risk, staff and managers confirmed there were no behavioural logs to monitor behavioural changes. This meant staff were not recording, analysing, and learning from displays of aggression, or recognising the signs which could indicate a person was becoming unwell. Staff had not received training in managing behaviours people may display.

Where one person had an identified risk of developing damage to their skin, staff did not use recognised risk management tools and preventative measures to reduce the risks. For example, there were no regular checks on their skin, no specialist equipment such as pressure relieving cushions and mattresses, and no instructions for staff to ensure the person was frequently moving around to reduce pressure to vulnerable areas. Staff had not received training in the prevention of pressure sores.

Another person had an identified risk of a transient ischaemic attack (TIA) or "mini stroke" caused by a

temporary disruption in the blood supply to part of the brain. The disruption in blood supply can result in a lack of oxygen to the brain and cause symptoms similar to a stroke. There was no risk assessment, care plan or instructions to staff in the person's care records about what signs they should be aware of, and how they should react to symptoms of TIA. This lack of guidance had been identified in the provider's own internal investigation and audit into concerns at the home in July 2018. However, the person's care records had not been updated which meant the person was still at risk of not receiving immediate medical attention to minimise the impact of an attack.

For another person there was a risk they would not receive medical attention when needed. The person had a history of abdominal pain, and had been diagnosed with a health condition. There was no information in the person's care records to show what the health condition was, and how staff should respond if the person's symptoms or condition worsened.

In another person's care record we saw they also had care needs for which there was no care plan. The registered manager said the health need was no longer a concern and this had happened some time before our visit, but how the condition had been resolved, was not present in their records. Other information we received about the person's behaviour indicated that this may relate to changes in their mental health, but this had not been considered by staff. Where people had recognised medical needs such as a diagnosis of diabetes, there was no care plan to instruct staff on how to recognise the symptoms of diabetes, or monitor the diet.

Some environmental risks were managed to ensure people were cared for in a safe environment. For example, electrical and water testing. However, the home operated an outside smoking area where four people smoked. Although people had individual risk assessments in place for smoking, these did not instruct staff on how to monitor the outside smoking area to keep people safe. We discussed this with the registered manager who said, "Now you have said this, I had not thought about it."

There had been a history of staff being put at risk by some people's behaviours. We were concerned staff continued to be placed at risk of people, through lone working. On the third day of our inspection visit the provider informed us of their lone working policy and the procedure staff should follow to maintain their safety, as well as other people's safety when lone working. However, staff did not describe this to us, and we could not be confident the policy was being followed by staff to mitigate the risks of lone working. The registered manager did not perform checks on staff's understanding or compliance with such policies.

On the first day of our inspection visit a member of staff was at the home completing part of their induction training. The service manager informed us the member of staff was there to work alongside an experienced member of staff until they could be sure the staff member was competent to work alone. During the day this staff member accompanied a person from the home into the local community, alone, without the appropriate training and support to understand the risks the person's behaviour may pose to them. The registered manager agreed this should not have happened. The service manager told us if the person started to display challenging behaviours that put the staff member at risk, the staff member could leave the person and return to the home. This meant the person would not have any support to manage their behaviour which placed them and the public at risk.

Improvements to the management of medicines were needed to ensure people always received their medicines as prescribed. The provider had failed to ensure the side effects from some medicines were being managed safely. Four of the five people at the home were prescribed and taking a specific medicine, with an associated risk which required close monitoring and some health checks, to ensure the dosages remained safe. These checks had not been consistently completed.

Each person at the home had a medicine administration record (MAR) which showed the medicines they were prescribed. Staff had not consistently completed the MARs to show people had received their medicines when they should. One person had two MARs that overlapped for one day. Two different staff had completed both MARs, this meant that an accurate record of who had administered the medicine was not made and it was unclear if the person had received double the dose.

There was a lack of records to support some statements staff made to us about the administration of medicines. For example, a nurse told us one person had missed their behavioural medicines for two days in November 2018. The person's records could not be found so we could check the accuracy of this statement and consider any implications on the person's health.

Some people were prescribed medicines that were to be taken 'as required'. There were no plans in place to ensure staff knew when people needed to receive these medicines, and when symptoms suggested people required treatment. This put people at risk of receiving inconsistent or delayed treatment for their health condition.

There was a process for reporting near misses and more significant medicines errors. This alerted the provider so they could act to reduce the risk of the same error happening again. However, on one person's MAR it showed they had not received their prescribed medicine on one occasion. Auditing procedures had failed to identify this omission, and so no investigation had taken place into whether the person had received their medicine as prescribed.

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

People were not having their health and emotional needs monitored, and risks to their health and behaviour were not regularly assessed by staff with the right level of competency and skills to keep them safe. The home was registered to provide nursing care to people. The provider told us up until October 2018 nursing staff had been working at Thistley Lodge up to five days per week. However, since 1 November 2018 there had been no nurse on site each day, to monitor and assist people with their health needs. We were told by a nurse who worked at another of the provider's homes locally they visited the home once a week to check medicines were being monitored by staff. Commissioners of people's care and support packages confirmed they expected people to receive treatment from trained nursing staff, as part of their agreed care arrangements.

Staffing levels during the day usually consisted of two care staff to support five people. Some people regularly went out in the community alone, which meant two staff were sufficient to support people with everyday tasks. At night however, only one member of staff was in the building, and they worked the night shift as a 'sleep in'. This meant they went to bed and slept after people went to bed. This staff member was only available in an emergency and relied on being woken by people who lived there. People were not supported by staff who were awake, and could provide them with immediate assistance with their health and medicines during night time hours.

Staffing levels were not always maintained at the agreed level of two staff during the daytime. The registered manager told us of several occasions, when a member of staff had falsified records regarding their attendance. The provider had taken action to improve staff behaviours before our inspection visit.

The registered manager was unable to tell us how they, or the provider, calculated the number of staff, and the skills mix of staff, that was required at the home. They did not assess people's agreed support levels, in

line with commissioner's expectations, and people's health and social care needs. Tt was difficult to be confident staffing levels met all people's needs, or that staff were competent and skilled at the level required. One person's care records detailed they loved to attend a weekly exercise class which they enjoyed and looked forward to. On 1 October 2018 their records showed they had been unable to attend the class due to staff shortages.

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

Following their investigation into incidents at the home, the provider had put measures in place to safeguard people. Some people had moved to another home, and others had left the service. Staff now discussed concerns and incidents at staff meetings. The provider told us these actions mitigated the risk of safeguarding concerns and incidents not being reported appropriately.

Staff told us they had regular online training in safeguarding and whistleblowing procedures, and knew how to raise concerns with their manager, a nurse or the provider. Information about how to raise a safeguarding concern was displayed in various places around the home so staff knew what action to take to escalate their concerns if they did not feel appropriate actions had been taken by the provider in response to safeguarding issues.

People indicated to us with their body language and nods they were happy at the home. Staff and people interacted with each other in a relaxed way, showing confidence and familiarity in each other. However, people at the home were not seen to mix with each other during all three days of our inspection visit. Most people spent their time in their room, or out in the local community.

The home was generally clean and free from odours. The manager conducted infection control audits to establish where any improvements were needed. Staff had received infection control training, and staff followed procedures for the correct use of protection equipment such as gloves and aprons, to reduce the risk and spread of infection.

The provider's recruitment process ensured risks to people's safety were minimised, as they took measures to check new staff were of 'good character.' The manager checked their DBS and references from a previous employer before they could work in the home. The Disclosure and Barring Service (DBS) is a national agency that keeps records of criminal convictions.

Requires Improvement

Our findings

At our previous inspection we rated Effective as 'Good'. At this inspection we rated it as 'Requires Improvement'. We found the management team did not have a full understanding of the Mental Capacity Act 2005 (MCA) and how to apply the principles of the legislation.

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 provider was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

The registered manager and the provider had not ensured that people always had relevant and up to date mental capacity assessments to determine when they needed support with complex decisions about their health and finances. We were concerned that people had been assessed as having limited capacity to make some decisions by other professionals, such as doctors and legal representatives. These assessments had not triggered the registered manager and provider to act in accordance with the MCA and consider where someone might require assistance to make a complex decision, and who should be involved in the decision-making process to act in the person's 'best interests'.

The registered manager understood the legal power of attorney process to ensure people's rights were protected, however, information about who held legal power of attorney to make decisions on behalf of people had not been recorded.

People were not always able to choose how they lived their daily lives, as care staff placed unnecessary restrictions on people. For example, one person at the home was unable to always chose when they could have a cigarette, as these were under the control of staff. Daily records showed staff discouraged or prevented the person from always accessing their cigarettes. In addition, staff monitored the food the person ate, and how much money they took out of their bank account. There was no authorisation in place

to support such actions.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Consent.

People were not always referred to healthcare professionals if there was a change in their health. Care records did not always show when people were seen by healthcare professionals and were treated for specific health conditions. For example, in one person's care records a general practitioner requested the person visit them for a review on the 16 July 2018. We could find no record of the review and staff were unable to tell us whether the review had taken place.

In another person's records we saw a general practitioner had highlighted, approximately 2 months before our inspection visit, a need for the person to receive tests and a referral regarding their thyroid, as blood tests indicated this may not be working as it should. Staff were unable to tell us whether the referral had been made or any follow up action had been taken.

Staff told us they received an induction when they started work which included working alongside an experienced member of staff. The induction was based on the 'Skills for Care' standards providing staff with a recognised 'Care Certificate'. Skills for Care are an organisation that sets standards for the training of care workers. The registered manager maintained a record of staff training, so they could identify when staff needed to refresh their skills.

However, we were not confident staff had all the skills they needed to support people safely and effectively. For example, the scheduled training did not provide staff with skills and training opportunities to understand mental health conditions, how to help people with physical health conditions such as diabetes, or how to assist people to manage their behaviours.

Staff training and development requirements had been identified in the provider's own investigation report of July 2018, to improve staff skills in several areas. The nominated individual told us staff had not yet completed those new training courses. It had been identified that a training course in 'Expressing sexuality/sexual needs of people in long term care' should be shared across the provider's whole organisation. The nominated individual confirmed this had not been actioned. We also found that staff had not always received training to support them in meeting their specific responsibilities. For example, the registered manager, who had specific responsibilities around the investigation and management of safeguarding concerns at the home, had received safeguarding training as a care worker, but not as a registered manager.

Staff told us they did not always have regular meetings with their manager where they could discuss their performance and identify training requirements. One member of staff told us, "I don't have regular supervision meetings, and if I do the issues I raise are not dealt with."

When people began using the service people were involved in assessing their needs. This involved assessing people's support, their nutritional needs and whether they required assistance to maintain their health. When people had a stay in hospital, or received medical treatment, there was no updated information in their care records which showed whether the level of care in place continued to meet their needs.

Each person could have their own food stored at the home, which staff supported them to prepare. However, items such as snacks were not available to people when they wished from the provider's food store, as some kitchen cupboards were locked. This did not promote choice and independence at the home.

The environment met people's needs. People could find their way around the home without assistance. Communal areas gave people a pleasant environment to socialise and a well-maintained garden offered people open space they could enjoy during warmer weather.

Requires Improvement

Our findings

At our last inspection we rated Caring as 'Good'. At this inspection we found people did not always have their choices respected, and staff were not always supported in a caring way by the provider. We have rated Caring as 'Requires Improvement'.

We looked at how people's privacy was protected by the provider. People's records were kept in the office which meant only staff could access this information. However, during our inspection we were told about a potential issue around the security of people's data. The nominated individual had taken steps to open an investigation into a possible data breach. They were investigating whether people's personal information had been shared inappropriately with external individuals. They told us they would keep us updated with the outcome of their investigations.

Staff members could tell us about the people they supported. This included people's life histories, where they used to live, what they used to do, and what they still liked doing. Staff members talked about those they supported with respect and fondness.

Staff were now always offered support from a caring provider. Staff were not always trained in how to support people safely, such as updated training in managing behaviours, which posed a risk to them in the workplace. Staff were not always supported by the provider to have regular individual supervision meetings with their manager, discuss their training needs, and participate in discussions about how the service should be run. One staff member told us, "I have infrequent supervision meetings. I have raised things with my manager, but things just haven't been done to support me."

Care records provided information about people's cultural and personal preferences, such as their religious beliefs and their sexual orientation. These personal preferences offered people an opportunity to engage in cultural or religious activities and maintain their sense of individuality and identity.

People were supported to maintain relationships with those that mattered to them. Friends and families could visit people at the home. Private areas were available for people to spend time together when needed or requested. Staff respected people's individual privacy in the home, by knocking on people's doors and asking their permission before entering their room.

People were supported to be as independent as they could be in developing and maintaining their living skills. For example, by undertaking their own personal care where they could, doing household chores and

laundry.

Requires Improvement

Our findings

At our last inspection we rated Responsive as 'Good'. At this inspection we have rated Responsive as 'Requires Improvement'. This was because people were not always supported with up to date care records that were person centred. People's preferences and choices were not always respected.

Care records were not up to date, for example, people did not have up to date information in their risk assessments and care records to instruct staff on how they should be cared for effectively, safely and responsively. This meant their care records were not written to support them individually according to their current support requirements.

Records contained information about people's life history, details about their family, school, their work and life experiences and their likes and dislikes. This information had been gathered when they came to the home, or updated at review meetings. However, there was a lack of information in people's records about what goals they would like to pursue to achieve independent living status (where this was an option for people) and how staff could support them to achieve more independence.

One of the aims of the provider was to meet people's life goals, to provide them with enjoyment and achievement in their lives. The provider aimed to do so through a programme where people are supported to work towards targets they identified, for example, to help them achieve better personal hygiene. Although people had been involved in setting goals, how these were being achieved, or what strategies were put in place to help people achieve their goals was unclear. The progress against people's targets was difficult to understand, as there was no information available to us about what goals people had already achieved, or steps towards their ultimate goals were being identified.

The 'Accessible Information Standard' (AIS) aims to make sure that people who have a disability, impairment or sensory loss, get information that they can access and understand and any communication support they need. People at the home did not have any specialist requirements identified by the provider as part of their care and support needs for their communication. However, we found some people struggled to communicate with us during our inspection, which may have been due to their mental health conditions. Care records did not describe how people in social and community settings should be assisted to communicate with people. No-one had been provided with specific communication tools to assist them, such as picture cards or electronic devices.

Records instructed staff about what types of social interactions and stimulation each person enjoyed.

Throughout this inspection we saw some people engaged in music, exercising and social engagement. People indicated to us, and we saw, they regularly went out to places of interest. Each person chose individually what they wanted to do with their time.

People knew how to raise concerns with staff members or the manager if they needed to. Where complaints had been recorded, the registered manager had followed the complaints procedures to answer and conclude complaints investigations. However, previous complaints and incidents at the home had not always been recorded and investigated when they were raised with staff. This lack of recording was highlighted in the provider's own internal investigation in July 2018. The registered manager and provider assured us that any complaints received at the home were now being recorded and investigated, in accordance with their complaints policy.

No-one at the home had end of life care arrangements in place. Where people wanted to engage in discussions about end of life arrangements, the registered manager told us this was on offer to people.

Inadequate

Our findings

At our previous inspection we rated Well Led as 'Requires Improvement'. This was because the provider had not fulfilled their regulatory requirements and their auditing systems were not effective at monitoring where improvements had been made at the service. At this inspection we continued to find the provider had not fulfilled their regulatory requirements, and their auditing systems and procedures needed to be improved. Because of the seriousness of the concerns we found and a lack of action to make those improvements, the provider is in breach of the regulations. We have rated the service 'Inadequate' in Well Led.

There was an established registered manager at the home who had been in their post since January 2018. 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.

The registered manager only worked at the home one or two days a week. We were told a service manager was allocated to work at the home for 2.5 days per week. However, we checked the rotas for the last three months to see whether these staffing levels had been met. Rotas showed for November 2018 and December 2018 the service manager was on site for no more than two days each month.

The registered manager also managed three other homes in the provider's group, and spread their time and attention between all four services. This meant they were not able to provide staff and people with regular on-site leadership and support. In addition, no managers worked at the weekends so staff had no onsite support of a senior staff member at all times.

We were concerned that there was not an open and transparent culture within the service. For example, we were told by a staff member that a nurse worked at Thistley Lodge for 2.5 days each week. We later found there was no nurse contracted to work at the home. In addition, when we asked another member of staff for a person's medicines records, they told us they were not on site, we later found out this was not correct. The registered manager was apologetic in how we had been responded to, and agreed that staff needed to be more professional and supportive of the inspection process.

There were no nurses working at Thistley Lodge when we inspected the service. This did not meet the provider's regulated activity of providing treatment for disease, disorder and injury and diagnostic and

screening procedures to people living at Thistley Lodge.

There was an 'on call' arrangement for staff to gain advice from nurses located at other services during daytime hours, and at night via the telephone. However, this did not provide immediate clinical support on site, as nurses were not always available to leave their usual role to attend the home. Following our inspection visit, the provider agreed to employ a nurse at the service several days a week to provide people and staff with clinical support and guidance and to meet their regulated activities.

A lack of clinical and management support meant people did not receive good quality care, as their health and safety needs were not being evaluated and assessed according to their needs. Auditing procedures were not in place to identify poor care practices, and prevent people from receiving care that did not meet their needs.

The registered manager had highlighted with the provider in a supervision meeting in September 2018 they lacked the capacity to continue to manage four services. However, we could not see the provider had responded to these concerns, only recognising that the registered manager was struggling to respond effectively to competing priorities.

Some people living at the service were on community treatment orders which required government agencies to be informed on a quarterly basis of how those people were cared for. In some cases, we found these agencies were not informed which meant the provider failed in their legal duty.

The registered manager told us one recent challenge at the home had been the retention and recruitment of staff. Vacancies were currently being recruited to, however, the provider was going through an organisational re-structure, so agreed staffing levels were not yet confirmed for the home.

We asked how the registered manager assured themselves staff levels were safe. They told us there was no staff dependency tool or calculation undertaken by the registered manager or provider to calculate the number of qualified, skilled and experienced staff required to meet the health and care needs of people at Thistley Lodge. The commissioned care for each person had not been taken into consideration in determining the number of staff, including nurses, needed on site to care for people, as agreed by the local authority.

We found the registered manager needed a clearer understanding of what physical and emotional support people needed to determine the number of staff needed at the home. The lack of leadership and clinical governance had impacted on the care people received, as risks to people's health were not being managed.

The registered manager had raised with the provider the concerns they had about the lack of leadership at the home, and the limited time they spent at Thistley Lodge. Records showed the registered manager had raised these issues with the provider September 2018. The provider had not acted to improve leadership at the home.

The registered manager told us they, and the provider, had recognised staff shifts of 12-hours were too long, as staff were tired and this placed them and people at risk. They told us the provider had recently implemented a system of six-hour shifts at the home, however, rotas showed, and staffing levels demonstrated, staff continued to work 12-hour shifts. The provider had failed to take appropriate action to remedy this situation.

The registered manager told us they did not regularly spot check staff performance, and supervision

meetings did not always take place to support staff with their professional development needs. This lack of governance did not provide staff with the guidance they required to effectively support people.
Quality assurance systems were not being maintained and used effectively to identify areas that could be improved at the home. The registered manager told us there were insufficient resources available to maintain a regular schedule of audits.

Accidents and incidents were being recorded each month, however, these were not being analysed and monitored by the registered manager or service manager to identify if patterns and trends were developing around people's health and care needs. The provider told us this information was being analysed at a higher level by quality assurance staff, but was not being shared with the registered manager. This did not assist the registered manager to assess whether the premises required improvement to prevent accidents, or whether people's care and support required review, to minimise risks to people in the future.

The provider had a quality assurance team in place that were visiting the home every three months to conduct some audits. The most recent audit was in September 2018. However, the audit procedure was ineffective in identifying the issues we found at our inspection. For example, care plan reviews were not reflective of people's needs, and risks were not being adequately managed. The head of quality assurance explained auditors and internal quality teams reported and analysed audit information sent to them from home managers, however, this was reliant on home managers reporting information correctly, rather than the provider completing their own due diligence checks. The head of quality assurance recognised some of our concerns may have been avoided.

We reviewed an internal investigation report completed in July 2018 by the head of quality assurance into the safeguarding concerns at this home. Their investigation was frank, honest and identified significant failings in incident recording, staff honesty and culture, that meant concerns were not taken seriously. For example, they identified staff needed training in several areas, reviews of lone working policies needed to be undertaken and cultural changes needed to be made around what should be reported. No action had been taken to address those concerns. Training had not been completed, staff continued to work outside the lone working policy and staff recording continued to vary in quality and accuracy. There was an acknowledgement from the nominated individual that identified actions had not been implemented since the report was produced in July 2018.

The culture that existed at the home impacted on people who lived there. Minutes of staff meetings recorded poor staff practice and the registered manager gave us examples, such as staff leaving earlier than planned and falsifying records. Staff told us they did not always feel valued and listened to. This promoted a culture that did not support staff and ultimately meant people received levels of care that fell below expected standards.

Because of our concerns on our 4 December 2018 visit, we wrote to the nominated individual to ask them to tell us what immediate action they would take to ensure people were safe. Their responses were followed up on 7 and 11 December 2018. The nominated individual told us they were disappointed in what we had found during our inspection, especially around a lack of effective care records, staff responses to us, concerns with how some important medicines were managed and the culture that continued to exist. They explained how a succession of transformation plans and reorganisation had hindered progress and put additional pressure on the registered manager. The lack of nursing staff also reduced the levels of good care people received. The nominated individual said they were committed to making improvements to this service.

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

2014, Good Governance.

The registered manager and provider did not understand their legal responsibilities to notify CQC of any serious incidents or safeguarding concerns at the home. From the provider's own internal investigation report dated July 2018, several significant incidents and safeguarding concerns had been identified, but had not been notified to CQC.

In addition, the registered manager and provider had failed to notify CQC of the absence of a registered nurse at the service.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Registration) Regulations 2009, Notification of other incidents.

The registered manager had displayed the ratings from the previous inspection in the lobby-way of the home and on their website. It is a requirement of the regulations for the provider to display their overall rating in a conspicuous location for visitors and anyone entering the home to see the current rating of the service.

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents (2e,gi) The registered person had not notified CQC without delay of any abuse or allegation of abuse in relation to a service user, and any event which prevents, or appears to the service provider to be likely to threaten to prevent, the service provider's ability to continue to carry on the regulated activity safely, or in accordance with the registration requirements. This includes an insufficient number of suitably qualified, skilled and experience persons being employed for the purpose of carrying out the regulated activity.

The enforcement action we took:

We imposed a condition of registration on the provider

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent (3) The provider had not ensured where service users lacked the capacity to consent to their care and treatment, they had acted in accordance with the 2005 Act.

The enforcement action we took:

We imposed a condition of registration on the provider

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment (2a,b,c,g) Risks were not always assessed, or

Treatment of disease, disorder or injury	mitigated against. Staff did not always have the qualifications, competence, skills and experience to provide care and treatment safely. Medicines were not always managed safely.

The enforcement action we took:

We imposed a condition of registration on the provider

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment (3) Systems and processes were not established and operated effectively, to investigate, immediately on become aware of, any allegation or evidence of such abuse.

The enforcement action we took:

We imposed a condition of registration on the provider

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance (1a,b) Systems and processes had not been established and operated effectively to ensure compliance with the regulations, to assess, monitor and improve the quality and safety of the services provided. In addition, to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users.

The enforcement action we took:

We imposed a condition of registration on the provider

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing (1) There were not always sufficient numbers of suitably qualified, skilled and experienced staff in order to carry out the regulated activity.

The enforcement action we took:

We imposed a condition of registration on the provider