Mrs Karen Syer & Mr Kenneth John Squire

The Lodge Care Home

Inspection report

Watton Road
Ashill
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Ratings

Overall rating for this service	Inadequate
Is the service safe?	Inadequate
Is the service effective?	Inadequate
Is the service caring?	Requires improvement
Is the service responsive?	Inadequate
Is the service well-led?	Inadequate

Overall summary

We received information of concern that people were being got out of bed very early in the morning. We brought the planned inspection forward because of these concerns. It took place on 21 August 2015 from 4.30am and was unannounced.

The Lodge Care Home provides accommodation and support to a maximum of 20 older people, some of whom may be living with dementia. At the time of the inspection there were 16 people using the service.

It is operated by a partnership with one of the partners being registered as manager. That person is referred to as the registered manager throughout the report. 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.

We found widespread and serious issues throughout the service indicating a significant deterioration in the quality

Summary of findings

of care since previous inspections and the last one in October 2014. There were nine breaches of regulations affecting the quality and safety of the service that people received.

People expressed mixed views about the service. Some felt that staff, although rushed, supported them well. Others had concerns about the way they were supported and how staff responded to their needs and preferences. Relatives felt that staff were able to meet people's needs.

People's safety had been compromised. Staff were not trained in recognising and responding appropriately to abuse and did not always recognise what might be seen as abusive or institutional practice. Risks to people's safety were not robustly assessed and managed. Recruitment processes were inconsistently applied, and did not properly contribute to protecting people using the service.

People did not receive effective care. The provision of training had deteriorated over the last year so that some new staff had little or no training and induction. Some staff had been placed in positions of seniority but without completing basic induction training or having done so in previous care work. Staff did not always understand how to support people who may be unable to make their own, informed decisions and focused more on responding to those who were able to express their views. There was a reactive rather than proactive approach to some aspects of promoting people's health. However, staff did respond to and act upon medical advice that they were given.

Staff responded kindly and warmly to people they were supporting, but day to day practices in the home did not properly promote people's dignity, privacy and independence.

Institutional routines had developed which did not promote care focused on the needs of each person. This unreasonably compromised people's choices which resulted in some people being woken up to get out of bed from 3.15am. As at our last inspection, opportunities for recreational and social activities were limited.

The service was poorly managed. The registered manager had not recognised and identified where the service was failing. There was limited auditing of the quality and safety of the service and mitigation of risks. There was also a lack of transparency and openness in dealing with other professionals. Improvements were not made and sustained in response to concerns or suggestions.

The overall rating for this service is 'Inadequate' and the service is in 'Special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

We will follow up the enforcement action we have taken after 5 November 2015.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was not safe.

People were not always protected from abuse because there was a poor understanding of what might constitute abuse.

Risks to people's safety and welfare were not robustly assessed and managed.

Recruitment procedures were not consistently and rigorously applied in a way that contributed to promoting people's safety.

Medicines were managed in a safe way.

Inadequate

Is the service effective?
The service was not effective.

The arrangements for staff support, training and induction were not robust. This meant people could not be sure that staff were competent to meet their needs.

People sometimes went for long periods without drinks, causing them some anxiety and putting them at risk of dehydration.

People were referred appropriately for medical advice, but the approach to some aspects of care was not proactive in promoting their wellbeing.

Inadequate

Is the service caring?
The service was not consistently caring.

Day to day practices within the home compromised people's privacy, dignity and independence.

Some staff interacted with people in a warm and kind manner.

Requires improvement

Is the service responsive?
The service was not responsive.

People's preferences were not acted upon and their needs were not responded to in a person-centred way.

Opportunities for social or recreational activity were limited.

Inadequate

Is the service well-led?
The service was not well-led.

There was a lack of application of effective systems to monitor the quality and safety of the service and to manage and mitigate risks.

Inadequate

Summary of findings

There was a lack of transparency and objectivity in responding to and learning from complaints and incidents to improve the experiences of people living in the home.

The Lodge Care Home

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 21 August 2015 and was unannounced. It was completed by an inspector and inspection manager.

Before we visited the service we reviewed the information that we held about it. This included information about events happening within the home that the registered persons are required to tell us about by law, for example relating to deaths or injuries. We also reviewed information about complaints and safeguarding concerns. We gathered information from a safeguarding practitioner and quality assurance officer from the local authority.

During the inspection we observed how people were being supported both by night staff and then day staff. We spoke with five people who used the service. We also spoke with two relatives, a visiting health professional and a training assessor. We spoke with five care staff, the registered manager and the cook.

We reviewed records associated with the care of seven people and their medicines administration records. For some of these people we also used 'pathway tracking'. This is a method of checking how people are supported at each stage of their care. We looked at records of recruitment, training and supervision of staff and a sample of other records associated with the management of the home.

Inadequate

Is the service safe?

Our findings

We commenced this inspection at 4.30am due to concerns that we had received and which had been investigated by the safeguarding team.

Staff were not all able to confirm that they had received up to date safeguarding training. One staff member said they had not received this and another said they thought they had but it would have been a long time ago. Staff were not clear where they could report any concerns outside the service if they were not able to raise them with the manager for any reason. They did not recognise that waking people to assist them to get up from 3.15am was potentially abusive.

The registered manager had given information to the safeguarding team who visited the service on 13 August 2015 that did not correspond with what we found during our visit. She had told the safeguarding team that people would get up from 5am if they wished. We found that staff were consistent in their information about people being assisted to get up from around 3.15am. We saw that five people were already up in the lounge by 4.30am. Two were in nightclothes and three were fully dressed. The registered manager told the safeguarding team that there was a diabetic care plan in place for one person. We found that this was not the case when we asked for it to be shown to us. The registered manager told us she had, "assumed it was there" when she had provided the information as part of the safeguarding team visit. We concluded that the registered manager had not effectively investigated the safeguarding concerns when she was made aware of them by the safeguarding team and was asked for information.

The registered manager had also told the safeguarding team that no one was locked in their room at night. However, all rooms we checked were fitted with locking bolts for which staff carried 'star' keys. One person, assessed as sometimes being confused and living with dementia, told us, "I don't like [another person using the service] coming in my room at night." They went on to tell us that staff locked them in and they had to wait until staff unlocked their door in the morning so they could come out of their room. Although the person had their own key there was no keyhole on the inside of the door and so they were unable to unlock or open the door themselves. We observed a staff member take them a cup of tea at 6.20am who had to unlock the door before going in. We concluded that the person was effectively being inappropriately restrained.

These issues represented a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found that assessments of risk posed to people were not properly and robustly assessed. For example, although there was a chart indicating how to assess a person's body mass index (BMI) and whether this was healthy, assessments of people's BMI's had not been completed. The information was not used to properly assess people's risk of not eating enough and to identify action to address the risk. We could see that people's weight was monitored but unintended weight loss was not followed up. For example, we found that one person had lost weight on each of four consecutive months from April to July 2015. No remedial action was taken to address this, which left the person at risk of poor nutrition.

Individual assessments of the risk of pressure ulcers did not take into account the nutritional status of each person, their overall health, age, gender or specific health conditions and medication. All of these have an impact and increase risk to people of developing pressure ulcers. This meant that risks of people developing pressure ulcers were not being accurately assessed and therefore there was a risk that the appropriate action was not taken to prevent these from occurring. While we were present, one person complained of a sore area on their body and asked the staff for some cream. A staff member attended to this promptly but there was no specific plan of care for the person showing how the risk was being managed and for checks on their vulnerable pressure areas to minimise risks.

Another person being cared for in bed and at risk of pressure ulcers, they were recorded as having developed a sore sacrum in February 2015. Daily notes indicated the repositioning chart had been put, "back in place" only after a sore area started bleeding on 15 August 2015. This meant that repositioning had not routinely been used as a preventative measure to help protect the person from developing pressure ulcers. Staff were unable to locate these records to show that the person was being

repositioned regularly to minimise risks and alleviate pressure on vulnerable points of their body. A senior member of staff was not aware that the repositioning charts had been reintroduced.

One person's care records showed that they had been assessed as at high risk of falls on 3 July 2015. The assessment showed that the person used a walking frame and staff were to give them support to walk and to stop them getting up from their chair too quickly. However, between 4.30am and 6.15am on the day of our inspection the person was sitting in the lounge without staff supervision. This meant that the person was at high risk should they attempt to get out of their chair on their own.

In three of the care records we reviewed we found that people were assessed as presenting a risk to the safety of others or of staff, from their behaviour. Assessments simply directed staff to assess the person's mood when they were working with them. There was a lack of clear guidance in care plans about circumstances staff should try to avoid, which actions they should take to minimise this risk and about potential triggers that could increase the risk.

The arrangements for people's safety in the event of an emergency such as a fire had not been properly assessed. If an emergency did occur one person was potentially at increased risk because they were locked in their room. There was neither an individual assessment for this person's risk, nor a reflection of the practice within the fire risk assessment for the home. We have referred this finding to the fire safety authority.

These issues were a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager had provided the safeguarding team with information about one staff member who was working without a valid and enhanced disclosure to confirm they were not barred from working in care. They informed the safeguarding team that the staff member was working as a cleaner alongside another domestic so that they were supervised, while the registered manager waited for the disclosure and a second reference. However, we found from the duty roster that the staff member had worked shifts in care, including night shifts, before the appropriate checks were completed. This included some shifts before the safeguarding team had visited and an early shift on the day of their visit. For another staff member we found that neither of the referees given on their application form had been contacted for references and that the manager had written one of the references herself. Recruitment processes were not robustly and consistently applied to help promote people's safety and ensure they were properly protected from unsuitable staff.

This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During the course of our inspection we noted that there were some delays in attending to people's needs even though there were three staff and the registered manager in the home after 7am. For example, one person who was up at 4.30am and in nightclothes because they were due to receive assistance with a bath, waited for almost six hours before being assisted. Two relatives told us that staff cared for people well but one commented it was sometimes difficult to find a staff member if they needed to. However, we saw that call bells were responded to promptly.

There were 16 people at the home at the time of our inspection. The registered manager told us that, if occupancy dropped to 15, there would be two staff on each shift. We noted from duty rosters that this was the case for the weekend following our inspection. Most staff worked long days and were entitled to breaks although they could not leave the home during these. We also noted from discussions with staff that, during the afternoon, one member of the care team was required to prepare and serve tea. This meant that, with only two staff on shift, staffing levels would effectively be reduced to one for the duration of the breaks or while staff were in the kitchen.

Staff told us that three people needed assistance from two staff to deliver their personal care. They said this was due to difficulties with their behaviour which presented a risk to the person and staff. One person needed a hoist, which required assistance from two staff, and another used a stand-aid although their care plan was not clear how many staff were needed to support them in using this safely. We asked that the registered manager review shift patterns and people's dependency levels promptly to consider whether staff were deployed in a way that met people's needs safely.

One of the aspects of the safeguarding concern raised with us was that staff were administering insulin without having received the necessary training. This was not substantiated

Inadequate

Is the service safe?

as we could see staff who administered insulin had received training and an update had been arranged for some staff. This was being delivered by a diabetic nurse specialist.

We reviewed the arrangements for managing medicines and medicine administration record (MAR) charts. We found that there was a lack of written guidance for staff about the use of medicines that were for occasional use (PRN), when these should be given and under what circumstances. For example, one person was prescribed a medicine to use should they become distressed. We found that there was a lack of guidance within records about what staff should do or try before giving the medicine. However, a staff member was able to explain when this would be used and what would be tried first in order to reassure and calm the person.

The senior staff member responsible for administering medicines on the day of the inspection followed a safe procedure for administering them, checking the MAR chart and medicines pack and signing the record after they had seen the person take their medicines. They told us they were responsible for checking and auditing medicines. They also said that new or inexperienced staff shadowed them during the administration round and were then observed administering them to ensure they understood how to do this. We noted that there were no records of assessments of competency to ensure consistent practice was followed but the staff member concerned told us how errors would be followed up by more monitoring and supervision.

Inadequate

Is the service effective?

Our findings

Staff spoken with told us that there were gaps in their training. For example, one senior carer who started work at the home almost a year before this inspection said they had not yet had training in moving and handling people safely but the registered manager was arranging this. They told us they had a workbook to complete for managing medicines but had not yet started it.

Another staff member had been promoted to a senior carer's role, with no previous experience of working in care and no induction. The staff member was in charge during night shifts without essential training such as fire safety, first aid and moving and handling to ensure they were competent and capable of meeting people's needs. They told us they had been shown what was expected of them by another member of staff. That member of staff told us they had been on night shifts for about four months and had themselves been shown what to do by another member of staff and not had a formal induction or training. This presented a risk that new staff would learn from others who may not perform as well as they should, rather than learning what was best practice. This placed people at risk of not receiving appropriate care.

The registered manager told us that there were no records for the induction of new members of staff as they had not received induction. She said that she had to 'throw staff in the deep end' because of staff shortages and recruitment difficulties. During our discussions she confirmed that one newly appointed senior carer in charge of some shifts, had no experience of working in care, no induction and no proper training in medicines, diabetes, dementia awareness and first aid. She informed us that the staff member had watched other staff giving medicines but did not yet administer these. This conflicted with the information given to us by other staff and a signature on a medication administration record showing that the staff member had given medicines. We asked the registered manager to immediately arrange alternative senior cover for night shifts pending the person completing appropriate training and induction.

We reviewed training records and found that very little training had taken place since 2013, with the exception of a fire safety questionnaire completed by some staff in 2014 and some training in the administration of insulin for senior staff. The registered manager told us that she had recognised that training was out of date and so had sourced a new training provider. She had printed off work books and knowledge tests but none of these had been completed by the time of the inspection. Although some staff were registered for further qualifications in care, a training assessor said that it was sometimes difficult to complete a competency assessment because staff had not completed the foundation training required.

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

At the last inspection in October 2014 we were informed that no one living in the home lacked the capacity to make decisions. However, we found that this was not the case during this inspection. One staff member confirmed that they and the registered manager had attended recent training in the Mental Capacity Act (MCA) 2005 and associated Deprivation Of Liberty Safeguards (DoLS). However, other staff had not received this. The way that the capacity of people to make specific decisions was assessed did not show that staff understood and applied the principles of the MCA. For example we found that one person was recorded as having "no mental capacity" to have any input into their care plan due to their level of dementia. There were no assessments in relation to individual, specific decisions, for example about the need for personal care or assistance with continence management. People's capacity to make such specific decisions was not assessed to ensure that their rights were promoted and any decisions about their care reflected their best interests.

We found that when staff felt that people could express their views and preferences verbally, they respected these. For example, they were able to tell us about the two people who liked to get up later in the morning. This included one person who liked to have a lay in and who staff said would be cross if they were woken too early. Staff told us that, in their opinion, some people were happy to get up from 3.15am. However, some of the people who had been assisted to rise early told us they were not happy with the arrangement, yet they had still been woken and assisted to get up extremely early. This reflected a lack of staff knowledge about obtaining meaningful consent from people, particularly from those who were living with dementia.

Inadequate

Is the service effective?

As a result of one staff member's recent training in DoLS, the staff member who had attended told us they felt that most people who lived at the home were not able to make their own decisions about leaving the service. They told us that the registered manager had recently completed applications to the supervisory body to ensure people's rights were protected when their freedom of movement was restricted.

We noted that people who were up early were not offered a drink until 6.15am, even though some of them had been up for at least two hours. Based on information from staff about the time they started to assist people, this could have been three hours for some of them. One person told us that, "I'm desperate for a cup of tea." Two other people repeatedly entered the dining room and said they were thirsty. One tried the kitchen door on more than one occasion and asked inspectors where they could get a kettle from.

Staff told us that most people generally went to bed after tea which was served at around 5pm to 5.30pm. They told us that they offered people hot drinks and biscuits during the evening but that most people were in bed and asleep so did not have this. This meant that, for some people, and based on the provision of drinks in the morning of our inspection they could have been without a snack or any drink for a period of up to 13 hours.

We spoke with one person about their food preferences and they told us they were vegetarian by belief and had been for a long time. They said that they normally had the same main meal as others but without the meat. When we discussed with them what was for lunch, they told us that they did eat fish. However, the cook told us that the person used to be a vegetarian but was no longer. This meant that the person might not be offered appropriate needs that met their beliefs and preferences.

People told us that they liked the food. Two people told us they were looking forward to their lunch and were pleased that it was to be fish and chips. We observed that this looked and smelled appetising. One person did tell us that they liked to have vinegar on fish and chips but had been told this could not be left out on the table because other people could drink it. However, we did observe at lunch time that vinegar had been put onto the food of people who liked it. The same person also told us that staff put salt on for them because this was not left out but there was too much so they had stopped having it altogether.

Staff were able to tell us about those people who needed particular assistance to eat and drink enough. They gave us consistent information about people who needed their drinks thickened due to swallowing difficulties. They could also tell us about people who needed soft diets or supervision with their meals to minimise the risk of choking or because they had trouble with their teeth. They also told us about people who needed assistance and how they were supported to eat. We saw from one person's care records that an appropriate referral had been made to the speech and language therapist regarding their swallowing difficulties. The advice that the professional had given was within the care records and staff were aware of these.

There was variable information about how people were supported with routine health care needs. One person confirmed to us that the chiropodist visited and there was a separate record for this within the office rather than within their care plan. They had expressed concerns in a survey for the provider that there were no routine dental check-ups and that they felt the service would wait until they had toothache before action was taken. We noted that this had happened and they confirmed they had been taken to the dentist recently as a result of a suspected infection. Antibiotics had been prescribed and obtained to help address the infection. They were hoping that the service would arrange routine visits for them in the future. We saw that there was no reference within the plans of care we reviewed regarding people's dental care or arrangements for monitoring to ensure their oral health.

We were able to establish from records and discussion with staff, that district nurses, speech and language therapy and occupational therapist had been involved with some people. A visiting healthcare assistant told us that they felt staff referred people to their team appropriately when treatment was needed and liaised well with the GP. They felt that staff had good knowledge of people's health care needs and followed their advice about caring for people.

Requires improvement

Is the service caring?

Our findings

We observed that there was institutional practice within the home's routines which did not reflect people's preferences and did not promote a caring approach to the provision of people's care. We found that there was a message for night staff in the communication book that they should, "try harder getting certain residents up. It's the way you go in and the way you act around them, if they refuse or not. If you have the right attitude they will get up." A further notice displayed set out what night staff were supposed to be doing and that they should, "give people their personal care, use deodorant and shave the men." We noted that duty roster showed that the night shift finished at 7am so that there was clearly an expectation from the registered manager that staff would be assisting people to rise early before they finished work. Staff reported this as regular practice and that most people were up before the day staff arrived for duty.

We found from guidance for night staff, recorded checks and discussion with staff, that people were checked routinely and regularly during the night. The need for this had not been individually assessed. This was institutional practice and not designed around the needs of each individual or dependent upon risk.

For one person, we observed that the staff member entered their darkened room at 5.30am without knocking or saying who they were, and put the overhead electric light on. We saw a staff member assisting another person to put on their underwear and trousers while they were sitting on the commode. The door of the person's room was wide open so that they were in plain sight from the corridor. We also observed that one person was in the lounge at 4.30am in their dressing gown. Staff explained that this was because they were going to have a bath when the day staff came in. They were still there, waiting for their bath at 10.15am in their dressing gown although they told us that they wanted to get dressed. Their night dress was up round their thighs and staff did not intervene. We concluded that people's privacy and dignity was not consistently promoted.

One person had their hair washed and staff dried and styled this with a hair dryer. However, this was done in the busier of the two lounges where other people were watching television and without respect for the fact they could no longer hear it.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was no information within the care records we reviewed about people's personal histories so that staff could engage meaningfully with people who were living with dementia and get to know them well. We also found that people who were still able to read but may be confused, could have been disorientated by information displayed on the whiteboard in the hall. This showed who was on duty but was dated 19 August, two days before our visit and had not been updated. This was put right during the course of our inspection.

We saw that staff were patient, calm and kind with people. They sat next to people when talking to them, made eye contact and on occasions touched people gently to offer comfort and reassurance. They also spoke respectfully about people to one another and during hand over. However, the practices we observed were not representative of a consistently caring service.

One person told us that they felt 99% of the staff were good. However, another person told us, "Most staff are good but there are one or two that don't want to do anything." Two relatives expressed confidence in the way that staff supported people and met their needs. One told us that they felt confident that staff would take action if anything happened to the person such as having an accident or becoming unwell.

Inadequate

Is the service responsive?

Our findings

The service was not responsive to people's needs or preferences. The routines were organised in such a way as to suit the staffing arrangements in the home and particularly to reduce the workload on the day staff. This meant that care was not provided in a person-centred way focused on the needs of each individual. At the time we arrived five people were up by 4.30am with four of them asleep in the lounge. Staff that we spoke with during the visit told us that it was normal practice to start getting people out of bed at 3.15am and they continued to do this until the day staff arrived. Day staff told us that it was usual for the majority of people to be up when they arrived to commence duty at 7am. None of the people who were up, including those already dressed and in the lounge by 4.30am was offered anything to drink until 6.15am, up to three hours after they were assisted to get up. No one was offered any breakfast before 8am.

At our last inspection of the service we were informed that people chose their own daily routines, including getting up and going to bed when they liked. At this inspection we found that things had deteriorated. Where people's preferred routines were shown within their plans of care, these were not always respected. Records did not show how people were consulted about and involved in arrangements for their own care.

For example, we found that one person was up, well-groomed and dressed and sitting in the lounge at 4.30am. Their daily routine in their care file showed that they had no difficulties sleeping. It stated that they usually woke at around 6am and liked a cup of tea taken up to their room. The person told us, "I don't mind getting up early" but that they had got up because they were woken up, not because they had wanted to. The same person told us just before lunch time, "I don't know what's wrong with me. I don't feel at all well. I can hardly keep my eyes open." Another person told us that they didn't like getting up early but that someone had got them up. They told us, "I was awake but I would have preferred to stay in bed."

Staff told us that people were usually ready to get up from 3.15am because they went to bed very early, usually after tea. We discussed with the registered manager that a habit had developed in that people would certainly be tired later in the day because they had been assisted to rise so early.

We found that one person had seen the GP two weeks before our visit and their notes recorded that they had a grade one pressure sore on their right ankle. Their skin condition had deteriorated and we noted that they had problems with cellulitis and leg ulcers. However, their assessment, completed in February 2015, had not been reviewed or updated in response to their changed condition, to be sure it reflected their current needs and to provide guidance for staff about meeting them.

As at our last inspection in October 2014, people expressed concerns that there was not much to do. The registered manager told us at that time that a full time activities coordinator had been employed to help meet people's social needs. At this inspection we found that it had not happened and there had been no improvements in meeting people's social and recreational needs. Staff said that they tried to spend time with people but this was not always possible, depending on shifts. One person told us that although staff were good they didn't have time to spend chatting. They went on to say, "I suppose it's all right if you haven't done anything all your life. I'm really brassed off. There's nothing to do." Another person told us, "I would like to see more going on. I'm only watching TV for something to do because there isn't much going on."

These concerns were a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Care plan documentation contained a lack of guidance for staff to follow about meeting people's needs. Most of the information consisted of tick boxes and was focused primarily on personal care needs. The impact of this was slightly mitigated as it was a small staff team. Staff said that they were shown what they needed to do to meet people's needs by more experienced colleagues. However, due to the lack of experience of several of the senior care staff and the lack of training for all staff, there was a risk that staff would still not have a clear understanding of how to meet people's individual needs.

There was information for people to refer to about making a complaint on the noticeboard in the main hallway. This had the up to date information about referring concerns to the Care Quality Commission as the regulator of care services, but referred in the centre of the information to the previous regulator. Information displayed for staff about the management of complaints and raising concerns referred to the previous regulator and contained contact

Inadequate

Is the service responsive?

details that had not been in use for approximately six years. There was the potential for confusion among people and staff about how a complaint could be raised and addressed or who to contact regarding any concerns about the way the service was being run.

Inadequate

Is the service well-led?

Our findings

We checked whether the registered manager had told us about incidents happening within the home and which must be notified to the Care Quality Commission (CQC). We found that they had not made any notifications of deaths or other incidents to CQC since 2012. We checked the register of admissions of people admitted since the start of 2013 and identified at least seven deaths that we had not been notified about. We did not check whether anyone admitted before that date had also passed away. We found that one death in March 2015 was unexpected and referred to the coroner. Again this event had not been notified as required. The registered manager told us that she was not aware she needed to inform us about deaths within the service.

This was a breach of Regulation 16 of the Care Quality Commission (Registration) Regulations 2009.

Despite a visit from a safeguarding practitioner and quality assurance officer in August 2015, in response to an allegation of abuse, the registered manager had also failed to notify us of the allegation and what action she was taking in response to this.

This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

There was a lack of audit systems for monitoring of the quality and safety of the service people received and for learning from findings. Despite a complaint being raised more than eight months before this inspection about the times people were getting up, and a recent safeguarding referral and investigation, the registered manager had not identified this as custom and practice and a potential infringement of people's rights and wishes.

We had concerns about the way the registered manager had responded to requests for reassurance and information about these issues, which did not indicate transparency about what was actually happening within the home. We concluded that the management of the service had not fostered a culture that was person–centred, open and which improved the quality of care and their practice in response to concerns.

Audits of medicines and staff competencies were not recorded to ensure they were robust, objective and consistent. Recruitment practices were also not objectively and robustly applied, including where the registered manager was employing family members or friends of family members.

Staff training was not kept up to date. This included a lack of appropriate induction programmes for new staff who were learning from colleagues rather than from best practice in the care sector. This presented a risk that people would not receive high quality and consistent care and potentially contributed to the institutionalised care we observed.

The fire risk assessment stated that the fire procedure was displayed in the hall for reference. However, there was no clear guidance on the noticeboard other than a floor plan. The registered manager had not recognised that further assessment was needed in relation to one person whose room was being locked while they were in it, or explored other options for securing their door that could better enhance their experience of the service and their safety within the home.

There had been a survey of people living at the home for their views. We found that there was no action plan developed to respond to people who had identified improvements they would like to see. Given the deterioration of the service between the last inspection and this one we concluded there was a lack of planning to drive continuous improvement.

No rigorous assessments of people's dependency levels had been undertaken to see whether staff levels remained adequate to ensure the safe running of the service. The registered manager was relying on numbers of people in residence to establish how many staff were required. This did not take into account changes in people's health, need for assistance with mobility, personal care and managing behaviour which may present a risk. It did not take account of the numbers of people who were living with dementia and needed more time to make decisions or to receive care at a pace that suited them.

The registered manager had not identified the issues and concerns we found during this inspection. We spoke with her about this. She did not have a good understanding of current regulations she needed to comply with and the standards that she was responsible for achieving.

Inadequate

Is the service well-led?

These concerns were a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us that they enjoyed working at the home and found the registered manager approachable. The manager prided herself on the fact that the home was run as a family business with several of her relatives working there. However, the lack of robust quality assurance systems meant that there was a risk that areas for improvement would not be effectively identified and actioned.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment Systems and processes were not established and operated effectively to prevent abuse. The provider had failed to ensure staff were trained to recognise and respond to abuse. There was a lack of effective systems and processes to investigate and response to an allegation of abuse as soon as the safeguarding team made the registered persons aware of it. Care and treatment was provided in a way that controlled and restrained a person in a way that was disproportionate to risk, by means of locking a person in their room. Regulation 13(1),(2), (3), (4)(b) and 7(b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Care and treatment was not provided in a safe way. People's risks of pressure ulcers, not eating and drinking enough and safety in the event of an emergency were not properly assessed and managed. Regulation 12(1), (2)(a) and (b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed Recruitment processes were not robustly applied to ensure all the required checks were in place before staff started working with people, to ensure they were suitable to work in care.

This section is primarily information for the provider

Action we have told the provider to take

	Regulation 19(2) and (3) and Schedule 3

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect People were not consistently treated with dignity and respect and their privacy and independence was not always supported. Regulation 10(1),(2)(a) and (b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 CQC (Registration) Regulations 2009 Notification of death of a person who uses services The registered persons had failed to notify the Commission of deaths taking place within the service. Regulation 16

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents The registered persons had failed to notify the Commission of other events taking place in the home, including about allegations of abuse. Regulation 18

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing There was a lack of suitable support, supervision and training, including induction and core training, to ensure that the skill mix of staff deployed meant they were competent to meet people's needs and carry out their duties. Regulation 18(1) and (2)(a)

The enforcement action we took:
We have issued a warning notice to the provider and registered manager for the breach of this regulation. They have to comply with this by 5 November 2015.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care People's care and treatment was not consistently appropriate, did not meet their needs and reflect their preferences. It was not designed with a view to ensuring their needs and preferences were met. Regulation 9(1)(a), (b) and (c) and 9(3)(b)

The enforcement action we took:
We have issued a warning notice to the provider and registered manager for the breach of this regulation. They have to comply with this by 5 November 2015.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance There was a lack of established and suitable systems for assessing and monitoring the quality and safety of the service and for identifying and managing risks. The registered persons did not act on feedback obtained from interested parties to improve the service and to evaluate and improve their practice.

This section is primarily information for the provider

Enforcement actions

Regulation 17(1)(2)(a), (b), (e) and (f)

The enforcement action we took:
We have issued a warning notice to the provider and registered manager for the breach of this regulation. They have to comply with this by 5 November 2015.