Indigo Care Services Limited

Green Lodge

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection was unannounced which meant the staff and provider did not know we would be visiting. This was the first inspection of the service since the new provider, Indigo Care Services Limited (also known as Orchard Care Homes) took over in April 2016.

Green Lodge is a purpose built care home providing accommodation across two floors. The home itself is positioned in a residential area and offers designated parking to visitors and people who use the service. The ground floor Ash unit accommodates up to 25 people with residential care needs. The upper floor is split into two units, Cedar and Oak. The Cedar unit offers accommodation for up to 15 people with residential care needs. The Oak unit is a dedicated dementia care unit designed for older people living with a dementia and can accommodate up to 17 people.

Each unit has its own kitchenette area, where people who use the service, their visitors and relatives can make tea and coffee. Each bedroom offers en-suite facilities and each unit also has additional bathing and showering facilities.

The service had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. At the time of inspection the registered manager was on annual leave.

Risks to people arising from their health and support needs were not always assessed, and plans were not always in place to minimise them. Risks to people arising from the premises were assessed, and plans were in place to minimise them. A number of checks were carried out around the service to ensure that the premises and equipment were safe to use. However the file that would be grabbed in case of an emergency such as a fire contained personal emergency evacuation plans for six people who no longer lived at the service. This meant that in the event of a fire, emergency services would be looking for people that were no longer there.

We found there was not enough staff to meet people's needs. On the ground floor there was one senior care worker and two care workers, nine people needed two to one care and nurse call alarms rang continuously throughout the day.

Medicines records for applying topical creams were inconsistent, controlled drugs had not been checked since April 2017 and the temperature of the fridge where medicines were stored showed temperatures of between nine and 12 degrees Celsius on 16 occasions from the 1st to the 27th of June 2017. Fridge temperatures should be between 2 and 8 degrees Celsius.

We found the care plans were not person centred, and did not reflect people's current needs. One person

was receiving end of life care and had a syringe driver in place but this was not documented in the care plan. One person had a do not attempt cardiopulmonary resuscitation (DNACPR) in place, however in their care plan a note stated the DNACPR had been returned to the GP to have the address changed. This had happened on 9 June 2017 and no staff member had chased this up for 18 days. The purpose of a DNACPR decision is to provide immediate guidance to those present, mostly healthcare professionals on the action to take should the person suffer cardiac arrest or die suddenly. It had been this person's choice not to be resuscitated but due to the DNACPR not being available their wishes would not have been respected.

Audits were taking place, however were not robust enough to highlight the issues we found during our visit. Many audits did not have action plan in place.
Staff did not receive supervision in line with the home's supervision policy. The manager completed senior care workers supervisions and the senior care workers completed care workers supervisions. However senior care staff said they struggled with the time to do this.

Staff understood safeguarding issues and felt confident in raising any concerns they had, in order to keep people safe.

Staff had received Mental Capacity Act (2005) and the Deprivation of Liberty Safeguards (DoLS) training and demonstrated a basic understanding of the requirements of the Act. The registered manager understood their responsibilities in relation to DoLS.

We found the premises was cluttered and dirty in some areas. The office upstairs was very untidy, people's files were not stored confidentially as the office was not locked. An old fridge and chairs had been left outside the premises and looked unsightly.

We observed and joined people for lunch and found this to be a task driven service rather than an enjoyable experience for people. Mealtimes were meant to be protected however people were interrupted to have medicines administered. Where people were provided a food supplement this was handed to them whilst they were eating their meal. People should be encouraged to eat as much as possible and the food supplement offered as a top up. Providing them at mealtimes would fill the person up and prevent them eating.

We saw some evidence that staff worked with external professionals to support and maintain people's health. However, one staff member found a problem with one person's urine output and documented it in a care plan review, stating must push fluids. This information was never passed onto anyone else not even other staff and there was no record of extra fluid intake.

The interactions between people and staff was kind and respectful. We saw staff were aware of how to respect people's privacy and dignity. People and their relatives spoke highly of the care they received. However, all the people we spoke with said they felt the staffing levels were too low and had to wait up to 30 minutes to get help.

Procedures were in place to support people to access advocacy services should the need arise. One person was using an advocate at the time of inspection.

We were told people had access to activities, which they enjoyed. However other than an impromptu sing a long upstairs no activities took place during insepction. People downstairs stayed in their own rooms and we were told they had always done this and it was their choice. Some of these decisions were made several years ago and were still accepted without being reviewed. There was no evidence that staff had attempted

to encourage people to come out of their rooms and prevent social isolation.

The provider had a clear complaints policy that was applied when any concerns were raised. People and their relatives knew how to raise any issues they had. We were aware of one complaint before inspection and the regional manager had addressed this, however, this complaint was not documented in the services complaints file. Only one complaint was documented and this was filed under compliments. This complaint had also been addressed by the regional manager but we saw no evidence of learning from it to prevent the same happening in the future. Complaints raised to staff were passed on during their meetings, however they weren't recorded or followed up.

We identified three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the registered provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Medicines were not always managed safely.

Risks to people were not always assessed to plan safe care or keep a safe environment.

The provider followed safe recruitment procedures however staffing levels were low.

Staff understood safeguarding issues and felt confident to raise any concerns they had.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff received training to ensure that they could appropriately support people.

Staff were not fully supported through supervisions and appraisals.

Consent was not always sought.

The dining experience needed improving. The environment was cluttered in some areas.

Is the service caring?

Requires Improvement

The service was not always caring.

Records were not in place for end of life care wishes and preferences.

Staff treated people with dignity, respect and kindness.

People were supported by staff who were kind and patient.

The service supported people to access advocacy services.

Is the service responsive?

Requires Improvement

Staff demonstrated a person centred approach to care. However records did not match staff knowledge.

People were not always supported to access activities and follow their interests.

There were systems in place to manage complaints however not all complaints were documented, followed up or lessons learnt from them.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Regular checks were undertaken to monitor and improve the quality of the service; however not all the audits had action plans in place and the audits had not highlighted all the concerns we raised.

Care plans did not reflect current needs, not all paperwork was completed or dated and care plans were not stored securely.

Staff felt supported by the registered manager, but felt they had not acknowledged the low staffing levels.

Limited surveys took place and where concerns were raised these were not followed up.

The manager understood their responsibilities in making notifications to the Care Quality Commission.

Green 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 was 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 was Green Lodges first rated inspection under their new provider.

This inspection took place on 27 June 2017. The inspection team consisted of one adult social care inspector, one specialist advisor and two experts by experience. A specialist professional advisor is someone who has a specialism in the service being inspected. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. At the time of our inspection 42 people were using the service.

We reviewed information we held about the service, including the notifications we had received from the registered provider. Notifications are changes, events or incidents the provider is legally obliged to send us within required timescales.

The provider was asked to complete a provider information return [PIR]. This is a form that asks the registered provider to give some key information about the service, what the service does well and improvements they plan to make. The registered provider returned the PIR in a timely manner.

During the inspection we spoke with ten people who lived at the service independently and two groups of three in the lounge and during lunch. We also spoke with six relatives. We looked at six care plans, and Medicine Administration Records (MARs). We spoke with 12 members of staff, including the regional manager, registered manager from another home in the group, unit manager, senior carers, care staff, administrator, cook, activity coordinator and domestic staff. We looked at six staff files, including recruitment, training and supervision records.

We also completed observations around the service.

Requires Improvement

Is the service safe?

Our findings

We looked at the arrangements for the management of medicines. Systems were in place to ensure that medicines had been ordered, stored and administered appropriately. Medicines were securely stored in a locked treatment room and were transported to people in a locked trolley when they were needed.

Medicines were given from the container they were supplied in and we observed the staff member explained to people what medicine they were taking and why. People were given the support and time they needed when taking their medicines. People were offered a drink of water and the staff member checked that all medicines were taken. However, we observed medicines, including nutritional supplements being administered to people whilst they were eating their lunch, which we were told was a protected time.

Appropriate arrangements were in place for the administration, storage and disposal of controlled drugs (CDs) which are medicines which may be at risk of misuse. However, despite the medication policy dated November 2016 stating that the controlled drugs were to be checked monthly or weekly as part of the medicine audit and recorded in the CD register the last check recorded in the CD register was 12 April 2017. Staff knew the required procedures for managing controlled drugs. We saw entries made on the medication administration record (MAR) matched the records in the controlled drugs record book and that the stock balance records were correct.

Medicines which required refrigeration were stored appropriately in a fridge which was within a locked room. Minimum and maximum temperatures were recorded daily and were mainly between 2 and 8 degrees centigrade. However, there had been 16 occasions during June 2017 where the maximum temperature for the fridge had been recorded between 9 and 12 degrees centigrade. This was higher than the maximum recommended temperature and there was no evidence of remedial actions taken. This meant that the quality of medicines may have been compromised, as they may not have been stored under required conditions. For two people we saw that their topical creams were appropriately stored in the fridge, however the date of opening had not been recorded on the medicine labels. Temperatures for the treatment room were recorded daily and were within the recommended temperature ranges.

Medicine stocks were properly recorded when medicines were received into the home and when medicines were carried forward from the previous month. This meant staff could monitor when medicines needed to be ordered. Staff had signed for the administration of medicines, which confirmed that care staff had given people their medicines as prescribed.

We also saw that care staff applied some creams. Although the home had a policy, stating that clear information on the application of creams should be available for care staff we saw this was incomplete. We looked at the records for four people who had creams applied by care staff. There were no records kept for one person to show where and when the topical preparations were to be applied. For this person we saw listed on the MAR "Fusidic acid cream apply three times a day for 10 days." However we noted that this cream had been applied inconsistently over 13 days. The records kept for three people showed inconsistent recording as to where and when the topical preparations were applied.

We looked at the guidance information kept about medicines to be administered 'when required'. There were arrangements for recording this information and we found this was kept up to date. This information helps to ensure people were given their medicines in a safe, consistent and appropriate way.

We looked at how medicines were monitored and checked by management to make sure they were being handled properly and that systems were safe. We found that the provider had completed medication audits, however they were not consistently robust and when issues had been found there was not a specific action plan in place to address the issues. For example, there were missing photographs of people, not all boxes had date of opening recorded and example staff signatures were missing. This information had been found in an audit going back to March 2017 and still had not been acted upon on the day of inspection.

Risks to people arising from the premises were not always assessed and monitored. Fire and general premises risk assessments had been carried out. We saw documentation and certificates which showed that relevant checks had been carried out on gas appliances, manual handling equipment and portable electrical equipment. There was no evidence of an electrical safety certificate and the regional manager followed this up. We were provided with the electrical installation condition report dated 5 July 2016 and rated unsatisfactory. It was recommended that any observations classified as Code 2 potentially dangerous were to be acted upon as a matter of urgency, there were 38 observations classed as Code 2. Further investigation was required for seven observations and improvement recommended for five observations. A quote had been requested for the work. Due to this taking so long we were told another electrical safety test would take place on 3 July 2017. During a fire safety audit in January 2017 the Cleveland fire brigade stated 'At the time of the audit the fixed electrical certificate dated 5th July 2016 identified a number of "Category 2 potentially dangerous" items. In order to reduce the risk of fire, it is recommended these items are rectified by a competent electrical engineer.' The provider had failed to act on this. We contacted the provider after inspection and asked them to assure us people were safe. The provider immediately called a meeting and arranged for the work to be started straight away. The provider told us we would be informed when the work was completed. At the time of writing this report we had not heard anything.

Records confirmed that monthly checks were carried out of emergency lighting, fire doors and control of substances hazardous to health (COSHH). We looked at the water temperatures staff took at the time of bathing or showering someone. We found the temperatures were quite low for example when showering someone a temperature of the shower was recorded at 30 degrees. Unless people had expressed a preference for a cooler shower these temperatures may have been uncomfortably low. The bath temperatures were mainly 36 degrees but sometimes recorded as low as 32 degrees. No staff members had highlighted the low temperatures as being a problem. The records for the temperature recordings by the maintenance person included the question, is the temperature of hot water within tolerances for this room between 39 and 43 degrees? and the maintenance person had said yes but not recorded what the temperature was. This meant comprehensive record of water temperatures was not being kept.

A Personal Emergency Evacuation Plan (PEEP) was in place documenting evacuation plans for people who may require support to leave the premises in the event of an emergency. However where people's needs changed the PEEPs were not updated. For example one person's PEEP stated they could move to a wheelchair with a walking frame. However, they could not mobilise without support from staff. We also found that the emergency grab file contained PEEPS for six people who no longer lived at the service. If an emergency took place such as a fire, emergency workers could be trying to find people who no longer lived there.

Risks arising from people's health did not reflect current needs. There were no risk assessments in place for people who had catheters, syringe drives or were insulin dependent diabetics. One comment in a person's

care plan stated they used an e-cigarette, there was no risk assessment in place. Where people's needs changed care plans were not updated. One person's needs had dramatically changed, however the care plan had not been updated to reflect this.

We saw a review of one person's care plan on the 15 May 2017, the review stated, 'No concerns this month, there has been no issues with the catheter, [person's name] has been encouraged to drink more fluids as their urine has been quite sludgy making it difficult to pass into the catheter.' This review was never passed on to anyone else, no healthcare professionals were notified or involved, no fluid chart was put in place and no risk assessment completed. During handover that day it was not passed onto other staff and the care plan had not been reviewed again. This meant the person was at risk of unsafe care, a urine infection and possibly dehydration. Managers and staff we spoke with during inspection had not been made aware of this and nothing had been put in place to support the person's health.

These findings evidenced a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Safe care and treatment).

We found staffing levels were low. There was one senior and two carers on each unit. The downstairs unit had 22 people living there and nine people needed two to one care. Staff we spoke with said, "If we are supporting someone who needs two carers and then another person who needs two carers needs us they have to wait about twenty minutes, it is really difficult."

We asked people and their relatives if they thought there was enough staff on duty. People we spoke with said, "If I need to go to the toilet, I can wait half an hour before someone can come and move me to the toilet," Another person said, "Sometimes I have to wait a long time when I am on the commode to be taken off and put back in my wheelchair, I need two people to lift me and there are not enough staff to do this at times." Another person said, "I am afraid there are not enough staff now we full, there are too many residents that need two to one care and that leaves staffing short to deal with others."

One relative we spoke with said, "I come in three times a day and another relative at least once a day so that we can be assured [relative's name] is being cared for when the staff are busy." Another relative said, "I try to help at meal times when someone needs food cutting up etcetera." And a third relative said, "If we have to help out then that is what we will do, the staff are clearly stretched."

Staff we spoke with said, "I often work after my 12 hour shift finishes to catch up on paperwork, I also come in on my day off to do paperwork, I don't get paid for these extra hours I do." And another staff member said, "Due to only having two carers on duty I often have to leave my jobs to support with care, there is not enough staff." Staff said they had put verbal complaints into the registered manager about staffing levels but nothing had been done, nothing had been put in writing. Throughout the day call bells were ringing the majority of the time. One care worker we spoke with said, "I have been signed off as not fit to work but returned as they are short staffed." We were told that extra staff had been requested to come in after we arrived to inspect.

We discussed staffing levels with the regional manager who said they would look into it. They explained this had not been highlighted to them previously and the dependency tool showed they had enough staff. They said this was the registered manager responsibility to say if the dependency tool was not reflecting staffing levels correctly.

These findings evidenced a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Staffing).

People we spoke with said they felt safe at Green Lodge. Comments included, "I need to be strapped in, due to my paralysis. I am always assisted by two members of staff every time I need the commode or need help getting into or out of bed. I need to be hoisted out of my chair and I feel safe with staff when they do this." Another person said, "Yes, I feel safe. Nobody can get in unless they have permission to get into the building and that make me feels safe." And another person said, "I need two people to hoist me, I trust the staff to do this safely." One relative we spoke with said, "[Person's name] is safe from harm due to the staff and that is reassuring."

Recruitment procedures were in place to ensure suitable staff were employed. Applicants completed an application form in which they set out their experience, skills and employment history and two references were sought. The service requested that a Disclosure and Barring Service check was carried out before staff were employed. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults. This helps employers make safer recruiting decisions and prevents unsuitable people from working with children and vulnerable adults.

The provider had a business continuity plan, which provided information about how they would continue to meet people's needs in the event of an emergency, such as loss of heating or loss of hot water. This showed us that contingencies were in place to keep people safe in the event of an emergency.

Staff understood safeguarding issues and knew the procedures to follow if they had any concerns. There were safeguarding policies in place and staff were familiar with them. One staff member said, "I understand safeguarding totally."

Accidents and incidents were monitored monthly by the registered manager but at the time of inspection the numbers of accidents and incidents were too low to find any patterns or themes.

Requires Improvement

Is the service effective?

Our findings

We found that staff were not adequately supported through supervisions and appraisals. Supervision is a process, usually a meeting, by which an organisation provides guidance and support to staff. The registered manager completed supervision for senior staff and the senior staff completed supervision for care staff. The senior staff we spoke with said they don't have time to do supervisions. One staff member said, "The manager does the supervision and appraisals for the senior Carers. We have supervision every three months and I've just had my appraisal done in the last month. Senior carers do the supervision of all carers, admin, kitchen and cleaning staff. I haven't done this for a while because I have to help the carers out" Another staff member said, "My last appraisal in 2016 was done by a senior carer so any concerns I had went through them not a manager." We asked to see evidence of training for senior staff to complete this role. The registered manager said this has been done but there was no recorded evidence to indicate this. We were told that moving forward the registered manager would address this and they would complete group supervisions with the senior team regarding completion of supervisions.

These findings evidenced a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Staffing).

We looked at what training staff had received and found that staff were suitably trained. Training staff had received included fire safety, infection control, safeguarding, moving and handling and dementia awareness. One staff member said, "I have just done manual handling training." A person who used the service said, "I think they [staff] are all highly trained."

New staff undertook a twelve week induction programme, covering the service's policy and procedures and using Care Certificate materials to provide basic training. The Care Certificate is an identified set of standards that health and social care workers adhere to in their daily working life. The registered manager said, "All new starters complete the care certificate and existing staff who don't hold a minimum of a Level 2 Award their system would automatically trigger an alert to say the care certificate needs to be completed." Each new staff member was allocated a buddy/mentor who would adapt the induction to the experience of the staff member. At week four the new staff member had a supervision meeting which would indicate how well the staff member was doing and provide more support if needed. A further supervision would take place at 12 weeks.

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 when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. The Deprivation of Liberty Safeguards (DoLS) are part of the Mental Capacity Act (MCA) 2005. They aim to make sure that people in care homes, hospitals and supported living are looked after in a way that does not inappropriately restrict their freedom.

We checked whether the service was working within the principles of the MCA and applying the DoLS appropriately.

The registered manager and staff had an understanding of the MCA and the DoLS application process. At the time of our inspection 29 people were subject to a DoLS authorisation.

We saw consent was sought from people who needed bed rails in place. However we found no other consent was sought such as consent to care or consent to records being kept. We discussed this with the regional manager and unit leader who said they would implement it straight away.

We saw people were regularly weighed to monitor their nutritional health. Where weight loss had occurred, appropriate referrals were made to dieticians and the speech and language therapy (SALT) team. However some weights were recorded incorrectly for example one person was weighed on the 18 March 2017 and they weighed 83.3 kilos, they were weighed again on the 22 March 2017 and they weighed 85.6 kilos meaning they had put nearly three kilos on in four days. We were told that this was a recording error; however this had not been picked up in any audits.

We asked people what they thought of the food. People we spoke with said, "The food is a bit primitive, there is enough to eat but it's plain and boring." Another person said, "I need soft food and it's alright, I am not a big eater though." And a third person said, "I don't like certain foods, and I accept I am fussy and there is only a limited budget but the food isn't good. Sometimes the mashed vegetables are lumpy and it is not cooked very well."

On the upstairs unit, lunch was 30 minutes late and people were left alone in the dining room for at least ten minutes and many got bored or restless and walked away. When lunch did arrive the cook said "I don't have time to dish up," and rushed away leaving a carer to do this with no utensils or information on who wanted what. The staff member said, "We do this by memory." Staff we spoke with said they knew what people's preferences were and their dietary requirements however they did not know who received soft food such as fork mashable or who was on pureed. The upstairs unit did not have nicely set tables or any condiments available to people. People were only offered hot drinks. The cutlery did not look clean and people were wiping them on the edge of the table cloth.

Downstairs one person in their room only wanted ham and some grated cheese, this person was offered a plate with one slice of ham and some grated cheese. This had not been made to look appetising and was placed on the person's trolley table that was very cluttered.

People were offered sandwiches and soup or sardines on toast, however if a person wanted sardines on toast this had to be specially ordered as one person was told they did not have time to make this. The sandwiches were plain ham or cheese and the soup on the board stated leek and potato but we were told they had ran out of leeks and potato's so the soup was vegetable. We were told they did not have a picture of vegetable soup. The tables were set nicely downstairs with nicely folded napkins and condiments however the dining experience was quite sombre and people were interrupted to have their medicines and were also offered food supplements. A food supplement is something that is offered if people were not eating their meals or as a snack during the day, they were not to be offered during a meal as they would fill

the person up so they were unable to eat. People were offered hot drinks and orange, not other choices were available.

We discussed people's dietary requirements with the deputy cook and we were told any changes to a person's dietary requirements or a new resident the list on the fridge would be updated straight away. All new information was cascaded verbally from staff. We checked the list and found this had not been updated and included information for people who no longer lived at the service. The deputy cook who said they needed to update the lists, they just did not have time. Nearly every question we asked was answered in "oh yes I need to do that", oh I meant to do that" or "that needs updating." This meant kitchen staff did not have up to date records on what people's dietary requirements were.

These findings evidenced a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Person centred care).

We saw people were provided with plates that had a ridge to stop food spilling off. These plates supported people who struggled with coordination.

We discussed the dining experience with the regional manager who was upset due to work they had done with staff around the dining experience. The regional manager said, "Every drink should be offered not just one drink. It should be a time of enjoyment and free from distraction such as receiving medicines." The regional manager was going to look into the dining experience.

People were supported to access external professionals to maintain and promote their health. Care plans contained evidence of referrals to professionals such as GPs, the district nurse, dieticians, speech and language therapist and psychiatrists. However we could not evidence that staff reported all concerns such as potential urine infections to the relevant healthcare professional.

We found the premises to be cluttered in some areas such as the senior care workers offices, the upstairs dining room and the activity room. The activity room still had wine glasses and half bottles of Prosecco from a recent 'ladies day' activity on the 22 June 2017. One relative said, "The transition from one organisation to another [new provider] has brought paint and wallpaper but they have cut staff and it is an issue."

Requires Improvement

Is the service caring?

Our findings

For people receiving end of life care, we found nothing documented in their care plans to support this. This meant we could not evidence the people were receiving the care that was to their wishes and preferences. End of life care plans for other people we looked at stated '[Person's name] does not wish to discuss this." We observed the services hairdresser went and sat with the person receiving end of life care and this was done in a dignified and peaceful manner. Staff did try their hardest to make sure someone was always with the person but due to staffing levels this was not always possible.

People and their relatives told us they were happy with their care and staff were kind and caring. One person said, "I am very happy with the care I received." Another person said, "Staff bath me twice a week and I am happy with this."

Relatives we spoke with said, "I come here often as I only live five minutes away and each time I have never been worried about the care my parent receives." Another relative said, "We come here at odd times, not to catch anyone out but to see for ourselves if the home is the same after we leave and our relative's happy."

Staff we spoke with said, "We do our best with very little but we never compromise on care and kindness." Another staff member said, "We struggle but we do the best we can and thank goodness we do, as long as the residents are okay then so am I."

The person who comes in to do people's hair visited on the day of inspection. They said, "I have been coming here for 17 years and I love it." And "I only have one resident into the salon at a time so we can have a really good chat and I have got to know them really well." We saw one person getting their hair cut and there was great hilarity and banter going on.

People said care was delivered with dignity and respect. All the people we spoke with agreed that staff always knock on their doors, keep curtains and doors closed when overseeing dressing. Through observation we saw staff knocking on people's doors before entering. During the day we saw one person had an accident and staff dealt with this compassionately and in a very supportive way, clearly respecting the person's privacy and dignity.

People's independence was promoted. One person said, "I always do as much for myself as I can. Staff let me put the hoist sheet underneath me before they hoist me into my wheelchair. I am very independent you know."

One person had decided to have a lie in and came into the lounge without anything on their feet. A staff member quickly attended to this person, brought their slippers and some breakfast. The person was clearly happy about this and thanked the member of staff.

Procedures were in place to support people to access advocacy services should the need arise. At the time of inspection one person had access to an advocate. Advocacy services help vulnerable people access

information and services and be involved in decisions about their lives.

Requires Improvement

Is the service responsive?

Our findings

We looked in detail at the care plans for six people who used the service. Care plans were supposed to be reviewed monthly but this was not happening. The provider had introduced 'resident of the day' and on this day the care plan was to be reviewed, family were to be contacted, bedroom deep cleaned and everything relating to that person checked. We were told by staff that they did not have time to do this and the regional manager said they were struggling to get staff to 'buy in' to resident of the day. One person's day was originally the 12th of each month and then slipped to the 15th of each month. The care plan was reviewed on the 15 May 2017 and we saw during our visit on the 27 June 2017 the care plan had not had not been updated since, despite concerns that were found on the 15th May 2017. Care plans did not always reflect current needs such as now being cared for in bed.

We found the handwriting in some reviews difficult to understand and many kept referring back to the services past name of Ashbourne Lodge. One person who had lived at the service for a number of years could no longer communicate in English. As their dementia had progressed they had reverted to their native language. No one at the home could speak this language and the unit manager showed us some flash cards they had produced with English on one side and the person's language the other side. The unit manager said these did not seem to be working. Often people with dementia don't recognise the written word. We asked what else they had tried to do to support this person, the unit manager said, "The cards were not successful, the social worker is aware and we tried an interpreter but that didn't work." We asked why the interpreter didn't work and they didn't know. This meant the person could not communicate effectively with staff. Staff had not accessed other means of communication such as communication applications on tablet style computers. There were no details in this person's care records about key words which staff could use, or information on how this person conveyed their needs and this person had no access to anyone who could speak the same language as them. The regional manager said they would make sure all the care plans were updated to reflect current needs straight away. We saw no evidence of the person's agreement to what was documented in the care plans or any relative's involvement. However relatives we spoke with did say they felt involved. One relative said, "As a family we are involved in our relative's care plan as the decision making processes and all that goes with that, we do feel involved and listened to with regards to what is best."

The care plans did contain details of the person's life history such as family life, past work life and significant events in their life. This supported staff with topics that would encourage better communication and an understanding of the person. One staff member said, "We try hard to learn about the residents and what they did before they came here so we can try and preserve that memory for them." Care plans also documented a person's preferred routine such as what time the person likes to get out of bed, what they like to do during the day plus their likes and dislikes. However we could not evidence these preferences were reviewed to make sure they still current. For example the majority of people living downstairs stayed in their rooms, and looked socially isolated. We asked the unit manager why this was and they said, "They have always stayed in their room." The regional manager said "We need to make sure this is the case and ask people what we can do to encourage them to leave their rooms, such as a certain activity."

We looked at the provision of activities. One staff member said, "Activities are not easy to deliver because of staffing issues." On arrival we were told it was the activity coordinator's day off but they later came in to cover care for staff sickness. The activity coordinator said, "There is a whole range of activities scheduled such as singing, social mornings, exercises, nail painting, bingo, trips out, arts and crafts, bread making and word searches. We were told they had both ladies and gentlemen's sessions. The lady's had just had a ladies day with prosecco on the 22 July 2017. We knew this had taken place as we saw the used wine glasses and half bottles of prosecco were left in the activity room, five days later.

One staff member said, "We have project 'busy' where some of the residents upstairs with dementia come into the kitchenette to help wash dishes and keep themselves busy under supervision in a kitchen situation. " We observed this activity going on when we arrived in the morning. The activity coordinator said, "I love the interaction with the residents, I used to be a senior carer but applied for the activity coordinators job because I would rather work with the residents than complete paperwork all the time."

We asked people who used the service if they were happy with the activities taking place. One person said, "I get sick of the singers that come in. They are so loud I can hear them when I'm still in my bedroom."

We saw very little activity going on during the inspection day. We saw an impromptu sing a long upstairs but nothing took place downstairs. The activity board did not reflect what was happening and a staff member said, "The activity list scheduled is not accurate." Another staff member said, "Activities are not easy to deliver because of staffing issues." We saw the activity board said 'day out' on Friday, when we asked were the planned outing was for, no one could tell us. We asked the unit manager and they also did not know but said they could send us some information on where people were going but we never received it. The covering manager sent information on trip logs which showed two people had enjoyed a trip to the garden centre in May 2017 and two people had enjoyed Redcar seafront, a museum and Preston Park also in May 2017.

There was a policy in place for managing complaints, which contained information on the timescales for resolving complaints. We were aware of one complaint before the inspection but we found the complaints file to be empty. We later found another complaint filed in the compliments section. Although complaints had been addressed we could see no evidence that there were any lessons learnt from them. One complaint was about staff's treatment of someone around dignity and respect. We could not see any evidence that this was discussed at staff supervisions or meetings. Any verbal complaints were discussed in the daily 'flash' meetings but we could not see evidence that these were recorded or acted upon.

Relatives we spoke with said they knew who to complain to. One relative had asked for their relative to have a room downstairs as they were unhappy upstairs but nothing had been done. We passed this onto the regional manager and we were informed after inspection that this person was now downstairs.

Requires Improvement

Is the service well-led?

Our findings

The service had a registered manager who had been registered with CQC since July 2016. 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 carried out a number of quality assurance checks to monitor and improve standards at the service. Quality assurance and governance processes are systems that help providers to assess the safety and quality of their services, ensuring they provide people with a good service and meet appropriate quality standards and legal obligations. The registered manager completed audits in medicines, infection control, bed rails, mattresses, kitchen and staffing. Not all audits contained an action plan to address any issues or concerns. We found the audits had not picked up all the issues we found. For example care plans not documenting current needs, risks assessments not all in place, PEEPs in place for people who no longer lived at the service, the electrical safety certificate being unsatisfactory, staffing levels were low, complaints not always followed up and no record of consent to care. Audits completed by the regional compliance manager had also not highlighted everything we had found.

Care plan files were not stored securely on the upstairs unit. The office was left open and extremely cluttered.

The registered manager completed an action plan for all concerns identified within the service, concerns identified on quality visits were also added to this action plan. Some of the concerns we raised were not on this action plan. However some were such as the activity room was untidy and cluttered, this was signed off as done, however we found the activity area was still untidy and cluttered. Meal time experience had been acknowledged as poor, but records indication this had been actioned and improvements to this had taken place 24 May 2017. However we found the dining experience to be poor. This meant this audit was not effective in sustaining improvements.

We asked how feedback was obtained from people and their relatives. The regional manager said that head office send surveys to the registered manager for them to send out. On the day of inspection these could not be found. The registered manager emailed a laundry survey that had been completed in February 2017; this had only been sent to 15 people and 11 returned. A staff survey had also been completed in April 2017 again only 15 were sent out and six were returned. The majority of staff had said staffing was too low and morale was not good. Action plans for both of these surveys said they would be addressed on the 7 July 2017, up to five months after the survey. We asked the registered manager why only 15 surveys were sent out and why they were waiting so long to address the issues raised especially the low staff morale. The registered manager said, "When I undertook the staff survey audit I only gave out the surveys to the staff members that were on duty at that time I do understand that the staff survey should have been given out to all staff members for them to complete. In regards to the actions to be addressed following the surveys I did not address the actions at the time but they have been addressed at today's flash meeting and will continue to

do so going forward. Yesterday when I was advised that I had not set any actions following the survey I added the date 07/07/17 to ensure that the actions were addressed within the coming week." This evidenced that nothing had taken place to address the concerns people and staff who completed the survey's raised until it was highlighted at our inspection.

These findings evidenced a breach of Regulation 17 (Good governance) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Staff said they felt supported by the registered manager and they were approachable. Comments included, "I like the manager, it is the first manager I have felt comfortable with to be confident and voice my opinion," "I have a lot of respect for the manager, I am valued for what I have to say." And "They are a good manager." However, all staff said the culture is open and transparent but the lack of staff is an overriding issue for them. Staff had verbally raised concerns but nothing had been done.

We did not see much evidence of regular meetings for people who used the service and their relatives. One record just stated that people were asked if they were happy and if anything could be improved. People had just said no.

Meetings for staff had taken place twice this year so far and topics discussed were medicines, fire safety, paperwork and infection control. Daily 'flash' meetings took place to provide staff with quick updates and discuss any concerns with the people who used the service. However, not all concerns were discussed in the meeting such as the person who needed fluids pushed.

Services that provide health and social care to people are required to inform the Care Quality Commission, (CQC) of important events that happen in the service. The registered manager of the service had informed the CQC of significant events in a timely way. This meant we could check that appropriate action had been taken. The service was correctly displaying the rating from the previous CQC inspection.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People were not provided with a meal time experience that met their needs and preferences and promoted their wellbeing and quality of life.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Medicines were not always administered safely. Risks to people arising from the premises and their health were not assessed and monitored. Personal emergency evacuation plans were still in the evacuation pack for people who no longer lived at the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Audits completed by the registered manager and regional compliance manager did not highlight the concerns we raised. Care files were not updated to reflect current needs and were not stored securely in the upstairs unit. Feedback was not sought robustly or followed up in a timely manner.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staffing levels were low. People had to wait up

to half an hour to be supported. Staff were working over and above their contracted hours to get work done. We could not evidence staff received appropriate supervision