Care Quality Commission

Bupa Care Homes (CFHCare) Limited

Godden Lodge Residential and Nursing Home

Inspection report

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Ratings

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

Overall summary

Godden Lodge Nursing and Residential Home provides accommodation, personal care and nursing care for up to 133 older people. The service consists of five separate houses; Boyce House and Murrelle House for people living with dementia and who have nursing needs, Cephas House for people who require nursing and palliative care, Appleton House for people living with dementia and who require residential care and Victoria House for people who require residential care.

The inspection was completed on 21 July 2015, 22 July 2015 and 24 July 2015. There were 105 people living at the service when we inspected.

The overall rating for this provider is 'Inadequate'. This means that it has been placed into 'Special measures' by CQC. The purpose of special measures is to:

- Ensure that providers found to be providing inadequate care significantly improve.

Summary of findings

- Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.
- Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.

Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains 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 the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will be kept under review and if needed could be escalated to urgent enforcement action.

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

At our last inspection on 15 May 2014 we found that the provider was not meeting the requirements of the law in relation to consent to care and treatment. An action plan was provided on 6 October 2015 and this confirmed that the provider was compliant. Documentation viewed at this inspection showed that the improvements had been made however additional improvements were required to ensure that the provider acted in accordance with legal requirements.

Arrangements were in place to inform the registered provider and manager of what was going on in the service. However, they were not as effective as they should be and there was a lack of managerial oversight of the service as a whole as areas of concern, particularly in relation to Murrelle House, were identified. Systems in place to identify and monitor the safety and quality of the service required inadequate.

The deployment of staff in Murrelle House was not appropriate to meet the needs of people who used the service and required reviewing so as to ensure people's care and support needs were met. Staff did not always have enough time to spend with people to meet their needs.

Medicines were not consistently stored safely and improvements were required with medicines management to ensure that people received their prescribed medication.

The implementation of staff training was not effective in all the houses to ensure that staff knew how to apply their training and provide safe and effective care to people. Some staff did not demonstrate an understanding of how to support people living with dementia and how this affected people in their daily lives.

The dining experience for people was variable and not always appropriate to meet people's individual nutritional needs. Consideration by staff was not well-thought-out to ensure that eating and drinking was an important part of people's daily life and a positive experience.

On Boyce House, Victoria House, Cephas House and Appleton House people told us that staff treated them with kindness and were caring. People were positive about the care and support provided and the atmosphere within these houses was observed to be relaxed and calm. On Murrelle House people did not consistently receive a service that was caring and relatives comments about the standard and quality of care provided were variable. The majority of interactions by staff were routine and task orientated and we could not be assured that people who remained in their bedroom received appropriate care to meet their needs. Staff did not always demonstrate a caring attitude towards the people they supported and staff failed to promote people's dignity or show respect to individuals.

Opportunities provided for people to engage in social activities was limited on Murrelle House and this meant that some people lacked effective social interaction that promoted their wellbeing and gave them a sense of purpose. Inconsistencies across the service in relation to the quality of the information included in people's care records were highlighted and required improvement.

Summary of findings

In general people's healthcare needs were well managed, although a number of relatives told us that GPs and other healthcare professional input was often at their insistence and request.

There was a system in place to ensure that newly employed staff received an induction and staff were supervised. Suitable arrangements were in place to respond appropriately where an allegation of abuse had been made. There was an effective system in place to deal with people's comments and complaints.

You can see what actions we told the provider to take at the back of the full version of the report.

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?

Requires improvement

The service was not consistently safe.

Steps were not in place to ensure that the deployment of staff was appropriate to support people safely.

The management of medicines did not ensure people's safety and wellbeing. This referred specifically to Cephas House and Murrelle House.

Staff recruitment processes were thorough to check that staff were suitable to work in the service.

Is the service effective?

Inadequate

The service was not effective.

The dining experience for people was variable and not always appropriate to meet people's individual nutritional needs. This referred specifically to Murrelle House.

Improvements were required to ensure that staff's training was effective and good practice was embedded through their everyday practices with people who used the service.

Improvements were required to ensure that staff recognised people's deteriorating healthcare needs and made sure that appropriate healthcare professionals were contacted at the earliest opportunity.

Is the service caring?

Inadequate

The service was not caring. This referred specifically to Murrelle House.

Not all care provided was person centred, caring and kind.

People and those acting on their behalf were not always involved in the planning of their care.

People were not always treated with dignity and respect.

Is the service responsive?

Inadequate

The service was not consistently responsive.

People were not always engaged in meaningful activities and supported to pursue pastimes that interested them, particularly for people living with dementia.

Not all people's care records were sufficiently detailed or accurate.

Staff were not consistently responsive to people's needs. This referred specifically to Murrelle House.

Effective arrangements were in place for the management of complaints.

Summary of findings

Is the service well-led?

Inadequate

The service was not well led.

There was a lack of managerial oversight of the service as a whole.

The quality assurance system was not effective because it had not identified the areas of concern that we found.

Godden Lodge Residential and Nursing 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 July 2015, 22 July 2015 and 24 July 2015 and was unannounced.

The inspection team consisted of two inspectors on 21 July 2015 and 22 July 2015. In addition, the inspectors were accompanied by two specialist advisors on 21 July 2015, one was an End of Life Care specialist and one was a Dementia specialist. On 22 July 2015 the inspectors were assisted by an expert by experience. An expert by experience is a person who had personal experience of caring for older people and people living with dementia.

Before our inspection we reviewed the Provider's Information Report (PIR). This is information we have asked the provider to send us to evidence how they are meeting our regulatory requirements. We reviewed the information we held about the service including safeguarding alerts and other notifications. This refers specifically to incidents, events and changes the provider and manager are required to notify us about by law.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We spoke with 17 people who used the service, 16 relatives, 22 members of care, nursing staff, ancillary staff, the manager and deputy manager. In addition, we spoke with two healthcare professionals to seek their views about the quality of the service provided.

We reviewed 15 people's care plans and care records. We looked at the service's staff support records for six members of staff. We also looked at the service's arrangements for the management of medicines, complaints, compliments and safeguarding information and quality monitoring and audit information.

Requires improvement

Is the service safe?

Our findings

The arrangements for the management of medicines were not consistently safe. Medicines on Cephas House were not stored securely. This meant that medication was easily accessible to people not authorised to have access. During the morning medication round on Murrelle House on the first day of inspection, a nurse was observed to directly handle one person's medication by placing their tablets in the tablet crusher with their fingers. This meant that poor hygiene methods were being used and there was a potential risk of cross-infection. In addition, some medicines may be harmful to the care worker if they have direct contact with them and this could change the original properties of the medication.

Improvements were needed to ensure that people received their medicines as prescribed in all the houses of the service. This was inconsistent and some people might be at risk because of poor practices in some houses of the service. The 'Topical Medicines Application Record' for people across the service, showed that the administration of people's 'topical' cream for skin care had not always been clearly recorded to demonstrate this had been given as prescribed. Not all people had been given their medication in line with the prescriber's instructions, for example, the instruction on the medication administration record [MAR] for one person recorded that one of their medicines should be swallowed whole and not crushed. This was disregarded by staff and the medication was being crushed. This meant that the original properties of the medication may not be retained or continue to be effective for the person to whom it was prescribed.

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

People's comments about staffing levels were variable. People and those acting on their behalf on Boyce House, Victoria House, Cephas House and Appleton House told us that staffing levels were appropriate.

However, this was in contrast to what we were told on Murrelle House. One relative told us, "It [staffing] could be a lot better and generally they do not seem to have enough staff." They explained that this had resulted in their member of family looking unkempt in physical appearance on some occasions and there not being sufficient staff available to assist people properly with their care needs. A further five relatives told us that they did not feel there were always enough staff available on Murrelle House and this often resulted in their member of family remaining in their bedroom throughout the day and/or not being given the opportunity to sit in the communal lounge until lunchtime. One relative told us that when they visited each week their member of family was always in bed. They told us, "They [staff] don't get them up." Another relative told us that often when they arrived on Murrelle House their relative's personal care had not been completed and for the duration of their visit, which could be for several hours, they rarely saw a member of staff. They told us, "Why does not one of the staff pop their head in here."

Our observations on the first two days of inspection showed that staff did not always have enough time to spend with people to meet their needs. The care and support provided was routine and task orientated and this was evident from our observations. The deployment of staff was not always suitable to meet people's needs, for example, we noted that there were times when the main communal lounge was left without staff support for between 10 and 15 minutes. On one occasion we observed one person to be distressed and anxious as a result of the grassed area outside being mowed and trimmed. Over a 15 minute period they were overheard to repeatedly state, "What's he doing", "Do something, I don't like it" and, "Go away." The person's physical distress was noted to increase as no action was taken to alleviate their anxieties as a result of no staff being available to support them and monitor the situation. People had experienced poor care because there were insufficient staff deployed to meet their needs.

The manager was unable to confirm how staffing levels at the service were calculated so as to determine the number of staff required. We discussed this with the manager and they confirmed that a dependency 'banding' was completed for each person. However, there was no systematic approach to determine the number of staff required, to review the service's staffing levels and to ensure that the deployment of staff met people's changing needs and circumstances.

This is a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

People who used the service and those acting on their behalf told us that they felt safe. One person told us, "Yes I am safe." Another person told us, "I feel very safe and I like it very much." Staff had received safeguarding training and

Requires improvement

Is the service safe?

were able to demonstrate a good understanding and awareness of the different types of abuse, how to respond appropriately where abuse was suspected and how to escalate concerns about a person's safety to a senior member of staff or a member of the management team. Staff also confirmed they would report any concerns to external agencies such as the Local Authority or the Care Quality Commission if required.

Suitable arrangements were in place to ensure that the right staff were employed at the service. Staff recruitment records for staff appointed within the last six months showed that the provider had operated a thorough recruitment procedure in line with their policy and procedure. This showed that staff employed had had the appropriate checks to ensure that they were suitable to work with people.

Inadequate

Is the service effective?

Our findings

At our last inspection of the service in May 2014, we found that documentation relating to consent to care and treatment required improvement. We asked the provider to send us an action plan which outlined the actions to be taken to make the necessary improvements. An action plan was provided on 6 October 2014 and this confirmed that the provider was compliant. Documentation viewed at this inspection showed that the improvements had been made.

At this inspection staff confirmed that they had received Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) training. The majority of staff demonstrated a good understanding and knowledge of MCA and DoLS and how people's ability to make informed decisions can change and fluctuate from time to time. However, our observations on Murrelle House showed that not all staff supported people in making decisions or gained their consent prior to providing care and support. People were not actively consulted or spoken with prior to care being provided, for example, when assistance with manual handling was provided by staff or when staff provided support with personal care. This showed that sufficient efforts were not routinely made to gain people's consent.

Appropriate applications had been made to the local authority for DoLS assessments. Where these had been agreed the provider had notified the Care Quality Commission. The arrangements for the administration of covert medication had been assessed for individual people. However, there was little information recorded to show that it had been agreed in their best interests by appropriate people involved in their lives, such as, Pharmacist and GP. 'Covert' refers to where medicines are administered in a disguised format without the knowledge or consent of the person receiving them, for example, in food or in drink. We also found that some of the information recorded was conflicting, for example, one person's information recorded that their medication should be administered with yoghurt. Our observations showed that the nurse on both days of the inspection crushed and mixed the medication with orange juice.

Comments about the quality of the meals provided were variable with both positive and negative comments.

Our observations showed that the dining experience for people on Boyce House, Victoria House, Cephas House and Appleton House was positive. People received their meal in a timely manner, staff support was observed to be appropriate and the meals provided were sufficient in quantity and looked appetising.

However, this was in contrast to our observations of the dining experience for people living with dementia on Murrelle House. Our observations showed that consideration by staff was not well-thought-out to ensure that eating and drinking was an important part of people's daily life, was a positive experience for people or treated as a social occasion.

People were not always given a choice of drinks and were not readily available to people throughout the day or with the lunchtime meal. Staff failed to provide information or explanation to people about the meals provided and support and encouragement to eat or drink was not always provided, for example, one person was noted to have difficulty eating their meal and requested staff support. The person was observed to repeatedly state, "Help me please, please help me", "Help me, I can't feed myself, I can't, I don't feel very well. Please help me" and, "Help me please." A staff member was overheard to say, "You're alright, you can eat without help." The person received support from a member of staff after 15 minutes. The care records for this person recorded that they should always be supervised at mealtimes, required assistance with eating their meal on occasions and required prompting and encouragement. This showed that the person's needs had not been met and that people were not getting enough help to eat and drink. In addition, we found that some interactions with people by staff were hurried and did not promote their wellbeing. We observed two staff not allowing people to eat at their own pace or give the person enough time to chew and swallow all of their food. Snacks and drinks were not available outside of designated times despite some people's care records detailing that these should be provided.

We could not be assured that people who remained in their bedroom received appropriate care, for example, we found following discussions with staff that one person had not received a drink throughout the day. This was brought to the manager's and deputy manager's attention immediately. Records showed that within a 40 minute period the person was provided with and drank 650

millilitres of juice. This meant that people were left with little or no support that met their needs, were at risk of social isolation and their health and safety was potentially placed at risk.

The nutritional needs of people were identified and where people who used the service were considered to be at nutritional risk, we found that an appropriate referral to a healthcare professional such as GP, Speech and Language Therapist and/or dietician had been made. However, where instructions recorded that people should be weighed at regular intervals, for example, weekly or monthly, this had not always happened or been followed. This meant that staff could not be sure that people were maintaining their weight or were not losing weight. In addition, we found that a record of the meals provided and fluids taken had not always been maintained in sufficient detail to establish if people's dietary needs were being monitored, managed or encouraged. This was of specific concern for those people who were supported in bed due to their ill health. There were no clear records of the nutritional care and support these people were receiving and staff were unable to confirm what nutritional care they had received during the day, placing their wellbeing and health at risk.

This was in breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Although staff told us they had received regular training opportunities in a range of subjects and this provided them with the skills and knowledge to undertake their role and responsibilities and to meet people's needs, our observations of care provided on Murrelle House did not show that staff knew how to apply their training and provide safe and effective care to people.

Several people were living with dementia, some in the early stages of the condition whilst others were living with more advanced dementia. Although staff told us they had received training relating to dementia, we found examples of poor staff practice which indicated a lack of learning from training provided to staff. Some staff did not demonstrate an understanding of how to support people living with dementia and how this affected people in their daily lives; for example, some staff did not communicate effectively with individual people or provide positive interactions. Staff were dismissive in some cases and did not always wait for a response from the person. People were often seen to receive care and support with staff who remained silent throughout the time that this was provided. This showed that staff were not sufficiently skilled or confident in engaging with people who had dementia associated needs.

On the first day of our inspection on Murrelle House we observed two members of staff assisting a person to move in a way that was unsafe and put them at risk of harm. Staff were observed to transfer the person from their chair to a wheelchair by placing their arms under the person's armpits and pulling the person up. The person grimaced and looked to be uncomfortable whilst this was being carried out. Although records showed that both members of staff had received manual handling training, this showed that staff did not know how to apply their training and provide safe and effective care to the people they supported.

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

In general people were supported well to maintain their health and access healthcare services. People and those acting on their behalf on Boyce House, Victoria House, Cephas House and Appleton House told us that their healthcare needs were well managed. People's care records showed that their healthcare needs were clearly recorded and this included evidence of staff interventions and the outcomes of healthcare appointments. Relatives of people living in these houses confirmed that they were kept informed of their member of family's healthcare needs and the outcome of healthcare appointments. One relative told us, "They [staff] let me know if there is any change by phone."

However, this was in contrast to what we were told on Murrelle House. People told us that they were not always assured that some of the nurses and care staff took effective preventative action at the right time to keep people in good health or to recognise the signs where a person's health was deteriorating. Relatives told us that GPs and other healthcare professional input was often at their insistence and request.

Staff told us they received an effective induction over four or five days depending on their role and responsibilities. This included an 'orientation' induction of the premises and training in key areas appropriate to the needs of the people they supported. We spoke with two newly employed members of staff and they confirmed that they

Inadequate

Is the service effective?

had completed an induction and this had included opportunities whereby they had shadowed a more experienced member of staff. This was so that they could learn the routines of the service and understand the specific care needs of people living there. They told us that they had found this to be very good.

Staff told us that they received good day-to-day support from work colleagues. However, not all staff were able to tell us when they had last received supervision and some staff told us that they had not received regular supervision. This meant that although staff felt supported they might not always have a structured opportunity to discuss their practice and development to ensure that they continued to deliver care effectively to people. Records viewed confirmed this.

Inadequate

Is the service caring?

Our findings

People and those acting on their behalf on Boyce House, Victoria House, Cephas House and Appleton House told us that staff were kind and caring. People were positive about the care and support provided and the atmosphere within these houses was observed to be relaxed and calm. Staff demonstrated affection, warmth and compassion for the people they supported. It was evident from our discussions with staff that they knew the care needs of the people they supported and the things that were important to them in their lives. There were good signs of wellbeing and we observed that people were engaged with others and visitors. Interventions between staff and people living at the service were delivered in a kind and considerate manner. We saw, for example, prior to any intervention, staff approached people advising them of what was about to happen and staff sought their consent and communicated well with people they supported.

This was in contrast to what we observed on Murrelle House as people did not consistently receive a service that was caring and compassionate. Relatives comments about the standard and quality of care provided were variable with both positive and negative comments. One relative told us, "The standard of care is not that great and it could be better."

Although staff were able to tell us about the basic needs of the people they supported, our observations showed that the majority of interactions by staff were routine and task orientated and they spent little time with the people they supported, either in the communal lounge or with people who spent a lot of time in their bedroom.

Our observations showed that one person throughout the afternoon of the first day of the inspection liked to mobilise independently whilst sitting in a chair. Although the chair was heavy they managed to move from one side of the room to the other and this was repeated several times through the course of the afternoon. On at least four occasions one member of staff was seen to drag the chair with the person in it to a place of the staff member's choosing. On the fifth occasion when the person tried to mobilise the member of staff held the chair in place, effectively restraining the person so that they could not move. This was seen to upset the person and they flailed their arms in the air and repeatedly stated, "No, no, let me go." The member of staff did not let go and no explanation was provided to the person to explain the member of staff's rationale for doing this. They showed no compassion or understanding for the person and did not attempt to determine why the person was mobilising in this way. The person was treated unkindly and in an uncaring way.

We observed poor practices from staff when they supported people. We noted staff interactions were poor and they did not always demonstrate a caring attitude. Staff failed to promote people's dignity or show respect to individuals, for example, people were supported with their mobility and/or assisted to eat without any verbal communication from staff. In addition, repeatedly we heard staff use the term 'feeding' to describe people who required assistance from staff to eat. This is a derogatory term and did not promote people's dignity or individuality.

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

The manager confirmed that Cephas House was set up to provide end of life care. The manager told us that only one person was identified as receiving end of life care as they were currently unable to offer palliative care as there were insufficient permanent registered nurses available. The needs of the person approaching the end of their life had been assessed and they and those acting on their behalf were supported to discuss their end of life arrangements. A referral had been made to access specialist palliative care services and at the time of the inspection steps were being taken to have access to equipment they needed to meet their end of life needs.

People were supported to maintain contact with family and friends and relatives told us that they were always welcomed and that there were no restrictions on visiting times.

Inadequate

Is the service responsive?

Our findings

People's comments about the things for them to do and occupy their time were variable. People on Victoria House and Appleton House told us that they received the opportunity to participate in a variety of activities and things of interest to them at regular intervals. However, this was in contrast to what we observed on Murrelle House. People told us that the opportunities provided to engage in meaningful activities was limited and not very forthcoming. Staff responsible for supporting people to access meaningful pastimes told us that they did their best to support people to pursue their hobbies and interests within each of the five houses. Staff explained that their role was to visit one house for one hour each day and this included weekends. They stated that there were a number of constraints which prevented them from engaging regularly and to deliver a meaningful programme of social activities to people who used the service.

Our observations during our inspection showed that there was a lack of meaningful engagement and people were not supported to pursue their interests or hobbies, for example, on Cephas House during the first morning the person responsible for activities talked with three people in the communal lounge and with one person in their room. In the afternoon they played a game of dominoes with one person and three people watched a film. This meant that only eight out of 23 people on Cephas received support and meaningful interaction. There were no opportunities for social engagement or activities for people living in Murrelle House and Boyce House on the first day of inspection and on the second day karaoke was provided for one hour. We found that there was no evidence that activities provided were linked to people's past hobbies or interests and involved 'everyday tasks' such as assisting staff to lay the table, help with laundry, dusting or gardening. In addition, there was no indication that reminiscence, including memory boxes, objects of reference and life story work was used to help trigger memories or enable people the opportunity to independently entertain themselves. This meant that people were not encouraged to keep active or to stay involved in their surroundings. Records confirmed our observations, for example, the activity log for one person showed that they had not participated in any social activities since 2 July 2015. This was not an isolated case.

We found inconsistencies across the service in the quality of the information included in people's care records. Some provided sufficient detail to give staff the information they needed to provide personalised care and support that was consistent and responsive to their individual needs. However, others were not fully reflective or accurate of people's care needs, for example, several people's care records had not been reviewed and/or evaluated since May 2015. Others did not contain sufficient relevant information on how people's dementia affected their day-to-day living and how they were to be supported. They did not include detail about people's strengths, abilities and aspirations. Daily records did not provide adequate information detailing how people spent their day or how they had been so as to maintain their wellbeing. In one instance we found that some aspects of the person's daily care records had been updated 20 minutes prior to the actual time recorded. This meant that we could not be assured as to the accuracy of the information or be assured that the person's needs were being met. This was brought to the manager's and deputy manager's attention at the time of the inspection. Where people could become distressed and anxious, we found that staff's interventions and actions taken to comfort and reassure the person or to resolve a situation were not always recorded.

People were not always actively involved in the planning of their own care and support. Relatives told us that they had not always been asked to be involved in the planning of their relative's care other than at the initial pre-assessment stage.

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

The provider had a complaints policy in place and had procedures in place that ensured people's concerns were listened to. People and their relatives told us that if they had any concern they would discuss these with the management team or staff on duty. People told us that they felt able to talk freely to staff about any concerns or complaints. Staff told us that they were aware of the complaints procedure and knew how to respond to people's concerns. A record was maintained of each complaint and included the details of the investigation and action taken.

Inadequate

Is the service well-led?

Our findings

The provider used questionnaires for people who used the service and those acting on their behalf to seek their views about the quality of the service. The management team also monitored the quality of the service through the completion of a number of audits. This also included internal reviews by the organisation's internal quality assurance team at regular intervals.

Although these systems were in place, they were ineffective and had not highlighted the areas of concern we had identified, particularly, in relation to Murrelle House. There was a lack of managerial oversight of the service as a whole as each house was managed in isolation by individual 'house' managers. The provider did not have an effective system in place to review staffing levels to ensure that the deployment of staff was suitable to meet people's needs. In addition, improvements required were identified in relation to some aspects of medicines management. People experienced poor care outcomes and the lack of robust quality monitoring meant that there was a lack of consistency in how well the service was managed and led.

Although overall there was a positive culture in the service. This was not the case in Murrelle House. Care was not always caring or compassionate but primarily routine and task orientated and there was a lack of understanding from some staff that their behaviour was unacceptable and was impacting on people's wellbeing.

The manager was supported by a newly appointed deputy manager, 'house' manager's and qualified nurses. In general it was clear from our discussions with the manager and deputy manager and from our observations that they had an understanding of their roles and responsibilities. However, our observations on Murrelle House showed that although the 'house' manager was on annual leave at the time of our inspection, responsibility by the nurses for leading each shift was weak and inconsistent. There was a lack of evidence to show that staff were supervised properly and that some of the nurses were an effective 'role model' to care staff.

People were not always actively involved in the improvement of the service they received. The manager told us that daily, weekly and monthly meetings with staff were undertaken to facilitate communication between all departments to understand what was happening with the service each day. Staff confirmed this and records were maintained of the topics discussed and actions to be taken and agreed. Although there was some evidence of meetings having taken place for people who used the service and those acting on their behalf, some interactions and involvement requests had been turned down. This did not ensure active involvement in the service by all the people and their families, for example, relatives on one house told us that a request had recently been made to the organisation's Quality Manager for a meeting but that this had been dismissed.

There was evidence to show that satisfaction questionnaires for people who used the service and those acting on their behalf had been completed and a report compiled in May 2015, so as to determine peoples' views about the quality of the service provided. The reports detailed the main areas of strength and the areas for improvement. However, only positive verbatim feedback from people and relatives was included in the report despite there being areas for improvement recorded, such as, 'Promptness of staff attending to needs of resident' and, 'Quality of care my relative receives.' No action plan had been completed as to how the areas for improvement were to be addressed, if it related to specific houses or the service overall. The latter area for improvement was a concern as our inspection had highlighted a number of concerns relating to care provided to people using the service.

This was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The manager confirmed that Boyce House was part of the Promoting Safer Provision of Care for Elderly Residents (PROSPER) project in relation to falls. This is a two year project that aims to improve safety, reduce harm and reduce emergency hospital admissions for people living in care homes across Essex by developing the skills of staff employed within the service. They also told us that they were part of another initiative run by Essex County Council, FaNs (Community Friends and Neighbours). This is a three year programme that supports groups of people and organisations who are willing to take an active interest in the wellbeing of people living in care homes in their local area. This showed that the provider worked together with other external organisations to promote best practice and to keep themselves up-to-date with new initiatives.

Inadequate

Is the service well-led?

Encouragement to increase staff performance was provided through a number of special incentives, such as, the Bupa UK Nursing Special Recognition Award and the Everyday Hero Award. Information relating to these was recorded on the staff noticeboard. In addition, there were a small number of financial incentives for staff and an annual 'care award' scheme where staff could be nominated and their efforts recognised.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment We found that the registered provider had not ensured that people were protected by the provider's proper and safe management of medicines.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs We found that the registered provider had not protected people against the risks of receiving inadequate nutrition and hydration. This was in breach of Regulation 14(1), 14(2)(b) and 14(4)(d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing We found that the registered provider had not ensured that there were sufficient numbers of staff deployed so as to make sure that they can meet people's care and treatment needs. This was in breach of Regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing We found that the registered provider had not ensured that staffs training, learning and development needs had

This section is primarily information for the provider

Action we have told the provider to take

supported them to fulfil the requirements of their role to meet people's needs. This was in breach of Regulation 18(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care We found that the registered provider had not protected people against the risks of receiving care and treatment that was inappropriate and did not meet their needs. This was in breach of Regulation 9(1)(a) and (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:
We have served a warning notice to be met by 14 September 2015

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care We found that the registered provider had not ensured that people's assessments included all of their needs that they were reviewed regularly and an accurate record of care and treatment provided remained accurate. This was in breach of Regulation 9(3)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:
We have served a warning notice to be met by 14 September 2015

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance We found that the registered provider and manager had not protected people against the risks of inappropriate or unsafe care as the arrangements to assess and monitor the quality of the service provided was ineffective. This was in breach of Regulation 17(1)(2)(a), (b) and (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Enforcement actions

The enforcement action we took:
We have served a warning notice to be met by 14 September 2015