Mr & Mrs J Dunn

Ocean Hill Lodge Residential Care Home

Inspection report

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Ratings

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

Overall summary

Ocean Hill Lodge provides accommodation and personal care for up to 18 predominantly older people. Mrs Dunn, one of the providers of the service, is also the registered manager for the service. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. We have referred to Mrs Dunn as the registered person throughout this report. We carried out this unannounced inspection of Ocean Hill Lodge on 8 and 13 July 2015.

When we inspected the service in February 2015, we found a number of breaches of legal requirements relating to the following issues. We had concerns about the internal and external environment of the premises, in particular a strong smell of urine throughout the building and a lack of appropriate storage facilities. We saw during this inspection that the service had taken action to provide more appropriate storage. However, there remained environmental concerns because of the continued severe urinary odour in certain areas of the

Summary of findings

building, in particular in communal areas. The registered manager had not fulfilled the action plan to eliminate the unacceptable smell in the premises. In addition, we found furniture used by people was very worn and dirty. The provider told us there currently were no available funds to replace old and worn chairs and carpets in the service.

The last two inspections highlighted significant gaps in staff training. At this inspection we found staff had received some training, however, the organisation and delivery of appropriate training was not taking place. The registered manager did not have a clear plan for staff about what training was required and when it needed to be undertaken. Staff told us, "Training isn't great. We've had first aid and there is a day of moving and handling planned but it is very hit and miss generally". Training records showed that not all staff had received relevant training for their role and refresher training was not up-to-date.

At the last inspection we found the service did not have a system for supporting staff by providing regular supervision and appraisal. Staff were not consistently supervised, supported and trained to carry out their roles. Records showed that staff had not had an individual supervision meeting or appraisal since November 2014. Following the last inspection in February 2015 we received an action plan stating that supervision had begun with staff. During this inspection the registered person and staff confirmed that supervision had not happened following the last inspection. The registered person told us she had intended to do this, but lack of time and staff shortages had led to this not happening. Staff confirmed they had not received an appraisal for years, if at all, and had received no professional development, except for minimal training. One staff member told us' "Supervision is not happening. I have never had an appraisal and I don't feel I get adequate supervision to do my job".

At the last inspection we found the registered person had not protected people against the risks of unsafe medicines administration. At this inspection we found the action plan to improve and monitor the administration of medicines had not been met. We found two serious errors when people had received the wrong medicines, multiple medicine administration recording (MAR) errors and failures to have enough prescribed medicines to administer to people. This meant that people were not receiving their medicines at times and that the administration of medicines system generally was not safe.

People's care and treatment was not being planned and delivered in a way that ensured people's safety and welfare. This issue had also been identified in the previous inspections in September 2014 and February 2015. We saw care records were very brief, did not provide staff with clear direction to be able to meet people's needs, were not up to date, and were not being adequately reviewed. There was confusion between the registered manager and the care staff about whose responsibility it was to ensure care records were regularly reviewed.

We found the registered person had not ensured people were protected under the Mental Capacity Act (2005) legislation and Deprivation of Liberty Safeguards. The service used a number of potentially unreasonable restrictive interventions such as stair gates on people's rooms, another stair gate blocking the exit to the stairway on the first floor landing, and a number of alarmed pressure mats placed in peoples' bedrooms. These were in place to make staff aware that people had got up from bed but also to prevent people coming downstairs in the night. We found no risk assessments in place either about the fire risk that blocking off the stairs could cause or about whether these measures were reasonably restricting people against their will with consideration of their capacity to consent under the Mental Capacity Act 2005. People without capacity to consent to these measures had not been adequately protected.

The service had a complaints procedure; however, people were not aware of how to access it and one person told us they did not feel confident that anything would be done if they did make a complaint. In discussion with the registered person we found an incident which constituted a complaint from a person's relative, that had not been recorded as a complaint and the person had not received feedback about the issue from the service.

The registered person did not have appropriate systems in place to assess, monitor and improve the quality of the service. This was particularly evident in relation to the lack of medicines audits, infection control audits and supervision and appraisal systems.

Summary of findings

Staff interacted with people in a friendly and respectful way and people were encouraged and supported to maintain their independence. For example, one person told us how much they enjoyed going out to a local community club and meeting friends. People made choices about their day to day lives which were respected by staff.

People received care and support that was responsive to their needs and their privacy was respected. People told us staff treated them with care and compassion. Comments included; "They're nice, if you want anything they [staff] will try to get it", and "The staff are good. I have no complaints." Visitors told us they were always made welcome and were able to visit at any time. People were able to see their visitors in communal areas or in private.

During the inspection we identified seven breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People were at risk from harm because the provider's actions did not sufficiently address the on-going failings. There has been on-going evidence of the provider failing to sustain full compliance since 2013. We have made these failings clear to the provider and they have had sufficient time to address them. Our findings do not provide us with confidence in the provider's ability to bring about lasting compliance with the requirements of the regulations. We are taking further action in relation to this provider and will report on this when it is completed. 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.

• 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.

• Services placed in special measures will be inspected again within six months.

• The service will be kept under review and if needed could be escalated to urgent enforcement action.

You can see what action 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?

Inadequate

The service was not safe.

The service had a pervasive smell of urine odours.

We found people were not safe due to poor and therefore unsafe medication administration practices.

People's planning of care was inadequate and people's care plans were not being reviewed in relation to potential risks.

Is the service effective?

Requires improvement

The service was not effective.

The standard of decoration and facilities in the home was poor and did not

provide comfortable surroundings for people to live in. Maintenance and redecoration were not consistently carried out, resulting in people living in an unsatisfactory environment.

The service was not providing staff with effective support both through, clear management roles, and supervision and appraisal in line with its own organisational policy.

People were supported to receive appropriate food and drink and people had choice in this area.

People were supported to access health services effectively.

Is the service caring?

Requires improvement

The service was caring.

Staff were caring and respectful when people needed support, or help with personal care needs.

Staff showed a commitment to respecting and understanding peoples' needs by taking time to listen to people.

Most people who lived at the service did not have an adequate care plan to ensure all their needs were being met.

Is the service responsive?

Requires improvement

The service was not consistently responsive.

Concerns and complaints were not consistently recorded and there were no audits in place to monitor outcomes for people and trends.

People were supported to receive prompt and appropriate healthcare when required.

Summary of findings

The service provided an adequate range of activities for people to participate in.

Is the service well-led?

Inadequate

The service was not well led.

Management had not met the actions of the plan provided to the CQC following the last inspection.

The management of the service was poorly organised which led to a lack of safety and an ineffective service.

There was a lack of quality assurance and audit processes in operation to support the effective management of the service.

Ocean Hill Lodge Residential Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 9 and 13 July 2015 and was unannounced. The inspection was carried out by two inspectors on the first day of inspection and one inspector on the second day of inspection.

We looked at previous inspection reports before the inspection and an action plan provided by the providers following the last inspection. We also reviewed the information we held about the home and notifications of incidents we had received. A notification is information about important events which the service is required to send us by law.

During the inspection we spoke with 12 of the 18 people who lived at Ocean Hill Lodge and who were able to express their views of living at the service, three relatives and seven external professionals who had experience of the home. We looked around the premises and observed care practices on the day of our visit. We used the Short Observational Framework for Inspection (SOFI) over the lunch time period on the second day. SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We also spoke with six care staff, the cook, and Mrs Dunn who is both one of the registered providers and holds the role of registered manager. We have referred to Mrs Dunn as the registered person throughout this report. We looked at six records relating to the care of individuals, three staff recruitment files, staff duty rosters, staff training records and records relating to the running of the home.

Inadequate

Is the service safe?

Our findings

When we entered the service there was an immediate very strong urinary odour in the corridor and then throughout the building. During the last inspection the same issue had been identified.

Prior to this inspection we received a complaint about the pervasive severe urinary odour at the service. We contacted the registered person about this and received assurances that action would be taken to deal with this including bleaching floorboards and replacing carpets alongside an on-going carpet renewal schedule. The registered person also told us verbally on another occasion and in the action plan submitted to us, that the unacceptable strong urinary odour would be addressed and a professional carpet cleaning service would be used to deep clean the carpets. We found that none of these actions had been done.

During this inspection, the registered person told us carpets were cleaned as required and she was aware that some carpets required replacing. We were told this would be done only when finances allowed. On the second day of inspection the smell was less, although still there. We were told the carpets had been cleaned over the weekend using the service's carpet cleaner.

We noted a number of issues in the environment of the home which were unsafe which included the following. During the last inspection we identified a serious trip hazard posed by loose wiring connected to pressure mats in a communal corridor. We saw that this had not been addressed and was continuing. . However, with us present carrying out the inspection, we saw the loose wiring was made safe by the second day of inspection. We saw a radiator cover in a corridor which was not fixed in place and posed a risk to people if it was leant on for balance.

The registered person was not maintaining appropriate standards of cleanliness, hygiene and maintenance for people who used the service. This was a continued breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A new cleaner had been employed and we saw daily, weekly and monthly cleaning schedules had been put written. However we did not see that these had improved the situation.

During the last inspection we found that the administration of peoples' medicines was unsafe and that there was a breach of Regulations. We received an action plan from the provider that stated daily checks of the Medicine Administration Records (MARS) would be carried out to reduce the amount of recording gaps and errors made when administering medicines. We had also found in February 2015 that the service was not auditing the medicines management procedures or appropriately addressing the cause of medicine errors. The registered manager stated in their action plan that the service would use a medicine compliance audit to resolve these issues. These planned actions had not been carried out. We saw there had been two serious medicine errors in the last five months. On one occasion medicines were given to the wrong person and on another a person received two medicines, one that had been stopped and that had been replaced by the second.

We spoke with the registered person about how the errors had occurred and subsequent actions that had been taken to minimise further risks. The registered person said only that the incidents were 'human error'. We found no evidence that there had been any investigation into these errors or that any actions had been taken to help prevent similar errors reoccurring. We looked at the service's administration of medicines policy and found it did not contain a procedure to use in the event of medication errors.

We looked at the Medication Administration Records (MAR) for six of the seventeen people that lived in the service at the time of our inspection. We found over 20 recording errors in their records in only a three week period. Neither staff or the registered person were aware of these errors.

We looked at the MAR charts for people who lived at the home. We saw not every person had photographic identification attached to their records. We were told this photographic identification was routinely used by this service as a safety measure to assist staff to be clear about who they were administering medicines to.

We saw several instances when medicines were unavailable to be administered to people because their stock of medicines had run out. This was because new stock had not arrived in time. In these situations the person did not receive their prescribed medicines, which included important pain relieving medicines and medicines that maintained people's health

Inadequate

Is the service safe?

Some medicines must be managed under more strict conditions to keep them safe and these are known as Controlled Drugs. We found that three of these medicines were being held in the service's controlled drug storage and were dated to be used between 2010 and 2012. These medicines had not been returned to the pharmacy for required appropriate disposal. The registered person and staff we spoke with were unaware these medicines were still in the care home.

The registered person was not ensuring people were protected against the risks of unsafe medicines administration because medicines were not being handled safely, securely and appropriately. This was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The Cornwall Council food safety inspection carried out in June 2014 stated that it was unsafe practice to have two freezers kept on a carpeted floor in the conservatory area of the home. The service was required to replace the flooring where the freezers were kept with a non-absorbent floor covering. This was to enable easier cleaning of food spillages that could result in the spread of infection. The service had carried out this recommendation since the last inspection. However the two large chest freezers remained in the conservatory, which is a communal area of the home.

Care and support were not adequately planned and reviewed. Records showed people's risks were not always identified. For example, there were no risk assessments in place to manage risks to people from the environment in the care home, such as from hot water or from accessible window openings. People were not being generally protected as there was no risk assessment, including fire risk, for medical oxygen, which was in use in the building.

Routine reviews of people's care plans in relation to any potential risks that might impact on them were not taking place. This was breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us staffing levels were too low during weekends and after the service recently lost a number of staff, the service were reliant on the existing staff group to cover shifts while the recruitment of replacement staff took place.

The staffing rota showed there were three care staff working in the morning and afternoon shifts and two staff each night. One staff was awake and on duty while the other staff member was sleeping-in, but could be woken when required. People told us there were enough staff to meet their needs. One person said, "The staff are nice. They take time to talk to me and help me if they can".

We observed staff were not rushed, answered call bells promptly and spent time on an individual basis with people. There was a mix of staff skills and experience on each shift. Care staff who had been employed for a number of years worked together with staff that had joined the service more recently. The service had recently employed one person who was on induction and we saw this person was supported by the existing staff group.

There were systems in place to protect people from the risk of abuse. Staff we spoke with had an understanding of how to keep people safe from abuse and reduce the risk of harm to people. Staff had received refresher training in safeguarding processes. One staff member said, "I wouldn't hesitate to report any abuse that I saw." The registered person had introduced a clear procedure for making appropriate alerts regarding people's safety to the local authority if required.

Relatives told us they were happy with the care and support their family member received and believed it was a safe environment. One commented, "I think my (relative) is safe at this home". A person who lived at the home said, "I am well looked after here. I like it and I do feel safe".

Requires improvement

Is the service effective?

Our findings

The standard of maintenance and decoration of the service was poor and did not provide adequate facilities for people to live in. For example, the general decoration of the home was heavily worn, chairs in the conservatory and lounge area were old and severely worn, and carpets in communal ground floor areas, corridors and first floor corridors were also heavily worn. Carpets in several people's bedrooms were also heavily worn and were not repairable. Relatives of people who lived in the service told us, and other professionals we spoke with acknowledged, that the home was 'tired' and required considerable updating and maintenance.

We spoke with the registered person about the decoration of the home as this had been raised during the last inspection. We were also told in the service's action plan, which was given to us after the last inspection, that a budget to replace worn and stained armchairs had been put in place but we found that furniture had not been replaced. The registered person acknowledged the significant need for urgent re-decoration, new furniture and new carpets where necessary. However, there was no redecoration and replacement schedule or maintenance planning in place to do this.

The provider was not ensuring there were suitable arrangements in place to provide a safe and adequately comfortable environment for people using and working in the home. This was a continued breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The training needs of the staff were not adequately met. Staff told us they did not feel they received adequate training or support to carry out their roles effectively. Staff did not know about best practice developments in care for older people and people with dementia because they had not received any training in these areas.

The service did not have a training schedule in place. This meant it was difficult for the registered person to identify which staff required updated training in a particular area. Annual training updates, set out in the provider's training policy, such as moving and handling, had not taken place appropriately. This meant some staff were using equipment they had not received adequate training to use appropriately. This put people at risk. Staff and the registered person told us training in moving and handling was scheduled to take place in the days following the inspection.

Staff members we spoke with confirmed they received limited training. However, this was not done in a structured way and staff told us they did not have a work related development plan to assist them in their roles. Staff confirmed they had undertaken a recent refresher training course on medication. This was confirmed by a local pharmacist who conducted the training. However, we found staff were not competent in administering and recording the medicines managed by the service. Training in other areas required updating. Health and safety training was last attended by some staff in October 2007. The registered person acknowledged the training programme required updating.

Staff commented that lines of responsibility in the home were not clear. Staff told us the registered person found it difficult to accept assistance in making improvements in the administration of the service. Staff told us they had felt unable to continue taking on more responsibility for updating care plans and audit procedures because the time required to do this was not made available by the registered person. One staff member said, "Although the (registered person's) door is always open, it can sometimes feel like we're making decisions on our own. Roles and responsibilities aren't always clear". Staff told us they had not received individual supervision to ensure they were working appropriately or annual appraisal. One staff member told us, "I have worked here for years and I have never had an appraisal". Staff told us there were infrequent team meetings.

The provider was not providing staff with effective support to ensure safe and effective care was provided to people that used the service. This was a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager told us they had undertaken training in the requirements of the Mental Capacity Act 2005 (MCA). The MCA is designed to empower those in health and social care to assess capacity themselves, rather than relying on expert testing from clinical professionals. This applies to everyone involved in the care, treatment and support of people aged 16 and over who are unable to make all or some decisions for themselves. The MCA is

designed to protect and restore power to those people who lack capacity. However, we saw that the service had not carried out any mental capacity assessments for people where necessary. We saw that people were being restricted through the use of stair gates at the head of the stairs and at peoples' bedroom doors, and that alarmed pressure mats were in place at various places around the home. The registered manager told us two of the four people who had stair gates in front of their bedroom doors had capacity and had requested the gates in order to protect their privacy and had signed their consent. However, two people did not have capacity to consent to the use of stair gates at their doors and there were no assessments or best interest decisions recorded regarding the use of these items, which significantly restricted people's ability to move around the home. None of these restrictions of personal freedom had been considered appropriately under the Mental Capacity Act to ensure that they were necessary and appropriate restrictions to impose upon people. The rights of people that lacked capacity were not being protected adequately.

The home had not appropriately considered the impact of restrictions put in place for people that might need to be authorised under the Deprivation of Liberty Safeguards (DoLS). The legislation regarding DoLS provides a process by which a person can be deprived of their liberty when they do not have the capacity to make certain decisions and there is no other way to look after the person safely. A provider must seek this authorisation to restrict a person for the purposes of care and treatment. Following a recent court ruling the criteria for when someone maybe considered to be deprived of their liberty had changed. The provider had not taken the most recent criteria into account when assessing if people might be being deprived of their liberty. During the last inspection we found the service had not requested appropriate authorisation from the local authority for people who were being restricted into the home for their own safety. . During this inspection the registered person acknowledged that this was something they were aware needed to be assessed for people who lacked capacity and were being restricted from going out of the home without an escort.

These were breaches of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were offered a choice of drinks. We observed staff encouraging people to drink to reduce the risk of dehydration. One person needed their fluid and nutrition intake monitored and we saw this was appropriately recorded. This showed staff were monitoring people's nutrition and hydration needs effectively. Over the two day period of the inspection we saw people have a number of meals. People were involved in choosing their meals in a variety of ways. For example at breakfast time people had a choice of options including cereals, toast with spreads or a cooked breakfast, such as scrambled eggs. People made meaningful food choices. When planning meals ahead of time people's preferences were taken into account, and people were encouraged to say what preferences they had during monthly resident's meetings. Menus were planned on a monthly basis ahead of time, however, people were free to choose an alternative meal if they wanted. One person told us, "I enjoy the food. It's tasty and we have a choice". Another person told us, "The food is good here. It's all healthy".

Relatives told us they had been offered a meal with their family member at the home and found the meals to be good and healthy. They told us, "The food seems good. People are offered choice and I haven't heard anyone complain about it". One person needed their food cut up in order to swallow it safely and we saw this was done and the person was appropriately supported with their meal. People told us they were happy with the food provided at the service.

The home followed the recording procedures detailed in the 'Safer Food, Better Business' guidance. This is a Food Standard Agency publication for specific businesses including residential care homes, to help caterers and staff prepare and cook food safely. Cornwall Council had undertaken a food hygiene inspection report in June 2014. Overall the report was satisfactory, with some requirements made which we have noted elsewhere in this report.

People told us they had access to health care services such as GP services, dental treatment, chiropodists and opticians as and when required. One person told us, "If I need it, they sort out an appointment for me straight away". We saw staff took appropriate action, including ensuring samples were collected to send to the GP for testing, when two people complained of feeling unwell with symptoms of an infection.

Medical appointment details were recorded in the staff communication diary and also in people's care records. One professional from outside the service who had regular

Requires improvement

Is the service effective?

contact with the home said, “The staff maintain good communication with our agency. They seem on top of people’s health needs”. A staff member commented, “We always keep a log of health appointments for the staff team to be aware of. It’s important to keep appointments such as the dentist so people’s health is looked after.”

We spoke with the district nursing team who provided support at the service. They had confidence in how the staff supported and cared for people. They said staff were keen to care for people and always asked for advice. They told us there were no current pressure area care needs for people at the home and there was a low incidence of skin tears. Local health care practitioners told us they did not have any concerns about care at the home and appropriate referrals were made on behalf of people who lived at the home.

Requires improvement

Is the service caring?

Our findings

There was a relaxed and friendly atmosphere at the service. We saw people felt at ease to move about freely and engaged in a relaxed way with each other and staff. People told us they were happy and we saw people spent time in the communal lounge watching television or privately in their bedrooms. People had access to private space at the service to meet with others if they wanted to.

Staff were caring and respectful when people needed support or help with personal care needs. A relative said, "They are nice here, very caring". Another person said, "It is like an extended family".

People we spoke with were well dressed. Staff appropriately supported people with their personal care and people looked smart and were assisted to wear their own jewellery and take pride in their appearance. This showed staff commitment in respecting and understanding peoples' needs.

During the inspection we saw staff being very kind to people. They were seen to be taking time to sit with individuals, talk with them and offer choice. People were actively involved in making simple day to day decisions about whether they wanted a drink, which choice of meal they had and whether to they took part in organised activities or not. One person liked to take an active role in preparing the dining tables for meals, putting out napkins and cutlery etc. Staff encouraged this person and helped them feel valued and helpful.

Staff supported people to express their views and we saw that regular resident meetings took place to allow people to comment on the running of the service. However, it was not usual practice for people to be involved in making more formal decisions about what their care, treatment and support would be. People were not involved or consulted in putting their care plan together or in reviewing their care.

There were no restrictions on visitors coming into the home at any time during the inspection. Those we spoke with told us the service kept them informed and involved in their relatives care and support. However, when we looked at care planning records they rarely showed where relatives or people who used the service had been involved.

Relatives were positive about the standard of care they felt their relatives received from the service. Comments included, "Staff are friendly and approachable", "You can talk to them about anything, there is a really caring feeling about this home".

We spoke with staff to gain an insight into their understanding of the way people should be cared for. Staff gave examples of how to treat people with dignity. One staff member said, "The staff know the importance of treating people with dignity it's what you would want for your own family".

Observations over the two day inspection confirmed staff responded to people in a respectful way. However we also saw that some people that lacked capacity did not have their dignity maintained because they were potentially inappropriately restricted in moving around the building.

We saw that most people were supported to be as independent as they wanted to be. For example, one person accessed activities in the local community which they told us they enjoyed. Staff promoted people's independence and interests. We saw some people had an interest in religion and the service had organised for a religious service to be held regularly at the service, which people could attend if they wanted to.

We saw that people were supported at the end of their life to have a private, comfortable and dignified death. Although the service did not have appropriate end of life care planning in place, we saw that in practice the service had ensured people were treated appropriately and compassionately. A relative commented, "The care given to my mother has been excellent and her end of life care surpassed my expectations".

People had the necessary medical care in place to keep them comfortable. For example, one person was using oxygen to assist their breathing and was regularly visited by health professionals to ensure their comfort.

Requires improvement

Is the service responsive?

Our findings

The service had a policy and procedure in place for dealing with complaints. However, some people told us they were not aware of how to make a complaint and would feel uncomfortable doing so. One person commented, "What would be the point of complaining anyway". Other people said they would tell staff or management if they were unhappy. We were told there had been no complaints received by the service, however, we found a relative had raised a verbal complaint about the care of a relative. This was recorded as an incident in daily records but was not raised as a formal complaint which would require an investigation and response.

This was breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found people were not assured of consistent, co-ordinated and person-centred care when they moved between services. For example, one person had moved into Ocean Hill Lodge three months before this inspection and did not have a care plan in place to meet their needs. This meant care was not properly planned in a way that met the person's individual preferences and needs.

We saw that routine care planning reviews did not take place consistently. People told us they did not routinely discuss their care plans. Some people had signed their care plans, but this was not consistent. The service did not have a process for assisting people who lived with dementia to be involved in their care management. The registered manager told us people with dementia could be accompanied by a family member if they wanted to. However, in practice relatives told us they were not asked to attend reviews of care unless there was a significant issue.

Care records contained limited information about people's health and social care needs. Plans were individualised and relevant to the person, however, in the absence of reviews, if care plans had changed this was not reflected in the plan. Records gave very little guidance to staff on how best to support people.

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

There were a limited number of activities available for people to take part in if they chose. For example, the service arranged for a drummer to visit the home and encouraged people to take part in a group drumming activity. Staff told us they had recently started to involve people in 'arm chair exercises' and there was a weekly bingo session held at the home. One staff member had taken the responsibility for increasing the number of appropriate activities on offer to people. However this had yet to deliver individualised activities to everyone that used the service. For example, one person was confined to their room and to their bed for most of the time. This person did not have any form of stimulating activity other than watching the television. Some people told us they had enjoyed some personalised slide show presentations of things they were interested in, which had been put together by staff. However other people that were not able to join in actively in the communal areas were not being actively supported to have any meaningful activity in their bedrooms.

The service used the regular resident meetings as a way of learning from people's experiences and concerns. However, this feedback did not always result in an improvement to the quality of the service. For example, people reported they enjoyed going out on trips into the local community and asked for more stimulating things to do rather than watching the television as the main source of entertainment. We found trips outside of the service had not taken place in several months. One relative fed back in a questionnaire that their relative, "would like to be taken out more often".

People told us they received care and support when they needed it. Call bells were answered quickly and we saw people were assisted appropriately and with patience by staff.

People told us they could express their views about what was important to them and about their health and wellbeing. People said they normally did this by talking to staff rather than by any formalised, written process. One person told us, "I would tell them if I wasn't happy with the way I was cared for but I don't get involved in anything else".

Relatives told us they were kept informed of changes to people's needs. During the inspection we saw one person had a placement review attended by family members, medical professionals and the person themselves. However, the registered person told us it was rare for reviews of this type to happen.

Inadequate

Is the service well-led?

Our findings

During the last inspection we found the provider did not have an effective system to regularly assess and monitor the quality of service that people received. We also found that the home was not being managed to either keep people safe or give them an adequate environment for them to live in. We received an action plan about the measures that would be brought in to address this. During this inspection we saw the registered provider had not carried out the majority of their action plan.

There was an unclear management structure at the home. Some staff we spoke with told us the registered person was mainly supportive and helpful. However other staff said they felt undermined and criticised by the registered person. Staff were not clear about how management responsibilities were organised. For example, one person told us, "The management structure isn't very good or clear. Staff told us they had stepped back from taking on further responsibilities, particularly in care planning and reviews because they were not adequately supported by being provided with adequate time, in order to fulfil the role. Senior care staff had been involved in these areas of service delivery but had not been allowed to continue by the registered person. This registered care service was failing to meet an adequate level of service in many areas due to the poor management of the care home.

Records and systems for delivering adequate care in the service were poorly organised and maintained. The services central office was highly disorganised, cluttered and chaotic. During the inspection it was difficult for the registered person or staff to find documents and records that we requested. The content and management of these systems were key to delivering a safe and adequate registered care service. This disorganisation and disarray made it very difficult to find important and specific information during the inspection. Therefore this information was not easily available to the registered person and staff to enable the service to be delivered satisfactorily. The registered person acknowledged the office was still in disarray despite the situation being identified in our inspection in February 2015.

Many areas of documentation relating to the management of the service needed considerable improvement. For example, peoples' care records and care planning was in a very poor condition. Peoples care needs must be identified and planned comprehensively in order that the person's individual needs can be fully met. Another example was that the service did not have either a staff training record or plan in place. This made tracking staff training very difficult. We saw the impact of this on the staff with low morale and lack of skill in some areas. They were uncertain about what to expect from the service in terms of their professional development.

There were almost no active quality assurance or audit processes to monitor the quality of the delivery of the service. For example, the service did not have either systems to audit the management of medicines, hygiene or infection.

Systems are needed to identify and address the safety concerns highlighted in this report. There was no on-going audit or plan for the redecoration, replacement of fittings and maintenance of the home in order to ensure it was maintained to an adequate standard. These areas had been highlighted as in breach of the Regulations at our previous inspection in February 2015.

We spoke with the registered person about the current lack of appropriate quality assurance for the home. They told us management and administration was a major challenge for them. The registered person confirmed the service had carried out a quality assurance survey to gather the views of relatives of people that used the service. We saw that 12 questionnaires had been returned by relatives of people. from service user's family in May 2015. Their comments were mostly positive. Professionals who were familiar with the running of the home were not routinely asked for their views about the care and support provided at the service. The quality assurance process was not adequate because it did not gather the views of people who used the service or external professionals with knowledge of the service.

We spoke with seven professionals over the period of the inspection and their views were mainly positive about the quality of care people received. However they also said the environment of the service was not good enough.

The provider was not operating effectively to ensure compliance with these Regulations. The provider was also not assessing and monitoring the quality of the service. This was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

We spoke with seven professionals over the period of the inspection and their views were mainly positive about the quality of care people received. However they did note that the environment that people were living in within the home was poor.