Sai Om Limited

Eden Lodge Residential Care Home

Inspection report

Park Road
Bestwood Village
Nottingham
Nottinghamshire
NG6 8TQ

Tel: 01159770700
Website: www.edenlodgecarehome.com

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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

We inspected the service on 6 April 2016. The inspection was unannounced. Eden Lodge Residential Care Home provides accommodation for up to 60 older people. On the day of our inspection 24 people were using the service. This was because the provider is only currently using one section of the service.

When inspected the service on 14 July 2015 we found there were breaches of regulation and improvements were required to ensure incidents of a safeguarding nature were handled appropriately, people received care and support from adequate numbers of experienced staff and that staff recruitment practices were safe. There were also improvements needed in relation to the way the registered provider monitored and assessed the service to identify and act on any improvements needed. We told the provider they must send us a written plan setting out how they would make the improvements and by when. The provider sent us an action plan and told us they would make the improvements.

During this comprehensive inspection we looked at whether the provider now met the legal requirements in relation to breaches of regulation we had found. We found that although some improvements had been made there were further improvements needed. We also found the service had deteriorated in other areas.

The service did not have a registered manager in place at the time of our inspection. 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. There was a manager in post and they had submitted an application to register with us.

Although people felt safe in the service, people were not always protected from unauthorised restraint and information of concern was not always being acted on or shared with the local authority. Risks in relation to people's care were not always planned for appropriately to ensure people received safe care and support. Safe recruitment practices were not always followed and medicines were not managed safely. People were supported by enough staff to ensure they received care and support when they needed it.

People were not supported to eat and drink enough. People were supported to make decisions but there was a lack of understanding of supporting people who lacked the capacity to make certain decisions. People were supported by staff who had received training and supervision. Staff were responding to people's daily health needs.

There was a lack of consistency in people's needs being recognised and responded to by staff and in how privacy and dignity was respected. People were supported to make choices about how they spent their day.

People did not have their care and support planned for appropriately and this led to people receiving inconsistent care which was not always safe. People knew how to raise concerns and complaints were

responded to appropriately. People were involved in giving their views on how the service was run and felt the management team were approachable.

There was a lack of appropriate governance and risk management framework and this resulted in us finding multiple breaches in regulation and negative outcomes for some people who used the service. You can see what action we told the 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.

People felt safe in the service and knew who to speak with if they had any concerns. However incidents were not consistently shared with the local authority to ensure they were investigated and dealt with appropriately.

Risks in relation to people's care and support were not assessed or planned for appropriately.

Medicines were not managed safely and the recruitment of staff did not follow safe practice.

Is the service effective?

Requires Improvement

The service was not always effective.

People were supported to make decisions in relation to their care and support but there was a lack of understanding of how to support people who lacked the capacity to make certain decisions.

People were not always supported to maintain their nutrition. People's daily health needs were responded to.

People were supported by staff who received appropriate training and supervision.

Is the service caring?

Requires Improvement

The service was not consistently caring

There was a lack of consistency in people's needs being recognised and responded to by staff and in how privacy and dignity was respected. People were supported to make choices about how they spent their day.

People's rights to privacy and dignity were not always respected.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People did not have their care and support planned for appropriately and this led to people receiving inconsistent care which was not always safe.

People were not always supported to follow their hobbies and interests or to have enough stimulation.

People knew how to raise issues and there were systems in place to ensure concerns were dealt with appropriately.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

There was a lack of appropriate governance and risk management framework and this resulted in negative outcomes for some people who used the service.

The management team were approachable and people were involved in giving their views on how the service was run.

Eden 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 was also done to check that improvements to meet legal requirements planned by the provider after our 14 July 2015 inspection had been made.

We inspected the service on 6 April 2016. The inspection was unannounced. The inspection team consisted of three inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Prior to our inspection we reviewed information we held about the service. This included previous inspection reports, information received and statutory notifications. A notification is information about important events which the provider is required to send us by law.

During the visit we spoke with eight people who used the service. Some people who used the service had limited verbal communication and some were out so we also relied on observations and spoke with four visiting relatives to get their views.

We spoke with two members of support staff, the cook, the deputy manager, the manager, the registered provider's representative who we refer to as the nominated individual and a second representative of the provider. We looked at the care records of four people who used the service, medicines records, staff training records, as well as a range of records relating to the running of the service including audits carried out by the manager.

Requires Improvement

Is the service safe?

Our findings

When we inspected the service on 14 July 2015 we found there were improvements needed to ensure people were kept safe from the risk of harm and were cared for by sufficient numbers of suitably experienced and skilled staff. During this inspection we found improvements had been made in some areas but other improvements had not been completed. Additionally we found new concerns about a lack of assessment for risks in relation to people's care and support and concerns about medicines management.

When we visited in July 2015 we had concerns about the recruitment of staff and found the registered provider was not taking steps needed to ensure staff recruited were safe to work with the people who used the service. We asked the registered provider to make improvements and they sent us an action plan telling us these improvements would be made.

Following our inspection Nottinghamshire County Council carried out a quality audit in the service in December 2015. They identified there were still concerns in relation to the information held about staff who had been recruited in the six months prior to their visit.

Despite the registered provider having feedback from us and the local authority that there were issues in relation to staff recruitment, systems were not put in place to monitor this and ensure the providers recruitment policy was adhered to. During this inspection we found safe recruitment practice was still not always being adhered to and people were placed at risk of being supported by staff who were not suitable to support them.

We saw one member of staff had recorded on their application form the last place they had been employed prior to being employed by service but the registered provider had not sought a reference from this employer. A second member of staff had cited their last two places of employment were working with vulnerable people but a reference had not been sought from one of these places of employment and there was nothing recorded to say why this was. The provider's representative told us they had improved the recruitment procedures and was unaware there were still issues with the records held in staff files. However it was the registered provider's representative who had been the decision maker for the employment of one of these staff. This showed there was a lack of oversight of the safe recruitment of staff.

This was an ongoing breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

When we visited the service in July 2015 we told the registered provider they needed to make improvements to ensure people were protected from the risk of abuse. There was a lack of sharing information with the local authority and ensuring plans were in place for staff to support people who sometimes communicated through their behaviour. During this inspection we found this had not been fully actioned.

We observed two separate occasions when two people were subjected to bullying from other people who used the service. One person was in a lounge with two other people who used the service and both people

were calling the person derogatory names and telling the person to leave the room. The registered provider's representative told us they had witnessed similar incidents but this had not been acted on and the information had not been shared with the local authority. We observed another person who lived with a dementia related illness was shouted at by other people who used the service and this caused them distress.

Some people communicated with behaviour which may challenge staff. We found this was not being assessed or managed appropriately. There was a lack of care planning in place detailing what may trigger this behaviour and what staff should do. For example one person sometimes communicated through their behaviour and this caused them to resist staff supporting them with personal care and placed them at risk of neglect. There was no behaviour plan in place giving staff guidance on how to protect the person from neglect when they resisted personal care. We spoke with staff and they told us they found that holding the person's hands whilst another member of staff carried out the personal care was effective. There was no care plan in place detailing this as an authorised type of restraint and so there was a risk the person was not being supported in the least restrictive way. The manager was unaware of this practice and had told us that restraint was not used in the service.

This was an ongoing breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Other information had been shared with the local authority when it was needed. There had been a significant incident in the service in which a person had been placed at risk and there had been a separate allegation against a member of staff. We saw the registered provider had shared this information with the local authority and taken action to reduce the risk of harm to people who used the service. Staff had received training in protecting people from the risk of abuse and staff we spoke with had a good knowledge of how to recognise and respond to allegations or incidents of abuse. There was information displayed in the service informing staff how to raise concerns of a safeguarding nature to the local authority.

Risks in relation to people's care were not managed safely. One person had been assessed by the Speech and Language Team (SALT) as being at risk of aspirating fluids and needed to have a thickening agent in their drinks to a 'syrup consistency'. We saw staff put the thickening agent in the person's drink but on one occasion they did not wait for the drink to thicken and had not stirred the drink enough to ensure the thickening agent was effective. The person started to cough immediately after taking a drink, which would indicate they were aspirating the fluid but staff did not recognise this and the person continued to drink and cough until we intervened and informed staff the drink was not a 'syrup' consistency as recommended by the SALT team. This placed the person at risk of aspiration.

A person who was at risk of falling had been seen by the community nursing team seven days prior to our visit. They had recommended a sensor be placed in the person's bedroom to alert staff if they got out of bed in the night, so they could go to assist them promptly. The manger had not followed this advice as they thought the person was no longer attempting to get out of bed and that hourly checks were sufficient. However records of night time checks on the person showed they were regularly found with their leg out of bed. This meant that if the person fell there was a risk they could be on the floor for up to an hour.

Risks in relation to people developing a pressure ulcer were assessed using a recognised tool. However the documentation had been adapted to fit in with the rest of the documentation used in the service. During this adaption some of the information staff needed to assess the risk people may face had been removed and therefore the results would not accurately identify the risk. Additionally staff were not completing the assessment accurately. For example on one person's assessment staff had used information of them having

an average appetite whereas other records showed this person had a very poor appetite and was losing weight. This meant the assessment did not show the correct risk the person faced.

People had been assessed as not being safe to administer their own medicines and so relied on staff to do this for them. However we found that medicines were not being managed safely and there was a risk of people not receiving their medicines as prescribed. One person was nearing the end of their life and had been seen by the community nursing team to ensure everything was in place to make the person safe, comfortable and pain free when the time came. Records showed the community nursing team had instructed the manager seven days prior to our visit to ensure appropriate pain relieving medicines were in place by the end of that day. On the day we visited, the medicines were still not in place. The manager told us they had attempted to do so by contacting the prescribing surgery. However decisive action, such as alerting the community nursing team that the medicines were not in place had not been taken. This placed the person at risk of being in avoidable pain at the end of their life.

Medicines were not disposed of safely. We found staff had a nominated bottle in the medicines cabinet, used to pour 'any refused liquid medicines 'into. This was stored with other medicines which would be administered to people and it posed a risk that the mix of medicines could be administered to a person in error. The bottle was half full of liquid medicines which was a mix of unknown liquid medicines and staff were not recording what had been disposed of into the bottle. We asked the manager to address this immediately.

Staff were not always following safe protocol in relation to the administration of medicines. We saw where staff had handwritten medicines onto people's Medicines Administration records (MAR) the entries had not been witnessed by a second member of staff to ensure the entry was accurate. This posed a risk of errors being made and we found there had been one error which could have resulted in a person being overdosed on a pain relieving medicine. It was recorded on one person's MAR that they were to be given one type of medicine, one tablet daily but we found in the dispensing pack, the person was being given two tablets daily. This error had not been recognised and the person had continued to be given two tablets instead of one. We asked the manager to address this on the day of our inspection.

We saw staff were not always using the appropriate coding on people's MAR charts and when medicines were administered they were not always signed for. When people were prescribed medicines to be taken as and when they required them (PRN) there were no written protocols in place detailing what these medicines had been prescribed for, so that staff would know when to administer them. Some people did not have a photograph in place or their allergies recorded to ensure medicines were given safely and there was a lack of staff specimen signatures.

The manager could not provide any records to evidence that staff who were responsible for administering medicines had received medicines refresher training to ensure they knew about best practice and were following safe practice. The manager told us that because she had been unable to find any records of staff completing this training, further training had been booked and we saw evidence of this. Staff were not having their competency assessed to ensure they were following safe practice.

One person was prescribed a medicine and there was information in their care plan which stated they should avoid certain food. We spoke with the cook and they were not aware of this person being on the medicine and so they food was not being avoided.

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

All of the people who used the service that we spoke with told us they felt safe. They told us that if they were concerned they would talk to a member of staff or the manager. One person said, "I have been here over a year and feel safe as the personal care, food and all staff are good." Another person said, "Yep it is safe here for me, I like it here." Relatives also told us they felt their relations were safe. One relative told us, "[Relation] is safe here; I cannot fault the care in this place."

Prior to the inspection we had been told about two people who were not safe to be in the community alone had left the service undetected on two separate occasions. We saw that steps had been put in place to minimise the risk of this happening again and there was information in both people's care records alerting staff to the risks.

People received care and support if they suffered a fall, records showed steps were taken to check for injuries and the person was monitored appropriately. For example we saw two people had fallen recently and staff had recorded an assessment of each person detailing if the person was displaying any signs of injury. Each person was then checked hourly and staff were completing monitoring records to show if the person had been affected by the fall.

When we inspected the service in July 2015 we found there were not sufficient numbers of staff to support people who used the service. We asked the registered provider to make improvements and when we visited this time we found this had been actioned.

People told us they felt there were sufficient numbers of staff to support them. One person told us, "The staffing seemed to be increased." Another person said, "They do answer calls at night, though I do not need them much." During our visit we observed staffing levels were sufficient to meet the needs of people who used the service. Call bells were answered in a timely way and there were staff available if people asked for or needed support.

Staff we spoke with told us they felt there were enough staff to meet the needs of people. The manager told us there were a minimum of four staff on duty until the afternoon and then there were three staff on duty for the remainder of the day and night. They told us this could be changed dependent on people's changing needs.
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Requires Improvement

Is the service effective?

Our findings

People were not always supported with their nutrition and hydration. Although people we spoke with said they felt the food was good and they got regular meals and snacks, we observed people who needed support to eat and drink enough did not always get this. We observed one person was struggling to eat their meal was not given any support from staff until we drew this to staff attention. The person had been left with their meal in front of them and they had picked up the plate with both hands and put it to their mouth to try and eat. There were no staff in this lounge and so we fetched a member of staff and asked them to assist the person.

This person's care records stated the person was at risk of weight loss and they had been prescribed fortified drinks. They were being weighed weekly as a result of the risk. However there was no care plan in place for nutrition which detailed how to support the person to eat more such as having smaller portions of food offered and assistance to eat it. We saw one person was asleep at the dining room table at lunchtime and had not eaten any of their meal. Staff did not attempt to encourage the person to eat and just took their meal away. When the person woke they were not offered any other food and they left the dining room without having eaten. This meant people were not being fully supported to eat and drink enough.

Another person who was at high risk of losing weight had been losing weight recently. However there was no care plan in place detailing how staff should support the person to eat and drink enough. A further person had a record in their care plan which stated the person's appetite had reduced. This had not triggered a care plan to be implemented to support the person with their nutritional intake.

We saw that some people spent time in their bedrooms and when we visited them they did not have access to a drink. We saw one person was in their bedroom all day due to them deciding they did not want to get dressed. We visited this person throughout the day and they did not have access to a drink other than when the morning and afternoon drinks rounds were carried out.

We saw from care plans that people's nutritional risk was not assessed regularly to see if their weight had changed and if they needed any changes to the support they were receiving. The record kept of people's weights was poorly maintained. This did not show the amount of weight change that had taken place since the person had last been weighed and whether any action had been taken. Some of the records were inaccurate, for example one person was shown to have gained 10 kilograms in one month.

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

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). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

There was a lack of understanding of the MCA. We saw that the principals of the MCA were not correctly applied in the care plans of the people we looked at. We found people's capacity to make decisions had been assessed whether this was needed or not. For example one person had a capacity assessment in place for 'pressure ulcer prevention' but the information in the care plan stated the person did not need any support with this. Therefore a capacity assessment and best interest decision was not needed.

The manager displayed an understanding of DoLS and had sought advice from the DoLS team and had made applications for people who used the service. However other staff did not have a full understanding of DoLS and we saw an application had been made to restrict the liberty for one person who had the capacity to make their own decisions, and therefore cannot be lawfully deprived of their liberty. One person had a DoLS in place to enable staff to support them with their personal care. The authorising officer from the local authority, who are responsible for approving any DoLS applications, had recorded that the person would need two members of staff to support them with personal care if they became resistant to this. Staff we spoke with were not aware this person had a DoLS and this recommendation had not been recorded in the person's care plan. There was no guidance in the person's care plan informing staff of the least restrictive ways they could support this person when they resisted personal care, other than an entry which stated, 'Can be resistive to personal care' and 'Staff to act in best interests giving personal care.'

This was an ongoing breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People we spoke with told us they felt they could make decisions about what they did. One person described how they made decisions about when they got up in the morning and when they went to bed. They told us, "I do what I want to really." One relative told us, "Staff are good and they listen to us as well and there are no restrictions."

People were supported by staff who were trained to support them safely. People who used the service and relatives we spoke with told us they felt the staff knew what they were doing and had the right skills. We observed staff supporting people and saw they were confident in what they were doing and had the skills needed to care for people appropriately. For example staff used equipment to support some people to move from chair to chair and we observed this was done safely.

Staff we spoke with had completed training in areas they felt were needed to support people. They told us they were aware the manager was making improvements to training and was in the process of sourcing more practical training for them. Records we saw showed training delivered to staff was up to date, with the exception of medicines training.

People were cared for by staff who received feedback from the management team on how well they were performing and discussed their development needs. Staff told us they had regular supervision from the manager and were given feedback on their performance, and we saw records which confirmed this.

People were supported with their day to day healthcare. People described when they had been poorly and told us staff had called their GP quickly. One person told us, "I had chest pain and an ambulance was

called." We saw this was the case from records with people being supported to have access to their GP and other health appointments, such as the optician for routine appointments. A relative commented on their relation's health and said, "Physically [relation] is better than before."

Staff sought advice from external professionals when people's health and support needs changed. Staff we spoke with described involving various other healthcare professionals when needed. We saw people had referrals made to external professionals such as the dementia outreach team and the Speech and Language Team (SALT).

Requires Improvement

Is the service caring?

Our findings

We saw staff encouraging and supporting people, taking their time and working at people's own pace. However at other times there was a lack of meaningful interaction. Conversations between people living at the service and staff were short and infrequent as staff were focused on completing tasks. The atmosphere at lunchtime was quiet and impersonal and staff went about their duties in a functional manner. There was very little conversation or interaction between people using the service or staff. People in one of the communal rooms commented that the music was too loud and made it difficult for them to hold a conversation. One person told us they had not been asked if they wanted this turned on in the first place and added, "This isn't the type of music I listen to either."

One person showed signs of distress on a number of occasions and staff responded promptly each time whilst the person was sitting in the lounge. However staff did not show the same compassion and interest when the person was sat at the dining table and waiting for staff to give them their lunch and assist them. The person asked a member of staff for a drink during this time but it was not given. The person then told another member of staff they were thirsty and the member of staff went to get them drink. However rather than take the drink straight to the person they stopped to give someone else a dessert and a drink. This meant the person had to wait even longer to have their needs met. It was clear the person was thirsty but when the person was given their drink they were not offered support and we saw them struggling for a few minutes trying to tip the beaker up until they managed to get a drink.

We saw occasions when people's dignity could have been respected better and responded to more promptly. One person sat at a table with tea spilt over it and cereal spilt over the floor for around half an hour before it was cleaned up. The same person was left with their apron on for 45 minutes after finishing their meal. We saw another person who was walking down the corridor with only a blanket covering them and they said they could not get dressed as they could not find their underclothing. We also saw in a care plan related to behaviour that staff were using phrases that did not promote people's dignity such as, 'when [person] is in a mood' or '[person] is destructive' to describe the person and their behaviour.

We saw that people had locks on their doors and that people could choose to lock their door when not in their room. Staff knocked on bedroom doors before entering and were able to describe how they would promote people's privacy and dignity whilst supporting them.

People we spoke with told us they felt they were treated with dignity. One person told us, "The dignity and care is given." The manager told us that nine of the staff were dignity champions and that it was their role to promote dignity and awareness. Staff spoke of 'experiencing care' through using a wheelchair and having a meal fed to them so they understood how this felt. We saw the dignity values were displayed in the service to ensure staff knew how they should support people with this.

People were positive about the care they received and the staff who supported them and told us they were happy living at Eden Lodge. One person told us, "Staff chat, laugh with me, it is good here." Another person said, "The girls (staff) do look after me." Relatives also spoke positively, with one saying, "Honestly, this place

gave me my [relation] back." Another said, "The place has a feeling that all the domains (the five key questions we inspect against) you mentioned are met to a large extent."

Staff described treating people as individuals and spoke of their job satisfaction in helping people and making a difference to people's lives. We saw there was information in people's care plans which gave staff an overview of what each person liked and disliked and what was important to them. This included people's life history and hobbies and interests, however it was unclear how this information was being used to inform their support. Staff spoke of following a person centred approach but apart from fortnightly church services held in the service couldn't think of ways they supported people's individual interests.

We saw that some people's bedroom doors had been personalised with their name and something which was important to them. For instance there was a photograph of one person on their door and a notice stating, 'My name is [name] and I like cats'. This gave staff basic information about what was important to people. One member of staff told us people who used the service had been involved in choosing the colours for their bedroom doors which were going to be re-painted and that people had been included in discussions about the wall paintings in the corridors of the service. People had wanted the dining room decorated as a garden theme to bring 'the outside in' and one person had suggested having a hedgehog on the picture which had been included.

People we spoke with told us they felt they were given choices about what they did and how they were supported. One person told us, "I have the choice of when to go bed and can lie in bed during the morning." A relative confirmed this and said, "[Relation] gets the attention they want and always has their way. Staff work around [relation's] need." Staff told us people and family members were involved in decisions about their care and support and they felt that people had a voice in their care. People were supported to have choices in relation to what they ate through discussion in regular meetings held for people who used the service. The manager told us they had asked people to think of food ideas and suggestions before the next meeting so that these could be added to the menu.

The manager told us that one person was currently using an Independent Mental Capacity Advocate (IMCA). IMCAs are a legal safeguard for people who lack the capacity to make specific important decisions, they represent people where there is no one independent of services who is able to represent the person. The manager also told us that that advocates had been used for two people recently when they were needed. Advocates are trained professionals who support, enable and empower people to speak up. There was information on display in the reception area of the service to inform people how to access an advocate if they needed one. This meant people were supported to have access to an advocate if they needed one.

Requires Improvement

Is the service responsive?

Our findings

People's care and support plans were not person centred and were not used by staff to provide consistent care and support. Care plans were complex and repetitive. Information about people's support needs was difficult to find and we often needed to look at several records to find information about one aspect of a person's support needs. For example, we looked at one person's plan who needed support with behaviour. Information relating to this was spread across at least five different sections of the plan, however there was no specific care plan in place relating to behaviour. This made it difficult to get a clear understanding of how to best support the person in this area. Staff told us they were aware of the care plans but did not look at them regularly and did not to rely on them to inform them about people's care and support.

People did not have their care and support planned for appropriately. One person was nearing the end of their life and records showed the community nursing team had asked the manager to ensure care plans were put in place to guide staff in how best to support the person, including an end of life care plan. On the day of our visit, seven days after the community nursing team had requested the care plans, the plans were still not in place. The manager informed us this was being addressed but the failure to have this information in place put the person at risk of not receiving safe, effective and dignified care. There was also a risk the person's wishes would not be known or respected at the end of their life.

One person, who lived with a dementia related illness, needed support from staff to get dressed each day but the person was sometimes resistant to this support. On the day of our visit the person spent the day in their bedroom in their nightwear as staff said the person was refusing to get dressed. At one point during the day we found this person alone in their room on the floor with their mattress on top of them. After taking action to ensure the person was safe we looked at this person's care plan and found there was guidance in place informing staff that the person was unable to use their call bell and so needed to be checked throughout the night. However this did not extend to checks being made on the person if they were in their room during the day. We visited the person again after this incident and saw they were in the process of pulling the mattress off the bed again. There were no plans in place detailing this behaviour or guiding staff in how to keep the person safe. We shared this information with the local authority safeguarding adults team as we were not assured the person would not be placed at risk again in this way.

One person who had a catheter did not have a care plan in place for this, therefore staff did not have clear guidance on how to safely care for the catheter and how to recognise when things were not right, such as the person developing an infection. In addition the district nurse and the community nursing team had recorded three times in the person's care plan that there were issues with the person's input and output of fluid and the importance of the person receiving support to drink enough. Despite this staff were not keeping records of when the person had a drink or records of urine output. There was a lack of information available to staff in relation to people's health conditions. One person had been admitted to the service following a stroke, however there was no care plan in place giving staff information on how this affected the person, how to recognise the person may be having another stroke and what to do about it.

People were not protected from the risk of developing pressure ulcers. We saw one person had been

assessed as being at high risk of developing a pressure ulcer and had a current pressure ulcer. Information about pressure area care was recorded in various documents in the person's care plan. However there was no designated care plan in place detailing how to reduce the risk. The community nursing team had recorded that staff needed to ensure the pressure ulcer prevention mattress was at the right setting for the person's weight, however the mattress was set at a level far higher than the person's weight and so may not have been effective. Records showed the person needed special diet to promote healing of the pressure sore however this diet was not being given. Additionally the person's care plan stated that the person should be repositioned regularly but there was no guidance as to how often this should happen. The deputy manager was unable to locate repositioning records so it was not clear how often this was happening. This put the person at risk of developing further pressure ulcers.

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

People were not always involved in planning their care and support. Care plans were written by senior staff with little evidence that the person or their family had been involved or consulted. Two people we spoke with told us they had been involved in a review of their care plan but another two told us they had not. One person told us, "Assessments or care plan review, I have not seen anything like it." This meant people were not given the opportunity to have a say in how they wanted to be cared for. Care plans were task focused and contained little information about people's preferences for their care and support. People's preference relating to the gender of staff providing personal care was not recorded.

People were not supported to follow their interests or take part in social activity. One person we spoke to talked about the lack of social activities on offer at the service. One person told us, "I have been here for a year, but do not know about the activities." We observed a lack of stimulation for the majority of people. On the day or our visit we saw people sitting in communal area without any meaningful activity or sitting in their rooms alone and unoccupied for long periods of time. We did note that an activities coordinator had recently started at the service and was working on developing activities within the service.

People were supported to maintain relationships with friends and family. People had visitors throughout the day and they were welcomed into the service. The management team told us about their plans to build links with the local community, however at present the service was very isolated from the local community, this meant that people were not regularly supported to take part in activities outside of the service or develop new relationships.

There was a complaints procedure on display to inform people how to raise concerns and staff were aware of the complaints procedure. The complaints procedure displayed on the resident's notice board did not contain telephone numbers so that people could raise concerns outside of the service, such as to the registered provider, the local authority or the local Government Ombudsman.

People could be assured that complaints would be taken seriously and acted on. The manager told us there had been one complaint made since our last inspection and we saw this had been recorded and acted on appropriately.

Requires Improvement

Is the service well-led?

Our findings

When we inspected the service on 14 July 2015 we found there were improvements needed to ensure the systems in place to identify and bring about improvements were effective. During this inspection we found some improvements had been made, however we found shortfalls in the quality of care delivered and the systems in place had not identified these.

When we inspected in July 2015 we had concerns about the systems in place to ensure people would be kept safe from the risk of fire. We asked the registered provider to make improvements and we found during this inspection that the registered provider had made these improvements. Changes had been made to the building and to the fire systems and there were routine tests being carried out to ensure the systems were safe. Records showed the systems were effective, for example, a recent check had identified an emergency light was not working and when we checked, this light had been replaced with a new one.

People who used the service and relatives we spoke with told us they were happy with the care being delivered. However we found that the systems in the service, designed to monitor and identify improvements needed were not always effective and there was a lack of effective governance which led to some people not receiving safe and consistent care. The representative of the registered provider was visiting the service at least weekly and the visits consisted of discussions with the manager about what improvements were being made and what further action was needed in the service. However the visits were not being used as a way of the registered provider carrying out checks of the quality of care being delivered in the service.

Care plans were not being audited to ensure they met the current needs of people who used the service and we found there were shortfalls in relation to people's needs being assessed and planned for. The management team did not routinely analyse and record the cause of pressure ulcers. This meant there was no learning from this to see if changes needed to be made to people's care.

The systems in place to check medicines were managed safely were not effective and we found issues in relation to the safe management of medicines. We saw there were medicines audits being carried out and the last audit had been in February 2016, however the audits had not identified the shortfalls we found in relation to medicines. We saw there was two actions arising from the audit and one of these had a deadline of 30 March 2016. The manager told us this was on order but the deadline for action had passed seven days earlier.

An audit carried out by the manager showed there were a number of problems with the alarm call system, with call points in some bedrooms not working at all. Others did not have a cable running from them, which would make it easier for people to ring the call bell if they needed assistance. The manager told us quotes had been obtained for a new system but this had not been ordered yet. Steps had not been put in place to ensure people had access to a working call bell until the issues with the systems were addressed.

At the time of our inspection a maintenance person was not employed to address maintenance issues. The

manager told us they were in the process of employing a maintenance person and that in the meantime contractors were being used. We found issues in the environment were not being acted on in a timely way. We saw a radiator part pulled off the wall which had not been reported. The deputy manager said it had been broken before and they had fixed it but said the damage was worse now. A member of the cleaning team we spoke with told us the radiator had been broken for at least a week. We visited several bedrooms and saw that people did not have a bedside lamp in place and the over-sink lights were not working in three of these bedrooms. This meant lighting would not be available to people at night unless they got out of bed to switch the light on.

Records showed checks were being carried out on the hot water taps to minimise the risk of people being scalded. The records showed that in many of the hot water outlets the temperature of the water was higher than the recommended safe temperature. We saw this had been recognised by the manager and a contractor had been contacted on several occasion, however on the day of our visit we found the water temperatures records showed there was still a risk of people being scalded and this had not been reported to the contractor so that action could be taken to reduce the temperatures.

Additionally there were risks in relation to legionella as although there were systems in place to manage the risks of legionella, these did not include records to show individual water outlets being run to minimise the risk of bacteria in the system. This posed a risk as there were a high number of vacant bedrooms in the service and it was not known when each outlet was last run. Legionella is a bacteriological disease found in stagnant water which can cause a potentially fatal form of pneumonia.

There was no registered manager in post when we inspected and there had not been since 2012. The registered provider had employed two managers during this time but the registration process had not been completed. The registered provider had employed a third manager who was working in the service when we inspected and they had submitted an application to register with us.

We found the manager was working hard to bring about improvements to the service, however the audits the manager was carrying out were identifying a considerable number of issues that need to be addressed, particularly in relation to the environment. The manager was tasked with obtaining quotes for the work to be carried out whilst also trying to make improvements to the care planning and care delivery in the service. Quotes had been obtained to address some of these issues, such as the refurbishing of bathrooms. However there were a high number of identified issues for which there was no planned action. The manager said this was because of the volume of things that needed to be sorted, they had to prioritise.

We found that records were not always maintained and completed in full and this posed a risk that people would receive inconsistent care. One person who spent most of the day in their bedroom was known to be at risk of causing injury to themselves. During our inspection we found them in an unsafe position in their bedroom and there was a lack of recording for that day of when the person had last been checked on by staff.

Staff followed a bath/shower rota which allocated one per week, however it was not clearly and consistently recorded when someone had had a bath or shower. This meant there was a risk that people may miss their weekly bath or shower without staff noticing.. We discussed this with the manager on the day of inspection who then took action to implement a bath/shower record.

One person was supposed to be supported to reposition due to a risk of pressure ulcers developing and we saw there were only one day's records available and these were mainly blank. The deputy manager told us they felt sure the person would be supported with this but was unable to produce any further records to

evidence this.

We saw there were recording issues in staff recruitment files in that when a Disclosure and Barring check (DBS) was returned with the results, there was insufficient detail recorded to show whether the person had a previous criminal conviction or caution. This would not provide enough information for the registered provider to establish if a risk assessment was required to ensure the staff member was safe to work with people who used the service.

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

People we spoke with knew who the manager was and commented positively on their role. One person said, "Manager is ever so nice and accessible." Another person told us, "Manager is here since 3-4 months and decoration and changes can be seen. It sounds good." A relative told us, "The new manager is approachable. It is welcoming place for me." We found the manager was clear about their responsibilities and they had notified us of significant events in the service.

Staff we spoke with told us the manager was approachable and one member of staff told us the manager was working hard to update the building and said it was nice to see things being put right. This member of staff described the manager as, "Approachable and good for the place."

People who used the service and their relatives were given the opportunity to have a say about the quality of the service. The minutes of the meetings showed that current issues were being discussed and people had the opportunity to contribute to the discussions. We saw that feedback forms were sent to people who used the service and their relatives each year. The manager told us there were plans to carry out a survey using an improved form, which would include a picture format form for people who lived with a dementia related illness. We saw there were survey forms in the reception area of the service for visitors to complete if they wished.

The manager told us that there had not been links established with the community prior to them starting work in the service and so they were working to establish these links. They told us they had started to establish links in the village and this was important as people needed to be supported to be a part of the wider community.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment People who use services were not protected against the risk of abuse or harm. Regulation 13 (1) (2)(3)(4)(a)(b).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs The nutritional and hydration needs of service users were not being met. Regulation 14 (1)(2)(a)(i)(ii)(b).

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People who use services and others were not protected against the risks associated with unsafe or unsuitable care because of inadequate systems to assess the quality of the service. Regulation 17 (1) (2)(a)(b)(c)(d)(e)(f).

The enforcement action we took:

Served a warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance People who use services and others were not protected against the risks associated with unsafe or unsuitable care because of inadequate systems to assess the quality of the service. Regulation 17 (1) (2)(a)(b)(c)(d)(e)(f).

The enforcement action we took:

Served a warning notice