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Eaton Lodge Nursing Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection was carried out on 5 and 6 May 2016 and was unannounced.

Eaton Lodge Nursing Home provides accommodation and personal and nursing care for up to 24 older people and people living with dementia. The service is a large converted property. Accommodation is arranged over three floors and a lift is available to assist people to get to the upper floors. The service has 14 single bedrooms and five double bedrooms that people could choose to share. There were 22 people living at the service at the time of our inspection.

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

Although people and their relatives told us that staff were kind and caring, people were not treated with dignity and respect at all times. Staff referred to people at times as 'the feeds' or 'the normals'. The registered manager had not recognised that this was not a respectful way to refer to people.

The provider and registered manager did not have oversight of the service. They had not supported staff to provide a good level of care and staff were not all aware of their roles and responsibilities. Checks on the quality of all areas of the service had not been completed to make sure they were of the required standard. The provider and registered manager were not aware of the shortfalls in the service that we found at the inspection. The registered manager had not informed us of important events that happened at the service, without a delay, as they are required to.

There were no arrangements for the safe management of the service when the registered manager was absent or on leave. There were enough care staff, who knew people, to meet their needs. People's needs had been considered when deciding how many staff were required on each shift. Staff worked as a team to meet people's needs.

The provider's recruitment procedures were not followed consistently. Staff had not all completed health declarations stating they were physically and mentally fit to fulfil their role. Gaps in employment had not always been questioned. Disclosure and Barring Service (DBS) criminal records checks had been completed. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services.

Staff had not completed all the training they needed to provide safe and effective care to people. The provider's process of regular meetings between staff and a manager to discuss their role and practice had not been followed. However, staff told us they felt supported and were confident to raise any concerns they

had.

Plans were not in place to keep people safe in an emergency, including plans to evacuate people from the building. Following the inspection we raised our concerns about fire safety with the local Fire and Rescue Service. Staff knew the signs of possible abuse and were confident to raise concerns they had with the registered manager or the local authority safeguarding team.

Risks to people had not always been identified, including risks posed to people from the use of bedrails. Guidance for staff about how to manage risks had not always been provided or was not clear. Some people's pressure relieving equipment was not used correctly and there was a risk that people would sustain skin damage because of this. Risks to people had not been reviewed regularly to identify any changes.

Assessments of people's needs had not been consistently completed to identify any changes. Detailed guidance had not been provided to staff about how to meet people's needs and no guidance had been provided to staff about how to provide one person's care and treatment. People's care plans had been reviewed but any changes noted had not been used to plan or make changes to the care people received. Staff, including registered nurses, were not always following people's care plans and the correct guidance. For example, one person's catheter had not been changed as often as recommended by the manufacturers, placing them at risk of developing an infection. People were supported to have health checks such as eye tests and blood tests.

People received the medicines they needed to keep them safe and well. However, medicines were not always ordered, stored, recorded or disposed of to keep people as safe as possible.

The Care Quality Commission is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. Arrangements were in place to apply to the supervisory body for a DoLS authorisation when people who lacked capacity to consent were restricted. Staff did not know that one person had a DoLS authorisation in place and had not taken action to comply with the conditions of the DoLS.

Staff were not following the principles of the Mental Capacity Act 2005 (MCA). People's capacity to make some decisions had been assessed. When people needed to make a specific decision their capacity to do so had not always been assessed. Guidance had not been provided for staff about the day to day decisions people were able to make and how people might tell staff about their decisions. Decisions made in people's best interests had not been reviewed to make sure they continued in the person's best interest.

Accurate records were not maintained about the care and support people received and about the day to day running of the service. Information was not available to staff to help them provide safe and consistent care to people.

People told us they liked the food but some people who needed a special diet were not offered a choice of foods. People were not offered the opportunity to eat in the dining room so they had to eat in their bedrooms or in the lounge. Some people enjoyed having lunch at a table in the garden during our inspection.

People and their representatives were confident to raise concerns and complaints they had about the service. However, complaints had not always been resolved to people's satisfaction. Action had not been taken to check complaints and use them to continually improve the service.

People were asked for their views of the service regularly. Some people needed to support to share their views. The registered manager had not always given people the opportunity to complete surveys and questionnaires with support from their family and friends. People and their relatives had had not been informed of the outcome of surveys or about any improvements the registered manager had made. Staff did not have regular opportunities to share their experiences of the service.

People were supported to participate in a range of activities, including bingo and art and craft sessions. The range of activities was being developed and people told us they enjoyed those they took part in. Staff were motivated and felt supported by the registered manager, who they said was 'approachable'.

People and their relatives had been asked about their end of life care preferences and these were used to plan people's care. People's wishes were not always followed and one person's relative had complained their relative's wishes had not been respected.

Equipment and areas of the service, including bathrooms and people's bedrooms were not kept clean. Cleaning schedules were not in place for all areas of the building and equipment to make sure they were cleaned regularly.

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

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

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

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

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

You can see what action we told the provider to take at the back of the full version of the report. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

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.

Risks to people had not always been identified and action had not been taken to reduce risks. Guidance had not been provided to staff about how to keep people safe in an emergency.

The provider's recruitment policy had not been followed consistently, gaps in employment had not been checked and not all staff had completed a health declaration.

People were not always protected from the risks of unsafe medicines management.

Parts of the service were not clean.

Staff knew how to keep people safe if they were at risk of abuse. There were enough staff who knew people, to provide the support people needed.

Is the service effective?

Inadequate

The service was not effective.

Staff did not always follow the principles of the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards. People had not always been given the opportunity to make decisions themselves before decisions were made in their best interests. Staff did not know all the decisions people were able to make. Guidance had not been provided to staff about how to support people to make decisions.

Staff had not completed all the training they needed to meet people's needs. Staff did not have the opportunity to meet regularly with a line manager to discuss their role, practice or any concerns they had.

People received food and drinks to help keep them as healthy as possible. However, not everyone received a choice of food.

Care and treatment had not always been planned to meet people's health care needs. People were supported to have

health checks and to attend healthcare appointments.

Is the service caring?

Requires Improvement

The service was not always caring.

People said that staff were kind and caring to them. People were given privacy.

People were not always treated with dignity and respect. For example, people who needed soft food to help them swallow safely were called, 'the feeds' by staff.

Staff did not have detailed information about people's likes, dislikes and preferences; or their life before they began to use the service. This would have helped staff get to know people and how they preferred their care provided.

People and their families had been asked about their end of life care preferences. People's preferences had not always been supported.

Is the service responsive?

Inadequate

The service was not responsive.

Assessments of people's needs were not completed regularly. Care was not planned and guidance had not been provided to staff to meet each person's needs. There was a risk that changes in people's needs would not be recognised quickly and people would not receive the care they required.

The number and types of activities on offer to people had recently increased and people had more things to do during the day.

Systems were in place to resolve any concerns people had. However, complaints had not always been resolved to people's satisfaction. People and their relatives told us they were confident to raise any concerns they had with the staff.

Is the service well-led?

Inadequate

The service was not well-led.

Systems were not in place to make sure the service was adequately managed in the registered manager's absence. Staff did not have clear roles and responsibilities and were not always held accountable.

Checks were not completed on the quality of all areas of the service. People and their relatives had been asked to share some feedback about the service they received but had not been informed of the outcome of the survey or about any improvements the registered manager had made. Staff did not have regular opportunities to share their experiences of the service.

Records about the care people received were not clear and accurate and there was a risk that action would not be taken to provide the care people needed.

The registered manager and provider had not shared important information with CQC without delay, to help us understand □ what had happened at the service.

Eaton Lodge Nursing Home

Detailed findings

Background to this inspection

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

This inspection took place on 5 and 6 May 2016 and was unannounced. The inspection team consisted of two inspectors, a pharmacy inspector and a specialist professional advisor, whose specialism was in nursing care for older people.

Before the inspection, we did not ask the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. This was because we inspected the service sooner than we had planned. We looked at previous inspection reports and notifications received by CQC which a provider is required to send us by law. Notifications are information we receive from the service when significant events happen, like a death or a serious injury. We spoke with Kent local authority staff about what they had found when they visited the service and a clinical nurse specialist for older people who had been supporting the registered manager to make improvements to the service.

During our inspection we spoke with five people living at the service, one person's relative, the provider, registered manager, and staff. We visited some people's bedrooms, with their permission; we looked at care records and associated risk assessments for seven people. We looked at management records including staff recruitment, training and support records, health and safety checks for the building, and staff meeting minutes. We observed the care and support people received. We looked at their medicines records and observed people receiving their medicines. Most people were not able to tell us their views about the service. We did not use the Short Observational Framework for Inspection (SOFI) because people who were unable to speak to use received their care and support in their bedrooms. SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We last inspected Eaton Lodge Nursing Home in August 2014. At that time we found that the registered provider was complying with the regulations.

Inadequate

Is the service safe?

Our findings

People and their relatives we spoke with told us they felt safe at the service. However, our findings did not agree with the feedback we received.

People were not always safe at Eaton Lodge. Some risks to people had not been identified, assessed and regularly reviewed. Action had not been taken to reduce some risks and guidance had not been provided to staff about how to keep people safe while maintaining their independence.

Staff told us some people were at risk of falling out of bed. The risk of people falling out of bed had not been assessed to identify risks of people falling and any action needed to keep them safe. Bedrails were used on most people's beds whether they were at risk of falling out of bed or not. Some people had bedrail protectors fitted to one or both of the bedrails on their bed. The registered manager did not know why everyone did not have two protectors on their bedrails and if this was people's choice. Bedrail protectors are used to reduce the risk of people injuring themselves on the rails and at times to reduce the risk of people getting trapped in the rails. The use of bedrails and bedrails protectors on each person's bed had not been assessed to make sure people could get in and out of bed safely and to identify any risks of them getting injured or trapped.

Accident records showed that one person had become trapped between their bed and the bedrails three times and had been injured. Reviews of the person's moving and handling plan stated, they remained 'at risk of falls and limb entrapment'. The risk of the person falling out of bed or the risks to the person from the bedrails had not been assessed. The registered manager did not check accidents records or care plan reviews to look for patterns and trends and action had not been taken to prevent the person from becoming trapped again. When the person became anxious they moved around a lot in their bed and put their legs over the bedrails. The registered manager told us that when the person was anxious the bed was lowered to a few inches above the floor, a crash mat was put on the floor next to the bed and the bedrails were not used. However, staff told us they always used the bedrails when the person was anxious. Guidance from the Medicines and Healthcare products Regulatory Agency about the safe use of bedrails states that 'Risk assessments should be carried out before use and then reviewed and recorded after each significant change in the bed occupant's condition'. This guidance had not been followed.

Risks to peoples' skin health, such as the development of pressure ulcers, had not been assessed consistently. Pressure relieving equipment was available to people who needed it, however this was not always used correctly. For example, one person was lying on a pressure relieving mattress set for a person who weighed 125kg, this person weighed approximately a quarter of this. The person had developed skin damage. Lying on a mattress that was too firm may not have given the person the best protection from developing further skin damage.

Some people needed to change their position regularly to keep their skin healthy. Detailed guidance had not been provided to staff about how often people needed to be repositioned to reduce the risk of them developing skin damage. One person's skin care plan instructed staff to turn the person 'regularly' and was

not specific about how often the person needed to be supported to move. The person was at high risk of skin damage and had not been repositioned for five and a half hours on one day. The registered manager confirmed that the person had not been supported to move often enough. This person had developed skin damage. National Institute for Health and Care Excellence (NICE) guidance recommends: 'Encourage adults who have been assessed as being at high risk of developing a pressure ulcer to change their position frequently and at least every 4 hours. If they are unable to reposition themselves, offer help to do so, using appropriate equipment if needed. Document the frequency of repositioning required'. This guidance had not been followed and care was not planned to keep the person's skin as healthy as possible.

Before our inspection one person had sustained injuries when they were being transferred using a hoist. Moving and handling risk assessments had been completed and some guidance was provided to staff about how to move people safely. Details of the types of equipment and techniques to use had not been consistently included for staff to refer to. Staff relied on each other to know what equipment and techniques to use. Checks were not completed to make sure that people were always moved safely. Each person had recently been provided with their own hoist sling to meet their needs and staff knew how to use these safely in the way people preferred.

Risk assessments had not been consistently reviewed to make sure they were up to date. For example, one person's skin risk assessment had been not been reviewed monthly as required.. The person was at very high risk of developing skin damage and spent most of their time in bed, getting up once or twice a fortnight. Spending long periods in bed can increase people's risk of developing skin damage.

Plans to keep people safe in an emergency did not include guidance to staff about how to move people to other parts of the building to keep them safe in the event of a fire. Evacuation equipment was in place but guidance to staff about what equipment to use to evacuate people safely had not been provided. Staff were not able to tell us how they would safely evacuate people from the building. An inspector walked along one of the fire escape routes to check its safety. The registered manager had to stop the inspector from banging their head on equipment overhanging the path. The risk to people from the obstacle had not been assessed and action had not been taken to reduce the risk. A wooden fire escape route was 'wobbly' and some steps had an uneven surface. During the inspection the provider arranged for the fire exit stairs to be refurbished, we will follow this up at our next inspection. Following our inspection we informed the local Fire and Rescue Service about our concerns.

A call bell system was fitted in people's bedrooms and communal areas. People told us that staff responded promptly when they rang for help. The bell in the lounge was only in reach of one person and other people relied on staff checking on them or other people alerting staff to their needs to keep them safe. Staff did not regularly check on people in their bedrooms who were unable to call for assistance, to offer them support if it was required.

The provider had failed to assess the risks to people's health and safety. They had failed to do all that was reasonably practicable to mitigate the risks to people and ensure that equipment was safe and was used in a safe way. The provider had failed to respond to and manage risks associated with major incidents and emergency situations. This was a breach of Regulation 12(1)(2)(a)(b)(e) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The building and equipment were not clean. Before our inspection one person's relative had complained to the registered manager about the cleanliness of the environment and furniture. We found similar concerns during our inspection.

Areas of the service, including the clinical room, bedrooms, and bathrooms were not clean. A cleaning schedule was in place but not all areas of the service were included. We observed that there was garden soil on the floor behind the door in the dining room. The registered manager told us that they had spilt the soil when they were carrying new plants into the garden the weekend before our inspection. The soil had not been cleaned up since then. Other floors, including people's bedroom floors and the floor of a shower room that had recently been used were not clean. Wooden boards were used in the shower room by people who did not want to rest their feet on the floor. The registered manager told us these should be 'scrubbed' after every use but they said they were not confident that this always happened.

Cleaning schedules were not in place to make sure that equipment, including hoists was cleaned regularly. Equipment being used by people was not clean, including a hoist and a shower seat. Some people needed special mattresses to keep their skin healthy. These mattresses were thin so another foam mattress was placed underneath to keep people comfortable. The foam mattresses were not fitted with covers and it was not possible to clean them properly because the surface could not be washed or wiped. Checks had not been completed to make sure that the foam mattresses had not become soiled.

There was a sluice room on each floor for emptying and cleaning commodes and other equipment. There were cleaning chemicals and clinical waste stored in these rooms. These rooms were not kept locked and were accessible to people and visitors to the service. Clinical waste was not stored safely in one of the sluice rooms. Waste was stored in an open clinical waste bag on the floor of the sluice room. It is good practice to use a pedal bin for the safe storage of clinical waste to reduce the risk of staff and other people coming in to contact with soiled items. In one sluice room access to the hand wash sink was blocked and staff were not able to wash their hands before leaving the room. In another sluice room a pair of scissors was stored on the lid of a clinical waste bin. The registered manager told us the scissors were used in people's catheter care. New catheters are sterile while in their packaging to minimise the risk of infection to people. There is a risk that contaminated scissors may be used when managing people's catheters. The registered manager had not completed a check of sluice rooms to make sure they were clean and safe.

Before our inspection we received concerns about the management of laundry when the washing machine had broken down. The machine was working at the time of our inspection; however systems were not in place to stop clean clothes becoming contaminated by dirty clothes stored nearby. Soiled clothes were in bins underneath clean clothes. The management of laundry had not been assessed and the risk of the transfer of infection had not been identified.

Toiletries, including soaps, razors, creams and tooth brushes were stored together in plastic boxes in people's bedrooms. The boxes were not clean and appeared to be soiled. People's tooth brushes were in contact with their other personal care products and the soiled boxes. Action had not been taken by staff to keep people's personal care items clean.

Most of the furniture in people's bedrooms was worn and shabby making it difficult to keep clean. The provider had ordered new bedside tables for every bedroom and ordered new wardrobes and chests of drawers for every room during our inspection.

A maintenance person completed some maintenance checks and day to day maintenance tasks at the service. On the day of the inspection the water from the taps in several people's bedrooms was too hot. The water from one bedroom tap was 51°C and increased the risk of scalds. Health and Safety Executive guidance states that water temperatures must not exceed 44°C. During the inspection the provider arranged for all the thermostatic mixing valves on taps to be checked by a plumber and for any faulty valves to be replaced. We will follow this up at the next inspection.

The building was secure; however the identity of people was not always checked before they entered. Internal doors were not locked and people moved freely around the service and were not restricted. Environmental risk assessments had been completed; however some areas of the building were not safe and posed a risk to people. Windows on the upper floors had been fitted with restrictors to protect people from the risk of falling out of them. However, some restrictors were broken. During the inspection the provider arranged for all the window restrictors to be checked and broken ones replaced. We asked the provider to update us on this following the inspection.

The provider had failed to assess the risk of the spread of infections and take action to prevent, detect and control the spread of infections. The provider had failed to have suitable cleaning schedules in place to ensure the service was clean and hygienic. The provider had failed to make sure the premises are suitable for the purpose for which they are being used. This was a breach of Regulation 15(1)(a)(b)c(e) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not always protected from the risks of unsafe medicines management. Medicines were stored securely, including those more liable to misuse. However, medicines were not always stored at the correct temperature, for example some medicines were stored in a trolley, in front of a radiator and in direct sunlight. Other medicines were appropriately stored in a fridge but the temperature of the fridge was not checked regularly and the thermometer in place at the time of inspection was broken. There was a risk that high or very low temperatures would reduce the effectiveness of people's medicines.

Most medicines were stored in a secure room. The room was not clean and benches were soiled with the residue from previous spillages of liquid medicines. The room was disorganised and untidy, with cardboard boxes filled with the next cycle of medicines stored under and on top of a sink, where they were at risk of becoming wet or soiled. Effective processes were not in place for the management of medicines that were no longer needed. Some medicines were being sent for destruction shortly before our inspection but large stocks remained. Medicines that are surplus, unwanted or expired should be disposed of promptly as there was a risk they could get mixed up and accidentally be given to people. High risk medicines were disposed of appropriately and records were kept so this could be checked.

Systems were not in operation to manage the stocks of medicines and there were excessive stocks of some people's medicines. There was a risk that these medicines may go out of date before they were used and be less effective. Bottles of liquid medicines which were in use did not show a date of opening. This was important to ensure medicines are used safely within a given shelf life. Arrangements were in place to obtain medicines that might be needed urgently in addition to people's usual requirements, such as antibiotics.

Before our inspection concerns had been raised by visiting health care professionals about the accuracy of records relating to medicines. We looked at people's medicines administration records (MARs) and other records used to monitor the administration of medicines. Some entries on people's MARs had been handwritten. These had not been checked by a second person to reduce the risk of mistakes. Staff should sign the MAR after they had administered a person's medicine and checked they had taken it. On occasions staff did not do this and only signed the MAR later if or when they remembered. An unsigned MAR may indicate to other staff that a person may not have had their medicine. The registered manager did not check the MAR to identify any errors or omissions. Other important records were not always kept in the correct order and did not meet the standards set out by the Royal Pharmaceutical Society of Great Britain, for example medicines that are liable for abuse. Effective checks had not been made on records to identify any concerns that may put people at risk.

Some people had pain relief patches. These patches can damage people's skin if they are put in the same

place on each application. Records of where patches had been applied were not kept. It was not possible for nurses or other health care professionals to check where patches had been applied and take action to reduce the risk of people's skin being damaged. Creams had been prescribed to many people to keep their skin as healthy as possible. These were applied by care staff. Records of when prescribed creams were applied did not state the name of the cream or where it had been applied. Staff could not check that the correct creams had been applied or that creams were applied to the right place.

Staff told us that medicines safety alerts and recalls were received and acted on. Records of the action staff had taken were not kept and checks could not be completed to make sure that people were not offered faulty medicines or devices. Systems were not in place to make sure that staff received medicines safety alerts and recalls promptly in the registered manager's absence.

The provider's policy to support people to manage their own medicines when they wanted to was not being followed. For example, some people used inhalers, to help them breathe more easily. The use of the inhalers had not been risk assessed and was not monitored to check that they were being taken when they were needed or more often than prescribed. Using an inhaler more often may indicate that someone's needs had changed and they may need to see their doctor.

A syringe driver (a portable pump to deliver medicines over 24 hours) was held in stock at the service. Staff did not know when it was last serviced and service records were not available. They could not check if the syringe driver was safe to use.

We observed people receiving their medicines. This was done in a caring and respectful way and the nurse stayed with people to ensure they had swallowed the medicines and drinks safely.

The provider had failed to operate proper and safe medicines management processes in relation to the ordering, storage, disposal and recording of medicines. This was a breach of Regulation 12(1)(2)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider's recruitment procedures were not followed consistently. Checks required to make sure staff were honest, trustworthy and reliable had not been fully completed for all staff. Gaps in staff's employment history had not been explained in one of the six staff files we looked at. This information helps providers check why potential staff may have gaps in their employment. . References with information about staff's conduct in their last employment had been obtained.

Only one of the six staff files we looked at contained a completed health questionnaire. One of the questions asked if the person had suffered back pain or neck problems and this had not been answered. There was no evidence this had been discussed with the staff member. This staff member later asked for support to look after their health and improve their back position to reduce the impact of their role on their health. Checks had not been made to make sure that reasonable adjustments could be made to support staff to properly perform their role.

Disclosure and Barring Service (DBS) criminal records checks had been completed for all staff before they began working at the service. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services. Checks on the identity of staff and the qualifications of nurses had been completed. Nurses PIN numbers were checked to make sure they were registered with the Nursing and Midwifery Council and a note of the expiry date was kept to prompt the registered manager to check the PIN was in date.

The provider had a 'discipline procedure' in place and this had been followed in practice by the registered manager. The records of disciplinary meetings had been recorded and relevant documents were held on staff files.

Before our inspection concerns had been raised about the staffing levels at the service and how unexpected shortfalls were managed. The registered manager and provider confirmed, before the inspection, that one nurse had worked a 24 hour shift because only the registered manager and provider could book agency nurses and they were both unavailable. The registered manager had not taken action at the time of our inspection to prevent this from happening again.

We looked at how staffing at the service was managed to make sure there were enough staff deployed at all times to meet people's needs. People told us there were enough staff to meet their needs. One person told us, "I have a call bell in my bedroom. If I need something urgently staff come when I press the bell". Some staff told us they were not rushed and had time to spend with people. Other staff told us that on occasions the service was short of staff and they did not have time to do some basic checks on people.

The registered manager used a dependency assessment system to decide how many staff were needed to provide the service at different times of the day, taking into consideration peoples' needs and the skills of the staff. This was reviewed and adapted to meet people's changing needs and staffing levels had recently been increased. Staff rotas showed that the assessed level of staffing was provided.

Catering, housekeeping and maintenance staff were employed so nurses and care staff could concentrate on caring for people. One nurse and one care staff were on duty throughout the night to provide the care and treatment people needed.

Staff knew the signs of possible abuse, such as changes in people's mood. They knew how to report any concerns they had and were confident any concerns they raised to the registered manager would be listened to and acted on. The registered manager was aware of safeguarding procedures and had raised concerns they had with the Kent local authority safeguarding team. Staff felt confident to whistleblow to the registered manager or to the Care Quality Commission when they had concerns about their colleagues' practice.

Inadequate

Is the service effective?

Our findings

Care had not been consistently planned to keep people as healthy as possible. One person had a catheter to help them pass urine. Plans were not in place to make sure that the catheter was changed regularly. The registered manager and nurses did not know that the manufacturer recommended that the catheter was changed every four weeks. The catheter had been changed approximately every three months and was not changed for 16 weeks on one occasion. Failure to change the catheter as often as recommended by the manufacture put the person at risk of infection.

Lubrication gel was not used for the insertion of the new catheter when it was changed. It is good practice to use a lubrication or pain relief gel to reduce the risk of trauma and infection caused by the catheter. Catheter bags used during the day were not replaced as often as recommended. Staff changed the bags once a month or when they were 'grubby'. The date the bag needed to be replaced was not recorded to make sure it was replaced when it should be. It is good practice to replace catheter day bags every seven days to reduce the risk of infection. Disposable bags were used at night which was good practice.

Some people had wounds that were being treated by the registered nurses. Wound assessments had been completed to help nurses check if wounds were healing or not. Wounds were not always assessed regularly to identify any changes quickly. One person's wound was being assessed every month. It is best practice to review the wound each time the dressing is changed or every few days.

People were supported to have regular health checks, including eye tests and medication blood tests. Systems were in place to make sure that people received the correct dose of blood thinning medicines when it was changed by their health care professional. Guidance had not been provided to staff about the signs of over and under treatment of people on blood thinning medicines, or possible side effects of taking blood thinning medicines, such as bruising. This was important to ensure staff were aware of any signs and symptoms and what actions to take to keep people safe. Registered nurses knew how medicines, such as antibiotics, interacted with blood thinning medicines and requested blood tests to make sure any changes were identified quickly.

The provider had failed to assess, and plan people's care and treatment to meet people's health care needs. This was a breach of Regulation 12(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A visiting health care professional told us that staff contacted people's doctors without delay if they had concerns about people's health and followed their advice and guidance. For example, staff had contacted one person's doctor two days before our inspection when the person was feeling unwell. Their doctor had visited and prescribed medicine and staff had offered the person pain relief. The person told us they were feeling better.

People who showed signs of depression had been referred to the community mental health team. Staff followed the treatment plan prescribed by the team and records showed the people felt happier, their

appetite had increased and they had gained weight.

People were supported by staff or people who knew them well to attend health care appointments, including outpatient appointments. This was to support them to tell their health care professional about their health and medicines and to make sure that any recommendations were acted on when they returned to the service. People's doctors reviewed their medicines regularly.

People were not always supported to make choices about all areas of their lives. Some people were able to chat to staff and tell them about their choices and what support they needed. For example, several people told staff what they wanted to eat and drink each day. Other people were not offered choices in the way they preferred and were not supported to make decisions and choices. For example, some staff showed people a drink when asking if they wanted a drink to help them understand the question they were being asked, other staff did not. The nurse gave people a choice of drink to take with their medicines, ensuring their preferences were respected.

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 be as least restrictive as possible. We checked whether the service was working within the principles of the MCA. We found that the MCA was not applied consistently by staff.

The registered manager told us that most people were not able to make complex decisions about their care and treatment. Some people needed to make complex decisions including consenting to the use of bedrails. Assessments of people's capacity to make complex decisions had not been made, including decisions about medicines and the use of bedrails. One person's relative had given permission for bedrails to be used on the person's bed. The registered manager told us they thought the person had capacity to make the decision themselves. An assessment of the person's capacity had not been completed and the person had not been given the opportunity to make the decision them self.

Decisions had been made in people's best interests by people who knew them well when the registered manager thought people did not have the capacity to make the decision. Decisions made in people's best interests had not been reviewed to make sure the person's needs continued to be met in the most appropriate way. For example, a decision had been made, several years ago, to administer one person's medication without their knowledge. This decision had not been reviewed by people who knew the person well to make sure it was still in the person's best interests.

People's capacity to make 'less complex' day to day decisions had been assessed. The information from the assessment had not been transferred to a care plan so staff had no guidance about what decisions people were able to make and the support staff should provide to help people to make straightforward decisions. Some staff told us everyone living at the service was able to make straightforward decisions, such as what they wanted to drink and how they shared these with staff. Other staff told us people were not able to make and share their choices and wishes. Guidance had not been given to staff about how to offer people choices in ways they understood and how people told staff about their choices. There was a risk that people would not be consistently offered choices in ways they understood.

Most staff had not received training in relation to the MCA. Some staff assumed people had capacity to make less complex decisions however, some staff assumed people did not have capacity and they were not able to make decisions, such as what they ate and where they spent their time. Some staff told us how they

would prevent people with capacity making unwise decisions, such as people who were at risk, drinking alcohol, this was not in line with the MCA. Staff told us some people's capacity 'fluctuated' from day to day. Guidance had not been provided to staff about how to support people to make decisions when they lacked capacity for a short period of time.

Information was not always provided in a way that was suitable for people's needs. For example, menus did not include pictures of food to support people to make choices about what they wanted to eat. The provider said they would use pictures on a tablet computer to support people to make choices about their meals. We will follow this up at the next inspection.

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 are called the Deprivation of Liberty Safeguards (DoLS).

The registered manager was not fully aware of some of their responsibilities under DoLS. The registered manager had made applications to the local authority for standard DoLS authorisations to deprive most people living at the service of their liberty. They told us they applied for DoLS authorisations when people became unwell. Assessments had not been made before the applications were made to check if people had capacity or were at risk of being deprived of their liberty.

At the time of our inspection one person was the subject of a DoLS authorisation and others were waiting to be assessed by their local authority. The registered manager and staff did not know that the person had a DoLS authorisation in place. The person's care had not been planned to comply with the conditions of the authorisation which were to, 'Implement a care plan to demonstrate that they are monitoring the authorisation'. Checks were not made to make sure that the person was not deprived of their liberty for longer than necessary to keep them safe.

A couple of people enjoyed going out regularly with staff and told us they were supported to do this.

The provider had failed to assess and plan people's care in accordance with the Mental Capacity Act 2005, including best interest decision making; lawful restraint and the application for authorisation for deprivation of liberty through the Mental Capacity Act 2005 Deprivation of Liberty Safeguards. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff worked through an induction when they started work at the service to get to know people, the care and support they needed and to understand their roles and responsibilities. This included shadowing more experienced staff. The registered manager worked with colleges to provide student placements and apprenticeships. There were four apprentices working at the service at the time of our inspection. The apprentices were working towards the Care Certificate. This is an identified set of standards that social care workers adhere to in their daily working life. It aims to help develop key skills, knowledge, values and behaviours which should enable staff to provide people with safe, effective, compassionate and high quality care. Progress of staff completing the Care Certificate was regularly monitored and discussions were held with apprentices to check their understanding and competency. One apprentice said they worked on one section at a time and a received feedback after each one had been completed. Another apprentice commented, "The Care Certificate is very good. It breaks training into different topics and is easy to follow".

The registered manager used a training schedule to keep track of what training staff had completed. This had not been used to plan the staff training and staff had not completed all the training they needed to perform their duties. Some staff had not completed fire safety training and, health and safety training and

some had not completed training on safe moving and handling. Staff were not able to tell us how they would safely evacuate people from the building.

Staff completed training about medicines management; however staff told us they did not always sign the medicines administration record when they supported people with their medicines as they should do. Checks had been completed on the competency of staff to administer medicines safely. However, these checks did not clearly identify which areas of administration had been checked and which had not. These checks could not be used to plan staffs' continued development in the safe management of medicines. Staff had been trained and competency assessed on how to use a syringe driver but did not check the equipment was safe to use.

We looked at six staff members' supervision records. One registered nurse, who had worked at the service for over two years, had no recorded one to one supervision or clinical supervision. The registered manager told us that they held clinical supervision meetings to discuss clinical practice with nursing staff every six months but were not able to show us any records of this. The purpose of clinical supervision is to provide a safe and confidential environment for nursing staff to reflect on and discuss their work and personal and professional responses to their work. The focus is on supporting staff in their personal and professional development and in reflecting on their practice.

Staff told us they did not meet with the manager on a one to one basis for supervision and coaching. Staff, including apprentices, had not received supervision since their employment or had not had supervision regularly. The registered manager had identified this and was putting a process in place to address this shortfall and staff had been allotted time during their shift to meet with the registered manager for one to one discussions. Staff were not aware when they would be offered supervision.

The provider did not have an appraisal procedure in place, to review each staff member's practice and development over the previous year and set goals for the next year. Any personal development goals staff had and plans that were in place to help them achieve these goals were not recorded. Checks could not be completed to make sure staff were supported to develop in their role and achieve their goals.

The provider had failed to make sure staff received appropriate support, training, professional development, supervision and appraisal to enable them to carry out the duties they are required to perform. This was a breach of Regulation 18(1)(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager had updated nursing staff on a new revalidation process which had been introduced at the beginning of April 2016.

People told us they liked the food at the service. One person told us, the food was, "Very nice". One person's relative told us, "My mum loves the food". On the days of our inspection meal times were pleasant, social occasions for some people and they enjoyed their meals in the garden. People were not offered the opportunity to eat their meals in the dining room. The dining room was being used as an area for staff to complete paperwork and have breaks and was not set up as a dining room which people could use. The registered manager told us that people preferred to eat in their bedroom or in the lounge. People were not asked each day where they would like to eat their meals. During our inspection people ate lunch in the garden and told us they enjoyed this. The provider had plans to refurbish the dining room, including the purchase of new tables and chairs and instructed staff to offer people regular opportunities to eat in the dining room in a social environment.

Other people ate their meals in the lounge or sat in bed. We observed that some people struggled to eat their meal in bed as the bed table did not fully reach over the bed. One person's plate was balanced on their lap and food had spilt onto their bedcovers. The person appeared distressed by this. The registered manager did not take action to make sure the person was supported to eat as independently as possible and guidance had not been provided to staff about how to support them. We observed that another person was positioned correctly in bed with the bed table across the bed in front of them and they could easily reach the food.

People who had difficulty swallowing or were at risk of choking were offered soft or pureed food. Foods were pureed separately and presented in an appetising way so people were able to taste the separate flavours of each food. Staff had not considered offering a choice of foods to people who needed soft or pureed food and they were not asked what they would like to eat each day. One person refused their pureed meal often. Staff offered the person a food supplement if they did not eat their meal. Staff did not know what the person liked to eat and what they disliked.

Other people were offered a choice of meal and alternatives were prepared at their request. Several people chose to eat fried eggs and chips regularly and this was prepared at their request. Staff purchased take away foods for people when they requested it.

When people lost weight they were referred to the dietician for support and advice. This advice was followed and people were offered food fortified with extra calories and prescribed supplements. They had gained weight. Meals were balanced and included fruit and vegetables. All meals were homemade. Communication between care staff and catering staff was good, catering staff were aware of any changes in people's Likes, dislikes and any food allergies they had.

The provider had failed to offer everyone using the service a choice of meals. Some people were not given all the support they needed at meal times to make sure meals were within their reach. This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service caring?

Our findings

People and their relatives we spoke with told us they were happy with the service they received at Eaton Lodge, their comments included: "The staff are ever so good. I have a good laugh with them. If I want anything the staff will always help me" and "The staff are lovely". One person gave a 'thumbs up' when we asked them about the staff. One person's relative told us, "My relative always looks well looked after. I can't fault the staff". However, our findings did not agree with the feedback we received.

Staff did not always talk about people in a respectful way. People who needed soft or pureed food were referred to by the staff as 'the feeds' and people who did not need soft or pureed food were called 'the normals'. We raised our concerns with the registered manager. The registered manager told us she had not considered this before and agreed that this was not a respectful way to describe people. When staff spoke to people they used their preferred names.

People appeared relaxed in each other's company and in the company of staff. People and staff shared jokes and laughed together. Staff showed genuine affection for people and people responded in a similar way. One staff member said, "If the residents are happy, I am happy".

Some people were not involved in planning their care. A limited amount of information was available to staff about people's life history, for example, about their career or how many children they had. This information helps staff get to know people and provide their care in the way they prefer. People and their families had been asked to share information before they moved into the service, this information had not always been provided and action had not been taken make sure staff had information about everyone.

Detailed information about people's preferences, likes and dislikes was not available for staff. Some people's care plans contained basic information such as 'Likes a weekly shower' and 'No spicy food'. The care plans for other people contained no information. Some people were able to chat to staff and tell them how they liked their care provided, most people were not. Staff relied on information shared with them by other staff and their own observations and there was a risk that people may not be supported in the way they preferred.

Guidance was not provided to staff about how to share information with people or about any support people needed, such as using glasses or hearing aids. One person we spoke with told us they needed hearing aids but they had not been supported to wear them. Some people were living with dementia and found it difficult to understand what staff were telling them. Ways of supporting people to understand had not been considered, such as using pictures, signs or objects. There was a risk that information would not be provided to people in a way that they understood.

Before our inspection we were told by whistleblowers that some people were not supported to get out of bed often and were at risk of becoming isolated and depressed. Opportunities for people to get up regularly had not been planned and people were not asked if they wanted to get up each day. Guidance was not given to staff about how to offer people the opportunity to get up and explain the benefits to them, in ways

they understood. We found several people who were only given to opportunity to get out of bed once a week or once a fortnight. Staff had not discussed this with people to find out how often they would like to be offered the chance to get up. Staff visited people in their bedroom to provide them with support and told us they did not have time to sit and chat to people. Activities staff tried to spend time with people in their rooms each day. Some people were at risk of being isolated as they were not encouraged and supported to spend time with other people in the communal areas of the service.

Systems were in place to make sure laundry was returned to the correct person. One person's relative told us staff asked them to name all their relatives clothes. They said that if the clothes went missing this was usually because they did not have the person's name in them. Staff and people's relatives were asked to look at unnamed items to make sure they were returned to the right person.

People had privacy. Staff offered people assistance discreetly without being intrusive. They explained to people about the care they would receive before it was provided. Staff knocked on people's bedroom doors before entering. People had privacy when they washed and dressed and curtains were used to give people privacy in shared rooms. Staff made sure that doors and curtains were closed and people were covered when they provided people's personal care.

People told us staff responded quickly when they needed support. One person said, "I have a call bell in my bedroom. If I need something urgently staff come when I press the bell". People's friends and relatives were able to visit whenever they wanted. They told us they visited regularly and were made to feel welcome.

Personal, confidential information about people and their needs was kept safe and secure. Staff told us at the time of the inspection that people who needed support were supported by their families, solicitor or their care manager, and no one had needed to access any advocacy services.

Some people and their families had been asked about their care preferences at the end of their life. Their choices and wishes were included in a 'Thinking Ahead' document and was available to staff and visiting professionals. Before the inspection one person's family had complained to the service that their relative's wishes had not been respected at the end of their life. The registered manager had investigated the complaint and reminded staff that they must respect people's wishes and provide the support they needed where and when they wanted it. They had spoken to the complainant and told them the action hey had taken.

Another person's relatives had complimented the staff saying, "Thank you for taking such good care of my dad [person's name] in his last months of life and special consideration for my mum". A palliative care nurse specialist had visited some people and staff knew how to contact them at any time for support and guidance. The registered manager and one of the nurses had completed 'six step' best practice training programme and was committed to providing people with high quality care in the last days of life and after a death. Some people had made decisions with their family and doctor not to be resuscitated. These decisions were known by staff who shared them with other health care professionals when necessary. People's families and friends were supported by staff and were able to stay at the service with people if they chose to. No one living at the service was receiving end of life care at the time of our inspection.

Inadequate

Is the service responsive?

Our findings

Most people had not been involved in planning their care, with their relatives when necessary. People had not all been supported to tell staff about their care choices and their preferences were not recorded so staff did not know how they wanted their care and treatment provided. Some people had been involved in planning their care but, their choices and preferences were not included in their care plans for staff to refer to. A few people were able to tell staff how they liked their care provided and told us that staff did as they requested. One person's relative told us staff contacted them quickly about any changes in their relative's needs.

Staff told us that they did not refer to people's care plans for information about the care and support people needed and relied on information from other staff or on their own experience. People did not always receive consistent care in the way that they preferred. For example, staff told us one person would refuse to eat their meals often and was at risk of losing weight. Some staff told us that they sang quietly to the person while supporting them at meal times which encouraged them to eat. Another staff member said that they had found that sitting quietly with the person encouraged them to eat. Other staff did not know that the person preferred to be supported like this at times. Guidance had not been provided to staff about the best ways to support the person to eat their meals and the person continued to refuse their meals at times.

Before people were offered a service, a basic pre-admission assessment of their needs was completed with them and their relatives, to make sure the staff could provide the care they required. Further detailed assessments had not been completed when people began using the service to follow up on needs identified in the pre-admission assessment. One person had moved into the service shortly before our inspection. A basic assessment of their needs had been completed over the phone. Further assessments of their needs, including risks to their skin and their moving and handling needs had not been completed. A care plan, including guidance to staff about how to provide the care and treatment the person needed, in the way they preferred, had not been written. The person was at risk of not receiving consistent and effective care and treatment as their care needs had not been recorded for staff to use as a guide.

Assessments of other people's needs had been completed but had not always been reviewed regularly to identify any changes in their needs and support. There was a risk that changes in people's needs would not be identified quickly.

People's care plans did not contain detailed guidance to staff about how to support people. For example, guidance had not been provided to registered nurses and care staff about how to manage people's catheters, including the action needed to reduce the risk of the catheter blocking and signs that it was blocked, how to clean and care for the insertion site and how often the catheter and bags needed to be changed. There was a risk that people's catheters would not be cared for correctly to keep them healthy and reduce the risk of infection.

People's moving and handling care plans did not contain guidance to staff about how to move people safely considering their individual needs and preferences, such as any physical weakness or action to be taken if

the usual techniques could not be used. For example, one person's plan stated 'Sliding sheet for movement in bed is not always feasible'. Guidance had not been provided to staff about how to reposition the person in bed if it was not possible to use a slide sheet. Staff told us about some people's preferences when they were being moved. These were not included in people's care plans and there was a risk that people may not always be moved safely.

Some people sat on their hoist sling during the day, this put them a risk of developing skin damage. The slings were designed to be removed once they had been used to transfer people and reduced the effectiveness of pressure relieving cushions. Guidance had not been provided to staff about monitoring people's skin to make sure any changes were identified quickly. One person's daily records noted that they had marks on their skin. The registered manager told us these may have been caused by the hoist sling.

Some reviews of people's care plans had been completed. However, these had not been completed consistently to make sure that any changes were identified quickly and care was then planned with people to meet their needs. Any changes in the way that care was offered were noted in the review, but changes to the care plan were not made.

The provider had failed to assess people's needs and plan their care with them, with a view to achieving peoples' preferences and ensuring their needs were met. This was a breach of Regulation 9(1)(3)(a)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some people had social and spiritual care plans in place, other people did not. The information provided in the care plans was very limited, including 'Enjoys TV and Radio', 'Enjoys entertainment' and 'Loves food and to be fed'.

Before the inspection the registered manager had recognised that people did not have enough to do during the day. A new activities person had been appointed and had been in post for approximately two weeks. A new programme of activities had been developed and had started three days before our inspection. Activities included aromatherapy, memory games and gentle exercises. The activities person told us, "We have bingo this afternoon which is always fun. Tomorrow is arts and crafts and Wednesday is our 'beauty day'".

During our inspection some people took part in games of prize bingo. People's visitors joined in the bingo games and everyone told us they had enjoyed them. People who wanted to go out were supported by staff to do this. One person told us about their shopping trips into the local village, and another person enjoyed going out to a local café. Activities staff spent some time with people who chose or were not able to get out of bed. One staff member told us, "We are spending a lot of time with people doing different activities. Quite a lot is done on a one-to-one, like massages and manicures". One person told us, "The girls have done my make-up. They also manicure my nails because I can't manage that myself".

A process to receive and respond to complaints was in place. Information about how to make a complaint was available but action had not been taken to make sure it was meaningful to everyone, such as using large print or pictures. Records of complaints, other than written complaints, and the action taken to investigate and resolve them were not maintained as required by the provider's complaints policy. Checks were not be made to make sure that complaints received were used to improve the service.

One written complaint had been received shortly before our inspection. This followed two complaints made in person to the registered manager. Concerns about the cleanliness of a person's bedroom and the 'extremely tatty' furniture, made previously, had not been addressed to the complainant's satisfaction. The

registered manager planned to investigate the other concerns and respond to the complainant in the timescale given in the provider's policy. People and their relatives told us they were confident to raise any concerns they had with the registered manager and staff.

Inadequate

Is the service well-led?

Our findings

The registered manager had been managing the service for several years. Staff told us they felt supported by the registered manager and were confident to raise any concerns they had with her. One staff member told us, "The manager is the best". The registered manager was always available to give staff advice and support, including overnight, at the weekend and when they were on leave.

Systems were not in place to support the registered manager and delegate some of the responsibility for managing the service, such as providing out of hours support to staff and completing administration tasks. When the registered manager was on leave or away from the service there was no deputy manager to oversee the management of the service. Following our inspection the provider told us they planned to appoint an administrator and a deputy manager to support the registered manager. They also arranged for the registered manager of another of their services to visit the service and support the registered manager. Staff were motivated and enjoyed working at the service. All the staff we spoke with said they enjoyed their job. One member of staff commented, "I really love it here".

The registered manager did not have a clear vision of the quality of service they required staff to provide. The registered manager did not delegate tasks and completed many nursing tasks themselves, such as planning and reviewing people's care and treatment, and covering nursing shifts and staff were not involved. The registered manager was not aware of the shortfalls in staff practice such as gaps in medication records and they lack of regular care reviews. Staff had not been held accountable and responsible for the service they provided. Values including dignity and respect did not always underpin the service provided to people each day.

Staff shifts were planned in advance. Cover for staff sickness and holidays was arranged by the registered manager and was usually provided by other team members. Action had not been taken following an occasion when nursing cover could not be found, to make sure that staff had all the information they needed to maintain staffing levels in the registered manager's absence. For example, staff told us they were not able to book agency staff and did not know what they would do if the situation happened again.

The registered manager relied on the good will and availability of staff who lived locally to provide support in an emergency, such as to evacuate people from the building. A rota was not in place and the registered manager did not know if staff would be able to respond quickly if they were contacted in an emergency. Practices and checks had not been completed to make sure the process worked and staff responded promptly.

Care staff worked together as a team to provide care to people. One staff member told us, "The team work OK together". Staff were not given feedback about their performance to develop their skills and make them feel valued as there was lack of staff meetings and one to one meetings.

People were asked for their views and opinions about the service. An annual quality assurance survey was sent to people and their relatives and some responses had been received. The registered manager

addressed any concerns raised and told the person about the action they had taken. The feedback received from everyone was not collated to look for patterns and trends and feedback was not provided to people and their relatives about any action taken to improve the service.

Staff completed 'client satisfaction' surveys with people each month, including their feedback on the food. The registered manager had not considered asking people to complete the surveys with their family or asking family members to reply on behalf of their relatives who were not able to do this for themselves.

Staff did not have regular opportunities to share their views about the quality of the service and make suggestions about changes and developments. The registered manager told us staff had the opportunity to give feedback about the service during their supervision meetings but staff did not receive supervision regularly and some staff had not had supervision since they were employed. Staff meetings were not held regularly and notes of what had been discussed were not available for staff to refer to if they were not able to attend the meeting. The provider had met with each staff member shortly before our inspection in response to an incident that had happened at the service. Records of these meetings were not available at the service and were not provided to us after the inspection.

The provider and registered manager did not have oversight of the service. They had not completed checks on all areas of the service to make sure that it was of a good standard, such as medicines management and infection control audits. Checks had not been made on audits completed by staff, such as environmental checks to make sure these were being completed regularly and effectively. Shortfalls in the quality of the service found during the inspection had not been identified by the provider or registered manager.

The registered manager and provider did not consistently monitor and challenge staff practice to make sure people received a good standard of care. Staff told us that the registered manager was observant and spoke to staff about their practice at times. One staff member told us the registered manager, "Can come down heavy on staff when needed". The registered manager told us that not all the checks they completed were recorded and so the development of the service could not be monitored. The provider had not completed regular checks on the quality of the service and systems were not in operation to make sure that the provider received regular information about the service.

The registered manager and provider had failed to assess, monitor and improve the quality and safety of the service provided to people. This was a breach of Regulation 17(1)(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were systems in place to share important information between staff members and between the registered manager and staff. Handover meetings were held at the beginning of each shift and were led by the nurse on shift. Staff told us that they received information about people's changing needs in the handover meeting. They said that they caught up following leave or days off at the handover meetings and by asking other staff members about any changes in people's care. The registered manager attached information sharing letters to staffs' pay slip on occasions with reminders and updates. The last letter was sent in March 2016 and reminded staff that they needed to make sure their training was up to date.

Records in respect of each person's care and support had been kept. These did not contain all the information needed to assess, review and plan people's care, such as what they had eaten and drunk or when and where prescribed creams had been applied. Records of decisions made in relation to people's care had not been consistently recorded. One person was being monitored as they may be at risk of falling. A falls risk assessment had not been completed and the decision to monitor them, with the reasons why the monitoring was needed, had not been recorded.

Records of when people had been supported to change their position were not kept consistently and checks had not been completed to make sure that people received the support they needed to keep their skin as healthy as possible.

On occasions information was held in two different places and it was difficult for staff to assess the care people had received. For example, when people's position was changed in bed this was recorded on one record. When the same people were supported with their continence needs, which involved changing their position, this information was held on another form. It was not easy for staff and visiting health care professionals to check if people's position had been changed regularly and plan their care to meet their needs.

Records about people were not always specific and accurate. One person's records showed that they had a red mark on their skin on one day. The following day's records stated 'no change'. The registered manager told us that 'no change' meant the person's skin was clear and healthy. The nurse on duty told us that 'no change' meant that the red mark was still there. Inaccurate or unclear records could put people at risk of not receiving the care and treatment they needed quickly.

The provider had failed to maintain an accurate, complete and contemporaneous record in respect of each person, including a record of the care and treatment provided to them and of decisions taken in relation to the care and treatment provided. This was a breach of Regulation 17(1)(2)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Providers and registered managers are required to notify us when people have died at the service without delay. The registered manager had delayed sending notifications to CQC after people had died. For example, notifications that people had died had not been sent for three to four months.

The provider had failed to notify the Commission without delay of the death of a service user. This was a breach of Regulation 16 Care Quality Commission (Registration) Regulations 2009.

Providers and registered managers are required to notify CQC when significant events happen at the service, such as a safeguarding concerns or when someone is injured. The registered manager had not recognised when some notifications needed to be sent to CQC, such as notifications that the police had been contacted or the outcomes of DoLS applications.

The provider had failed to notify the Commission (CQC) without delay of incidents that had occurred at the service, including contact with the police. This was a breach of Regulation 18 Care Quality Commission (Registration) Regulations 2009.

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 16 Registration Regulations 2009 Notification of death of a person who uses services The provider had failed to notify the Commission without delay of the death of a service user.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider had failed to notify the Commission (CQC) without delay of incidents that had occurred at the service, including contact with the police.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider had failed to assess people's needs and plan their care with them, with a view to achieving peoples' preferences and ensuring their needs were met.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had failed to assess and plan people's care in accordance with the Mental Capacity Act 2005, including best interest

decision making; lawful restraint and the application for authorisation for deprivation of liberty through the Mental Capacity Act 2005 Deprivation of Liberty Safeguards.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs The provider had failed to offer everyone using the service a choice of meals. Some people were not given all the support they needed at meal times to make sure meals were within their reach.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The provider had failed to assess the risk of the spread of infections and take action to prevent, detect and control the spread of infections. The provider had failed to have suitable cleaning schedules in place to ensure the service was clean and hygienic. The provider had failed to make sure the premises are suitable for the purpose for which they are being used.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to make sure staff received appropriate support, training, professional development, supervision and appraisal to enable them to carry out the duties they are required to perform.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to assess the risks to people's health and safety, do all that was reasonably practicable to mitigate risks to people and ensure equipment was safe and was used in a safe way. They had failed to respond to and manage risks associated with major incidents and emergency situations. They had failed to operate safe medicines management processes They had failed to assess and plan people's care and treatment to meet their health care needs.

The enforcement action we took:

We have served a warning notice to be met by 15 July 2016

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The registered manager and provider had failed to assess, monitor and improve the quality and safety of the service provided to people. They had failed to maintain an accurate, complete and contemporaneous record in respect of each person, including a record of the care and treatment provided to them and of decisions taken in relation to the care and treatment provided.

The enforcement action we took:

We have served a warning notice to be met by 15 July 2016