HC-One No.1 Limited

# Godden Lodge Care Home

## Inspection report

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## Ratings

| | |
|---|---|
| Overall rating for this service | Inadequate |

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

# Summary of findings

## Overall summary

About the service
Godden Lodge Care Home is a residential care home providing personal and nursing care for people aged 65 and over. Some people have dementia related needs and other people require palliative and end of life care. The service consists of 4 houses: Victoria House, Cephas House, Boyce House and Murrelle House. At the time of inspection Murrelle House was not operational. The service can support up to 133 people and at the time of our inspection there were 77 people living at the service.

People's experience of using this service and what we found
The delivery of care for people was not always safe. Information relating to people's individual risks was not always recorded or did not provide enough assurance that people were safe. Suitable arrangements were not in place to ensure the proper and safe use of medicines. The staffing levels and the deployment of staff was not suitable to meet people's care and support needs.

Lessons were not learned, and improvements made when things went wrong. Staffs' training was not embedded in their everyday practice. We have made a recommendation about staff training.

Not all staff felt supported or valued by the management team. People at risk of poor nutrition and hydration were not properly and accurately assessed and we could not be assured if people's hydration needs were being met. We have made a recommendation about people's fluid intake. The premises did not meet people's needs, particularly for people living with dementia. We have made a recommendation about this.

People and their relatives told us they were treated with care and kindness. However, the care provided was not always caring or person-centred. This was attributed to inadequate staffing levels and poor deployment of staff, high agency staff usage and the impact this placed on the quality of care people received. Many interactions by staff remained task and routine led. People were not always treated with dignity and respect.

Not all care plans contained enough information to ensure staff knew how to deliver appropriate person-centred care and treatment based on people's needs and preferences. Where information was recorded this was not always accurate or up to date. People were not supported or enabled to take part in regular social activities that met their needs.

The leadership, management and governance arrangements did not provide assurance the service was well-led, that people were safe, and their care and support needs could be met. There was a lack of understanding of the risks and issues and the potential impact on people using the service.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

The service worked with other organisations to ensure they delivered joined-up care and support and people had access to healthcare services when needed. People were protected by the prevention and control of infection. Staff had received an induction and formal supervision.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
The last rating for this service was Requires Improvement [Published April 2021]

Why we inspected
This inspection was prompted by a review of the information we held about this service.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

The overall rating for the service has changed from Requires Improvement to Inadequate based on the findings of this inspection.

Enforcement
We have identified breaches in relation to risk and medicines management, staffing, care planning, person-centred care and quality assurance at this inspection.

Please see the action we have told the provider to take at the end of this report.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the 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.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

| | |
|---|---|
| **Is the service safe?**<br>The service was not safe.<br>Details are in our safe findings below. | **Inadequate** |
| **Is the service effective?**<br>The service was not always effective.<br>Details are in our effective findings below. | **Requires Improvement** |
| **Is the service caring?**<br>The service was not always caring.<br>Details are in our caring findings below. | **Requires Improvement** |
| **Is the service responsive?**<br>The service was not responsive.<br>Details are in our responsive findings below. | **Inadequate** |
| **Is the service well-led?**<br>The service was not well-led.<br>Details are in our well-led findings below. | **Inadequate** |

# Godden Lodge Care Home

**Detailed findings**

## Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection team consisted of 2 inspectors on both days of inspection and 2 Experts by Experience on the first day of inspection. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Godden Lodge Care Home is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Godden Lodge Care Home is a care home with nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was a registered manager in post.

Notice of inspection

This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We spoke with 17 people who used the service and 8 relatives about their experience of Godden Lodge Care Home. We spoke with the provider's representative of the service [Regional Area Director], the registered manager, 1 house manager and 9 members of staff, including nursing and care staff, an activities coordinator and a housekeeper.
We reviewed a range of records. This included 12 people's care records and 13 people's medicines administration records. We looked at 3 staff files in relation to recruitment and other staff files relating to training and supervision records. A variety of records relating to the management of the service, quality assurance information and policies and procedures were viewed.

Inadequate

# Is the service safe?

## Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At our last inspection we rated this key question Requires Improvement. At this inspection the rating has changed to Inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management
• The provider failed to ensure risks to people were assessed and monitored for their safety.
• We observed 3 separate incidents whereby staff performed unsafe moving and handling practices. Staff placed people at potential risk of harm by placing their hands under people's armpits when assisting them with transfers. We saw one person taken to the communal lounge from their bedroom in their wheelchair and although footplates were attached, the person's feet were not placed on the footplates. These techniques were unsafe and could cause injury. These incidents referred to Boyce and Victoria House.
• Not all risks to people's safety had been assessed and recorded. Risk assessments had not been completed for all people newly admitted to Boyce House. Where some risk assessments were in place, these were generic and not person centred.
• Not all people who had a catheter or tube fitted directly into their stomach so they can eat and drink safely, had the risks identified. A person's care records referred to them being at risk of self-harm and exhibiting behaviours that could be distressing to themselves and others. No risk assessment was completed detailing the risks posed and the steps required to keep people safe. This placed people at potential risk of not having risks to their safety met in an appropriate and safe way.
• One person was observed to be lying in bed. The bed was placed at its lowest position with a crash mat and sensor alarm in place. Though the bed had been moved away from the wall, this created a significant gap of approximately 6 to 10 inches between the bed and wall. If the person rolled over this could cause the person to become entrapped, placing them at risk of harm. This referred to Victoria House.

Using medicines safely
• Medicines were not stored safely to ensure people's safety. An incident occurred on Cephas House whereby 1 person told us they had helped themselves to their medicines as this was not administered by staff in a timely way and the medicine trolley had been left open by the qualified nurse. We fed this back to the provider's representative and the registered manager for further investigation.
• Staff told us not all medicines relating to the above person were being stored safely. While there was a lockable facility available in their bedroom, this was not being used, placing others at risk of harm of accessing this medicine.
• Thickeners were prescribed for people who experienced swallowing difficulties. A person's drum of thickening agent was left on their bedside cabinet. This meant it was easily accessible to others living at the service, placing them at potential risk of harm or death if ingested. This referred to Boyce House.
• On Boyce House, 1 person's syringe driver tube was observed to have become disconnected from the machine. We could not be assured if the person using the service had received all of their pain relief medicines. This had not been noticed by staff and the deputy manager was informed immediately.

Effective arrangements were not in place to mitigate risks for people using the service or ensure medicine practices were safe. This demonstrated a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• Appropriate fire detection, warning systems and firefighting equipment were in place and checked to ensure they remained effective. These ensured the provider was able to respond effectively to fire related emergencies that could occur at the service.
• Hot and cold-water outlets were tested at regular intervals to ensure the water emitted remained safe and within recommended guidelines. An analysis for legionella had been carried out and this confirmed no bacteria was detected.

Staffing and recruitment
• People's comments about staffing levels were not positive. People told us this impacted on their wellbeing and primarily related to the use of agency staff. Comments included, "The staff look after us well, except for the agency ones. They aren't really interested in us and they just don't know me", "I really don't like the agency staff helping me because they just don't know me at all, nor what I need" , "Sometimes I have to wait for help a long time, especially at night" and, "During the day, if I need help that's fine as there's always someone around but there's definitely a shortage at night when I need help to get to the toilet."
• Permanent staff told us staffing levels were satisfactory, but it was frustrating when staff phoned in sick at the last moment and agency staff were required to be deployed to the service. Staff told us high usage of agency staff was worse at weekends and the quality of agency staff deployed to Godden lodge Care Home was inconsistent.
• People's dependency needs were assessed, and this was used to inform staffing levels. However, these arrangements were not effective as it failed to review the mix of staff roles and combination of skills required to better meet the increasing and changing demands of people with complex needs.
• Observations throughout the inspection showed care provided by staff was primarily task and routine focused. This referred to people receiving task-based care rather than care that was person-centred.
• The service did not have sufficient numbers of activity coordinators available across the site to facilitate social activities for all people using the service. There was a lack of housekeeping staff to cover all of the houses.

Effective arrangements were not in place to ensure there were enough staff available to meet people's needs with the correct skill mix. This demonstrated a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• Staff recruitment records for 3 members of staff were viewed. Relevant checks were completed before a new member of staff started working at the service. This included an application form, written references, proof of identification and Disclosure and Barring Service [DBS] checks. DBS checks provide information including details about convictions and cautions held on the Police National Computer and helps employers make safer recruitment decisions.

Learning lessons when things go wrong
• The provider's representative was open and honest about the concerns identified as part of the inspection process; and acknowledged there was work to do to improve the shortfalls identified, including the culture at the service. The latter referred to some people not always experiencing positive outcomes due to poor staff practices and a failure by the management team to monitor what was happening at the service.

Systems and processes to safeguard people from the risk of abuse
• People's comments about their safety were positive and included, "I feel safe" and, "Yes, I always feel safe."

• Staff understood what to do to make sure people were protected from harm or abuse. Staff confirmed they would escalate concerns to the management team, the organisation and external agencies, such as the Local Authority or Care Quality Commission. However, staff failed to escalate the incident whereby 1 person helped themselves to their medicines to the Local Authority and Care Quality Commission. Following the inspection this was completed retrospectively.

Preventing and controlling infection
• We were assured the provider was promoting safety through the layout and hygiene practices of the premises. The service was clean and odour free. There were robust cleaning schedules in place, and this included frequent touched areas in the home.
• We were assured the provider was using PPE effectively and safely.
• Although the provider had not ensured all staff received infection control training so they understood their associated roles and responsibilities, no concerns were highlighted during the inspection.

Visiting in care homes
• Relatives were able to visit their family member without restrictions imposed and in line with government guidance. People's and relative's comments included, "My family can visit when they want to" and, "You are free to visit whenever you want to."

Requires Improvement

# Is the service effective?

## Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At our last inspection we rated this key question Requires Improvement. The rating for this key question has remained Requires Improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Staff support: induction, training, skills and experience
• People received care and support from staff who did not always have the skills and competencies to effectively carry out their role.
• The staff training summary demonstrated the overall percentage of staff having completed mandatory training in line with the registered provider's expectations achieved was only 64.7%.
• Observations of staff's practice did not provide assurance staff were skilled and competent to effectively apply their learning in their everyday practice. For example, not all staff's understanding of dementia care was effective, or person centred to meet the needs of people using the service.
• Newly employed staff at Godden Lodge Care Home had received an 'in-house' robust induction. Probation reviews were recorded to discuss a new employee's performance and progress or to enable them to provide feedback on their experience and expectations.
• Staff received formal supervision, but these primarily consisted of group discussions relating to work related topics. There was nothing to suggest the staff member's welfare, training needs, monitoring of their performance was actively discussed and recorded. Not all staff felt supported in their role and responsibilities.

We recommend the provider seek independent advice and guidance to improve the service's staff training arrangements.

Supporting people to eat and drink enough to maintain a balanced diet
• People's comments about the food were positive. Comments included, "Food is pretty good, mostly hot" and, "I like the food, it is very nice."
• The dining experience for people was positive. People had access to enough food and drink throughout the day and meals were nicely presented. People were not rushed to eat their meal and where they required staff assistance, this was provided in a dignified and respectful manner.
• Where people were at risk of poor nutrition, their weight was monitored, and appropriate healthcare professionals were consulted for support and advice. This referred to the dietician, occupational therapist, physiotherapist or Speech and Language Therapy [SALT] team.
• We could not determine how people's fluid targets had been assessed and reached. Fluid intake records viewed showed people's fluid targets were not always met. No information was recorded to demonstrate how this was being monitored and addressed to mitigate their risk of dehydration.

We recommend the provider seek national guidance to ensure people's needs relating to fluid intake are

appropriately assessed and monitored.

Adapting service, design, decoration to meet people's needs
• On Boyce House, the environment was not appropriate for people living with dementia. There was a lack of visual clues and prompts, including signs using both pictures and text to promote people's orientation. There were no contrasting colours on the walls as these were painted a plain colour.

We recommend the provider seek national guidance to ensure the premises are suitable to meet people's needs and for the service provided at Godden Lodge Care Home.

• Godden Lodge Care Home is a purpose-built care home consisting of 3 houses. People had access to a small garden, and this was adjacent to each house.
• There were enough dining and communal lounge areas for people to use and choose from within the service. Most people had personalised rooms which supported their individual needs and preferences.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
• Initial assessments were not always completed and did not consider all people's physical, mental and social care needs. Where assessments were completed, these were basic and did not always incorporate key information, such as their life history, wishes, preferences or demonstrate these had been conducted with the person using the service and/or those acting on their behalf.
• People's protected characteristics under the Equality Act 2010, such as age, disability, religion and ethnicity were identified as part of their need's assessment.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
• The service worked with other organisations to ensure they delivered joined-up care and support.
• People had access to healthcare services when they needed it and relatives confirmed their family members healthcare needs were met. Comments included, "Recently [name] was coughing, antibiotics were prescribed, and I was kept up to speed" and, "They keep us up to date with healthcare issues."

Ensuring consent to care and treatment in line with law and guidance
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 MCA 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. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

• Where people were deprived of their liberty, applications had been made to the Local Authority for DoLS assessments to be considered for approval and authorisation.
• People's capacity to make decisions had been assessed and these were individual to the person. However, a best interest decision was not always recorded where people had bedrails or a sensor alarm mat in place.

The provider gave us an assurance this would be rectified for the future.

Requires Improvement

# Is the service caring?

## Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At our last inspection we rated this key question Good. At this inspection the rating has changed to Requires Improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity
• People and those acting on their behalf told us existing staffing levels and the high use of agency staff impacted on the quality of the care people received. This referred to the difference and quality of care provided by permanent and agency staff.
• People were complimentary regarding the care provided by permanent staff but less positive about the care and support provided by agency staff. Positive comments included, "I am looked after very well, staff are all very nice", "Regular staff, I have got no problems, they are good carers" and, "If I need help, that's fine." Where less favourable comments were made these included, "A male agency member of staff was with my regular carer, they were watching what was going on. I said perhaps you could do my bed, I like my pillows all puffed up and they said they had not made a bed before" and, "[Agency staff] are not as caring as the regular staff."
• Many interactions by staff remained task and routine led. This referred to staff providing drinks, supporting people to eat their meals and assisting people with their personal care and comfort needs. There was an over reliance on the television despite some people being asleep or disengaged with their surroundings and not watching the television. This referred to Boyce and Victoria House.
• Observations between some members of staff and people using the service demonstrated they were not consistently supported in a caring or empathic manner. There were numerous occasions whereby staff had missed the opportunity to effectively communicate with the people they supported. For example, the inspection team found the atmosphere and level of engagement on Cephas House to be jolly, whilst on Boyce House, the atmosphere was noiseless, lacklustre and dreary.

Respecting and promoting people's privacy, dignity and independence
• Though staff were able to tell us how they would uphold people's dignity and treat them with respect, care was not always delivered in a way which respected the person being supported or maintained their dignity. This was inconsistent across all three houses.
• On day 2 of the inspection on Boyce House, 2 male members of staff walked past a female person who was naked from the waist down. The male staff walked past this person without acknowledging this person required support to have their dignity and modesty upheld.
• People were left in a state of undress in bed for a prolonged period and could be seen by others as their door was left wide open. Nothing was done by staff to preserve people's dignity and modesty.
• Not all people who had been newly admitted to Boyce House had had their suitcase unpacked. For example, 1 person was admitted to the service 9 days prior to our inspection. On the second day of inspection we observed their suitcase to be positioned on the floor, none of their clothes had been

unpacked and hung in the wardrobe or placed in their chest of drawers. This did not ensure all people were treated with dignity and respect at all times.

Supporting people to express their views and be involved in making decisions about their care
• People, and those acting on their behalf, had been given the opportunity to provide feedback about the service through the completion of a satisfaction questionnaire.

Inadequate

# Is the service responsive?

## Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At our last inspection we rated this key question Good. At this inspection the rating has changed to Inadequate. This meant services were not planned or delivered in ways that met people's needs.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- The provider failed to ensure all people living at Godden Lodge Care Home, received care and support that was personalised and responsive to meet their needs. Staff did not always engage with people in a positive way and care throughout the inspection was task and routine led; and not person-centred.
- Not all people living at Godden Lodge Care Home had a plan of care detailing their care and support needs and how this was to be delivered by staff. Not all care plans were up-to-date or reflective of people's current care needs. This meant there was a risk that relevant information was not captured for use by care staff and professionals or provided enough evidence to show that appropriate care was being provided and delivered.
- We found contradictions in people's records which could lead to confusion for staff and the overall level of care and support to be delivered. This included contradictions in people's dietary needs, their skin integrity and falls information.
- Some people's personal history was sparse and therefore staff were not provided with a good understanding of the person's past life to help understand them and initiate conversation.

Meeting people's communication needs

Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

- We did not see enough evidence of how the Accessible Information Standard [AIS] had been applied. The activity programme and menu were not in an easy read or large print format to enable people with a disability, living with dementia or sensory loss to understand the information.
- The provider did not provide information in alternative accessible formats to ensure people, including those living with dementia, had information they could access and understand.
- Not all care plans had communication records in place to guide staff on how best to communicate with the people they supported.
- People raised concerns about some staff's ability to effectively communicate with them. A person told us they found staff's accents could be an issue. They told us, "I don't understand what some of them are saying."

Supporting people to develop and maintain relationships to avoid social isolation; support to follow

interests and to take part in activities that are socially and culturally relevant to them
• People's and relative's comments about social activities were not favourable. Comments included, "I just feel isolated and the activities aren't very stimulating when there are any", "I don't leave my room because there's nothing to do and there's no one you can really talk to in the lounge. I watch TV and yes, I am fed up a lot of the time" and, "Some days there are no activities. The activity coordinator goes off to do other jobs."
• We spoke with 1 activity coordinator. They told us there were occasions when they were required to help out elsewhere. When this happened, no activities were completed. Limited activities took place on Boyce House. On the first day of inspection, 2 people were observed to play bingo during the morning. In the afternoon 1 person was offered the opportunity to play a game but they declined. No other activities were provided, with no activities considered or provided for people who remained in their bedroom.
• No activities were provided on Victoria or Cephas House. On the second day of inspection there was an over reliance on the television and radio on Boyce House. However, people on Victoria House were supported to attend a Valentine's party on Cephas House. People who attended told us they had had a good time.
• People's care and support plans did not show how the service responded to their differing needs in terms of interests, social activity and stimulation.

Suitable arrangements were not in place to make sure people received person-centred care to meet their needs, to ensure robust care planning arrangements were in place or had the opportunity to participate in meaningful social activities. This demonstrated a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Improving care quality in response to complaints or concerns
• The service had a complaints procedure in place for people to use if they had a concern or were not happy with the service.
• Complaints and concerns raised recorded information detailing the actions taken and if the complaint was resolved to the satisfaction of the complainant.
• A record of compliments was maintained to capture the service's achievements.

End of life care and support
• Where people required end of life care and support, the service worked with healthcare professionals, including palliative care specialists and others, to provide a dignified and pain-free death that was as comfortable as possible.
• People's care plans recorded information about their wishes and preferred priorities, such as their spiritual and cultural needs at the end of their life. Without this information, staff would be unable to ensure people's wishes at the end of their life were respected.
• Information provided to the inspection team made no reference to end of life care training for staff. Although we had no concerns about people's end of life care, we would expect staff to have attained this training.

Inadequate

# Is the service well-led?

## Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At our last inspection we rated this key question Requires Improvement. At this inspection the rating has changed to Inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong; Continuous learning and improving care

• Improvements made following our inspection in 2021 had not been sustained and maintained in the longer term.

• Quality assurance and governance arrangements at Godden Lodge Care Home were not reliable or effective in identifying shortfalls in the service. Specific information is cited within this report demonstrating the provider's arrangements for identifying and managing these were not robust and required significant improvement. There was a lack of understanding of the risks and issues and the potential impact this had on people using the service and those acting on their behalf.

• The provider had not identified, including but not limited to, the lack of robust risk assessment, inadequate medicines management and care planning processes for people being discharged from hospital to Godden Lodge Care Home. The provider had failed to ensure and monitor the skill mix of staff was appropriate for the needs of the people being supported.

• The provider's representative was receptive to our findings and suggestions and demonstrated a commitment to developing the service to enable greater oversight and governance of the service and to ensure people received safe care and treatment. The representative told us they would involve other teams from within the organisation for advice and support. Following the inspection an action plan was forwarded to us detailing the actions to be taken to make the required improvements.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

• Suitable role models were not available to provide support and guidance to staff to enable them to effectively carry out their roles and responsibilities. This meant some staff experienced high levels of stress and work overload.

• Daily 'walk arounds' by the management team and daily flash meetings with staff were not happening as stated. Where records were completed, these had not picked up our observations.

• Staff were not able to demonstrate an understanding of the providers vision and values for the service.

Effective arrangements were not in place to assess and monitor the quality of care provided, to ensure compliance with regulations. This was a breach of Regulation 17 [Good governance] of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014.

• Where the provider had needed to act on the duty of candour, they were aware of their responsibilities.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
• Arrangements were in place for gathering people's and relatives' views about the quality of service provided. The last survey was completed in 2022, of which 19 people responded. Feedback was collated to demonstrate the provider was listening and action being taken to address people's comments, suggestions and feedback.
• Staff meetings were held to give the management team and staff the opportunity to express their views and opinions on the day-to-day running of the service.
• Relatives comments relating to communication were variable, with both positive and negative comments.

Working in partnership with others
• Information demonstrated the service worked closely with others, for example, the Local Authority, healthcare professionals and services to support care provision.

This section is primarily information for the provider

# Action we have told the provider to take

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

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 9 HSCA RA Regulations 2014 Person-centred care<br><br>Suitable arrangements were not in place to make sure people received person-centred care to meet their needs, to ensure robust care planning arrangements were in place or had the opportunity to participate in meaningful social activities. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>Effective arrangements were not in place to mitigate risks for people using the service or ensure medication practices were safe. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 18 HSCA RA Regulations 2014 Staffing<br><br>Effective arrangements were not in place to ensure there were enough staff available to meet people's needs with the correct skill mix. |

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 17 HSCA RA Regulations 2014 Good governance<br><br>Effective arrangements were not in place to assess and monitor the quality of care provided, to ensure compliance with regulations. |

**The enforcement action we took:**

Warning Notice Served