Holly Spring Limited

Spring Lodge Residential Care Home

Inspection report

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Ratings

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

Overall summary

At an inspection on 11 October 2013 we asked the provider to take action to make improvements to care and welfare, staff recruitment and staff training. Following that inspection we also issued a warning notice telling the provider they had to improve quality assurance processes. We carried out a follow up inspection on 17 January 2014 to check compliance with the warning notice and found improvements had been made.

The inspection took place over two days on 18 and 20 November 2014 and was unannounced.

We found that the provider and the registered manager had not taken action to improve care and welfare, staff recruitment and staff training, and were not meeting legal standards. In addition we found the provider and the registered manager had breached nine further regulations, relating to assessing and monitoring quality,

Summary of findings

safeguarding vulnerable adults, cleanliness and infection control, medicines management, meeting people's nutritional needs, respecting and involving people in their care, consent to care, staffing levels and notifying the Care Quality Commission of events.

Spring Lodge Residential Care Home provides accommodation and personal care for up to ten older people. The home is situated in a residential area of Worthing close to the sea front. Some people living in the home were living with dementia or a learning disability which meant their ability to understand and communicate their needs and wishes was limited. There were nine people living in the home at the time of our inspection.

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

Following our inspection, the registered manager submitted applications to cancel both the registered manager and provider registrations with CQC. These applications are currently under consideration. She also told the local authority of her intention to close the home on 5 December 2014. Social services worked closely with relatives to ensure that everyone using the service was safely transferred to another home.

The registered manager was responsible for care and decision making in the home. The culture of the home was not centred on the needs of people using the service, and care practices were poor. Staff were not supported effectively and there was a lack of governance to improve the quality of care.

People's care was not delivered safely. Risk assessments in respect of moving and handling were not accurate or up to date and we witnessed moving and handling practice which was unsafe. An urgent referral to social services safeguarding team was made for one person using the service because we were concerned for their care and welfare. People were not protected from abuse. The registered manager had not followed safeguarding guidance when signs of abuse were witnessed.

People's dignity was not respected. The registered manager had taken actions to control potential behaviours which may challenge without taking professional advice and without putting behaviour management plans in place. Actions included rationing sweets, chocolate, toilet paper, wipes and incontinence pads. People were 'told off' if they didn't 'behave' and were spoken about in a way which was derogatory. Some people using the service were unhappy and fearful. There was a set routine in the home about what time people could get up, what they did during the day, what time they ate, what time they got ready for bed and what time they went to bed. People were not free to make their own choices. There were no planned activities, these were on an ad hoc basis when staff had time.

Care planning around the administration of medicines was unsafe and records were difficult to read and were incomplete. There was a risk that people would not receive the right medicines at the right time and staff were not given enough information to administer medicines safely.

The home was dirty. The provider had not employed a cleaner and staff did not have time to complete cleaning tasks in addition to caring for people. The infection control policy did not refer specifically to the home and made no reference to 'The Health and Social Care Act 2008 Code of Practice on the prevention and control of infections'. This code of practice was not followed in the home, and unsafe procedures were followed in respect of cleaning, laundry, food storage and the disposal of contaminated waste. People using the service were at enhanced risk of infection because of these poor practices.

There was not enough staff on duty at night to keep people safe. Only one member of staff was on duty during the night shift in the home and they were expected to carry out cleaning and laundry duties whilst looking after nine people. This level of staff did not meet people's needs and was unsafe. Staffing levels were not based on people's assessed needs.

Recruitment procedures were unsafe as proper checks were not carried out. Two members of staff were working without a full criminal records check. Appropriate references and employment histories were not obtained.

Summary of findings

During our inspection an attempt was made by the registered manager to fake a reference. The registered manager could not be sure that the staff recruited were suitable for the role.

People using the service were at risk of malnutrition and dehydration. Risk assessments were inaccurate and out of date and suitable actions, in terms of monitoring and seeking professional advice, had not been sought to address the identified risks. One person was identified at risk of choking but the advice of a speech and language therapist had not been sought. This put the person at risk of harm.

Staff had not received sufficient training to carry out their roles. Moving and handling practical training had not been carried out and we saw unsafe moving and handling techniques in the home during our inspection. This unsafe practice put people at risk of harm.

Staff had received training in respect of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards however they did not know or understand the principles of the Act. Mental capacity assessments had not been carried out for anyone using the service where their capacity was in doubt and there were no best interest decisions recorded. There was a risk the home was providing care for people without valid consent. The provider had not made any applications under Deprivation of Liberty Safeguards to restrict their freedom of movement, yet people were not free to leave unsupervised. There was a risk that people were illegally deprived of their liberty.

People's health needs were not responded to promptly and care plans were not an accurate reflection of people's current needs and preferences. People were at risk of harm and inappropriate care because their needs were not attended to.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Safeguarding procedures had not been followed to ensure people were safe from abuse. Risk assessments for people using the service were not up to date which meant that staff were not given accurate information about how to address current risks. Unsafe methods were used to move people in the home, placing them at risk of being hurt.

Medicines were not administered or recorded safely.

The home was dirty and there was a high risk of infection due to unsafe laundry methods, unsafe contaminated waste disposal and staff not having time to clean the home effectively. There was a smell of urine in the home.

There were not sufficient numbers of suitably qualified staff on duty at all times. Only one member of staff was on duty at night which was a risk to both people using the service and staff. Staff were not suitably trained and proper checks were not carried out before staff were recruited.

Is the service effective?

Inadequate

The service was not effective.

The provider had not taken appropriate steps to ensure that people's nutritional intake was effectively monitored and that people were able to eat and drink safely.

Staff did not have effective training to carry out their role.

The provider did not follow legal requirements in terms of mental capacity assessment and there was a risk that people were illegally deprived of their liberty.

The provider had not sought professional advice to ensure care was based on the principles of best practice, from staff who had the knowledge and skills they needed to carry out their roles and responsibilities.

Is the service caring?

Inadequate

The service was not caring.

People were not treated with respect. People told us they were spoken to in a derogatory manner and were not able to make their own decisions about their care and support.

There was no plan of activities and people were rarely supported to go out except to local day centres. Toilets in people's rooms had curtains instead of doors which did not respect people's dignity.

Is the service responsive?

Inadequate

The service was not responsive.

The registered manager did not respond to people's changing health needs and did not seek medical advice promptly.

Summary of findings

There was not sufficient information recorded in care plans about people's needs for staff to be able to deliver a plan of care that responded to people's individual needs.

Is the service well-led?

Inadequate

The service was not well led.

The home was not run in accordance with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. The registered manager did not promote a positive culture of personalised care. Decisions in respect of the service were made autonomously by the registered manager.

Staff were not supported when they raised concerns. They were not free to whistle blow and a policy was in place which actively discouraged staff from doing so.

Records provided during the inspection, by the registered manager, were inaccurate, incomplete and may have been altered during our inspection.

Spring Lodge Residential Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked 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 18 and 20 November 2014 and was unannounced.

The inspection team consisted of two inspectors.

Before the inspection, we reviewed all the information we held about the service including previous inspection reports and notifications received by the Care Quality Commission. A notification is when the registered manager tells us about important issues and events which have happened at the service. We also reviewed the Provider Information Return (PIR) submitted by the registered manager. This is a form that asks for some key information about the service, what the service does well and improvements they plan to make. We used this information to help us decide what areas to focus on during inspection.

During the inspection we spoke with three relatives, three people using the service, six members of staff, a GP, a social worker, a visiting chiropodist and the registered manager. We reviewed the care records of four people in detail and the records of two staff. We also reviewed other records relating to the management of the service such as medicines administration records, training records and policies and procedures. Not everyone was able to verbally share with us their experiences of life at the home. This was because of their dementia and complex needs. We therefore spent time observing people in communal areas to understand their experiences.

Inadequate

Is the service safe?

Our findings

People and their relatives spoke to us about unsafe care. One person described how they never felt safe due to their anxiety about being 'put outside.' Concerns about the person's safety were recorded in the communication book, but there was no care plan in place to ensure they remained safe. Another described incidents of bullying by the registered manager. Following our visit on 18 November 2014 staff told us they found the person to be upset because they had been' told off' by the registered manager for talking to the inspectors. A relative told us they were concerned their family member was not looked after safely. They said "My mum can't get up, she has slipped out of her chair before and she's very weak. They just pick her up under her arms and put her in the wheelchair - she shouts 'don't drop me' I don't know if they have hoists". One visitor told us their relative objected to visiting the home because they felt the home needed cleaning and said "All I can see is cobwebs everywhere." We were also told by a relative that they were unhappy that clean clothes smelt of urine. One person living at the home said there was no hot water in the upstairs of the building.

People were not protected from abuse. The accident book showed multiple incidents which should have been reported to social services and notified to the Care Quality Commission. These included a fall resulting in injury, bruises sustained from being hoisted in a sling of an unsuitable size, threatening behaviour involving knives, abuse between people using the service and people with dementia leaving the home unnoticed. One person had won sweets in a raffle and staff had taken them away because the registered manager had told them that people weren't allowed food in their rooms. Staff said the person was allowed the sweets but they should be rationed. Care records contained no explanation or rationale for this decision. Proper steps to notify authorities for independent investigation had not been taken. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, relating to safeguarding people from abuse.

Risks to people's safety were not fully assessed and managed. One person was immobile and unable to weight bear. We observed staff, on 18 November 2014, moving the person inappropriately by lifting them up underneath their arms. A member of staff said "We always lift her under the arms. She should be hoisted really as she has no strength." We raised concerns with the registered manager that this method of moving and handling was not safe for the person, as they would be at risk of injury. On 20 November 2014, we observed staff attempting to hoist the same person using a sling that was the incorrect size. It was evident from our observation that staff did not know how to use the hoist correctly. The registered manager then attempted to move the person from their wheelchair into an arm chair by encouraging them to stand up on their own. The person was not confident to stand. We asked the registered manager to make an urgent referral to an occupational therapist for assessment. We also asked social services to make an urgent assessment of the person's needs. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which states the provider must take proper steps to protect people from unsafe care.

Risks associated with unsafe moving and handling were not managed safely, because the home did not have the correct equipment. There was only one sling in the home and people did not have individual slings measured for their size. We were told this meant that people were not always moved with a hoist, because the sling would not fit them. The accident records showed that one person had been bruised when they had been moved using this sling and the hoist. People were at risk of being injured by unsafe and incorrect hoisting with equipment that was not safe. This was a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, relating to safety, availability and suitability of equipment.

People's medicines were not managed safely. Care plans did not include any information about which medicines people were taking, why they were taking them and how they preferred to take them. On 20 November 2014 we heard one person become very distressed about taking their medicine. Staff told us this was a normal occurrence. There was no information in anyone's care plan about what to do if someone refused their medicines, how to manage the situation and what advice should be sought from professionals. Care plans showed that one person suffered from seizures. There was no guidance in their care plan to tell staff what to do if they had a seizure. Staff did not know what to do if the person had a seizure. Care plans did not include specific information about the types of medicines being taken such as side effects or what action to take if a

dose has accidentally been missed. Additionally there were no care plans in place for medicines which are to be taken 'as required' known as PRN medication. Staff were making decisions about whether people should take their PRN medication without training or specific guidelines to protect both themselves and the person taking the medicine. There was a lack of guidance to enable staff to support people to take their medicines safely. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, relating to the safe management of medicines.

A review of the Medication Administration Records (MAR) for everyone living in the home, showed that on 18 November 2014 three people had been given medicine at 9am which had not been signed for. The registered manager was doing the medication round at this time. Staff who administered medicines on other occasions told us they had not been trained in medicines administration before administering medicines for the first time. For seven people living in the home we found the lists of medicines printed on their MAR charts was unreadable, and there was a risk that staff administering medicine would administer the wrong medicine. Other medicines which had been discontinued by the GP, were still printed on the MAR chart, creating a risk that staff could continue to administer discontinued medicine. There was a clear space on each person's MAR chart for the recording of any allergies. This information was blank in all cases. Care records stated that one person was allergic to a specific drug but this was not written on the MAR chart. There was a risk that a prescribing GP or staff within the home may not be aware of the allergy. Training records showed that all staff who administered medicines had completed e-learning training, however there was no evidence that competency checks had been carried out by the registered manager so that she could assure herself of staff's competency in administering medicines. The records were not an accurate or safe record of medication administration. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People were cared for in an unsafe environment, which was dirty. There was a strong smell of urine especially in the staff room, the staff toilet, the laundry and two different people's bedrooms. One bedroom which smelt of urine had soiled underwear on the floor. There was dust and cobwebs in people's rooms and the front room carpet was dirty and badly stained. The floor in the laundry was bare concrete which was dirty and there was a dirty mat on the floor. Plaster on the walls in the laundry was crumbling and falling away leaving holes in the walls, which made it hard to keep clean. The bin in the kitchen was uncovered and there was a gap in the kitchen between the cupboards and the floor covering. This was a dirt trap and could not be cleaned effectively. A mop and bucket was stored in the laundry for cleaning all areas of the home. We did not see any other mops and buckets designated for other areas of the home. Care staff were expected to complete cleaning tasks, in-between caring for people, because no separate cleaner was employed by the provider. Staff told us they did not have time to clean and this was evident from the state of the home. There were no cleaning schedules so the registered manager could not be assured of what cleaning had been carried out and when it had been done. There was no evidence that the registered manager had checked the cleanliness of the home. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, relating to cleanliness and infection control.

When we visited the laundry we found one washing machine and one dryer. The washing machine contained a full load of washing which smelt of urine. Staff told us that the registered manager had instructed them to use the washer on program nine only; a 30-degree fast wash. We noted the program was set to program nine. Staff told us that soiled and unsoiled washing was mixed and washed together, potentially contaminating unsoiled clothes. A staff member said that staff were 'told off' for separating laundry between soiled (urine and faeces) and other laundry such as tea towels, unsoiled bedding and towels by the registered manager. We found the clean laundry smelt of urine. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Food was not stored safely which presented a risk to people's health. There were several containers of food in the freezer that were not dated or labelled. This included frozen fish and meat and ice cream. There was pork and minced beef stored but not dated in the fridge, so it was not clear how long it had been there. Similarly, there was an open packet of hot cross buns in the cupboard, named for a person, but not showing the date of opening. There was a risk that food could be kept too long in the fridge,

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Is the service safe?

freezer or cupboards and would be unsafe or unsuitable for people to eat. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We asked the registered manager for a copy of the home's infection control policy. The policy stated 'This home believes that adherence to strict guidelines on infection control is of paramount importance in ensuring the safety of both service users and staff.' It is clear from our evidence that the home was not adhering to guidelines on infection control and had therefore breached its own policy. The policy made no reference to 'The Health and Social Care Act 2008 Code of Practice on the prevention and control of infections and related guidance' in relation to care homes. The code of practice outlines what registered providers in England should do to ensure compliance with the registration requirement for cleanliness and infection control and sets out the ten compliance criteria against which registered providers will be judged. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The upstairs communal toilet was fitted with a raised toilet seat, fixed in place by sticking plaster. This presented a hygiene risk. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Clinical waste was not managed safely to minimise the risk of cross infections. The only yellow clinical waste disposal bin in the home was located in the main bathroom. This bathroom was also used to store equipment which prevented safe, easy access. Staff carried soiled incontinence pads from bedrooms both upstairs and downstairs through the home to this clinical waste bin. Staff told us that sometimes there was a shortage of bags and they had to carry this waste in carrier bags and sometimes they had to carry the waste through the home unprotected in any bag at all. On 20 November 2014 the yellow clinical waste bin contained used incontinence pads, some were wrapped and some were not. Soiled waste carried unprotected through the home is an infection control risk. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

There was no access to hot water upstairs at the home when we visited on 18 November 2014, which meant it was difficult to maintain good hygiene. On 20 November we found that hot water was available from the taps upstairs.

Risk assessments for the home were out of date and did not reflect the risks we identified during our visit. The risk assessment for the kitchen was dated 20 October 2010. Risk assessments for the rest of the building were dated September 2010 and were signed by the registered manager in December 2013. This indicated that the risk assessments had not been reviewed. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

There were not enough staff on duty to keep people safe. There was no assessment to show the staffing levels required to support people, based on their individual needs and the layout of the premises. At night there was only one waking staff member on site. Although the rotas showed a second care worker should sleep on site, staff told us this was not the case, and the second staff member could be at home, 'on call'. Staff told us they had been advised by the registered manager not to tell the inspectors they worked a night shift on their own. Several staff told us they had worked a night shift alone and had felt vulnerable and at risk and could not meet people's needs. One person wandered around the home and could not be left alone due to their high dementia needs. Other people required two staff members for safe moving and handling. The staffing arrangement was unsafe for the people living in the home and for staff. This was a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Staffing levels during the day were also not safe. Two members of staff were on duty mornings and afternoons. There were no additional staff to undertake cleaning, and to cover the chef when they were not at work. Staff said this was not enough because they had to care for people with high needs. One person was very distressed all day during both of our visits and needed to be comforted constantly by staff. This was a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Staff turnover was high which meant the experience of the staff team was compromised. Six staff had left and five had been recruited in the past few weeks. One member of staff had been recruited but stayed less than a month. Staff told

Inadequate

Is the service safe?

us they were looking for other jobs. The high turnover of staff represented a risk to people using the service as people build relationships with a steady team of staff, who get to know them well and understand people's individual care needs.

Recruitment procedures were unsafe, because staff had not been checked for their suitability for working with vulnerable people. An enhanced disclosure of criminal record had not been requested for all staff. References obtained for two members of staff were not suitable as one was unsigned and undated and another was reference from a friend. There was no reference in relation to a member of staff's care experience. Schedule 3 to the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 states that satisfactory conduct in previous employment concerned with the provision of services relating to health or social care is required. In addition, the registered manager had not investigated gaps in applicants' employment history There was a risk that staff may not be suitable as appropriate checks had not been carried out. This was a breach of regulation 21 of This was a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Inadequate

Is the service effective?

Our findings

On 11 October 2013 we found care was not delivered effectively to promote people's health and welfare and the provider did not have systems in place to obtain a full employment history from potential recruits. Staff did not have the right moving and handling skills and their training was not up to date. Following the inspection, the provider sent us a series of emails confirming that appropriate actions would be taken. On 18 and 20 November 2014, we found that the provider had not made improvements in these areas. The provider was not meeting the requirements of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, and therefore people using the service remained at risk.

People living at the home and their relatives said that care practices were not effective. One visitor told us "[My relative] has lost a lot of weight and I don't know why, [they] only eat about four teaspoons of food." In contrast, some people told us that they liked the food and one relative said "This is the best restaurant in Worthing."

The provider did not follow best practice guidance to minimise the risk of people suffering malnutrition. The provider had not taken steps to ensure that people had adequate amounts of food. One person had lost 6kg in the last year and they looked thin and frail. Their nutritional risk assessment, last completed in May 2014 had not been correctly calculated, but still resulted in a score that showed they were at high risk of malnutrition. The provider's assessment tool stated this person should have been referred to a dietician for advice, but this action had not been taken. Instead, this person was given liquidised food without any assessment of their specific needs or advice from a speech and language therapist. Their relative said they had not been involved in the decision. One member of staff told us that the person ate biscuits, but another told us this person found it hard to swallow. The food monitoring charts did not provide any meaningful information about the person's nutritional intake as they recorded 'liquidised food' giving no information about what kind of food had been liquidised. This person was not supported to have suitable food, taking account their preferences and specific needs.

Records for another person living in the home showed they had lost 11.2kg in weight over seven months. There was no action taken to address the weight loss and no care plan in place to support weight gain. A risk assessment indicated that the person's weight should have been checked every two weeks. This person's weight had been recorded at monthly intervals, however, and with no action in place to encourage weight gain. This showed the provider was in breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, relating to meeting people's nutritional needs.

The provider had not ensured that there were systems in place to monitor people's fluid intake, to minimise the risks of dehydration or developing a urinary tract infection. Fluid charts for one person showed significant gaps. For example they showed one person had not had a drink for 14.5 hours on 15 November 2014, with their first drink at 3.30pm. This person took only a few sips of fluid at a time and was at risk of dehydration, yet there was no risk assessment in place or care plan to support them to drink more. The fluid charts were not used to trigger any specific actions to encourage increased fluid intake. The person was at high risk of dehydration. This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider had not ensured that all staff were effectively trained to carry out their role. Six members of staff had not received practical moving and handling training, this included the two members of staff we observed moving a person using a hoist on 20 November 2014. Three members of staff had not received infection control training and infection prevention and control practices in the home were poor. We were also told that some staff had not completed safeguarding training since starting work at the home. There were additional gaps in other areas of training such as first aid, learning disabilities, food hygiene and control of substances hazardous to health. This was a breach of regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider did not follow legal requirements in respect of consent and the Mental Capacity Act 2005 (MCA). Staff could not explain the requirements of the act and its key principles. People working with or caring for adults who lack capacity to make decisions for themselves have a legal duty to consider the Act. The provider had not carried out mental capacity assessments for those people whose capacity to make specific decisions about their care was in doubt. One person had a record in their care plan which said '(The person) is unable to make any decisions because

Inadequate

Is the service effective?

of [their] memory problems,' but there was no evidence that an assessment had been carried out in line with the MCA. There were other examples of where decisions had been made for people without due consideration of the MCA legislation. For example, in relation to people's money and the use of bed rails. People's human rights were therefore not being protected using the MCA. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider had not acted in accordance with Deprivation of Liberty Safeguards (DoLS). These safeguards, which are part of the MCA, protect people's rights to be cared for in the least restrictive way. Staff said no one was allowed to leave the home unsupervised and the communication book included a statement that one person 'is not to go out at all or accept any phone calls.' This person was being deprived of their liberty, without the legal authorisation of the local authority. A recent Supreme Court Judgement had widened and clarified the definition of deprivation of liberty. The registered manager was not fully aware of the implications and had not made any DoLS applications. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People were not receiving the care they needed to deliver good health outcomes. Staff reported that they had raised concerns that one person had a suspected urine infection, due to their agitation and changes in behaviour. Some staff said they had been raising concerns for two weeks and others said four weeks, but the registered manager had not contacted the GP. Instead the registered manager had said the person 'just needed to drink more'. We insisted a test was undertaken for this person, and consequently they were prescribed antibiotics to treat their urine infection. The provider had not sought prompt intervention to support this person's health needs. This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Inadequate

Is the service caring?

Our findings

People were not treated with kindness, respect and compassion. Staff did not provide care in the way people liked. One person described staff acted "like a bull in a china shop" when providing personal care. People told us the registered manager spoke with them like they were children. They said they could talk to the registered manager and staff but felt they only showed care for them 'sometimes.' They didn't feel understood by staff. A relative said staff were kind but acknowledged they did not know what standards to expect from the home.

Staff did not provide care in way that protected people's dignity. We heard a person screaming in the lounge when a chiropodist was treating their feet. Staff told us that the person wasn't in pain, they just didn't like their feet being touched and always screamed in this way. Staff had not recognised this person was not being cared for in a dignified way, by having their feet treated in the lounge in front of others. They had not considered this person's feelings and given practical support to guide them to the privacy of their room for treatment.

We observed people were spoken to in an inappropriate and disrespectful way. One person was 'told off' by the registered manager for ringing their call bell. They were told the call bell was for emergencies only. Another person using the service also told us they could only ring their call bell in an emergency. We also saw that some people were not able to reach their call bells.

Care practices lacked dignity. Staff told us that when they were on duty at night alone, if one person could not be left, they took that person with them to deliver personal care to another person. We were told that people had to ask for toilet paper, because it was rationed. People were required to ask staff for it and they were given four sheets of toilet roll. This was demeaning and deprived people of their dignity and privacy.

The premises were not designed to protect people's privacy and dignity. Most rooms had an ensuite toilet or bathroom. We saw that three of the ensuite toilets had only a curtain across the door; this was immediately opposite the open door to the room. The curtain did not afford much privacy and people walking past the room could see in. Whilst we were in one person's room, a person of the opposite gender wandered into their toilet. We were told that this person often did this. This design of the premises compromised people's privacy.

People were not supported to make their own decisions about their care and the way they lived their lives. We found the home had a set routine about when people got up, what time they had their meals, got ready for bed and when they were went to bed. The routine was displayed on the wall outside the registered manager's office. Staff told us that the registered manager liked people to be sat up in the lounge each morning. People were assisted to prepare for bed quite early because after 8pm there was only one member of staff on duty. Staff reported that some people were tired and liked to go to bed early but they were required to follow the home's regime.

People were not given choices for the main meal of the day served at lunchtime, although staff said that if anyone refused the food, they would offer something else.

People told us they had not been involved in planning their care and they did not know what was written in their plan of care. Relatives told us they had not been involved in care planning and most said that decisions were not discussed with them. We saw care plans being updated on 18 November; the updates were carried out by a member of staff and did not include discussion or involvement with people using the service or their relatives.

People were not treated with respect and kindness or supported to maintain their independence. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Inadequate

Is the service responsive?

Our findings

People's care was not planned to support their individual needs. Relatives were not kept informed about people's care. One relative said, "I don't know if [they] have a pressure sore, [they] said [they hurt] and they are still saying this. I worry because [they] don't move very much. I don't think [they] have been seen by nurses."

This person was at high risk of pressure ulcers due to their weight loss and immobility. Their care plan showed the pressure ulcer risk assessment had not been updated since April 2014, and the risk assessment itself had not been scored correctly giving an incorrect overall risk. Daily records showed there was some repositioning of the person but this was not consistent and there was no care plan in place describing how often the person should be repositioned to preserve their skin integrity. This increased the risk of pressure ulcers for the person. Care planning for maintaining skin integrity was confusing. There was a body map in the plan with crosses showing places of skin damage, but the body map was not dated and there was no indication as to whether the crosses referred to bruises, scratches, swellings or pressure ulcers. The body map identified three areas of potential skin breakdown but there were only records about one area and it was not reported that the area had healed. There was no plan of care around the areas of concern or a record of what treatment was provided. There was no assessment or care plan or communication about the risks of pressure ulcers. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The care plan for one person stated that they were to be assisted to have a bath once a week. Records showed that the person had a bath on 3 October 2014 and then not again until 14 November 2014, a gap of six weeks. This plan of care had not been followed and there were no records to indicate why this was the case. A visitor said that staff had told her that their relative 'gets upset sometimes when they try to give a bath'. The visitor also said their relative didn't like having baths now because staff threw her in. The update to the care plan said '[they] love [their] baths.' The care plan was therefore unclear, as there was conflicting information about the person's preferences and lack of guidance on how to provide a bath. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Care plans did not include guidance on how to support people's specific behaviours. We observed one person who was unhappy. Care records included an assessment from the learning disabilities team, stating that the person was 'profound of grievance'. There was no care plan or risk assessment about how to support the person when they were upset. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The end of life care plan in one person's records was not personalised showing their particular wishes. It did not show that the person's views had been the focus of the plan, or that the provider had been proactive in developing a care plan in line with the Gold Standard Framework (GSF) for end of life care. The GSF helps put people at the heart of end of life care, enabling them to be listened to in the final stages of life. We asked a relative if this had been discussed with them and they were not aware of any end of life care plan. There was no effective, person centred, inclusive end of life care planning for this person. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Care plans were not accurate or up to date and did not reflect our observations or feedback from staff. We found shortfalls in the risk assessments, support plans and reviews of plans, in respect of bathing, moving and handling, nutrition, behaviours which may challenge others, skin integrity, safeguarding, falls, mental capacity, mental state, deprivation of liberty and medication. There were no records of people's preferred daily activities. Plans had not been updated following the death of people's close family members. Information about one person's skin condition was recorded in the communication book but not in their care plan. We also found information in the communication book which had not been responded to. Risk assessments for moving and handling for one person had not been reviewed since May 2014, yet the home's policy entitled 'Resident moving and handling' stated the manager would carry out reviews each month. There was not enough accurate information recorded about people's needs for staff to be able to follow a plan to deliver the required care. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Inadequate

Is the service well-led?

Our findings

People using the service told us they had little choice about their care and decisions were made for them. Some said they felt punished by the registered manager if they rang their call bell or spoke to CQC inspectors. One person, commenting on staff turnover, said “I don’t like it when staff leave and new staff come in, it happens quite a lot.” A relative said “My big bug bear is staff turnover.”

Relatives expressed concern about the way the home was run. One relative said “I feel sorry for the staff. They don’t get paid a lot and I don’t think they are happy in their work. They don’t take the residents out and they say things like ‘don’t let [the registered manager] know I have told you this,’ She rules with a rod of iron.” Another relative told us that they had only found out about a pressure ulcer after their relative’s death. The registered manager had not told them about the ulcer and they had not been aware because their relative had been unable to express pain. Following the inspection another relative contacted us because they had moved their relative from the home due to concerns about the registered manager. Their relative had suffered a fall but staff had been told by the registered manager that they were not to inform the family. This person later found out, and when asked, the registered manager had confirmed their relative had fallen. They told us “I have lost trust in the home and the manager – what else hasn’t she told me?”

The registered manager demonstrated a lack of candour and honesty. She told us that two members of staff worked a night duty but later we found out that staff worked alone at night. Several different staff members said they had been asked by the registered manager not to tell us they worked alone at night, and one member of staff said they had been asked to lie about safeguarding training. The registered manager had established a controlling culture in the home, where care was not personalised and staff, visitors and those living at the home were not listened to or respected.

The home was badly managed. Care planning and infection control procedures were poor and the registered manager did not have an understanding of the risks, legal requirements and standards of good practice. The registered manager did not understand her responsibility to create accurate care plans for people and ensure the delivery of safe, personalised care. There was rationing of supplies, such as toilet paper, incontinence pads and wipes. Healthcare professional referrals were not made promptly to support people’s health needs. We were told by staff that people had things which were important to them, such as sweets and chocolate, taken away.

The registered manager did not understand her responsibilities and staff were not supported to provide a good standard of care. Staff said the registered manager had told them that she would report them to safeguarding if a person fell, following a recent fall at the home. Another staff member said "If something went wrong she wouldn't back us up." Staff said the registered manager kept them ‘in line’ by suspending them, deterring them from whistle blowing and threatening to report them to regulatory bodies. Staff reported that they were asked to lie to inspectors or withhold information of concern. Staff were put at risk by working night shifts alone. Staff were not supported with the appropriate number of staff on each shift. When they raised concerns, no action was taken. There was a very high turnover of staff which indicated a lack of staff support. This was a breach of Regulation 6 of the Health and Social Care Act (Regulated Activities) Regulations 2010.

The registered manager had failed to report incidents to the CQC. The CQC had not been notified of a safeguarding referral in respect a pressure ulcer. Relatives told us another person had fractured a hip shortly after admission, but this incident had not been recorded in the accident book. The accident book showed many incidents which should have been notified to CQC and reported to social services. This was a breach of Regulation 18 of the Health and Social Care Act (Regulated Activities) Regulations 2010.

Records management was poor. Documents were created or changed retrospectively. For example, the accident book had pages removed that the registered manager could not explain. Not all accidents had been recorded. Staff told us they had been asked to write a name on a reference for another staff member. We were shown a policy for infection control and prevention on the second day of our visit. It had not been available on the first day, and when reviewed it did not reflect the home and was not signed and dated as an approved policy. It was unclear where this policy came from or how it related to practice in the home.

Records were incomplete. The accident records did not summarise each incident, the action taken nor any evidence of changing practice or learning. Staffing records were not sufficient to establish staff turnover. Records

Inadequate

Is the service well-led?

relating to care lacked risk assessments, information about people's life history and preferences and monitoring data to support improved care. This was a breach of Regulation 20 of the Health and Social Care Act (Regulated Activities) Regulations 2010

The provider's policies had not been reviewed to ensure they were accurate and up to date. The whistleblowing policy was inappropriate and referred to incorrect Health and Social Care Act regulations. Whistleblowing is when a person raises a concern about dangerous, illegal activity or any wrong doing within their organisation. The whistleblowing policy at Spring Lodge required staff to exhaust all internal reporting opportunities before reporting concerns to external bodies. The policy also threatened staff with disciplinary action if any allegation turned out to be false. The policy for infection control was not specific to the home or fit for purpose.

The registered manager had not implemented governance systems to identify areas for development and support improvement in the quality of care. There had been no audits or reviews of care practices, and there were no plans for staff development. Areas of non-compliance identified at the last inspection had not been addressed to improve the quality of care. This was a breach of Regulation 10 of the Health and Social Care Act (Regulated Activities) Regulations 2010

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 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services How the regulation was not being met: The registered person did not take proper steps to ensure that each service user is protected against the risks of receiving care or treatment that is inappropriate or unsafe, by means of the carrying out of an assessment of needs, the planning and delivery of care and where appropriate, treatment, in such a way as to meet the service user's individual needs and ensure the safety and welfare of the service user. Regulation 9 (1) (a) (b) (i) (ii).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers How the regulation was not being met: The registered person did not protect service users and others who may be at risk, against the risks of inappropriate or unsafe care and treatment, by means of the effective operation of systems designed to enable the registered person to identify, assess and manager risks relating to the health, welfare and safety of service users and others who may be at risk from the carrying on of the regulated activity, having regard to the information contained in the records referred to in regulation 20, appropriate professional and expert advice and where necessary, make changes to the treatment or care provided in order to reflect information relating to the analysis of incidents that resulted in, or had potential to result in, harm to a service user. Regulation 10 (1) (b) (2) (b) (iii) (iv) (c) (I)

Regulated activity	Regulation

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse How the regulation was not being met: The registered person did not make suitable arrangements to ensure that service users were safeguarded against the risk of abuse by means of responding appropriately to any allegation of abuse. Where a form of control or restraint is used in the carrying on of the regulated activity, the registered person must have suitable arrangements in place to protect service users against the risk of such control and restraint being unlawful. “Abuse” means sexual abuse, physical or psychological ill treatment, theft misuse or misappropriation or money or neglect and acts of omission which cause harm or place at risk of harm. Regulation 11 (1) (b) (2) (a) (3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control. How the regulation was not being met: The registered person did not, so far as is reasonably practical, ensure that service users, people employed for the purpose of the carrying on of the regulated activity and others who may be at risk were protected against identifiable risks of acquiring such an infection by means of the effective operation of systems designed to assess the risk of and prevent, detect and control the spread of health care associated infection and the maintenance of appropriate standards of cleanliness and hygiene in relation to premises occupied for the purpose of carrying on the regulated activity. Regulation 12 (1) (a) (b) (c) (2) (a) (c) (i)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines

This section is primarily information for the provider

Action we have told the provider to take

How the regulation was not being met: The registered person did not protect service users against the risks associated with the unsafe use and management of medicines, by means of the making of appropriate arrangements for the obtaining, recording, handling, using, safe keeping, dispensing, safe administration and disposal of medicines used for the purposes of the regulated activity.

Regulation 13

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010 Meeting nutritional needs How the regulation was not being met: Where food and hydration are provided to service users as a component of the carrying on of the regulated activity, the registered person did not ensure that service users were protected from the risks of inadequate nutrition and hydration, by means of a choice of suitable and nutritious food and hydration. In sufficient quantities to meet service users' needs and support, where necessary, for the purposes of enabling service users to eat and drink sufficient amounts for their needs. Regulation 14 (1) (a) (c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services How the regulation was not being met: The registered person did not, so far as is reasonably practicable, make suitable arrangements to ensure the dignity, privacy and independence of service users and that service users were enabled to make , or participate in making, decisions relating to their care and treatment. The registered person did not treat service users with consideration and respect, provide service users with appropriate information and support in relation to their care and treatment and encourage service users, or those acting on their behalf, to understand the care or

This section is primarily information for the provider

Action we have told the provider to take

treatment choices available to the service user, and discuss with an appropriate health care professional, or other appropriate person, the balance of risks and benefits involved in any particular course of care, express their views as to what is important to them in relation to the care or treatment and provide appropriate opportunities, encouragement and support to service users in relation to promoting their autonomy, independence and community involvement.

Regulation 17 (1) (a) (b) (2) (a) (b) (c) (i) (ii) (g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records How the regulation was not being met: The registered person did not protect people from the risks of unsafe or inappropriate care arising from a lack of proper information maintained in people's records and in staff records. Regulation 10 (1) (a) (b) (i) (ii)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010 Requirements relating to workers How the regulation was not being met: The registered person did not operate effective recruitment procedures in order to ensure that no person is employed for the purposes of carrying on a regulated activity unless that person is of good character, has the qualifications, skills and experience necessary for the work to be performed and ensure that the information specified in schedule 3 is available in respect of a person employed for the purposes of carrying on a regulated activity, and such other information as is appropriate. Regulation 21 (a) (i) (ii) (b)

Regulated activity	Regulation

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing How the regulation was not being met: In order to safeguard the health, safety and welfare of service users, the registered person did not take appropriate steps to ensure that, at all times, there were sufficient numbers of suitably qualified, skilled and experienced persons employed for the purposes of carrying on the regulated activity. Regulation 22

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff How the regulation was not being met: The registered person did not have suitable arrangements in place in order to ensure that persons employed for the purposes of carrying on the regulated activity are appropriately supported in relation to their responsibilities, to enable them to deliver care and treatment to service users safely and to an appropriate standard by receiving appropriate training, professional development, supervision and appraisal. Regulation 23 (1) (a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment How the regulation was not being met: The registered person did not have suitable arrangements in place for obtaining, and acting in accordance with, the consent of service users in relation to the care and treatment provided for them. Regulation 18

Regulated activity	Regulation

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents How the regulation was not being met: The registered person did not notify the Commission without delay of the incidents specified, which occurred whilst services were being provided in the carrying on of a regulated activity, or as a consequence of the carrying on of a regulated activity: any injury to a service user which, in the reasonable opinion of a healthcare professional, has resulted in the changes to the structure of a service users body or the service user experiencing prolonged pain or prolonged psychological harm, any injury to a service users which, in the reasonable opinion of a health care professional, requires treatment by another health care professional to prevent death or an injury to a service user which if left untreated would lead to the outcomes listed above, any abuse or allegation of abuse in relation to a service user, any incident which is reported to, or investigated by, the police. Regulation 18 (1) ((2) (a) (i) (iii) (b) (i) (ii) (e) (f)
Accommodation for persons who require nursing or personal care	Regulation 6 HSCA 2008 (Regulated Activities) Regulations 2010 Requirements relating to registered managers How the regulation was not being met: A person should not manage the carrying on of a regulated activity unless fit to do so. The registered manager is not fit unless they are of good character, physically and mentally fit to carry on the regulated activity and have the necessary qualifications, skills and experience to do so. Regulation 6 (1) (2) (a) (b)

This section is primarily information for the provider

Enforcement actions

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