CHD Living Limited

Park Lodge

Inspection report

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Ratings

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

Overall summary

We carried out this unannounced comprehensive inspection on 18 and 20 August 2015. At our last inspection on 19 January 2015 we found eight breaches of regulations and rated the service as 'Inadequate'. At the time, we judged one breach was serious enough, that we served a warning notice on the provider and told them to make the necessary improvements by 17 April 2015. This was because the provider was failing to protect people who used the service and others against the risks of inappropriate or unsafe care. They did not have effective systems to identify, assess and manage risks relating to their health, welfare and safety. We undertook a focused inspection on the 21 May 2015 to check that the provider had met the regulations and found the necessary improvements had been made.

The other breaches of regulations, we found at the inspection on the 19 January 2015, were in relation to the unsafe use and management of medicines, a lack of staff support and training, people's nutritional and hydration needs were not being met, care plans for the support people required were not detailed enough to describe how to meet people's individual needs, the provider did not send the Care Quality Commission (CQC) notifications

Summary of findings

in a timely manner and the provider had not taken the correct actions to ensure that the requirements of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) were followed. The provider sent us an action plan and told us they would make the necessary improvements by the end of May 2015.

Park Lodge provides accommodation and nursing care for up to 35 older people, some of whom may have dementia. There were 15 people living at the home when we visited.

The home did not have a registered manager. The previous interim manager at Park Lodge had left and a new manager was recruited in late May 2015, they had applied to the CQC to be the registered manager at this location. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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.

At this inspection we found the provider did not have suitable arrangements to protect people against the risks associated with medicines. We found that not all medicines were stored safely.

We observed part of the morning medicine administration round on both days and found the nurse was constantly disrupted and the medicines round took more than two and a half hours on each day. The length of time taken to administer medicines meant that there were risks that people might not receive their medicines at a time or at the intervals prescribed by their doctor.

We looked at the medicines administration records (MAR) for each person using the service. These showed several omissions in the recording of the application of creams or ointments, with no explanations given. This meant that medicines records were not adequate to show people were receiving their medicines as prescribed for them.

The provider did not have effective systems to assess, review and manage risks to ensure the safety of people and others. For example we saw the boiler room and the sluice room on the first floor were unlocked throughout the day and could be easily accessed by people walking by. In the kitchen we found numerous items of out of date food, which had not been noted by staff. We saw that a mop and bucket containing dirty water was stored in a cupboard containing dry food goods, such as flour and sugar increasing the risks of the spread of infection. The provider did not ensure that the premises were cleaned to an adequate standard. Where risks were identified these had not been followed up with an action plan so these could be minimised.

Training records showed that the majority of staff had received recent training in safeguarding adults at risk and staff were aware of what constituted abuse and the action they should take to report it. We observed that there were sufficient numbers of staff on duty to care for and support people to meet their needs, but at times staff were very busy and did not always have the time to engage and interact with people.

We saw that although people were supported to eat and drink throughout the day, people's nutritional needs were not regularly monitored and assessed so the risk of malnutrition could be identified early for action to be taken to minimise this. There was no permanent cook on duty and the choice of meals was reduced. For people who came to the dining room to eat their meals we saw the atmosphere in the dining room was not convivial; it was noisy with the phone ringing and staff using the area as a thoroughfare.

Care plans showed people had not been consulted about their preferences and how they would like to receive the care they needed. We found the care plans were not up to date, did not reflect people's current care needs and did not contain consistent information.

Park Lodge used a computerised system to maintain people's care records and daily notes. We found the computer system was slow, difficult to navigate and extract information from. Staff confirmed the computer system was slow. The lack of prompt access to people's records and the inaccuracies found meant there were risks a person's may not receive the care they required and records might not be easily retrievable and located promptly should these be required.

The manager did not ensure that daily, weekly or monthly checks of the building and of maintenance certificates and housekeeping were carried out as required. This lack of oversight of the home meant that people were not always protected against the risks associated with the premises.

Summary of findings

There were discrepancies in the recording of staff training and supervision which made it difficult to see if staff were being suitably supported in their roles. We did see the provider held staff meetings on a regular basis.

The provider had taken action to meet the requirements of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards. But this information was not always clearly documented in people's care plans and meant that staff might not be fully aware of existing restrictions on a person.

Despite the concerns we had about the service people at the home were mostly cared for by staff who were kind and respectful to people. We saw staff speaking kindly to people and assisting them in a calm manner. Staff knew who people were because they had taken the time to speak to, and get to know them. We observed the majority of the interactions between staff and people were positive. People received the privacy they needed and they were treated with dignity and respect.

We saw people and visitors had access to 'How to Complain' information which was on display and described the complaints process and the time frame for responses to a complaint. Records showed the complaints had been investigated and response letters sent to the complainants from the manager in a timely manner.

We found breaches of regulations in relation to the management of medicines, the cleanliness of the home, risks management, governance arrangements, meeting people's nutritional needs, person centred care and care planning, staff support and management record keeping. We have taken action against the provider and will report on this when our action is completed

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

As a result of repeated breaches of regulations we have taken action against the provider according to our enforcement policy. We have removed the location Park Lodge from the condition of registration of the provider as of 12 April 2016. This effectively means that the provider is not able to lawfully provide a care service from Park Lodge.

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. Appropriate risk assessments had not been carried out to ensure the safety of people. Individual risks assessments for people were not updated as required to reflect their changing needs.

The medicines administration practices were not safe to protect people against the risks associated with medicines.

Regular checks of maintenance and service records were not conducted, so people could not be assured of living in a safe environment.

Is the service effective?

Requires improvement

The service was not always effective. Records did not show if staff were adequately supported to fulfil their roles through training and supervision.

A lack of knowledge of nutrition and hydration meant although people were supported to eat and drink sufficient amounts to meet their needs, records of people's nutritional needs not always recorded regularly.

The provider had taken action to meet the requirements of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS).

Is the service caring?

Requires improvement

The service was not always caring.

People's privacy and dignity was respected by staff. They spoke positively about the care they received and about the staff.

Although people were cared for by staff in a kind and respectful way, the service was not being run a caring way to promote people's welfare and wellbeing.

Is the service responsive?

Inadequate

The service was not responsive.

People's care plans were not comprehensive and had not been reviewed as stated in the provider's action plan. There were therefore risks people might not receive appropriate care and treatment.

The variety of activities offered to people using the service did not consider people's preferences and past hobbies.

The provider had an effective complaints system.

Is the service well-led?

Inadequate

The service was not well led. The home had a new manager who was not yet registered with CQC.

Summary of findings

Quality assurance systems used by the provider to assess the quality of the service were ineffective in that, areas that required improvement were not identified so the appropriate remedial action could be taken.

The manager had an understanding of their management role and responsibilities. They understood their legal obligations with regard to CQC requirements for submission of notifications.

Park Lodge

Detailed findings

Background to this inspection

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

This unannounced inspection took place on 18 and 20 August 2015. This inspection was carried out to follow on from our inspection on 19 January 2015 when we rated the service 'Inadequate' and to check that improvements the provider told us they would make in relation to the breaches of regulations had been met.

This inspection was carried out by one inspector and a specialist advisor who was a Registered General Nurse.

Before our inspection we reviewed all information we held about the service and the provider including looking at the previous inspection reports and reviewing these in line with the action plan the provider submitted to the Care Quality Commission (CQC).

During this inspection, we spoke with six people living at the home, two relatives, two nurses, five care staff, the manager and area manager. We also spoke with the nurse from the local nursing impact team.

We looked at the care records for four people and more closely at the care and support three of the four people received. We reviewed the medicines records for all the people who lived at Park Lodge. We also looked at other records that related to how the home was managed including the quality assurance audits that the manager and provider, CHD Living Ltd, completed. We also looked at three staff files and five staff supervision records and the training records for all staff employed at the home.

We observed care and support in communal areas. To do this we used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

Inadequate

Is the service safe?

Our findings

On 19 January 2015 we inspected the service and identified a breach of the regulation in relation to people not being protected against the risks associated with the premises because the provider had not ensured that the premises were safe. This was because building works were taking place in the home and the lift was out of use. Also people did not have personal emergency evacuation plans and risk assessments for people were not up to date. We served a warning notice on the provider against this breach and told them to meet the requirements of the warning notice by 17 April 2015. We inspected against this breach of regulation in May 2015 and found the provider was meeting the regulations.

At the inspection in January 2015 we also identified a breach of the regulation in relation to the management of medicines because the provider did not have suitable arrangements to protect people against the risks associated with medicines. Specifically medicines were not administered or stored safely and securely and could have been accessed by people and visitors. The provider sent us an action plan and told us they would make the necessary improvements by the end of May 2015.

At this inspection we found the provider was not meeting the legal requirements in relation to ensuring the safe care of people and others by making sure medicines and risks were being managed appropriately. We found that not all medicines were stored safely. On the first day of the inspection we saw a medicines trolley waiting to be returned to the supplying pharmacy was left in the dining room, the trolley was not locked and staff were not present in the room at the time. This trolley contained numerous blister packs of medicines with medicines in them. This meant a person walking into that room would have had access to the medicines stored in the trolley which could have placed them at risk.

We observed part of the morning medicines administration round on both days. On the first day we saw the staff member who was administering the medicines was also answering the phone, dealing with staff queries and ordering medical equipment, whist administering medicines. On the first day the morning medicines administration round for the 15 people who lived at Park Lodge lasted for three hours. On the second day the nurse experienced the same disruptions as we had seen on the first day and the medicines administration round lasted two and half hours.

We spoke to the nurses about this. They confirmed there were a lot of interruptions; especially when there was no reception person or manager in to answer the phone. The nurses also said they would be expected to deal with members of the multi-disciplinary team, when they come to see people living at the home, even if this were during a medicines administration round. The NICE guidance on Managing Medicines in Care Homes, reference 1.14 states: 'Care home providers should consider ways of avoiding disruptions during the medicines administration round.' It goes on to give examples of how care homes can do this.

We spoke to the manager about this who agreed this was what happened. They said they had ordered red tabards for the nurses to wear that instruct people not to disturb them while they administer medicines.

Whilst, there were no indications people were not receiving their medicines, the interruptions meant that errors could occur with people's medicines and there were risks people might not have received their medicines at the time they required them and as prescribed. This was of concern particularly where the medicines should be taken at regular intervals or given at specific times to ensure their effectiveness.

The provider had not ensured that records in respect of the management of medicines were maintained as necessary. We looked at the medicine administration records (MAR) for each person using the service. These showed several omissions in the recording of the application of creams or ointments, with no explanation given. This meant we could not be sure people were receiving these medicines as prescribed. We also saw that abbreviations were used without an explanation of the full wording; an example of this was NKDA, which stands for No Known Drug Allergy. We saw for one person who required daily insulin (a medicine to manage diabetes) this was recorded under the heading of 'a medicine to be administered when required (PRN)' increasing the risks of this medicine not being administered appropriately. Records showed the MAR was not signed on one day indicating that the person might not have received the insulin on that day but no explanation was given to explain the omission.

Inadequate

Is the service safe?

Training records showed that 19 staff had completed the medicines competency workbook and that three nurses had undergone medicine competency training in January and April 2015. But the nursing staff on duty could not tell us if they had received this annual medicines competency assessment. This discrepancy in what staff told us and records meant that we could not be assured people were protected from the risk of receiving medicines from staff who had not been assessed as competent to administer medicines.

The provider did not ensure that the premises were cleaned to an adequate standard to ensure people were protected from the risks of the spread of infection. We saw throughout the home that although the premises appeared clean, the correct procedures for cleaning were not being used. We saw that different coloured mops were being used with different coloured buckets, for example in the kitchen a green mop and yellow bucket were being used to clean the floors. The correct procedure would be a green mop and bucket, a yellow bucket is for use in bathroom and toilet areas. We spoke to staff about this and could see from records that although they had received the correct training in infection control and health and safety, good practices were not being adhered to. This meant that there were risks of the spread of infection because correct procedures were not being followed. The above paragraphs show there was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider did not have effective systems to assess, monitor and mitigate the risks relating to the health, safety and welfare of people and others. On the first day of the inspection, we saw the boiler room and the sluice room on the first floor were unlocked throughout the day. Access to these rooms was inherently risky due to their nature, but they were easily accessible to people and visitors to the home. We spoke with the manager about this but on checking again at 4pm we found both doors were still unlocked. We spoke again with the manager about this and she said she would ensure staff locked the doors.

Reports showed that the kitchen had been checked as part of the monthly home audit assessment in July 2015 and this report stated 'Food had been checked and expiry dated food had been removed'. On checking the kitchen we found numerous items of out of date food that have not been disposed of, and which could have been given to people to consume increasing the risks of them eating unsafe items of food. For example there was an opened plastic tub of tartare sauce, an opened tub of black cherry topping both to be used by July 2015, neither had a date when they had been opened. There was an open tub of béchamel sauce with a use by date of May 2015.

We found that food was not covered or stored correctly to make sure it was safe to use. An open packet of raw bacon was not covered, and a large tin of orange segments opened on the 18 August 2015 was seen on the 20 August to have been left in the fridge without transferring the contents to a suitable container. On the first and second day we saw chicken slices and cheese slices that should be used within two days of opening still being used and the chicken slices had a use by date of the 18 August 2015. We saw on a work surface area designated for the preparation of raw meat and vegetables only, an open tin of tomato puree and a wrapped fruit cake.

Where risks existed, these had not been identified so action plans could be put in place to mitigate the risks. We observed a manual handling practice in the communal area and whilst the procedure appeared safe, the sling being used for the person was not the correct one for that individual. We asked staff why this was and they said this person's sling was in the wash and they had used someone else's sling. On the second day we observed the transfer of a person by wheelchair whose feet were dragging on the ground, as the foot plates were not attached to the wheelchair. We stopped the care staff and asked if this was the normal procedure for transferring the person and they said it was. The staff said "They hold their feet up, they don't need foot plates". We asked the manager to open this person care plan on the computer system and together we could see no reference to the absence of foot pates was mentioned. The wheelchair was then fitted with foot plates to ensure the person was transferred safely at all times.

Within a person's care plan their Waterlow score was due to be reviewed in May 2015, but it had not been completed, and before this their last Waterlow score was calculated in February 2013. (The Waterlow score gives a score about the estimated risk for a person to develop pressure ulcers). The manager looked at the records and confirmed this information was correct, saying they had not yet updated this part of the care plans for some people.

We also found the exit into the garden was via a ramp. This ramp was not suitably secured to the floor and meant there

Inadequate

Is the service safe?

were risks that people using that ramp could fall. This lack of attention to risks within the home was putting people's health and wellbeing at risk. The paragraphs above show there was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some aspects of the medicines management were being carried out safely. There were appropriate systems for storing, administering and monitoring of controlled drugs and arrangements were in place for their use.

There was evidence of personal emergency evacuation plans (PEEPs) for all people to assess and plan how they would escape in the event of a fire, and to ensure that appropriate fire safety measures were in place. This was readily available and kept near to a fire exit. We saw that the fire alarm and emergency lighting were being checked weekly. Fire drills were scheduled to take place every six months for day staff and every three months for night staff. We could only see evidence of day time fire drills which were occurring regularly but not of might time fire drills. The manager told us they would ensure that fire drills took place as planned. .

There were policies and procedures available to staff which set out how they should protect people from abuse, neglect or harm. Training records showed that the majority of staff had received recent training in safeguarding adults at risk. Staff we spoke with were aware of what constitutes abuse and the action they should take to report it. They were clear on who to report it to internally and externally. Where there had been safeguarding concerns about a person, the manager had dealt with these appropriately. The manager had worked with the safeguarding team from the local authority to investigate any allegations and had taken action to address the issues raised.

We observed that there were sufficient numbers of staff to care for and support people to meet their needs, but at times staff were very busy and did not always have the time to spend with people. Staff we spoke with felt there was adequate number of staff at the moment because of the low occupancy levels. Although we observed most people required the help of two staff for personal care or transferring. This meant that at times there were no staff to supervise people in the lounge area and they did not have access to a call bell. We spoke to the manager about this and they said that generally a staff member was in the lounge throughout the day and that staff numbers and ratios were assessed as and when people's needs change.

We looked at three staff files and saw that recruitment processes had been followed to ensure that staff were checked appropriately before they were assessed as suitable to work with people using the service.

Requires improvement

Is the service effective?

Our findings

On 19 January 2015, we inspected the service and identified a breach of the regulation in relation to the provider making sure that people's nutritional needs were being appropriately met. They sent us an action plan and told us they would make the necessary improvements by the end of May 2015.

At this inspection, we found the provider was still not meeting this legal requirement. We saw that people's nutritional needs had not been assessed appropriately to make sure risks of malnutrition were identified early so appropriate remedial action could be taken to support people with their nutrition.

We looked at the weight book which listed people and their weights. We were told one person required weekly weighing since July 2015, but the records showed only monthly weight checks between 4 July 2015 and 2 August 2015, during which time the person had lost 3.1 kilograms in weight. The next weight check record was 16 August 2015, when the person had gained 0.6 kilogram, no other records were available. We checked the computer records for this person and the last weight recorded was 4 July 2015 and the Malnutrition Universal Screening Tool (MUST) chart had not been updated since 11 April 2015. There was no specific care plan in respect of the 3.1 kilo weight loss or actions identified to address it.

In another person's care plan there was no information in the care summary about their eating and drinking requirements. This person had not had a MUST review since March 2015 when they were identified as high risk.

In another person's care plan information about their nutrition referred to a normal diet initially then at the end of the information it related to new guidance by the Speech and Language Team (SALT) advising a pureed diet. We saw in the complaints file that a safeguarding alert had been raised about this person having been given the wrong diet consistency, which had caused a choking hazard.

The cook had recently left the home and on the days of our visit we saw one of the care staff was cooking the meals. Hot meals were available to people although there was a reduced choice of meals on offer. There was no information available to show whether people's individual choices and likes and dislikes in regards to their meals were being met. We saw for lunch on the first day a beef stew had been prepared and the five people in the dining room appeared to be enjoying the dinner. The dessert was limited to tinned oranges or plums, with no custard, cream or ice cream available. We saw that chocolate bars were available for snacks and a bowl of fruit, mainly peaches was in the lounge, we did point out to staff one of the piece of fruit was inedible and they removed it.

Staff were not always given consistent instructions to support people with eating and drinking. We read in the minutes of the last team meeting in July 2015 "No drinks to be given before food as it fills people up". This meant that people might not be able to exercise their rights to make a choice of whether they had a drink or not. Fortunately staff disregarded the advice and we saw drinks were given to people during lunch and drinks both hot and cold were available throughout the day. The fact that staff did not always ensure that people's nutritional needs were being appropriately monitored and met meant there was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at food and fluid intake records these were recorded on the "Wellness charts" and we could see these were completed regularly with the amount of food and fluid a person had consumed. The manager told us that while there were a reduced number of people at Park Lodge they were trying to encourage staff to run a café style breakfast service where people could choose on the morning what they would like to eat. The manager was also taking time to speak to people and find out about their favourite foods and incorporate these into the menu plans.

In January 2015 the provider was breaching the regulation in regard to staff not receiving appropriate training and support. They sent us an action plan and told us they would make the necessary improvements by the end of May 2015.

Training records from the on-line training record were given to us on the first day and these showed of the 19 staff employed at Park Lodge 67% had completed the mandatory annual training in the last 12 months. Records showed that only seven staff had attended health and safety training, nine staff had attended first aid awareness training, only two staff had attended nutrition and hydration training and only 11 staff had attended dementia awareness training in the last 12 months, even though the majority of people at Park Lodge had dementia. Training was a mix of e-learning and class room teaching. Staff told

Requires improvement

Is the service effective?

us they had received updates in mandatory topics on line, one staff member told us all of the mandatory topics including dementia awareness were covered in a 30 minute session. One staff said they had not received diabetes or end of life training, and felt more dementia awareness training was needed. Another staff member said manual handling had been addressed in a three hour session and didn't feel this was enough.

Whilst two staff told us they had received recent supervision and we saw staff meetings were being held, we found that not all staff were being supported appropriately in the role. We looked at five staff supervision records, which showed two staff had attended a group supervision session in March 2015, but nothing since. Three other records showed staff had received one individual supervision session between March and May and had also not received an appraisal. We had also identified a lack of supervision and appraisals at our last inspection. One staff commented on the supervision as not very helpful as it was "A one way discussion with little opportunity for my input". This show that staff were not adequately supported to fulfil their roles through training and supervision and meant there was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

At our last inspection in December 2014 the provider was breaching the regulation in regard to the requirements of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). DoLS ensure that a service only deprives someone of their liberty in a safe and correct way, when it is in their best interests and there is no other way to look after them. The provider sent us an action plan and told us they would make the necessary improvements by the end of May 2015.

At this inspection we saw the provider had taken some action to meet the requirements of the MCA and DoLS. In the four care plans we looked at we saw some partially completed MCA assessment forms, however the information was general and not specific about the decisions that needed to be made. We asked the manager about this and they were able to give us a list of people where a mental capacity assessment had or was taking place, whether the assessment had been sent to the local authority for verification and in two cases the outcome. CQC had received a notification of decision for these two people. This information was not always clearly documented in the care plans and may mean that staff were not fully aware of the restrictions on a person. The manager said they were updating the care plans and would ensure this information was clearly documented.

Care plans showed people could access health services according to their needs. Staff told us that appointments could be made when people required them with their GP, the physiotherapist or the podiatrist. Specialist help was also available through the speech and language team and from the local impact nursing team who called at the home to assist staff with people's changing needs, where referrals were made.

Requires improvement

Is the service caring?

Our findings

Whilst people living at the home thought that staff were kind and respectful to them when providing care and support, we did not find that the service was as caring as it could have been to people. One person we spoke with said "They're (staff) lovely", another said about staff "Very good, kind".

The fact that the provider had not made the necessary improvements we identified at our previous inspection, in making sure people received a safe and appropriate standard of care at the home was not caring. For example, people were not being fully protected against the risks associated with medicines and they were not consistently assessed and monitored so the risks of malnutrition were minimised. We saw evidence that the provider had also not given enough consideration to making sure people received meals according to their choices and preferences and that people were living in an environment where the risk of the spread of infection was minimised.

During the first day of our inspection we undertook a SOFI observation during the lunch time. Five people came to the dining room to eat their lunch meal. The room had not been prepared in a convivial way to improve the experience of people during mealtimes. We saw menus were not on display, the cutlery was brought out as and when it was needed and the salt and pepper pots were on other tables but not the one where people were eating. People were also not asked if they would like any condiments so they could add these to their meals if they wanted to.

People were assisted with their meal when required and we observed that the majority of the interactions between staff and people were positive. Staff took their time when helping people and gave encouragement whilst supporting them. But staff did not always ask people before cutting up their food or putting a clothes protector on them. Staff did not always sit down when helping a person but sometimes stood beside them. The atmosphere in the dining room was not very cheerful, welcoming or friendly; it was very noisy with the phone ringing and staff using the area as a thoroughfare. We saw the laundry person walked through while people were eating carrying a bowl with items in it, we could not determine if the items were clean or dirty.

We saw staff speaking kindly to people and heard a staff member speaking to a person in another language, which the person spoke and engaging them in a conversation. We heard a person becoming distressed and heard staff speaking kindly and quietly to the person to help reassure them and staff went on to assist the person in a calm manner.

Staff we spoke with knew who people were because they had taken the time to speak to people and get to know them. Staff had not just relied on the information in the care plans which were not always up to date.

We saw that people had the privacy they needed and they were treated with dignity and respect at all times. We saw for people who stayed in their room the call bell was within reach and staff answered the bell promptly when it rang. One staff member said "We always close doors and are prompt at helping people". This helped to ensure people's dignity was maintained.

Inadequate

Is the service responsive?

Our findings

On 19 January 2015, we inspected the service and identified a breach of the regulation in relation to the care and welfare of people. This was because the provider had not ensured that people's care needs were assessed and information from these assessments used to plan the care and support people required. They had also not ensured people received social and recreational activities according to their needs. They sent us an action plan and told us they would make the necessary improvements by the end of May 2015.

At this inspection we found the provider was not meeting the legal requirements of the breach above.

The provider had told us in their action plan that all care plans would be reviewed by the end of April 2015 and then monthly reviews would be undertaken. We found that care plans had not been updated as they had planned and with the involvement of people or their representatives. On the first day of our inspection we asked the manager and area manager if all the care plans had been updated. They replied that five out of 15 care plans had been updated. We asked the reason why the other care plans had not been updated and the manager said they were getting to know people so they could update their information and they were also learning the computer system where care plans were kept.

On the second day of our visit the area manager told us that six care plans had been updated on 19 August 2015, the day in between our visits. They told us these had been updated by the CareSys lead and a manager from another home in consultation with staff and the manager at Park Lodge. (CareSys is the electronic data base system used to generate care plans). When we asked if people or their relatives had been involved in this process, the manager said the person whose care plan it was had not been consulted and stated "It's not appropriate, care plans are for professionals". When asked again if a copy of the care plans goes to the person the manager said "No because they can't read or understand them. They're not bothered how they get washed and dressed as long as it's done". This therefore showed a disregard to people's rights to be involved in their care and treatment and to be cared for according to their wishes, preferences and likes and dislikes.

We looked at four care plans. This included the electronic copy of the care plan, the copy from the person's bedroom and the copy kept on file. We saw the information about a person which should be the same in the three copies, was not. This meant that there were risks people might not receive care in a consistent way.

We saw the care plans did not fully addressed how people's needs should be met. For example for one person there was no specific plan about the action staff needed to take to care for and treat a person with diabetes. The care plan referred to hydration but did not provide information on the signs and symptoms to observe if the blood sugar goes low (hypoglycaemia) or high (hyperglycaemia) or diabetes in general so staff knew what to observe and what action to take. Another person had a percutaneous endoscopic gastrostomy (PEG) feeding tube. This is a method of feeding a person directly into their stomach through a tube when they are unable to take food orally. Their care plan did not give advice on how to care for the person in relation to this equipment; although we saw records from a nurse supporting staff in care homes in regards to PEG feeding, that specific action needed to be taken to protect and maintain the integrity of the skin and tissue around the tube.

We saw records from the impact nursing team which gave staff specific advice on the care a person required in relation to a urinary catheter, including attaching the drainage bag to a hanger. This advice had not been included in the person's care plan and on checking we saw the bag was not attached to a hanger. Another person had a contracted limb but we did not see this had been included in the person's care plan although other records showed that the GP had given guidance on how to care for the limb. The limb contracture was also not included in the risk assessment for the manual handling of this person as this could cause complications when moving the person.

For one person we saw the impact nursing team had given an information sheet with guidance on the range of blood sugars levels to expect during morning and evening blood testing. We looked at the daily handover sheets and the specific blood sugar records for this person and saw that blood sugars levels were recorded at different levels in the handover sheets, to the person's care plan. It was also recorded on several occasions, that the blood sugar levels

were out of range, some of these were on consecutive days. We found no evidence of any follow up action plan regarding this, such as contacting relevant healthcare professionals for advice and support.

In January 2015 the provider did not have suitable arrangements to make sure people had the opportunity to participate in a range of social and recreational activities that met their individual needs. Activities were not provided according to people's preferences, likes and dislikes.

During our inspection on 18 and 20 August 2015 we found that the action plan submitted by the provider to improve people's experiences in regards to social and recreational activities had not been fully met. There were no staff allocated in a consistent manner to coordinate social events and arrange activities for people according to their preferences and needs. An activity coordinator had also not yet been recruited as they had planned. We found that service users' care plans had not been updated to contain information about their social and recreational needs and had not considered their preferences for the activities they would like to take part in and the things they enjoyed doing. There was therefore no plan in place about meeting people's needs in this respect. A programme of activity as stated in the provider's action plan was also not available on the first day of the inspection.

We observed on the morning of the 18 August for the five service users in the lounge a staff member had put two small balls on each person's table and was going to each person individually and playing a game of catch. The member of staff had not considered the preferences and activities individual service users enjoyed doing. We saw that two people did not want to join in with this activity. One person threw the balls away and asked why they had been given the balls and what were they for.

On the second day of the inspection we saw an activities programme, although what was written on the plan was not being offered to service users, and nor were any other activities. For the morning the plan was for people to engage in throwing quoits and in the afternoon, playing dominos. We did not see these activities being offered and nor were people engaged in any other planned activity.

We saw that people who remained in their bedrooms apart from personal care delivery, their own radio or television, had no other social activity to engage in or stimulation. As the care plans for people had not been updated, we were unable to see whether people had chosen to stay in their bedrooms and what was in place to prevent social isolation and to promote stimulation.

The above therefore shows that you were not making sure that the care and treatment people received was appropriate to meet their needs and to reflect their preferences and choices. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw a poster titled 'How to Complain' was displayed in the main entrance hall and provided information about the complaint process and the time frame to expect a response after making a complaint. We saw that some of the information displayed was out of date with the name of a manager from 2014; we did not point this out to the manager at the time. The provider also maintained a summary of complaints that detailed the complaint, date action taken and the outcome so information about complaints could easily be analysed. We looked at complaints received during July 2015. The themes were about the deployment of staff within the home and the standard of personal care people received. Records showed the complaints had been investigated and a response letter sent to the complainants from the manager within the timescales as identified in the complaints procedure.

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Our findings

On 19 January 2015 we inspected the service and identified a breach of the regulation in relation to maintaining appropriate records that could be located promptly when these were required. The provider sent us an action plan and told us they would make the necessary improvements by the end of May 2015.

At this inspection we found that provider was still not meeting the regulation in relation to record keeping in that they had not ensured care records could be located promptly when these were required and that appropriate records were maintained to demonstrate how the service was being provided to people.

Park Lodge used a computerised system to maintain people's care records and daily notes, copies of the care plans were also kept in a person's room and on file. We found the three different copies of care plans were not up to date, did not reflect people's current care needs and did not contain consistent information.

The manager told us the care plans on the computer system were the most up to date but we found the computer system was slow, difficult to navigate and extract information from. Staff we spoke with also confirmed that the computer system was slow. This meant staff could not access accurate information about a person as quickly as they may need to.

We saw that daily records were also maintained through different methods, some on the computer, and when the computer was not working hand written notes were kept in the care plan.

The provider had made more laptop computers available for staff to use when updating daily notes. These same computers were used for staff to access on line training, which meant that staff may have to wait before being able to update people's daily notes.

The lack of prompt access to people's records and the inaccuracies found in the different copies meant there were risks that a person's records might not be easily retrievable and located promptly should these be required in an emergency.

At our inspection on 19 January 2015 we identified a breach of the regulation in relation to the effectiveness of the provider's systems to monitor and assess the quality of the service. We served a warning notice on the provider against this breach and told them to meet the regulation by 17 April 2015. We inspected against the breach of regulation in May 2015 and found the provider had taken steps to meet the requirements of this regulation.

At this inspection, we found the provider was not meeting this regulation in that they had not been able to fully meet their action plan. We found that the arrangements the provider had introduced remained ineffective in assessing, monitoring and improving the quality of the service and to make sure the provider was meeting legal requirements.

We found the provider did not sufficiently oversee the service to make sure daily, weekly and monthly checks of the building were carried out as required. They had also not ensured that maintenance certificates were up to date and that a good standard of cleanliness was being maintained at the home. There were therefore risks to the safety of people and others.

We saw that weekly checks of the kitchen had been carried out but not in February 2015 and no checks had been made since 2 August 2015. Daily food deliveries that should be checked for correct temperature at the time of delivery had not been checked since 22 January 2015. We found that daily checks of the fridge and freezers were not consistent and where a high temperature was found we did not see an action plan to monitor and remedy the issue. The temperatures of cooked foods were not monitored at every meal. The monitoring of the daily cleaning schedule had not been consistently checked in June, July or August 2015. The medicines audit between April and June 2015 recorded the same errors but no actions had been taken to remedy these errors. This lack of oversight of the quality of service provided to people by the provider meant that people were not always protected against the risks of poor care and treatment because these systems were not always effective in identifying areas for improvement and for ensuring that prompt remedial action was taken to make improvements. The above paragraphs show that the provider was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The staff training records held on a computer system were not consistent with the information we saw in staff files. In the three staff files we looked at, training certificates showed that more e-learning than was recorded on the training records had taken place. We spoke to the manager

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and area manager about the discrepancy between what staff were telling us and the training matrix but they confirmed the matrix was correct on the day of printing which was the 18 August 2015.

In January 2015 the provider was also breaching the regulation in regard to not submitting notifications, because the acting manager had not informed the CQC when a DoLS order had been applied for and the decision taken. The provider sent us an action plan and told us they would make the necessary improvements by the end of May 2015.

From our discussions with the new manager it was clear they understood their legal obligations with regard to CQC requirements for submission of notifications and since the manager had been employed these had been submitted in a timely manner. The records CQC hold confirmed this.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation and nursing or personal care in the further education sector Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **People who used services were not protected against the risks of receiving care and treatment that was inappropriate or unsafe by means of the planning and delivery of care and, where appropriate, treatment in such a way as to meet people's individual needs and ensure their welfare and safety.** Regulation 9(1)(a)(b)(c)(3)(a)(b)

The enforcement action we took:
We have removed the location Park Lodge from the condition of registration of the provider. This effectively means that the provider is not able to lawfully provide a care service from Park Lodge.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **People who use services and others were not protected against the risks associated with the unsafe use and management of medicines by means of making appropriate arrangements for the safe keeping of medicines and assessing the risk of, and preventing, detecting and controlling the spread of, infections, including those that are health care associated.** Regulation 12(1)(2)(f)(g)(h)

The enforcement action we took:
We have removed the location Park Lodge from the condition of registration of the provider. This effectively means that the provider is not able to lawfully provide a care service from Park Lodge.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs **People who use services were not protected from the risks of inadequate nutrition and dehydration, by means of the provision of a choice of suitable and nutritious**

This section is primarily information for the provider

Enforcement actions

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)(4)(a)

The enforcement action we took:
We have removed the location Park Lodge from the condition of registration of the provider. This effectively means that the provider is not able to lawfully provide a care service from Park Lodge

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The registered person did not ensure that service users were protected against the risks of unsafe or inappropriate care and treatment arising from a lack of proper information about them by means of the maintenance of an accurate record in respect of each service user which shall include appropriate information and documents in relation to the care and treatment provided to each service user; and ensure that the records referred to in paragraph (1) (which may be in paper or electronic form) are kept securely and can be located promptly when required. Regulation 17(1)(2)(a)(b)(c)(d)(ii)

The enforcement action we took:
We have removed the location Park Lodge from the condition of registration of the provider. This effectively means that the provider is not able to lawfully provide a care service from Park Lodge.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing 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 were appropriately supported in relation to their responsibilities, to enable them to deliver care and treatment to service users safely and to an appropriate standard, including by receiving appropriate training, professional development, supervision and appraisal.

This section is primarily information for the provider

Enforcement actions

Regulation 18(1)(2)(a)

The enforcement action we took:
We have removed the location Park Lodge from the condition of registration of the provider. This effectively means that the provider is not able to lawfully provide a care service from Park Lodge.