# Chelcare Limited

# Doddington Lodge

## Inspection report

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## Ratings

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

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

# Summary of findings

## Overall summary

We carried out an unannounced comprehensive inspection of this service on 15 and 21 September 2015. Breaches of legal requirements were found. After the comprehensive inspection, the provider wrote to us to say what they would do to meet legal requirements in relation to the breaches.

We undertook this comprehensive inspection to check that they had followed their plan and to confirm whether they now met legal requirements.

This inspection took place on 30 March 2016 and was unannounced.

Doddington Lodge provides accommodation and personal care for up to 41 people, some of whom are living with dementia. At the time of our inspection there were 34 people living at the home. Doddington Lodge had two separate living areas. The A side for people living with dementia and the B side for people who have complex health needs.

There was a registered manager 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 and associated regulations about how the service is run.

At this inspection we found the registered provider was still in breach of three of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 that we identified during the last inspection. These were Regulation 9 in relation to person centred care, Regulation 12 in relation to safe care and support and Regulation 17 in relation to the governance of the service. They were no longer in breach of Regulation 11 as they had improved how they worked to the principles of the Mental Capacity Act (2005). We found other breaches of regulations. These were, Regulation 14 in relation to nutrition, Regulation 18 in relation to staffing and Regulation 20A for failing to display their rating. These shortfalls in the service are described throughout all sections of this report.

There was no effective leadership in the service. Quality assurance systems in place had not identified the concerns that we identified during the inspection. There were no clear actions planned or taken to improve the care and treatment that people received. We had concerns in relation to how the service was managed.

People were not always kept safe from harm. There were not enough staff on duty to keep people safe or to respond to people's health needs at the times when they needed support.

People were not always treated with dignity and respect.

People did not receive the appropriate support to maintain healthy nutrition and people's specific dietary

needs were not always catered for.

People were not always supported to access health and social care services to maintain and promote their health and well-being when needed.

The provider had not clearly displayed their quality rating. Information supplied by the provider to the public did not reflect the last CQC inspection rating. This is a requirement to ensure that the provider is transparent about the quality of the service they provide.

Staff did not start working with people until checks had been made to make sure they were suitable to support and care for the people living in the home.

People did receive their medicines safely. Medicines were ordered, stored administered and disposed of safely.

People were given support to make choices and decisions about their care and support. Where people could not make specific decisions themselves these were made in their best interests by people who knew them well.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'. Services in special measures will be kept under review; if we have not taken immediate action to propose to cancel the provider's registration of the service, it will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

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

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

## 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.

People were not always protected from harm or abuse because risks to people's health and care had not been identified and managed appropriately.

People received their medicines safely as there were systems to ensure that medicines had been given as prescribed.

There were not enough staff to keep people safe and meet their health needs. There were no systems in place to determine how staffing levels were identified and deployed.

### Is the service effective?

**Inadequate**

The service was not effective.

Staff did not always receive the support and training they needed to meet people's individual needs.

People did not always have access to other health professionals to maintain their health and wellbeing.

People did not have the appropriate care and support to ensure that they had adequate nutrition.

### Is the service caring?

**Requires Improvement**

The service was not always caring.

People were not always treated with dignity and respect.

People did not always receive the care they needed.

### Is the service responsive?

**Inadequate**

The service was not responsive

People did not receive care that reflected their own individual needs or preferences.

Staff did not always respond and act appropriately to concerns that people raised.

There was a system in place to respond appropriately to complaints.

## Is the service well-led?

**Inadequate**

The service was not well led.

There was weak leadership in the home that failed to give staff direction and recognise the needs of the people using the service. The registered manager could not demonstrate how they would improve the service.

There were no governance systems in place to assess, monitor and to address risks to people.

The quality assurance systems were inadequate and had not identified the concerns and risks identified during the inspection.

# Doddington 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.

The inspection took place on 30 March 2016 and was unannounced. The inspection team consisted of two inspectors, one pharmacist, one specialist advisor who was a nurse specialising in dementia care and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We looked at the action plan that the provider sent us following the last inspection. We also looked at the information we held about the provider and this service, such as incidents, unexpected deaths or injuries to people receiving care, this also included any safeguarding. We refer to these as statutory notifications and providers are required to notify us about these events. This information was used in the planning for the inspection.

We used the Short Observational Framework for Inspection (SOFI) because some people were unable to communicate with us verbally. SOFI is a specific way of observing care to help us understand the experience of people living at the home.

We also spoke with nine people who lived there, one relative, one healthcare professional, three care staff, two team leaders and the registered manager. We looked at the care records of four people, including nutritional risk assessments, assessments of people's needs and daily records. We also looked at the systems for monitoring the safety and quality of the service.

Inadequate

# Is the service safe?

## Our findings

At our last inspection on 15 and 21 September 2015 we found that there were multiple breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The regulations breached were, Regulation 12 Safe care and treatment and Regulation 13 Safeguarding people from abuse and improper treatment. In December 2015 the provider sent us an action plan that told us what they planned to do to meet the legal requirements. At this inspection we found that some areas had not been improved and found additional breaches of Regulations.

At our last inspection we had concerns regarding how medicines were managed and administered. The provider had not ensured people received their medicines as prescribed and in the right way. The provider told us that they would review how medicines were given to people and make sure that they were managed safely. During this inspection we found that improvements had been made. We found that there were now appropriate systems in place for the safe ordering, storage, administration and disposal of medicines.

We identified a person whose care records indicated they had recently developed broken areas of skin . The care plan specified that the person needed close monitoring and regular turning in bed to reduce the risk of skin breaking down further. Staff who were on shift and responsible for providing care and support did not know this. Information and assessments were not filled in correctly. One assessment indicated the person was at very high risk of developing pressure ulcers however there was no date or time on the risk assessment, no action plan and no indication that pressure areas were being monitored. Staff could not tell us if the person had sore skin or not. It was unclear if the person had any 'red' or 'broken' areas that would indicate the development of a pressure ulcer as records and staff gave different accounts. We asked staff to check the person and take the appropriate action. A visiting health professional also told us that medical guidance and advice regarding pressure sore care was not followed by staff. They told us they had raised their concerns with the registered manager but no action had been taken.

One person told us they were in pain down one side of their body. We saw they had a cut to their face. They told us they had fallen. We spoke with the registered manager and they told us that this person had had a fall four days before our visit. Staff had recorded in the person's records that their feet were, 'Very red and blue.' We asked staff if medical attention was sought at that point, they told us 'no'. The registered manager told us that they had not sought medical advice because they didn't think that a facial injury was an indication of a head injury. The registered manager told us the person was at risk of falling and had fallen in the past. We could see no record of a risk assessment relating to this risk in the person's care records. Nothing had been done to identify any factors that may have increased the risk of falling or any action identified or taken to prevent further falls. We asked the registered manager to seek medical advice for this person.

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

People felt that there were not enough staff to meet their individual needs. One person told us, "I think they could do with more [staff]. I suppose there's times when we all get a bit agitated". We spent time on the A side of the home. The A side is where people living with dementia type illnesses lived. We saw that due to the nature of some people's health needs, people could display anxiety and behaviours that were a risk to themselves and others. We spent time in a communal area where seven people were sat. One person had a recent fall resulting in a head injury and another person had recently had an un-witnessed fall resulting in a bone fracture. From 10am until 1pm we did not see any care staff come to check that people were ok. There were frequent occasions during this time when people were seen to display signs of anxiety. We saw one person become distressed and anxious; they stood over another person and began to shout at them using threatening language. There were no staff nearby to help either person. We were concerned for the wellbeing of all people in the room but we were unable to get any staff attention until 15 minutes had passed. As we waited for help a further four people were showing signs of increased anxiety and changes in behaviour. . When a member of staff arrived it was a kitchen assistant who then took a further five minutes to get a member of care staff to respond. When we spoke to the member of staff they told us that often people could be left in communal areas with no staff around while people were being supported in their bedrooms and that sometimes, "Oh they (person) can be like this." They told us that incidents of behaviours did occur but were not always recorded and therefore could not tell us how frequently people displayed these behaviours or anxiety. We asked why staff had not responded sooner and they told us they were getting people up. The member of staff redirected the person to sit down and after a further five minutes people had started to become calmer. We found that there were no risk assessments or behaviour management strategies for this person. We brought this incident to the immediate attention of the registered manager. They could not tell us what they would do to prevent this from happening again.

People did not have any means of attracting staff attention if they needed to as there were no call bells and people were not able to move independently. Staff and the registered manager acknowledged that staff were not always able to be present in the room during busy periods as staff were in other areas of the home getting people up. Staff told us that it needed two staff to get each person up and that this usually took until late morning or lunchtime to complete this. Our observations and experience during the inspection showed that this did not provide the right level of staffing or support to keep people safe. The registered manager told us they didn't have a system to determine staffing levels and the provider had recently reduced the number of staff due to a number of bed vacancies. The registered manager told us that they thought there was enough staff. They were unable to demonstrate how they could deploy staff differently to make sure that people were safe at all times.

This was a breach of Regulation 18 Staffing of the Health and Social Care Act 2008 (Regulated Activities).

At the last inspection staff were not recognising and reporting safeguarding referrals to the local authority and Care Quality Commission. People were not protected from harm as there were no investigations taking place or actions taken to prevent future incidents of the same nature. The registered manager told us they would contact the local safeguarding team and take advice on managing the safeguarding concerns. They were also going to make sure that staff attended training on how to keep people safe. At this inspection while we found that appropriate action had been taken to address the specific concern about a person's safety that we identified at our last inspection and that staff had appropriate knowledge of how to keep people safe.

People gave us mixed views about whether they felt safe. One person said, "I feel more or less safe." A relative said, "I think people are safe, the staff wouldn't harm them but they are very busy and not around much." Staff were able to tell us what they would do if they suspected abuse and showed us that they had a good understanding of the different types of abuse. They also told us what they would do and who they

would contact if they suspected abuse. We could see that there were systems in place to protect the people that lived in the home and to make sure that the relevant authorities were informed and action taken to keep people safe. The registered manager understood their responsibilities to identify and report potential abuse under local safeguarding procedures.

Staff told us that checks were made to make sure they were suitable to work with people before they started to work for the provider. These included references, and a satisfactory Disclosure and Barring Service (DBS) check. DBS helps employers make safer recruitment decisions by preventing unsuitable people from working in care.

Inadequate

# Is the service effective?

## Our findings

At our last inspection on 15 and 21 September 2015 we found that there was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Decision making for people who did not have the capacity to make certain choices for themselves did not follow the legal principles of the Mental Capacity Act 2005 (MCA). A decision about disguising medicines in people's food without their knowledge (covert medicines) had been made by the registered manager with no best interest decisions for the person. The provider told us that they would review the policy on covert medicines and were going to get support from other professionals around their knowledge and practice of the MCA. At this inspection while we found that appropriate action had been taken and they were no longer in Breach of Regulation 11.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People told us that they were able to make choices and that staff respected their wishes. One person said, "Staff try their best to give us what we want." Staff told us about the importance of getting people's consent before carrying out any care or support. Staff were able to tell us what needed to happen if people could not make certain decisions about their care or support. Staff explained about best interests meetings and the importance of including appropriate people in the decisions, for example family members, advocates, social workers and the person themselves. We did see that staff made sure people were asked and given choices before having any personal care and what staff told us demonstrated that they had knowledge of the principles of the MCA. Not all staff had received training about the MCA, but they told us they were due to attend some in the near future.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We found that people's mental capacity to make decisions had been assessed and appropriate DoL applications had been made. At the time of inspection the registered manager told us that four people were subject to a DoL. Staff showed an understanding of what these restrictions meant for people.

People told us that they did not always get enough to drink. One person told us, "We normally have a drink by now. I don't like the fact there are not enough cups of tea". We saw that one person asked for something to drink as they had an unpleasant taste in their mouth, but this was not responded to by staff. We observed a time frame of over two hours in the morning where there were no drinks available to people, and a time frame of over three hours in the afternoon where there were no drinks provided or offered. We observed the lunchtime meal and asked people what they thought of the food they were provided with. Some people told us that the food was good and other people said it was "ok". Nobody we spoke with complained about the

food.

People were at risk of losing weight as they did not have their dietary needs monitored effectively to make sure their nutritional needs were met. Two people had lost weight over a period of 10 months. One person had lost 4.7kg and the other 18.1kg. In each of their care records we saw that staff should carefully monitor this. None of the staff we spoke with knew how to do this. We could find no evidence in either person's records that any action had been taken by the registered manager to address each person's weight loss. The registered manager confirmed that no action had been taken in order to manage people's weight loss. Another example was a person whose care records indicated had considerable weight loss and, "Needed to be encouraged to eat well." This person was got up late in the morning and had their breakfast served at 12.15pm, followed by their lunch 15 minutes later. We observed that after eating their breakfast they refused lunch only having the dessert. No further alternatives of food were offered for the rest of the afternoon. No referrals had been made for anybody with weight loss to the dietitian and people were only reviewed during routine visits to the home from the doctor. The registered manager could not explain to us why no referrals had been made or why no consistent monitoring of people's nutrition had taken place.

People's dietary requirements were not understood by staff. For example we asked the chef how they fortified the meals of people who had been identified at being at risk of malnutrition. The chef told us that they used a thickening agent . They did not know this would not provide people with extra calories. Staff did not know what consistency an individual's food needed to be to prevent any choking. They did not have adequate knowledge or training in how to safely prepare thickened fluids or how this could impact on people's ability to swallow. When we spoke with staff they were not sure how many people were diabetic or required specialist diets.

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

Staff told us that they felt they had adequate training to carry out their roles safely and effectively. However we found that not all staff received the appropriate level of training to match their roles. We saw that the responses from staff did not reflect best practice in supporting people with dementia. For example some people who appeared distressed were told to sit down and not given the support to understand what was making them distressed. When we asked staff about this they told us that, "This is just how they [people] are." Staff did not show an understanding of how to manage the anxiety and distress that people living with dementia may at times experience. They had not completed any training around dementia and were unable to demonstrate an adequate understanding of dementia and how to provide best possible care. Where people required specific food preparation no training had been sought to support staff to understand how to prepare the food safely. Staff told us that they felt they didn't have enough support and supervision. They told us that although they had regular supervision, they did not feel that they were able to raise concerns or have support with the job they were doing. The lack of effective training and support for staff meant people received inadequate care and support from them

This was a breach of Regulation 18 of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014.

Requires Improvement

# Is the service caring?

## Our findings

At our last inspection on 15 and 21 September 2015 we had concerns that people were not always treated with dignity and respect. One example found was a hole in a person's door that staff were aware of but nothing had been done to rectify it. This had left the person without adequate means of privacy in their own bedroom. At this inspection whilst we found that the hole in the door had been fixed, concerns remain around how people were cared for remained.

We saw that staff spoke with people with kindness and empathy for most of the time. However there were times when people were not treated with respect or dignity. We saw one staff member put a clothing protector on a person, despite the person saying they did not want to wear it. The staff member ignored their wishes and told them, "I know you don't like wearing it but it will save your clothes". The staff member did not respect the person's choice as to how they wanted to be supported with their care, and did not treat with the person with dignity and respect. Another example was a person whose room we had gone into with their permission because they were anxious and wanted us to press the call bell for assistance. In their room we found a soiled continence pad had been placed on the person's magazines on their bedside table. When a member of staff arrived they took the soiled pad and the magazines from underneath because these had become wet. This was done without checking with the person about the magazines, instead these were just collected up and put into a rubbish bag. This did not show respect for how the person may have been feeling or for the person's individual belongings. During our visit we heard staff referring to people as 'feeders' and 'walkers'. They told us that 'feeders' were people that needed support with feeding and 'walkers' were people that could walk without support. The registered manager told us that it was acceptable to refer to people in this way as long as it was 'not heard by the person themselves' and added "We don't say it to their faces". Both of these terms are derogatory and do not reflect a culture where people are afforded dignity or respect.

We observed that people were left without appropriate stimulation or support. We spent time in a communal area where seven people were sat. From 10 am until 1pm we did not see any care staff come to check that people were alright. During this time people were sat in chairs with no interaction from other people in the room or from staff. Staff did not have time to talk to people unless they were undertaking a care task. When the task was completed staff left the person to undertake
other duties. Time was not spent with people to enrich their time with conversation and company. Staff told us that there were not enough staff to be able to spend time with people and that getting people up was a priority and took up the morning. We did not see any individual activities for people happened during our visit.

People told us that they had not been involved in planning their care and support and had not been involved in discussing or reviewing their care. One person told us, "A care plan? No, I've never seen one of those. What is it?' Another person told us, "I don't know why I'm here. Nobody's saying anything to me. I haven't seen many people to ask." We reviewed three care plans and saw that people had not been involved in the process of making decisions about their care, treatment and support, nor had their relatives. For

example, people had not been asked questions such as whether they prefer to receive personal care from a male or a female carer, or how they wanted staff to address them. We discussed this with the registered manager who told us that work was being carried out on the plans so that people and their relatives were consulted. These would be shared with staff so they would be aware of how individuals wanted to be supported.

We saw that care was not always provided to people in a manner which demonstrated that they were actively involved in decisions about how their care was provided. For example, one person told us, "I like a bath but it's too much of a rush in the morning". We also observed that the television was on loudly in the main lounge areas. When asked, people told us that they did not want the television on and they had not been asked what they wanted to watch, or whether they wanted to sit in front of the television.

Inadequate

# Is the service responsive?

## Our findings

At our last inspection on 15 and 21 September 2015 we found that there was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. There was a lack of person centred care. Staff could not demonstrate knowledge of people's individual likes, dislikes and needs and there was inadequate information about people's interests and history to promote people's individual preferences, personalities or respect their personal histories. In December 2015 the provider sent us an action plan that told us what they planned to do to meet the legal requirements. They told us that they had employed a person to look at gathering the information for 'person centred profiles to be included in care plans.' At this inspection we found that people still did not receive person centred care.

We found that people's records still did not reflect people's life history or things and interests that were important to them. People did not have any activities to reflect their own hobbies and interests and staff could not demonstrate to us that time was given to individuals to pursue any interests they may have. There were no established links with any community activities or clubs and from what people and staff told us and from our observations we were not assured that care reflected people's individual needs.

During our visit staff did not always know important information about people or changes in their needs. We were with a senior member of staff when they were told by a person that they felt sick. This member of staff did not tell any other staff that the person felt sick and proceeded to ask staff to get them up. We observed in the staff handover at the end of the shift that this was not discussed. The member of staff who the person told could not explain to us why they had not informed other staff or checked to see if the person still felt ill. Following the handover the registered manager told us that they would inform staff to observe the person more closely.

In the main ground floor lounge where several residents were sitting, the heating had broken down and the room was very cold. The registered manager already knew the heating was broken and told us that they were awaiting an engineer to fix it. Four people told us they felt cold. We saw that people were not provided with blankets until later on in the afternoon when we raised our concern to staff. People had been sitting in a cold room for a period of three hours without staff recognising this and ensuring people were warm enough.

When we asked one person if they got support when they needed it they told us, "Nobody's saying anything to me. I haven't seen many people to ask." Our observations showed that until lunchtime people did not get attention from staff. For example we saw a person in a corridor who appeared distressed. They were banging on the glass of the door and repeatedly trying the door handles. We waited for five minutes talking to the person, but no staff responded. With the person's permission we went into their bedroom and found the call bell was unplugged so they would have been unable to press this for assistance. After pressing the call bell we waited a further five minutes before a staff member arrived. They could not tell us why the call bell had been unplugged and said that they were unaware the person was distressed until they had

responded to the call bell. The staff member spent five minutes talking with the person and they were relaxed by the time the staff member left. This did not demonstrate an approach that met people's individual needs.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities).

People were not involved in shaping their care and support. They had no involvement in their support and treatment plans. There were no systems in place to gather people's views or any concerns relating to their care. The people that we spoke with told us that they did not feel involved in their care. They did not know how they would be able to share any views or concerns on the care they received.

People we spoke with told us the registered manager was approachable and they were able to speak with them if they had a concern or a complaint. We looked at two recent complaints and we found that these had been responded to appropriately. We saw that there was a clear procedure in place for responding to complaints and this had been followed by the provider in their responses.

Inadequate

# Is the service well-led?

## Our findings

At our last inspection on 15 and 21 September 2015 we found that there was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. There was no consistent system for the provider to identify, address and monitor any concerns or risks relating to care. The registered manager was unable to tell us what actions needed to be taken to improve people's experiences of the care provided at Doddington Lodge. In December 2015 the provider sent us an action plan that told us what they planned to do to meet the legal requirements. At this inspection we found that no improvements had been made. Concerns remained about the management, leadership and governance of the home. This is a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During the last inspection in September 2015 there were five breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we identified six breaches of regulations. The registered manager was unable to identify where improvements were needed during the inspection. They had not identified the concerns we had found. At the inspection in September 2015 medical advice was not always sought from other professionals and appropriate referrals were not made. We found similar concerns during this inspection. The registered manager had continued to make decisions in isolation without the involvement of relevant professionals. We asked why some people with weight loss and who staff told us needed their food and drinks to be thickened had not seen a Speech and Language Therapist (SaLT). This would have provided important support and advice to make sure people's needs were met safely. The registered manager said, "We've never done that [refer to SaLT]." They could offer us no further explanation on this. A person with a head injury from a fall had not been seen by a doctor even though they continued to mention pain. The registered manager could not provide us with any documentation relating to this incident. Nothing had been done to ensure that the person's wellbeing was maintained or that the risk of further falls had been managed. The registered manager told us that they had decreased the amount of staff through the day in response to bed vacancies. They could not show us that they had a system to identify how they monitored the impact of this on people, even though our inspection raised concerns over the amount of staff cover and the impact on the safety of people. When we asked what improvements they felt had been made following the last inspection they could show us that improvements had been made to some care plans. There was no evidence that the most important actions had been prioritised. This meant that no improvements had been made to the care and support people actually received.

There was a lack of clear leadership and guidance for staff. Staff we spoke with felt that concerns or views were not always listened to by the registered manager. For example two staff told us that they had raised concerns with the registered manager over the length of time it took to get people up in the mornings. They said that no action had been taken in response to their concerns. A health professional told us that actions they raised with the registered manager were not always carried out. There was no proactive engagement with external organisations. For example where working with dietitians and speech and language therapists may have improved management of people's nutrition and weigh, this had not happened.

There were no systems in place to gather feedback from the people that lived at the home, their relatives or

other professionals. There had been only one staff meeting since the last inspection in September. Staff told us that they did not feel involved in how the service was run. The registered manager could not tell us how they were able to monitor the quality of the service and the experiences of the staff and the people that lived there.

The registered manager maintained that the care provided was of a high quality, something that we did not find during the inspection. There were no regular audits or checks on the safety and quality of the care being provided. We were not assured that adequate governance and quality assurance systems were in place to ensure that the provider was able to identify, address and monitor any concerns or risks relating to care. There had been a lack of progress in improving the service since the last inspection and there was no evidence of any lessons learnt from incidents, concerns or previous failings.

This was a breach of Regulation 17 of the Health and social Care Act 2008 (Regulated Activities).

When we arrived the CQC rating had not been displayed in the building. We asked the registered manager why this had not displayed the rating and they told us that they were not sure what to display, but they had not sought any advice from CQC. We also checked the provider's website; this also did not display the most recent CQC ratings or reflect the outcome of the last CQC inspection report. This did not provide transparency about the care and treatment provided by Doddington Lodge and did not help people to make informed choices about their care. We advised the registered manager that this needed to be rectified immediately.

This is a breach of Regulation 20A of the Health and Social Care Act 2008 (Regulated Activities).

Staff were aware of the whistle blowing policy and told us that they would feel comfortable to whistle blow if they felt that this was needed to ensure people's safety. Staff told us that they would not allow any abuse to happen and would report any concerns they had straight away.

The provider had when appropriate submitted notifications to the Care Quality Commission. The Provider is legally obliged to send us notifications of incidents, events or changes that happen to the service within a required timescale. This means that we are able to monitor any trends or concerns.