SHC Clemsfold Group Limited

Orchard Lodge

Inspection report

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Date of inspection visit: 14 and 15 September 2015
Date of publication: 04/11/2015

Ratings

Overall rating for this service	Requires Improvement
Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Overall summary

The inspection took place on 14 and 15 September 2015 and was an unannounced inspection.

Orchard Lodge provides personal and nursing care for up to 33 people with learning and physical disabilities, including two respite places. Most people have complex mobility and communication needs. Orchard Lodge is made up of two purpose built bungalows, Orchard Lodge which consisted of two units and Boldings Lodge. At the time of inspection, there were 29 people living at the service.

At the last inspection, on 3 November 2014, we asked the provider to take action to improve the way that they established and acted in accordance with people's best interests and to ensure staff received regular training and appraisal. The registered manager wrote to us at the end of March 2015 to confirm that they had addressed these issues. At this visit, we found that the actions had been completed.

The service has a registered manager. A registered manager is a person who has registered with the Care

Summary of findings

Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. While often based at the service, the registered manager had been working for the provider in a different role for over a year. An acting manager was in post. The provider informed us during our visit that a new manager had been appointed and was due to start in post in October 2015.

Following our last inspection, the service received a rating of 'requires improvement'. From April 2015 services have been required to display performance ratings. The provider had failed to do this, which meant that people using the service and relatives may not have been informed of our findings.

The lack of clear management had an impact on the day to day running of the service. Many of the staff were feeling demoralised due to staff absence, vacancies and a lack of clear direction. They did not feel that they were being listened to. One said, "We raise it (their concerns) but no matter what we raise they are not acting on it". Suggestions raised by staff and feedback received from people or their relatives had not always been acted upon in a timely fashion. Actions identified in audits had not been consistently followed up or completed.

People enjoyed good relationships with the staff who supported them. Staff were able to communicate with people and understand their choices. We found, however, that people were not facilitated by staff to use communication systems and to initiate communication. They relied on staff making suggestions that fitted with their wishes. **We have made a recommendation around how people are supported with communication**.

People were involved in a variety of activities. This included in-house activities such as craft or music and trips out to local attractions or towns. Some people attended day centre services or college. We found that records relating to people's activities had improved since our last visit but that some outings were curtailed due to staff vacancies, including for a driver.

Since our last visit, the registered manager had taken action to address breaches in the regulations. Where people lacked capacity to consent to decisions that restricted their freedom, assessments had been made in accordance with the provisions of the Mental Capacity Act 2005. This included best interest meetings and applications to the local authority under the Deprivation of Liberty Safeguards (DoLS). This meant that any restrictions were assessed and authorised as being required to protect the person from harm. Staff appraisals had taken place and an improved system for monitoring the status of staff training had been introduced. Staff were satisfied with the training on offer. They told us that there were opportunities to further their knowledge and to develop professionally.

People felt safe at the service and were treated respectfully by staff. Staff understood local safeguarding procedures and knew what action to take if they suspected someone had been harmed or was at risk of harm. There were enough staff on duty to keep people safe. Risks to people's safety had been assessed and reviewed. Any accidents or incidents had been recorded and reviewed in order to minimise the risk in future. People received their medicines safely and at the right time.

The premises were purpose built and well-equipped. People were able to access physiotherapy services via the in-house team. There were weekly GP visits and people were able to access other healthcare professionals as needed. Monitoring records were generally detailed but some contained gaps which suggested additional support may have been required to meet the person's health needs. In some cases, these did not appear to have been acted upon by staff. People were happy with the choice of food on offer and were supported to eat and drink if needed.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have told the provider to take at the back of the full version of the report.

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?

Good

The service was safe.

Staff had been trained in safeguarding so that they could recognise the signs of abuse and knew what action to take.

Risk assessments were in place and reviewed to help protect people from harm.

There were enough staff to meet people's needs and keep them safe. Due to staff vacancies the staffing numbers were maintained by using agency staff.

Medicines were stored, administered and disposed of safely.

Is the service effective?

Good

The service was effective.

Staff were knowledgeable about people's care needs. They had received training to carry out their roles and received supervision and appraisal.

Staff understood how consent should be considered and supported people's rights under the Mental Capacity Act 2005.

People were offered a choice of food and drink and supported to maintain a healthy diet.

People had access to healthcare professionals to maintain good health.

The premises were purpose built to cater for people's mobility and support needs.

Is the service caring?

Good

The service was caring.

People enjoyed good relationships with the staff who supported them. Staff understood what was important to people.

People were involved in making decisions relating to their care.

People were treated with dignity and respect.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's care needs were reviewed but monitoring was not always used effectively to ensure that changes in their health were noted and addressed.

Staff were able to communicate with people and offer choices but had not facilitated the use of communication systems to build on people's ability to initiate communication.

Summary of findings

Activities were sometimes curtailed due to a lack of regular staff and because of a driver vacancy.

People and their relatives felt able to approach staff if they had concerns, but they could not be assured of a swift response.

Is the service well-led?

Requires Improvement 

The service was not well-led.

The provider had failed to display their rating received following our last inspection.

There was a lack of clear direction and leadership which had impacted on staff morale and negatively affected the atmosphere at the service.

The registered manager and provider used a series of audits to monitor the delivery of care that people received. Actions were identified but had not always been followed-up or completed in a timely way.

Orchard 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 inspection took place on 14 and 15 September 2015 and was unannounced.

Two inspectors and an expert by experience with personal experience of a relative using this type of service undertook this inspection.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed the previous inspection report and notifications received from the registered manager before the inspection. A notification is information about important events which the service is required to send us by law. We used all this information to decide which areas to focus on during our inspection.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We looked at care records for eight people, medication administration records (MAR), monitoring records of people's weights, accident and activity records. We also looked at six staff files, staff training and supervision records, agency induction records, staff rotas, quality feedback surveys, audits and minutes of meetings.

During our inspection, we spoke with two people who used the service, five relatives or friends, the registered manager, two nurses, 10 care staff, one member of agency care staff, one physio assistant, the chef, a member of the maintenance team, an activity coordinator and two representatives of the provider. We also spoke with a GP, complimentary healthcare professional and entertainer who were visiting the service.

Good

Is the service safe?

Our findings

People told us that they felt safe at Orchard Lodge. Others conveyed by their body language that they felt safe; they appeared relaxed and were comfortable in the presence of staff. One relative said, “I do think he’s safe and they look after him nicely”. We spoke with staff about safeguarding adults at risk. Staff understood safeguarding and whistleblowing procedures should they suspect abuse had taken place. One staff member told us, "I would always tell my manager if I thought someone I was looking after was at risk. I’m sure they would do something but if they didn’t, I’d let the local authority know”. Another staff member said, “I think we are responsible for people’s good care as well as keeping them safe. That’s part of it and poor care is abuse”. Staff confirmed to us the registered manager operated an 'open door' policy in this regard and that they felt able to share any concerns they may have in confidence. They were aware that a referral to an agency, such as the local adult services safeguarding team should be made.

Before a person moved to the service, an assessment was completed. This looked at their support needs and any risks to their health, safety or welfare. Where risks had been identified, such as in moving and handling, the use of bedrails, malnutrition or from seizures, these had been assessed. For each risk identified, guidelines were in place to describe how to minimise the risk and the support that people required from staff. For example, moving and handling care plans detailed the number of staff needed to support the person, the equipment to use and guidance on how to carry out the transfer. For people who had epilepsy, there was clear information on measures that could reduce the instance of seizure, such as wearing sunglasses outside and controlling body temperature. We observed staff adhered to this advice when they ensured a person wore their sunglasses, whilst enjoying some fresh air. We also observed that staff were careful to ensure that people’s arms were protected when they went through doorways in their wheelchairs.

When we arrived we found that the door to the home was open. A side access door to Boldings Lodge was also open throughout the day. We saw that people had risk assessments in place regarding security of the premises. One read, ‘Front door of Orchard Lodge is kept locked for service user safety’ and noted a potential risk from strangers walking in. Although the registered manager was present in the office next to the main entrance on our arrival, and staff were working in Boldings Lodge, unauthorised access could put people at unnecessary risk. We discussed our concerns with the registered manager. They felt confident that the doors were monitored or secured if unattended.

There were enough staff on duty to meet people’s needs safely. Since a number of staff had left employment at the service in recent months, agency staff had been employed to maintain staffing levels. One staff member said, “A lot of staff have left recently but I know the manager is recruiting”. Staff told us that there was good continuity in the agency staff who worked at the home. One said, “We’ve had the same agency for two to three months now so it’s quite easy”. An agency staff member told us, “I feel like I’m one of the team”.

Each of the three units was staffed by a nurse and, depending on the unit, either three of four care assistants in the day. One person received one to one support and staffing had been planned for this. Staff rotas demonstrated that this staffing level had been maintained. We observed that staff were available and able to respond quickly when people asked for support. Throughout the day, staff were also able to spend time talking with people, sitting at the table, painting, and engaging with them. One staff member said, “Some days are busier than others but it’s fine. We have time to give to people so they can do activities”. Another told us, “We can look after them safely. We always work in pairs. You’ve always got back up”.

It was only at lunchtime we observed that some people who needed assistance to eat had to wait before being served their meals. During this time they were unoccupied and appeared bored. We discussed the possibility of parallel activities or staggered mealtimes with the manager. They told us that there was not usually a delay but that a member of care staff had been called away to accompany a person home from a nearby day-centre.

Staff recruitment practices were robust. Staff records showed that, before new members of staff were allowed to start work at the service, checks were made on their previous employment history and with the Disclosure and Barring Service (DBS). The DBS provides criminal records checks and helps employers make safer recruitment decisions. In addition, two references were obtained from current and past employers. These measures helped to ensure that new staff were safe to work with adults at risk.

Good

Is the service safe?

Where staff had been recruited from abroad, their eligibility to work in the United Kingdom had been verified. They had completed literacy assessments to judge their English language competency. At the time of our visit, the registered manager was recruiting new staff. This included full time hours for six care staff, an activity assistant for Boldings Lodge and a driver.

We observed staff administer medicines to people. Nurses explained their actions. One said, “It’s time for your medication now. I’m just going to (described procedure). Are you ok with that?” Medicines were labelled with directions for use and contained both the expiry date and the date of opening. Creams, dressings and lotions were labelled with the name of the person who used them, signed for when administered and safely stored. Medicines, including controlled drugs (these are drugs which are liable to abuse and misuse and are controlled by legislation) were safely stored in locked cupboards. Medicines requiring refrigeration were stored in locked fridges which were not used for any other purpose. The temperature of the fridges and the rooms in which they were housed were monitored regularly to ensure the medicines remained effective. Since our last visit, oxygen was clearly labelled with the name of the person it had been prescribed to. Records of administration were complete and demonstrated that people had received their medicines in line with the instructions from the prescribing GP.

Good

Is the service effective?

Our findings

At our inspection in November 2014, we found the provider was in breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This was because staff had not received annual refresher training or appraisal in line with the provider's policies. At this visit we found that a new system for monitoring staff training was in place and that the majority of staff had attended an appraisal meeting. The steps taken meant that the compliance action concerning supporting workers, set under the former regulations, was met.

People were supported by staff who had received training to carry out their roles. Staff spoke highly of the training offered by the provider. One said, "The training is super". Staff were required by the provider to attend training on an annual basis. This included training in moving and handling, fire, safeguarding, infection control, food hygiene, first aid and the Mental Capacity Act 2005 (MCA). Since our last visit, there was an improved system for tracking staff training. The acting manager said, "We can chase people up a bit more easily now". The provider had also introduced day courses to cover a number of topics, making it easier for staff to attend. We saw that a small number of courses were overdue but that staff had booked places on the next available course.

New staff attended a five-day induction programme run by the provider. In addition to the provider's mandatory training, this course included communication, duty of candour, dignity, eating and drinking, personal and intimate care, nutrition and hydration and epilepsy. New staff then had the opportunity to shadow experienced staff until such time as they were confident to work alone. Staff told us that they felt supported during their induction. One said, "I had a five day induction and did shadowing for two weeks. I like it". Another told us, "There was a lot of support around and I could always ask. The other staff were keen to help". Staff competency in moving and handling had been monitored by the in-house physiotherapy team. One agency staff member told us, "The physio is trying now to check on everything. She comes to the rooms, she checks how you are doing it. They are very keen on it (moving and handling)".

Additional training opportunities were available to staff. Examples of courses completed during 2015 included managing dysphagia (swallowing difficulties), communication and record keeping, venepuncture, leadership skills and roles in teams, psychosocial aspects of illness and person-centred care planning. Some staff were also enrolled to complete diplomas and health and social care. The provider worked with local universities to offer additional training. This included student nurse placements at the service and funding for existing staff to enrol on nurse training.

The majority of staff had attended appraisal meetings in February and March 2015. An appraisal is a formal opportunity to discuss the staff member's role, development needs and progress. In addition to this appraisal meeting, staff were scheduled to have three supervision meetings with their line manager each year. Supervisions for care staff were mostly on track and meetings had taken place in June and July 2015. We noted, however, that supervisions for nurses had not been carried out, with just one of eight nurses having received supervision in the same period. We discussed this with the acting manager. They explained that they were responsible for nurse supervisions but had fallen behind. They anticipated that this would improve once a full-time manager was in post. Some nurses told us that they would welcome more support and the opportunity for a discussion. Others felt adequately supported. One said, "It's not that often at the moment but that's fine. I can always ask the manager if I have a problem".

At our inspection in November 2014, we found the provider was in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This was because they had not followed the provisions of the MCA when people lacked the capacity to consent to limitations of their freedom of movement. At this visit we found that restrictions on people's liberty had been assessed. Where they lacked capacity to consent, best interest meetings had been held and Deprivation of Liberty Safeguards (DoLS) had been applied for. DoLS protects the rights of people by ensuring if there are any restrictions to their freedom and liberty, these have been authorised by the local authority as being required to protect the person from harm. The steps taken meant that the compliance action concerning consent to care and treatment, set under the former regulations, was met.

Staff had completed capacity assessments for people to determine whether they were able to make specific decisions. For example, people had been assessed to see if

Good

Is the service effective?

they could make decisions relating to the use of lap or chest straps in their wheelchairs or regarding medicine administration. We found, however, that there were also blank capacity assessments in some files. These did not include details of the specific decision to be made and simply stated that the person did not have capacity. We saw that this had been picked up in audits carried out by representatives of the provider and identified as an action point for staff to update in people's care plans.

Best interest meetings had been held for three people. These related to two safety gates used in bedroom doorways and a box bed with Perspex sides used by one person. Alternative, less restrictive options had been considered. At the time of our visit, the registered manager had applied for 11 DoLS for people who lived at the service. They had received decisions on three applications from the local authority. Staff had a good understanding of the MCA, including the nature and types of consent, people's right to take risks and the necessity to act in people's best interests when required. One staff member told us, "I know people have the right to make decisions for themselves unless it's proven they can't". Another staff member said, "I know about 'best interests' meetings. That's when people involved in a person's care and their families meet to decide what to do in a person's best interests if they can't decide for themselves". A third told us, "If they can't make the decision, we have to consult".

People were offered a choice of food and drink. Their dietary preferences and needs were noted when they moved to the service. These were updated via mealtime feedback forms, kitchen communication books and through direct feedback during resident meetings attended by the chef. One person told us, "The food's alright – good fish and chips". During lunch we saw that staff encouraged people to eat, offered alternatives and provided assistance. There was also information on people's preferences. In one care plan we read, 'I like to be prepared by being put in my chair, seeing my bowl, smelling my food, having a small taste on the end of the spoon before having a whole spoonful'. Some people used adapted cutlery, plates or beakers to promote their independence. One staff member told us, "We have good communication with kitchen staff. If there's any change in people's diets we will let them know".

Guidelines were in place for people who had specific dietary needs or who required their food to be presented in a particular way, such as thickened drinks or pureed meals. Kitchen staff used a 'service user food preparation plan', which described how food should be prepared and presented. People had been assessed and monitored to determine if they were at risk of malnutrition using the Malnutrition Universal Screening Tool (MUST). Where appropriate, referrals had been made to external healthcare professionals such as the GP, Speech and Language Therapist (SALT) or Dietician. One staff member said, "We have training on this as it's so important. Some people have special diets so we need to know what we're doing". This ensured that people had sufficient to eat in a way that reflected their preferences and reduced the risk of choking. Fluid monitoring was in place for people at risk of dehydration or for those who received their fluids via a gastrostomy tube (this delivers fluid and nutrition directly to the stomach). These had been used effectively with daily totals recorded to ensure people were sufficiently hydrated. Throughout the day we saw that people were assisted to drink. After lunch, one person made clear that they wished to have another cup of tea. This was quickly provided.

People had access to healthcare professionals. Physio services were provided in-house. This helped to support people with their posture, passive movements and in the use of specialist equipment such as tilt tables or standing frames. Physio therapists also led hydrotherapy or swimming sessions with people using the home's facilities. Weekly visits were arranged with local GP practices and there were regular visits from the chiropodist and reflexologist. People's health records demonstrated that professional advice was sought when required. There were also regular health checks and medicine reviews. The GP we met during our visit told us that staff were good at ensuring that their recommendations were followed. A visiting therapist said, "I'm very impressed with the care given. I can compare it with other homes I go into. They seem to know the residents well".

People's mobility and sensory needs had been considered in designing the premises, which had been purpose built. People's rooms and communal areas were personalised. In addition to the two hydrotherapy pools there was a sensory room. A sensory room can provide visual, auditory and touch stimuli to encourage people to engage with the environment or to provide a space for relaxation. Bedrooms and bathrooms were fitted with tracking hoists and bathrooms were adapted to facilitate safe bathing for

Good

Is the service effective?

people who could not mobilise independently. The premises and gardens were accessible. One staff member said, “The environment and the equipment – you can’t fault them”.

Good

Is the service caring?

Our findings

People appeared to enjoy the company of staff. One person said, "Yes, it's good here". Another who was not able to communicate verbally gave the thumbs up and nodded when we asked how they felt about living at the service. On returning home, another person was greeted warmly by staff who said, "Here comes (person's name). Welcome back! How was the day centre today?" We observed that staff encouraged people and had an understanding of what was important to them. Staff knew about people's family and friends and supported them to maintain these relationships. There was accommodation on-site for relatives to use if they wished to stay overnight. One staff member said, "There are a lot of caring people here. They are not just doing it as a job. They care about how they feel and do things that are interesting for them". A relative told us, "We are guided by (name of their relative). She is happy; she would let it be known to us if she wasn't. She is always happy to come back".

People were involved in planning their care and treatment. They, or their friends and relations, had been asked about individual preferences and interests. These had been used to determine the support they received and each person's care plan included a section on 'What matters to me'. We asked staff what they understood by the term 'person centred care'. One staff member told us, "I think it really means that the resident is at the centre of what we do. We treat people as individuals". Another staff member said, "I suppose it really means that people have care that's for just them and it's not a case of one size fits all".

During the day we observed that people were offered choices. After lunch one person was asked if they wished to stay and watch television or if they preferred to do something else. The person was able to indicate that they wanted to watch the television. One person told us how staff had helped them to personalise their room. They said, "I like it here. I like my curtains and look at my bed (cover) matching. (Name of staff member) helped me get it". We saw that staff encouraged people to be independent where they were able, for example by eating their own meals. One staff member said, "I don't interfere if I think someone can do something for themselves". Another explained, "Some people need a lot of help here but when you get to know them, you find out what they can do for themselves and you encourage that". On the wall in the kitchen and dining area there was a display board that showed which staff were on duty that day. This helped people to understand who would be supporting them. Information in people's care plans was presented in an easy to read format using pictures and symbols to aid understanding. In Boldings Lodge, people had personalised planners in their rooms that showed the activities and outings they would be involved in. This example of good practice was not often replicated for people in Orchard Lodge, although this did not have an impact on the caring approach by staff.

Staff treated people respectfully. They addressed people by their preferred names and gave them time to consider and respond to questions. One staff member said, "We have to remember it's their home. We won't go wrong if we remember that". At lunchtime we saw a member of care staff directed an agency staff member to refrain from putting clothes protectors on people until their meal was ready to be served. This upheld people's dignity. During the mealtime staff took care to keep people's clothes clean and to maintain their appearance. Staff respected people's privacy. They were discreet when asking people if they required assistance, such as to use the toilet or when sharing information about people's care within the staff team. We saw that they closed doors when providing personal care.

Requires Improvement

Is the service responsive?

Our findings

People and their relatives were asked for feedback on the service. There were regular residents' meetings. These provided an opportunity for people to discuss activities, staff changes and to share any worries they might have. People had also been asked to complete surveys. These asked if they like living at the service, if the felt well cared for, if their privacy was respected, if they could decide what to do, if they felt safe and if they knew who to speak to if unhappy. There were three responses on file, all of which were positive. Relatives had been invited to a cheese and wine evening in May 2015. They were also part of the summer garden party which, this year, had a Cinderella theme. These events provided an opportunity for them to meet with staff and the managers of the service. The provider sent surveys to relatives. We looked at the responses. One relative had commented, 'Have been impressed by the standard of care provided by Sussex Healthcare'.

We found, however, that some feedback had not been responded to in a timely way. In one survey response dated January 2015, a relative had given a low score to questions regarding the bedroom furniture and carpet. There was no evidence on file to suggest that the provider had responded to this feedback at the time it was received. In the staff meeting minutes from April 2015 we saw that a suggestion had been made to reposition one person's television making it easier for them to see when in bed. Following our visit, the registered manager told us that both of these points were in hand. We asked for clarification as to any action that had been taken at an earlier date but we did not receive a response. One person told us, "When I go to bed at night, I get cold. I've told them, and the night staff. I'm still cold". The person did not feel that they had been listened to as the issue had not been resolved. The registered manager told us that they welcomed feedback. They said, "No matter what it is – good or bad – we can follow it up". Nevertheless, we found that some feedback or suggestions for improvement had not been acted upon in a timely manner.

The lack of action in response to feedback on the services provided represents a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Most people who lived at the service were unable to communicate verbally. People's care plans included information on how they indicated a choice. For example, we read, 'For a yes, I can eye point and lean towards a desired object. For a no I will push or look away'. Staff had also completed the Disability Distress Assessment Tool (DisDAT) which described physical or vocal cues that would alert staff to how a person was feeling. We read, 'When I put my hand in my mouth I am distressed. When I scream and shout or kick my legs I am happy'. We observed that staff communicated with some people using gestures. One staff member said, "I know how to communicate with them".

One person used an adapted iPad to communicate and share photographs of activities they had been involved in. Staff explained that this person's family had been instrumental in moving this forward. We found, however, that there was limited use of specialist methods of communication in the service as a whole. One person had a communication book when they moved to the service but this was no longer in use. It was kept in their care plan rather than with them. This meant that it could not be used by visitors to understand how best to communicate with that person. In another person's care plan there was information on the Picture Exchange Communication System (PECS) which uses pictures rather than symbols. A third described how staff should show the person pictures of basic needs such as food, drink and toilet and encourage them to make choices. Neither of these systems had been actively used by staff at the time of our visit.

Whilst staff demonstrated skill in understanding people's wishes and offered choices accordingly, people were not enabled to initiate communication. Some relatives that we spoke with told us that it was difficult to learn what their relative had been doing during the week. One relative suggested that a diary or communication book would help them to feel involved and to be updated. They said, "That way, we know what (name of person) has done each day". Another relative said, "I don't like it when I get the response to a question – 'I wasn't here on duty then, so I don't know'". **We recommend that the service explores and makes use of communication systems to promote people's ability to communicate their views and share experiences with staff, relatives and visitors.**

People's individual care and support needs were detailed in their care plans. These described how they liked to be supported and how risks relating to their health or

Is the service responsive?

wellbeing should be managed. These were reviewed monthly by staff and updated with any changes. For example, following a period of illness, one person was no longer able to safely transfer from their wheelchair independently. Staff currently used a hoist to assist this person until such time as they regained their strength. Staff were aware of this change and it had been updated in their care plan.

Most staff felt confident that they were updated regarding people's current needs. One said, "We are told at handover, for example (person) has gone from having their drinks spooned to using an adapted cup". Another told us, "We get information every day". Key information was included in staff communication books. Staff told us that they read through the information added during any days off so that they were aware of changes. Other staff, however, felt that working in different parts of the service made it difficult to keep abreast of changes. One said, "There's no continuity and we're not in the same part of the building the whole time. Then we don't know answers to questions from relatives".

Where monitoring was required to mitigate risks, such as bowel monitoring for people who were prone to constipation, records were in place. We sampled monitoring records for people's weight, fluid intake, bowel movements and seizures. We found that bowel monitoring records were not always completed. We looked at gaps of more than four days in the records. In each case these were explained by looking through the nurse and care assistant daily notes. We found that a record had been made but had not been entered on the monitoring chart. We discussed how needs were monitored with the nurse on duty as we were concerned that gaps dating back to June 2015 had not been investigated. They were unable to provide an explanation. For one person we found that their record of menstruation was blank. This indicated that the person had not had a period in 2015 to-date. The nurse on duty was unable to confirm if this was the case, if this was normal for the person or if a referral had been made to the GP. We asked the registered manager to provide an update following our visit but did not receive any further information. We found that whilst monitoring records were generally of a good standard, we could not be confident that they were always used effectively to monitor and respond to changes in people's health needs.

Information about the daily and weekly activities was on displayed in a bright and visual format in each part of the service. There were photographs and memory boards of events such as birthdays and the annual garden party. This showed that the staff had made efforts to capture and record the events, and to provide people with an appropriate way of remembering them.

People were involved in a range of activities. During our visit there were group craft and musical activities taking place. These were enjoyed, though some people were more engaged than others. One person told us, "Going to bake – quiche, marmite and cheese straws. Nice". In records of the activities we saw that some people had particular hobbies such as fishing or horse-riding. Others had enjoyed trips to a local animal rescue centre, a jousting event, theatre and shopping trips. A number of people attended day centres run by the provider on a regular basis, another went to college. One person told us, "I go on the big bus. (Name of driver) is my driver. He drives very well. I like the day centre. We had a birthday party for (name of other person) today". Since our last visit the records of activity that people had been involved in were more detailed. This made it possible to see what each person had been involved in and allowed staff to monitor and develop their activity programme.

Staff told us that outings were sometimes limited because they had vacancies in the staff team. They explained that whilst there were enough staff to support people at the service, they were unable to send agency staff to accompany people on outings but neither could they leave only agency staff working in the unit. This meant that, sometimes, alternative in-house activities needed to be scheduled. One staff member said, "For some time there has only been one activity staff (in Boldings Lodge) but carers do it on a one to one basis". There has been a vacancy for an activity assistant and for a driver. A staff member told us, "It is lovely here, but I wish we were a bit nearer town, so we could go out for walks, to the shops and so on. We're very dependent on minibuses and drivers for accessing the Community". A relative said, "At home with us, we go out a lot and do things. I wonder if sometimes there aren't enough extra outings here".

The provider had a complaints policy which was clearly displayed, including in an easy to read format. People were also invited to raise any concerns during resident meetings. In the minutes of one meeting we read, '(Staff member)

Requires Improvement

Is the service responsive?

explained to the service users that no matter how many times they made a complaint they will be assured that the provision of care will never be affected'. This assurance had been included in the provider's complaints policy which was dated March 2015. Formal complaints had been dealt with appropriately and in accordance with the timescales set out in the policy. One relative told us that they had not needed to complain but would feel comfortable to do so. Another said, "I haven't had cause to complain as such, but I do mention things on quite a regular basis, they are probably fed up with me!"

Requires Improvement

Is the service well-led?

Our findings

The atmosphere at the service was calm. People received caring support from staff but there was a lack of enthusiasm. Many staff told us that their morale was low and that this was primarily due to staff absence, vacancies and a lack of direction from management. One said, "I don't feel that there is enough leadership. It's very confusing sometimes when you are trying to get an answer to something. I know they are looking to get a full-time manager. I hope things will improve then". Another told us, "I think we do our best here. We've had a lot of new staff and we don't have a full-time manager on site all the time so it can be difficult".

Relatives told us that they were able to visit freely. They felt able to approach staff if they had concerns. One said, "They are mostly very approachable, and there are one or two exceptionally good staff". Staff too felt able to raise concerns. One told us, "We know what to expect and I feel I can say what's on my mind". Staff had an understanding of 'duty of candour' and its relevance to the care and support of people living at the home. Duty of candour forms part of a new regulation which came into force in April 2015. It states that providers must be open and honest with service users and other 'relevant persons' (people acting lawfully on behalf of service users) when things go wrong with care and treatment, giving them reasonable support, truthful information and a written apology. All of the care staff members we spoke with were aware of this regulation and were able to describe its relevance and application. One staff member told us, "They get good care, I'm proud of the company".

The provider had not displayed their rating received following our inspection in November 2014. There was an A5 size laminated notice in the entrance hall which stated, 'CQC new ratings and report can be found in the statement of purpose'. When we checked this folder the latest inspection report was missing. From April 2015, providers are required to display performance assessments by law. This should be conspicuous and in a place accessible people who use the service. It should also be displayed on the provider's website.

This was a breach of Regulation 20A of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection in November 2014, a change in the management at the service was planned. We made a recommendation that the management arrangements for the service be confirmed at the earliest opportunity to ensure clear accountability and oversight. At this visit we found that the management arrangements were unchanged. The registered manager explained that the provider had been recruiting during this period but that it had taken time to identify the right candidate. The registered manager, although regularly based at the service, was working as an area manager for the provider. They told us that they had been in post as an area manager for a year and five months. The acting manager was a nurse at the service. Due to the holiday period and staff vacancies the acting manager had been working mostly as a nurse, leaving less time for management oversight. We found that this hiatus in clear management oversight had an impact on the service, in terms of governance and staff morale.

Staff told us that action was taken when people needed additional support. One said, "They get things done for the service users. They're very on the ball about that". They told us however that when they raised concerns relating to their work, these were not always taken on board or responded to. One said, "The trouble is management". Another told us, "The company itself doesn't lack anything. There are good facilities, but the problem is the support for the staff from the managers". When asked what could improve the service, another said, "Support is the main thing". We noted that nurse supervisions had fallen behind schedule due to time pressures on the acting manager. One staff member said, "She's the acting manager and a nurse at the same time. It's difficult". Another said, "Since (the registered manager) became the area manager she is no longer looking into all these problems". A third told us, "I feel able to say anything to (the registered manager), and I know she would listen. Sometimes though it's not acted upon". Staff had been reminded at staff meetings to direct any issues to the acting manager rather than the registered manager.

The provider told us that a new manager had been appointed and was due to start in post in October 2015. One staff member said, "If we have an experienced manager who is really motivated and devoted they will be able to get the place running really well".

There was a system in place to assess and monitor the quality of the service that people received. Audits were completed by the registered manager in their capacity as

Requires Improvement

Is the service well-led?

area manager, by representatives of the provider and by external contractors. These audits had identified areas for improvement. Whilst there was good progress in some areas, for example in health and safety, the system in place was not effective at ensuring that identified improvements were followed through and competed in a timely manner.

Following each monthly audit, an action plan was agreed. This included timescales within which the identified action should be completed. The action plans were blank. There was no evidence of completed actions or extended deadlines. One action to update the format of a hospital passport had appeared in the March and June 2015 visits. It was still not completed. Similarly actions recorded in an internal audit from March 2015 noted as for 'immediate action' remained. These included making reference to the decision to be made in assessments of people's mental capacity and ensuring that appropriate terminology, such as bed rails rather than cot sides, was used in people's care plans. These points had also been highlighted in an external audit during July 2015. During our visit we found that despite monthly reviews of people's care plans these issues remained unresolved. Some other audits had not been repeated. The infection control audit was dated 2013. A representative of the provider confirmed that this should be completed annually. The fire risk assessment had been due for update in June 2015. This review date had been highlighted in the action plan from an external health and safety audit during May 2015 but had yet to be actioned.

We found that learning from incidents at other services run by the provider had not always been implemented. Following injury at another service in April 2015, the safeguarding enquiry made a recommendation that where people were at risk of or had a diagnosis of osteoporosis, risk assessments were in place and reviewed yearly. For one person who staff told us had a diagnosis of osteoporosis, there was no risk assessment in place. The care plan did not make reference to the osteoporosis, though it did say only staff trained in supporting that person should assist them. Another person had an osteoporosis risk assessment dated 2006, which had not been reviewed.

The provider and registered manager had not consistently used the findings of performance assessments or feedback to improve their practice. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager showed us a new follow-up and monitoring form that had been introduced by the provider. They told us, "I think it's brilliant and it should work a lot better". This had been populated with actions raised in monthly monitoring visits during 2015 but had yet to be used to monitor progress.

There were also examples of audits driving improvement. The service had achieved an improved score in their external health and safety audit, from 80 to 92% over the course of a year. Monthly sling audits demonstrated that new slings were ordered when slings were found to be faulty, such as if a hole had developed or the label was faded to the point it was illegible. Accident and incident records were reviewed on a monthly basis and the information sent to the provider for further analysis. There was evidence of action taken such as GP referrals or practical solutions such as a change of footwear when redness was identified.

Since our last inspection the registered manager had taken action to address breaches in the regulations. The service was now meeting the requirements of the regulations in the areas of staffing, specifically regarding staff training and appraisal, and the need for consent. However, at this inspection we have highlighted additional areas for improvement.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **The provider had not acted on the findings of performance assessments or feedback for the purpose of continually evaluating and improving the service.** Regulation 17 2(e)(f)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 20A HSCA (RA) Regulations 2014 Requirement as to display of performance assessments **The provider had failed to display the rating received in its performance assessment by the Commission.**