# T C Irving & JW Irving

# Etherley Lodge

## Inspection report

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## Ratings

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

## Overall summary

This inspection took place on 21, 22, 23 October 2014 and was unannounced. At our last inspection the service was judged as compliant

Etherley Lodge provides accommodation for up to 38 people with personal care needs. At the time of our visit there were 28 people living in the home. The home is a large converted house and included three dining areas and three smoking rooms. The bedrooms were mainly single room accommodation. Bathroom and toilet facilities were shared, although we found the provider had installed toilet facilities in some rooms. Local amenities were accessible to the home.

Etherley Lodge had 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 2008 and associated Regulations about how the service is run.' Etherley Lodge has a registered manager in place

We found Etherley Lodge to be inadequate in all areas that we inspected. We looked at guidance for providers in mental health including the following:-

# Summary of findings

- National Institute of Clinical Excellence – Mental Wellbeing of older people in care homes published December 2013
- National Institute of Clinical Excellence - Quality Standard for service user experience in adult mental health published December 2011;
- Mental Health Act Code of Practice 2008

The provider had failed to take account of this guidance.

We saw other health and social care professionals had provided information about people's care needs and any associated risks to the provider. This information had not been transposed into the provider's care plans and there were no risks documented to ensure people were safe and their risks mitigated.

We found staff had not been safely recruited and where following a Disclosure and Barring check staff were found to have committed offences, these were not risk assessed to see if the staff were safe to work with vulnerable people.

We found the home was not clean and cleaning schedules did not demonstrate cleaning had taken place on a regular basis. We found a build-up of grease and grime in areas of the kitchen and the laundry area was cluttered with no segregation between clean and dirty areas. This increased the risk of cross contamination.

People on specialised diets were put at risk of potential health problems and kitchen staff

Kitchen staff were not aware of one person's specific dietary requirements. There was a menu in place but people asked at each meal for alternatives and the provider did not have in place a method to monitor people's nutritional input to ensure people were not put at risk of inadequate nutrition.

We found no provider assessments were in place as to the capacity of any of the 28 people at Etherley Lodge to make specific decisions in accordance with the Mental Capacity Act 2005. The provider therefore had not ascertained if people needed to be subject to Deprivation of Liberty Safeguards.

We found there were three smoking lounges throughout the home there was a constant smell of smoke. The provider did not have in place arrangements to offer people who did not smoke alternative living arrangements. Most people sat for the day in the smoking lounges and people were not protected from the effects of second hand smoke.

We asked two people about their care plan, one did not respond and the other person said, "What care plan?" We found there was no evidence that people using the service had been involved in the development of their plan of care and the plans did not reflect how to manage their diverse needs, current situation or discussion on future plans.

We discussed activities with people and were told they had asked for activities but none were provided. People were given a questionnaire to complete if they did not want to attend a residents meeting. We found the provider failed to respond to people's comments.

The provider did not have in place people's personal records which were accurate and fit for purpose. We found people's records did not accurately describe their needs for example we saw assessments had been carried out by adult services one person required their day to be structured, the provider's assessment did not include this and their care plan did not incorporate structured activities in their day. No information was given on how risks were to be minimised for people.

During the inspection we asked the registered provider and the registered manager for risk assessments for using wheelchairs and driving the home's vehicle and there were none available. When these deficits were pointed out to the registered provider they responded by creating risk assessments on the day of our visit. This meant the management team had not been proactive in ensuring people's safety.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

# Summary of findings

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

We always ask the following five questions of services.

**Is the service safe?**

Inadequate

The service was not safe.

Information provided by other health and care professionals was not included in people's care plans to enable staff to care for people appropriately.

We found staff had not been safely recruited and where some staff had committed offences these were not risk assessed to see if they were safe to work with vulnerable people.

We found the home was insufficiently clean to reduce the risk of the spread of infection and the provider did not have in place a robust arrangement for managing the premises.

**Is the service effective?**

Inadequate

The service was not effective

We found staff were not given access to people's care plans to understand people's needs. They were given 'special care schedules' with a list of tasks to be completed each day. Staff did not demonstrate what they had done on the special care schedules to provide the care for people.

We found the provider did not protect people from the risks of inadequate nutrition. We observed people were told what was for each meal and people then asked for a range of alternatives. Whilst alternatives were provided for people, the provider did not identify if people's dietary needs were then appropriately met. Kitchen staff were not aware of a particular diet for one person. People on specialised diets were put at risk of potential health problems.

Staff training did not meet the recommended requirements. We found staff caring for people with mental health issues who had not received training in mental health. Staff had not received training to meet the needs of people who lived at the home.

We found no evidence that the Mental Capacity Act 2005 had been considered or implemented appropriately for people.

**Is the service caring?**

Inadequate

The service was not caring.

We found the care and well-being of individuals, their preferences and their health needs were not being met, for example a person was discharged from hospital with a breathing disorder and returned to a bedroom which was damp

We found there were three smoking lounges and throughout the home there was a constant smell of smoke. The provider did not have in place arrangements to offer people who did not smoke alternative living arrangements. Most people sat for the day in the smoking lounges and people were not protected from the effects of second hand smoke.

# Summary of findings

We asked a person about their care plan and they said, “What care plan?” We found there was no evidence that people using the service had been involved in the development of their plan of care and the plans did not reflect how to manage their diverse needs, current situation or discussion on future plans.

**Is the service responsive?**

**Inadequate**

The service was not responsive.

Some people were on long term medication and had refused to see their GP for monitoring. When asked the registered manager was unable to give us the side effects of the long term medication to ensure the service could identify and respond to any ill effects appropriately.

People told us they had asked for board games and activities but none had been provided. The home did not provide activities in line NICE best practice guidance for older people.

We saw the provider gave out questionnaires to people prior to a staff meeting to ask their opinions about the service including their bedroom conditions and the service they received but did not follow up the concerns raised by people.

**Is the service well-led?**

**Inadequate**

The service was not well led.

We found the provider did not have in place a mechanism for routinely gathering the views and opinions of people who visited the service to enable them to come to an informed view about to the standard of care and treatment they provided to people.

Throughout the inspection we repeatedly asked the registered provider and the registered manager for risk assessments for example on using wheelchairs and driving the home’s vehicle and found these to be absent. When these deficits were pointed out to the registered provider they responded by creating risk assessments on the day of our visit. This meant the management team were not proactive in ensuring people’s safety.

We found the provider did not have in place record keeping arrangements which protected people. For example people who were at risk of falls did not have risk assessments in place. People’s personal records were not accurate and fit for purpose. We found people’s records did not accurately describe their needs or give information on how risks were to be minimised.

# Etherley 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 checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.'

This inspection took place on 21, 22, 23 October 2014 and was unannounced.

The inspection team consisted of a lead Adult Social Care Inspector and two other Adult Social Care Inspectors from the Commission and a specialist advisor with the Commission whose experience was in mental health services.

Prior to the inspection we reviewed information available to us including notifications. We asked the provider to complete 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 what improvements they plan to make. We also reviewed information sent to us by Durham County Council's Safeguarding Adult Team.

During the inspection we spoke with nine people who used the service and four relatives and we also spoke with nine staff members including the registered manager and the provider. We looked at seven paper and three electronic care records and observed people.

Following the first day of inspection we contacted the Prevention and Infection Control Team who visited the premises. We also contacted the District Fire Safety Officer, County Durham and Darlington Fire and Rescue Service. Both services provided a verbal report to us during the inspection and followed their verbal report with written information. After our inspection we also spoke to the Environmental Health department at the local council, they provided us with written information following their visits to Etherley Lodge.

After the inspection we spoke to three Adult Social Care managers and one social worker to gather their views.

Inadequate

# Is the service safe?

## Our findings

The provider told us in their pre-inspection information, "All residents that are admitted are only done so if an up to date care plan is available and assessment by us is made. This is to ensure we can fully meet their needs and Etherley Lodge is an appropriate environment for them." During our inspection we saw people had paper record files, these contained assessments given to the provider by other adult services. The assessments documented risks for people, however we found the provider's paper and electronic assessments did not contain this information and risk assessments were not in place. For example we saw in one person's care plan risks had been identified by the local authority adult services team. These included drinking and drug use but there was no care plan information and no risk management strategy in relation to these.

We looked at the paper records for a person and found an assessment of their needs prepared by Durham County Council's Children and Adults Services. This assessment identified that the person had a mild learning disability, a history of behavioural problems and needed support with behaviour, communication and activities. We saw in the provider's needs assessment this information was not included to enable staff to care for this person. We asked the registered manager about the blank communication plan. She told us, 'There is no plan.' We found the provider did not have in place care information which described how people were to be cared for.

We found the provider had in place an accident file. We reviewed the accidents recorded by the staff. We saw one person had a fall which was recorded in October 2014. We observed the same person being supported by staff; one member of staff let go of the person and the person reached out to grab the wall. The provider told us there were no concerns about the person's mobility. In information given to the provider by the local authority adult services team the person was described as being at 'risk of falls'. There was no analysis of the fall by the provider to ensure the person was safe and there was no risk assessment in place to address their needs.

This is a breach of Regulation 9 of the Health and Social Care 2008 (Regulated Activities) Regulations 2010

We asked about one person's requirement for topical medicine and, the lack of evidence to suggest topical medicines had been used and the provider did not respond. During our inspection we also raised concerns about the same person's health needs identified during the previous night. The registered manager told us the person did not like doctors and they had taken no action but were waiting for the person's GP surgery to open at 1pm. We advised the registered manager to contact 111 and seek further medical advice. We made a safeguarding alert to Durham County Council during the inspection as we were concerned about the provider failing to protect this person's health.

This is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010

We reviewed people's medicines and found the service used a prepared bio-dose system. We found no gaps in people's medicines records.

We looked at staff recruitment to see if staff had been safely recruited. On one person's file we saw two handwritten references. We asked the registered manager about the referees and she told us they were people known to them locally. We pointed out to the registered manager they could not guarantee the handwritten references came from staff member's referees. The registered manager told us they had checked with the author of the reference if they had written the reference, but was unable to produce any evidence of this. We found the sources of references were unclear.

We asked the registered provider about them undertaking Disclosure and Barring Checks on staff members to ensure they were suitable to work with vulnerable people. The registered provider showed us the checks they had carried out and we found some of the staff had previous convictions. We asked the provider for a risk assessment to demonstrate the provider had considered if there were any risks to people as a result of these checks. The provider told us there were no risk assessments. This meant the provider had not carried out appropriate checks to see if prospective staff members were safe to work with vulnerable people.

This is a breach of Regulation 21 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010

We found the home was insufficiently clean to reduce the risk of the spread of infection. We looked at the cleaning schedules for the building and found according to the schedules no lounges had been cleaned since 6 October

Inadequate

# Is the service safe?

2014. We also saw that no cleaning had been carried out on a further seven days in October 2014. We looked at three people's mattresses and found they were splattered with brown stains and cigarette burn holes and in one person's bedroom the mattress was dirty with the edges worn. The relatives of one person invited us into their relative's room to consider the cleanliness. We saw the surfaces were dusty and stained; there was debris under the bed. Their towel in the room was dirty with brown stains. We saw the provider had partitioned off a corner of the room and installed a toilet in the bedroom without adding a door. The toilet had brown stains in the bowl. One person told us they thought their relative was living in a 'dungeon'.

We saw the laundry area was cluttered; there was no segregation of dirty and clean washing. This meant the risk of cross contamination was not reduced. In the main kitchen we found the skirting boards were stained brown with grease built up on the floor edges and legs of fridges. The oven stood on vinyl tiles which we saw were torn with the inner material exposed. We saw chains hanging in a door way, the chains were stained brown. At the time of the inspection the dishwasher was broken and we saw inside a build-up of grime in the tray. We also saw under the sink the pipework was dirty with brown stains. This meant the kitchen was not sufficiently clean to reduce the risk of infections.

This is a breach of regulation 12 of the Health and Social Care 2008 (Regulated Activities) Regulations 2010

We asked the provider for the most recent Fire Risk Assessment and saw it was dated 22 September 2013; it had been due for renewal 22 September 2014. We found the control measures identified by the provider to reduce the risk of fire had not been put in place. For example one action stated, 'Cellar area to be cleared of all combustible materials and additional fire protect as per DFP report of 22/6/2011'. The completion date was 11 November 2011. We saw household paints and paper records stored in the cellar. This meant having identified a risk the provider had not reduced its potential impact.

In the same fire risk assessment we saw the provider had identified there were people who needed personal assistance to evacuate the premises. We found there were no personal evacuation plans in place. During our inspection we contacted the local fire safety officer and made them aware of our concerns. They visited premises on 22 October 2014 and sent the provider a report with required actions to comply with the Regulatory Reform (Fire Safety) Order 2005.

We spoke with the maintenance person who said they could not get jobs done because they had to drive people. We asked them how did they know what to do, they told us they had been at the home, "Long enough to know what needs doing". We asked the provider for the maintenance records and they showed us a list of 99 tasks dating back to February 2010. We found no indication if tasks had been started or completed. This meant the provider did not have in place a robust mechanism for managing the maintenance of the premises.

We looked at portable electrical testing and found no indication if some of the items had been tested, for example kettles in people's rooms. The provider was unable to give us a list of tested items. We found one person had extended a lamp cable across their bedroom floor. They told us it was because the main light in their room was not working. At our request the provided called an electrician to repair the light due to uncertainty about its safety. We also saw damp patches across the window wall of another person's bedroom. The person told us their room was cold. We asked the provider about the damp walls and he explained this was because the roof had leaked.

This is a breach of regulation 15 of the Health and Social Care 2008 (Regulated Activities) Regulations 2010.

We saw there were two wheelchairs in the home and asked the provider who used the wheelchairs; he said "no-one". The registered manager told us she brought a wheelchair in to the home and it was used for transporting people to and from ambulances. We saw in the provider's staff handbook no one was able to use the wheelchairs unless they were trained. We found two people had been trained in moving and handling. We asked the registered manager if we could see risk assessments for the use of the wheelchairs to make sure they could be used safely, she told us there were no risk assessments in place.

This is a breach of regulation 16 of the Health and Social Care 2008 (Regulated Activities) Regulations 2010

Inadequate

# Is the service effective?

## Our findings

In the provider information return the provider told us, 'The salient points on the care plan is transferred to the daily individual 'Special Care' schedules that staff have access to and informs them of what action should be taken - and when. These are used to ensure the appropriate care IS provided at a level required by the individual'. We attended a staff handover meeting and staff showed us people's schedules for each day; the nightshift staff recorded the times they checked people. However day staff had not routinely recorded what actions they had taken in relation to the tasks; this meant we were unable to evidence if people had received care.

We found staff did not have the information required to be able to care for people. The provider told us the staff did not have access to electronic care plans. We spoke to staff about the plans and they confirmed their lack of access to information. One staff member s said the "office is locked at night". We found the information on the 'special care schedules' did not describe people's needs.

This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010

We found the provider did not have in place care plans and risk assessments about people's nutrition. For example we spoke with the kitchen staff and asked about specific diets. We were shown the daily menu request sheet and we were told the people on the list with stars next to their name were diabetic. We asked if there was anyone on a low salt diet, they said, "No". During our inspection we found one person required a low salt diet and was to be encouraged to drink fluids. We discussed with the care staff on duty how was this measured and was told there were no measurement in place. This meant staff were not responding appropriately to people's nutritional needs.

We looked at the menu and saw it did not offer people choices nor ensured people on special diets were catered for. For example we saw one person was eating jam roly-poly and custard, we spoke to them about their diabetic diet. They said, 'yes and I have these as well' and showed us two low fat yoghurts. We did not see any guidance for staff in the form of a care plan or risk assessment to instruct them on how to care for someone with diabetes. This meant people were put at risk of diabetic complications such as confusion, blindness, infections, and diabetic coma.

This is a breach of regulation 14 of the Health and Social Care 2008 (Regulated Activities) Regulations 2010

The provider showed us daily diet sheets where people were told what the menu for the day was. People then asked for a range of other foods. We found one person who had been crossed of the lunchtime menu and was in the home at lunchtime that day. This approach meant the provider was not able to demonstrate people were protected from the risks of inadequate nutrition. During our visit one person's family who told us their relative was given their lunch in the smoking room without cutlery and the meal had gone cold. The family saw it removed from their relative uneaten. We spoke with a senior member of staff about the issue who said the staff would not have given someone their lunch without cutlery. On the following day we checked the special care schedule for the previous day and found the box to say the person had lunch and tea was ticked. We could not be assured this person had both meals.

In the provider's employee handbook we read guidance on the use of wheelchairs and the staff training required. We asked the registered provider who used a wheelchair; they said 'no-one'. We saw two wheelchairs in the home and pointed out to the provider a torn sign on the wall entitled 'Notice Safety Guidelines when using "wheelchairs". The provider said the notice was there just in case anyone needed to use a wheelchair. We spoke to the registered manager about the wheelchairs. She said she had brought a wheelchair into the home and it was used for getting people to and from ambulances. We asked to see the risk assessments in place to support this. The registered manager told us there were none in place.

This is a breach of regulation 11 of the Health and Social Care 2008 (Regulated Activities) Regulations 2010

There was no staff training recorded for the use of wheelchairs. Only one member of staff was trained in moving and handling. This meant people were put at risk as staff had not been trained in the use of wheelchairs.

The provider told us staff supervision meetings took place bi- monthly. We looked at staff supervision records which confirmed staff supervision dates had been recorded bi

monthly. We asked to see the records of the meetings. The provider told us they had recorded the meetings and indicated comments on the electronic records which said for example 'started well'. The provider was unable to produce any evidence of discussion which may include the staff member's personal development, their training needs or discussions about their concerns. This meant we were unable to ensure staff received effective support.

We looked at staff training and considered the 'Guidance on Mandatory Training for Providers of Care in regulated services published by the Regulation and Quality Improvement Authority September 2013'. On request the provider gave us a current staff skills analysis report. We saw the report listed training for 22 staff without dates. This meant the provider was unable to confirm when training had taken place or plan training updates. Out of the 22 staff listed we saw 13 staff had received training in adult protection; nine staff had been trained in Infection Control; five staff had been trained in Essential Food Hygiene. This meant staff had not received the mandatory training as set out in the guidance.

We also looked at training specific to the needs of people and found ten staff had been trained in the Mental Capacity Act 2005 and seven staff had been trained in Mental Health. We found insufficient numbers of staff were trained in mental health issues to enable them to care for the people at the home. Only two members of staff had received training on Diabetes Care and we identified times on the rota when no one on duty with the relevant knowledge to deal with diabetic concerns.

This is a breach of regulation 23 of the Health and Social Care 2008 (Regulated Activities) Regulations 2010

We asked the registered manager about people's mental capacity and they told us everyone had capacity. During the inspection we tried to talk with one person who did not respond to us. We saw the same person on two separate days fidgeting with a dirty towel and heard them singing to themselves. We asked the registered manager about the person's mental capacity, they told us the person had full capacity. In their paper file we found a copy of a "Refusal to accept/attend GP consultation(s)" document dated in 2011. This stated that '[the person] has the capacity to make their own decisions, and [they] request no input from her GP'; this was signed by the person. There was no evidence of mental capacity assessments in the person's file. Given the seriousness of the decision to refuse healthcare we looked for evidence of a best interest decision meeting taking place and found none. This meant that although the person had stated their wish not to see a GP in 2011 there was no recent mental capacity assessment to assess if the person's capacity had changed and they were still able to make this decision.

In one person's file we saw the local authority plan identified a person had communication difficulties. We found these difficulties had not been assessed. This falls short of the requirement of the Mental Capacity Act 2005 to take all practicable steps to help people make decisions, communicate in ways appropriate to service user's circumstances and permit and encourage people to participate as fully as possible in acts or decisions affecting them.

We saw in a person's file bank statements which showed money once deposited was immediately withdrawn. We spoke with the provider about these financial transactions and saw a document dated December 2004. The word 'yes' had been circled to indicate they wished for their mail, money and medication to be dealt with' by the office'. The document was unsigned. We found consent to care for finances had not been obtained.

We found no provider records as to the capacity of any of the 28 people at Etherley Lodge to make specific decisions in accordance with the Mental Capacity Act 2005. While the lack of documentation is a serious failure in itself it was also unclear whether any capacity or best interest's assessments had been carried out at all. As a consequence the service was unable to demonstrate the legal basis for making decisions on behalf of people without their consent.

This is a breach of regulation 18 of the Health and Social Care 2008 (Regulated Activities) Regulations 2010

Inadequate

# Is the service caring?

## Our findings

During our inspection we observed staff asking people to come into the hallway to be weighed in front of other people. We asked the registered provider about people's dignity being compromised by weighing them in front of everyone. The provider told us people are weighed there because it was the flattest floor but that they could be weighed from now on in the treatment room.

This is a breach of regulation 17 of the Health and Social Care 2008 (Regulated Activities) Regulations 2010

We considered the National Institute of Clinical Excellence - Quality Standard for service user experience in adult mental health published December 2011. We looked at how people were involved in their care plans. We asked two people about their care plans, both people were unsure if they had a care plan, one person said, "What care plan?" We found there was no evidence that people using the service had been involved in the development of their plan of care and the plans did not reflect how to manage their diverse needs, current situation or discussion on future plans.

We looked in people's rooms and found some of the rooms contained personalised items however due to the lack of cleanliness of the home we found people's possessions were not respected and cared for by staff. We found one person's room had not been cleaned and person items e.g. hot water bottles were dirty.

We found there were three smoking rooms in Etherley Lodge, and throughout the home there was a smell of smoke. There was nowhere in the home for people who did not smoke to avoid being in a smoky atmosphere. The smoking lounge doors were kept open and people and staff were not protected from the risks of second hand smoke. Irrespective of whether people smoked or not people sat in the smoking lounges or outside of the door. We did not observe staff directly working with people in the smoking lounges. This meant the conditions of the home did not accommodate the needs of people who did not smoke. Following the inspection we referred the home to the Environmental Health team who visited the premises and wrote to the provider about making improvements.

We saw staff talk with people outside of the smoking rooms and found they spoke appropriately to people. One family member told us that since their relative had received a particular diagnosis they could not "fault the staff" and they had been very caring. They family members told us the staff had moved their relative into a downstairs room.

We spoke with one person sitting outside on the wall whilst a delivery man was repeatedly carrying delivery boxes past them and asked what they were doing that day. They said, "I am doing some CBT" and explained they were using Cognitive Behavioural Therapy techniques on themselves. They discussed with us the benefits of such therapy. We asked about having a private space to do this to improve their well-being and they said there was nowhere. This meant the provider had not put in place support arrangements to promote people's well-being and their privacy needs.

We saw on the wall in the hallway the number for 'Care Direct' was displayed. Care Direct is the local organisation set up to receive safeguarding concerns. There was no further information provided to people to enable them to make choices about reporting safeguarding concerns.

Inadequate

# Is the service responsive?

## Our findings

We found there was a lack of person centred information in people's electronic records. For example we saw in one person's file a Lifestyle Passport Questionnaire, but saw this had not generated outcomes for them in their care plan.

We reviewed the records for a person who suffered from diabetes appertaining to their blood sugar levels. We found that although the staff monitored the person's blood sugar levels where the levels were higher than the expected level no action had been taken by the staff. We asked the registered manager what happened under those circumstances. They told us the carer reports it to a senior and said if they then tell the doctor they would say, "Well that's just the person." We found staff were given insufficient information to be able to respond to the changes in a person's blood sugar levels.

This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010

We asked the registered manager if anyone was on medication which required a follow up by a medical practitioner to see if the person was able to continue with the medication. The registered manager was unable to think of anyone. We suggested that she look to see if people were taking risperidone. The registered manager worked through people's records and found two people on risperidone. We asked the registered manager about GP follow up appointments. They told us people got occasional letters from the surgery asking for people to go for tests but the two people concerned refused to go. We asked in the absence of GP checks what the side effects were and what staff might look for. The registered manager was unable to provide a response and unable to show us the records when tests were last due. We found there was no guidance given to staff on the side effects of the long term use of medication to protect people who refused GP follow up appointments.

In the information given to us by the provider prior to our inspection the provider told us they held bi-monthly resident's meetings. We asked to see the minutes of the meetings and were given minutes for a meeting on 4 June 2014 and a meeting undated held in July 2014. In June 2014 the people who attended asked for more activities because they were bored. One person told us they would like to go to the seaside. We spoke to the registered manager about this person's wish and they told us if the person got there they could not walk. We spoke with two people about the meetings. They told us they had asked for board games but nothing had happened. During the feedback meeting with the provider we told the provider and the registered manager what had been said. They said they had board games and we asked where they were and there was no response. The registered manager said she had arranged a trip to see a pantomime and everyone said they would go but no one would get on the bus. We found there was a disparity between what the registered manager had arranged and meetings people's needs on a daily basis.

We spoke with two people about their daily life. One person said "There's no activities at all here", but also said that they was content to sit in his room and watch TV. Another person said "I go out now and then, depends on what I feel like, there's no timetable of activities."

One person said they were worried about leaving the home in the future and would like to do some cooking but said it could not be done at the home. We found paper and electronic records for the person and looked at information contained in their Self Directed Support Review which indicated activities that they would like to do or were capable of but this was not incorporated into their electronic care plan. We found the provider was not responding to the needs of people in their care.

We found the provider held meetings with people. The provider told us if people did not want to attend they were given a questionnaire to make a contribution. We saw people's questionnaire responses were put in their paper records. We found people did not always complete these records and some were incomplete, for example we saw one person had been assisted to complete the questionnaire and had said his room was 'poor'. The member of staff recorded at the bottom of the page the person had become verbally aggressive. We asked the registered provider and the registered manager what had they done about the condition of the person's room and we did not receive a reply. We found people were given the opportunity to express their views, but when these were expressed the provider was unable to demonstrate what actions they had taken in response.

We saw in one person's paper file the local authority had stated they needed to be gainfully employed to prevent social isolation and provide a daily structure that enhances

Inadequate

# Is the service responsive?

community opportunities and develops and maintain friendships. We spoke to the provider and the registered manager about the person and asked about structured days as required in the local authority plan. The provider and the registered manager said the person would not like that.

We looked at the age range of people and found out of 28 people 14 were aged 65 and over. The National Institute of Clinical Excellence – Mental Wellbeing of older people in care homes published December 2013 sets the standard 'Older people in care homes are offered opportunities during their day to participate in meaningful activity that promotes their health and mental wellbeing'. We found the care and treatment of 14 people over 65 did not take into account this standard.

We saw one person had recently been diagnosed with a life limiting disorder. We found their last care plan had been updated in August 2014.We asked to see an updated care plan which included what was required by staff to care for this person. The registered manager said the care plan had not been updated and the provider stated it was not due to be updated until next month but staff knew 'about it'. We asked the registered manager what signs were the staff looking out for to recognise deterioration in the person. She was not able to tell us. We found the provider had not responded to the changing health needs of a person in their care.

We asked the provider if we could see their complaints and we were told by the provider there had been no complaints. One person told us they had made a complaint about the condition of their bedroom. We pointed out to the provider another person had old us that they had reported t a member of staff speaking to them rudely. The registered manager told us they had just heard about the complaint. We asked the registered manager what would be done about it, the registered manager told us they would investigate.

In the PIR the provider told us about a person who was not vegetarian but who did not like red meat. We spoke to the registered provider who told us it was one of the person's fads. A senior member of staff told us the person was asked every week for a list of quorn products and then they are bought for the person. The person told us they wanted to be vegetarian and confirmed what the senior person told us about ordering quorn products. The person said had enough of quorn. We discussed with them being a vegetarian and other eating options, they told us they would like to try "anything but quorn". We found the provider had tried to respect this person's wishes and had provided an insufficient response to meeting this person's alternative diet.

We observed one person sitting in a tub chair on two consecutive days doing nothing. We spoke to the person and asked them about what did they liked to do. They told us they liked to knit but they could not do that because there was insufficient room in the tub chair. We fed this back to the provider who said, "She can have another chair, she did not tell me that." We pointed out that there was not a thorough assessment of the person's needs and if this had been conducted they may have had the opportunity to tell the provider what they liked to do.

This is a breach of regulation 9 of the Health and Social Care 2008 (Regulated Activities) Regulations 2010

At the start of our inspection we found one person had recently been discharged from hospital with a breathing disorder and found they had returned to their bedroom where the walls were damp. We were told this was caused by a leaking roof. We suggested to the provider their current damp bedroom would not promote the recovery of the person and they were moved to another room. We found the provider had not considered the person's well-being on discharge from hospital.

Inadequate

# Is the service well-led?

## Our findings

We read in the cleaning schedules the registered manager had signed to say she had completed a full audit of the previous week's records including care plans, medication and special needs schedules. We asked the registered manager for the auditing records, the registered manager was unable to produce the information. Due to the information we found on the cleaning schedules we found the provider had failed to address the lack of cleaning.

We looked at the cleaning schedules for the kitchen and asked the cook who checked they had cleaned the kitchen according to the schedules, they told us no one checked the kitchen cleaning. We found the provider had not assessed the risks to people's health in the kitchen.

We saw in a staff record box file a 'Visitor' feedback sheet and asked the provider "Are these carried out regularly?" The provider said, "Yes. We asked to see a file containing the feedback sheet and this was not produced. The provider said, "Our door is open and people come in and tell us." We found the provider did not have in place a mechanism for routinely gathering the views and opinions of people who visited the service to come to an informed view in relation to the standard of care and treatment provided to people.

This is a breach of regulation 10 of the Health and Social Care 2008 (Regulated Activities) Regulations 2010

We found the provider had failed to identify, assess and manage risks relating to the health, welfare and safety of people. We saw in one person's file it was alleged they had been involved in a serious incident. The provider had not instigated risk assessments to demonstrate the person's behaviours did not put other people at risk. This meant the provider had failed to assess if people living at Etherley Lodge were at risk of harm.

This is a breach of regulation 9 of the Health and Social Care 2008 (Regulated Activities) Regulations 2010

We found the provider did not have in place record keeping arrangements which protected people. People's personal records were not accurate and fit for purpose. We found people's records did not accurately describe their needs or give information on how risks were to be minimised.

We found people's records to be in both paper and electronic forms. The provider told us all the records were stored on the computer system. It was therefore unclear how the respective electronic and paper records worked effectively together.

We found people's records were stored in box files on open bookcases. The box files contained local authority assessments and other personal documentation. This meant the information was not securely stored. The provider told us only they and the senior staff had access to the electronic records. We found staff were unable to retrieve information on people which meant they did not have the full information to care for people.

Staff supervision records were not fit for purpose. They did not detail the conversations held with staff to ensure staff were getting the support they needed. We found staff records were stored in box files on open bookcases the staff records included application forms, references and other personal details. This meant the information was not securely stored.

This is a breach of regulation 20 of the Health and Social Care 2008 (Regulated Activities) Regulations 2010

During our inspection we asked the registered provider and the registered manager a number of questions in relation to people's care and welfare. We also pointed out to the registered provider and the registered manager assessment information provided by other adult services. Their responses placed blame the people who lived at Etherley Lodge for not wanting to do something. We found a lack of a positive direction in the service which engaged people to recover from their mental ill health and optimise their daily living. However one professional told us, "Some people can live there quite well, other people can't. It suits a particular kind of person."

Throughout the inspection we repeatedly asked the registered provider and the registered manager for risk assessments for example when using wheelchairs and driving the home's vehicle. There were not any available. When these deficits were pointed out to the registered provider they responded by creating risk assessments on the day of our visit. This meant we found the culture of the management team were not proactive in ensuring people's safety.

The management team demonstrated to us they were called out during the night to respond to situations and

Inadequate

# Is the service well-led?

they took responsibility for night time medicines as there were two care staff on duty and neither were trained in medicines' administration. They told us as they were on site it was easy to get to the home quickly and respond to people's needs.