Larchwood Care Homes (South) Limited

Chaplin Lodge

Inspection report

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26 August 2016

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Chaplin Lodge provides accommodation and personal care for up to 66 older people. Some people also have dementia related needs. A new provider took over the ownership of Chaplin Lodge on 21 January 2016.

The inspection was completed on 19 August 2016, 25 August 2016 and 26 August 2016 and was unannounced. There were 56 people living at the service when we inspected.

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

There was a lack of provider and managerial oversight of the service. Quality assurance checks and audits carried out by the registered manager were not robust as they did not identify the issues we identified during our inspection and had not identified where people were placed at risk of harm or where their health and wellbeing was compromised.

Arrangements were not in place to make sure that peoples medication records were completed to a good standard or that they received their prescribed medication as they should.

Suitable control measures were not put in place to mitigate risks or potential risk of harm for people using the service as steps to ensure people and others health and safety were not always considered. Risk assessments had not been developed for all areas of identified risk and bedrail assessments had not always been completed to determine that these were suitable for the individual person so that any risks identified were balanced against the anticipated benefits.

People did not think that there were sufficient numbers of staff available to meet their needs. Staff did not always have time to spend with the people they supported to meet their needs and the majority of interactions by staff were routine and task orientated. This had a significant impact on the delivery of care to people using the service.

Improvements were required to ensure that all staffs training were up-to-date and staff received a robust induction so that they had the skills and confidence to carry out their role and responsibilities effectively. Not all staff understood the relevant requirements of the Mental Capacity Act [MCA] 2005. Additionally, suitable arrangements were needed to ensure that staff received regular formal supervision and an annual appraisal of their overall performance. Improvements were required to ensure that where subjects and topics were raised by staff, this was followed up and there was a clear audit trail to demonstrate actions taken.

Not all of a person's care and support needs has been identified and documented. Improvements were

required to ensure that the care plans for people who could be anxious or distressed, considered the reasons for people becoming anxious and the steps staff should take to comfort and reassure them. Improvements were needed in the way the service and staff supported people to lead meaningful lives and to participate in social activities of their choice and ability, particularly for people living with dementia.

Although there was a complaints system in place, not all complaints evidenced fully how conclusions had been reached and actions followed up.

The dining experience was positive and people were supported to have enough to eat and drink. Consideration by staff was evident to demonstrate that the dining experience was an important part of people's daily life and treated as a social occasion. People were supported to maintain good health and have access to healthcare services as and when required.

Suitable arrangements were in place to ensure that the right staff were employed at the service.

Where appropriate people were enabled and supported to be independent. People were also treated with dignity and respect. Staff knew the care needs of the people they supported and people told us that staff were kind and caring.

You can see what actions we told the provider to take at the back of the full version of the report.

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.

Although staff had a good understanding of safeguarding procedures staff had not followed their individual responsibility to identify and report abuse at the earliest opportunity.

Risks were not suitably managed or mitigated so as to ensure people's safety and wellbeing.

Arrangements were not always in place to ensure that there were sufficient numbers of staff available to support people safely.

Significant improvements were required to ensure that the management of medicines was appropriate.

Effective recruitment procedures were in place to safeguard people using the service.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Improvements were required to ensure that all staffs training was up-to-date, that staff received a robust induction, regular formal supervision and an annual appraisal.

Not all staff understood the relevant requirements of the Mental Capacity Act [MCA] 2005.

People were supported to have sufficient to eat and drink.

People were supported to access appropriate services for their on-going healthcare needs.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Although some people stated that staff treated them with care and kindness, care provided was often task focused and people said that staff did not sit and talk with them for any meaningful

period of time.

Where appropriate people were enabled and supported to be as independent as they wanted to be. People were treated with privacy and dignity.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People's care plans were not sufficiently detailed or accurate to include all of a person's care needs and the care and support to be delivered by staff.

Not all people who used the service were engaged in meaningful activities or supported to pursue pastimes that interested them.

Improvements were required to ensure that complaints management was thorough.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

Although systems were in place to regularly assess and monitor the quality of the service provided, further improvements were required as they had not highlighted the areas of concern we had identified.

Quality monitoring processes were not robust and working as effectively as they should be so as to demonstrate compliance and to drive improvement.

Systems were in place to seek the views of people who used the service and those acting on their behalf.

Chaplin 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 19 August 2016, 25 August 2016 and 26 August 2016 and was unannounced. This was the service's first inspection under the ownership of the new provider.

The inspection team consisted of one inspector.

We reviewed the information we held about the service including safeguarding alerts and other notifications. This refers specifically to incidents, events and changes the provider and manager are required to notify us about by law.

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 spoke with 12 people who used the service, 10 members of care staff, two relatives, the registered manager and the provider's representative. We also spoke with one healthcare professional.

We reviewed 10 people's care plans and care records. We looked at the service's staff support records for eight members of staff. We also looked at the service's arrangements for the management of medicines, complaints and compliments information and quality monitoring and audit information.

Inadequate

Is the service safe?

Our findings

Whilst medicines were stored safely for the protection of people who used the service and people told us they received their medication as they should and at the times they needed them, the arrangements for the management of medicines were inconsistent and unsafe. We identified that 12 out of 18 people's medication had not been appropriately managed to ensure their safety and wellbeing.

We found unexplained gaps on the Medication Administration Record [MAR] forms, giving no indication of whether people had received their medicines or not, and if not, the reason why it was not recorded. For example, the MAR form for one person showed that their once weekly medication had not been administered on one occasion. We checked the box of medication received and this showed that the person's tablets remained in the box and had not been administered by staff. No rationale for this was recorded on the reverse of the MAR form and when we discussed this with a member of staff they could not account for the discrepancy. Additionally, not everyone had received their prescribed medication as they were 'asleep.' For example, staff consistently made the decision to not administer several people's prescribed night-time medication as they were asleep. We discussed this with staff and they confirmed that they had not contacted the prescriber, namely the person's GP, to gain their agreement to administer the person's medication earlier in the evening so as to ensure that they received their medication as they should. Furthermore, staff were noted to use the wrong code on the MAR form where people had refused their medication. For example, the code 'NT'-'Not Taken' was recorded instead of the code 'R'-'Refused.' Records showed that where people were prescribed a variable dose of medication, for example, one or two, the specific dose administered had not always been recorded. The latter meant that people could be potentially placed at risk of receiving too much or too little medication.

The MAR form for one person showed that they were prescribed Warfarin to reduce the risk of their blood from clotting. Whilst the person's blood test results issued by the anticoagulant clinic were readily available dated 27 July 2016 and recorded the specific Warfarin dose to be administered each day, a further instruction was recorded detailing that the person's next blood test was due on 3 August 2016. However, there was no evidence to show that this had been undertaken. We discussed this with the registered manager and staff and they confirmed that they were unaware if this had been completed or followed-up. This showed that the registered manager and staff had failed to recognise the importance of regular blood tests to ensure that they receive the correct dose of medication. The staff 'handover' book on Simes Unit detailed that a blood test was carried out on 12 August 2016, however it was not possible to determine if this related to the above medication or another healthcare issue. We discussed this further with the registered manager and they provided an assurance that the above would be addressed as a priority. The registered manager contacted us following the first day of inspection and advised that despite communication with the anticoagulant department at the local hospital, information relating to the results of the blood test on 12 August 2016 were not available. The results of the blood test were received on 23 August 2016 and showed that there was a change to the person's dose of medication. The MAR form as provided on 25 August 2016 showed that the new instruction had not been recorded on the MAR form.

All of the above showed that staff who administered people's medication had failed to ensure the safe

management of medicines.

Observation of the medication rounds on Parkview and Simes Units showed this was completed with due regard to people's dignity. However, staff training information provided to us showed that not all senior staff employed at the service had completed medication training.

Although intuitively staff knew the people they supported and some risks were identified and recorded relating to people's health and wellbeing, for example, the risk of poor nutrition, poor mobility and the risk of developing pressure ulcers, this was inconsistently applied. Additionally where risks were identified, suitable control measures were not put in place to mitigate the risk or potential risk of harm for people using the service.

The daily care records for one person consistently showed that since their admission they had either tried to get out of their comfortable chair or made several attempts to get out of bed. The records showed that the person had recently fallen out of bed. Although it was identified within the person's care plan that they were at risk of falls and falling from their bed, the risk assessment was not robust in identifying the steps to be taken to mitigate the risk or future risk of them falling. Furthermore, no consideration had been given to assess the person for the use of bedrails so as to reduce the risk of the person falling out of bed. We discussed this with the registered manager and they confirmed that a bedrails assessment should have been completed by staff.

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

The staff training information provided to us showed that 26 out of 58 members of staff had attained up-to-date training in safeguarding people. Others training showed that it had either expired; had not been up-dated or the renewal date for training was now due. Staff were able to demonstrate a good understanding and awareness of the different types of abuse and how to respond appropriately where abuse was suspected. Staff confirmed they would report any concerns to external agencies such as the Local Authority or the Care Quality Commission if required. Staff confirmed they would do this without hesitation in order to promote people's safety and wellbeing. Although the above was seemingly positive we found that following a recent safeguarding concern, staff had not followed their individual responsibility to identify and report abuse at the earliest opportunity on at least two occasions. This referred specifically to staff failing to raise and escalate concerns in a timely manner to a more senior member of staff where abuse was suspected to have taken place. This demonstrated that staff did not fully understand their roles and associated responsibilities in relation to the provider's safeguarding policies and procedures.

Where the provider's representative and registered manager had undertaken an internal investigation in relation to a recent allegation of abuse, they had failed to recognise an incident of possible restraint. Records available could not confirm if the restraint used was absolutely necessary, proportionate or the least restrictive option. We discussed this with the provider's representative and registered manager and they acknowledged that they had failed to recognise the incident as restraint or restrictive practices and this was their oversight. The provider's representative confirmed that a safeguarding alert would be raised as soon as possible to the Local Authority and Care Quality Commission.

This is a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Peoples' comments about staffing levels at the service were not positive. One person told us, "They [staff]

are very nice people but staffing can be very low." When asked as to the impact this had in regard to the level of care they received they told us, "You don't get the attention when you want it. I rarely receive a bath or shower as staff do not have the time. Staff do not always answer the call bell promptly. All you do is wait, wait and wait." When questioned further as to how long they had to wait for staff they were unable to provide a specific timeframe. Another person told us, "I think they need more staff. Sometimes you do have to wait for support to be provided." When questioned further as to how long they had to wait for staff they told us anything between 10 and 45 minutes. Another person told us, "I am quite happy. The staff are friendly but there are definitely not enough staff at all. Everyone [staff] are always running around trying to get things done. They [staff] do their best but you do have to wait for care on occasions."

Ten members of staff told us that staffing levels, as told to us by the registered manager, had not always been maintained. Staff told us that this had a significant impact on the delivery of care to people using the service. Staff confirmed that they did not have time to sit and talk with people using the service and when short staffed people often had to wait for long periods of time for care and support to be provided, for example, assistance with some aspects of personal care. Staff confirmed that people's comment about not receiving regular opportunities for baths and/or showers was accurate. Staff also advised when short staffed that breakfast could be late for people living at the service, for example, some people only receiving their breakfast at 10.30 a.m. Additionally there were also occasions when staff were still trying to get people washed and dressed as late as 11.50 a.m. Staff confirmed that they found these situations very stressful.

Our observations during the inspection showed that staff did not always have enough time to spend with people. The care and support provided was routine and task orientated and this was evident from our observations. Staff rosters for the period 25 July 2016 to 26 August 2016 inclusive showed that staffing levels as told to us by the registered manager were not always maintained and suggested that there were not always sufficient numbers of staff rostered to provide care and support to people using the service. The registered manager advised that this was often due to staff calling in sick at the last minute, staff not able to undertake their shift due to unforeseen circumstances and staff on annual leave. We discussed this with the registered manager and were advised that measures were in place to deploy staff where appropriate with 'bank' staff or agency staff, however it was recognised that 'bank' staff were not always available and the external agency were not always able to cover a shift particularly if it was at short notice. Additionally, we found that the staff rosters were not always accurate to reflect where changes had been made. Therefore it was not always possible to determine if staffing levels were appropriate or not but taking into account the discrepancies in service rotas, our observations, staff and people's voice we judged the service to be lacking sufficient staff to effectively deploy resources across the site to support people and to meet their individual needs and preferences.

This is a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff recruitment records for three staff appointed within the last six months showed that the majority of records as required by regulation and in line with the provider's policy and procedure had been sought. However, no recent photographs on any of the employment files viewed were available, the proof of identification for one person was not decipherable and there was only one reference for one person. We discussed the latter with the administrator who was responsible for ensuring that all records were in place. They could not provide a rationale as to the missing reference. This showed that staff employed had the majority of appropriate checks completed to ensure that they were suitable to work with people using the service.

Requires Improvement

Is the service effective?

Our findings

Improvements were needed to ensure staff had a structured opportunity to discuss their practice and development to ensure that they continued to deliver care effectively for the people they supported. The majority of staff told us that they did not always feel supported and valued by members of the management team or the organisation. When questioned further staff told us that they had not received formal supervision at regular intervals since January 2016 when the service was registered with a new provider. We found that this was accurate and not happening in line with the provider's own policy and procedure. The records for one member of staff showed that since January 2016 they had only received two supervisions. Both of these were generic, solely covered two specific topics relating to record keeping and use of mobile telephones and were not person specific or individualised. Improvements were required to ensure that where subjects and topics were raised by staff, this was followed up and there was a clear audit trail to demonstrate actions taken. Two members of staff told us that they could not remember when they last had formal supervision. Additionally, staff confirmed that they had not had an appraisal of their overall performance. The provider's representative confirmed that the provider and the registered manager were aware of the above. They advised that an action plan would be drawn up to enable them to address the shortfalls.

Prior to the inspection concerns were raised about one member of staff's conduct. The Care Quality Commission was given an assurance by the registered manager that the member of staff would be supervised at all times. Although an assurance was given, our observations on the second day of inspection showed that the member of staff was not appropriately supervised as their supervisor was not at the service. The member of staff was seen to wander through Chaplin Lodge and into the units without additional support. We discussed this with the registered manager and they apologised for their oversight of the situation.

The registered manager confirmed that all newly employed staff received a comprehensive induction. This related to both an 'in-house' orientation induction and completion of the Skills for Care 'Care Certificate' or an equivalent. The registered manager told us that in addition to the above staff were given the opportunity to 'shadow' and work alongside more experienced members of staff. The registered manager confirmed that this could be flexible according to a person's previous experience and level of competence. However, no induction records were available for three staff appointed within the last six months. We discussed this with the registered manager and they concluded following a discussion with senior members of staff that formal induction procedures had not been initiated or commenced for two members of staff. This meant that we could not be assured that staff had received a thorough induction that provided them with the skills and confidence to carry out their role and responsibilities effectively.

This is a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

On Parkview Unit we found that there was only one accessible wheelchair for up to six people using the service. When we discussed this with staff, staff confirmed that our observation was correct. Staff were

unaware as to why there were insufficient wheelchairs available on the unit and when we discussed this with the registered manager the manager indicated that they were not aware of the lack of wheelchairs available to people using the service. We discussed this with the registered manager and once brought to their attention an assurance was provided that additional wheelchairs would be purchased. The registered manager confirmed on 1 September 2016 that one wheelchair had been ordered and if it was suitable others would be purchased. Records also showed that no assessment had been completed to ensure that the wheelchair in place at the time of the inspection was suitable for the needs of the individual or cleaned in-between each use.

On Simes Unit we found that the satellite kitchen was not fully operational. This referred to the taps on both sinks not discharging any water. When asked as to how staff acquired water, for example, to make peoples drinks or to complete washing up, staff stated that washing up items were either taken to the activities room on the same floor or taken downstairs to the main kitchen. Additionally water was brought up from the main kitchen in containers throughout the day so as to make drinks. We discussed this with the provider's representative and they confirmed that the satellite kitchen had not been fully operational since 12 July 2016; however an order had been approved on 24 August 2016 for the works to be completed. Following the inspection the registered manager confirmed that the works commenced on 30 August 2016.

Not all staff were complimentary about the quality of the training provided. One member of staff told us, "The majority of it is online training. I much prefer 'face-to-face' training as I learn better this way. It is not in-depth and if you don't get all of the answers right you can go back and do it again. That makes no sense to me". Another member of staff said, "Not all of my training is up-to-date as I don't always have access to a laptop." They told us that they found this very frustrating and at a disadvantage to other staff members. Additionally, staff stated that there was not sufficient time whilst on shift to undertake the training particularly when the shift was short. During our inspection a summary report relating to mandatory training for all staff employed at the service was forwarded to us. This provided both numerical and statistical information and confirmed that seven out of a possible 17 subjects only achieved between 53% and 69% completion by staff. For example, 12 out of 58 members of staff had not attained up-to-date manual handling training. Training records showed that it had either expired, had not been up-dated or the renewal date was now due. Although improvements were required to ensure that all staffs training was up-to-date, there was no evidence to demonstrate people's care had been affected.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

Not all staff had received Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) training. Additionally, not all staff were able to demonstrate a basic understanding of MCA and DoLS and how these should be applied. Each person who used the service had had their capacity to make decisions formally assessed so as to ensure people's human and legal rights were respected. Appropriate Deprivation

of Liberty applications had been made to the Local Authority for their consideration and authorisation and where approved the Care Quality Commission had been notified. Observations showed that people were always consulted and asked to give their consent prior to the care and support provided by staff.

The majority of people living at the service were complimentary about the quality of food and meals provided. One person told us, "The food is generally very good." Another person told us, "The food is lovely on the whole and I have no complaints." People confirmed that the portions of food provided were appropriate and met their needs.

We found that the dining experience across the service was satisfactory and people were supported to eat and drink. People were supported to use suitable aids to eat and drink as independently as possible, for example, to eat their meal using a spoon and use of specialist beakers. This showed that people were enabled and empowered to maintain their independence and skills where appropriate. Where people required assistance from staff to eat and drink, this was provided in a sensitive and dignified manner, for example, people were not rushed to eat their meal and positive encouragement to eat and drink was provided. However, some staff failed to provide sufficient information, explanation or reminder to people about the actual meals provided, for example, people were not told what food items were on their plate. People were not supported to wash their hands or offered wipes so as to ensure that their hands were clean prior to eating.

People told us that their healthcare needs were well managed. One person told us, "If I am not well staff do get a doctor." People's care records showed that their healthcare needs were recorded and this included evidence of staff interventions and the outcomes of healthcare appointments. Each person was noted to have access to local healthcare services and healthcare professionals so as to maintain their health and wellbeing, for example, to attend hospital and GP appointments, District Nurse and Community Dementia Nurse Specialist. A healthcare professional confirmed to us that staff alerted them at the earliest opportunity where advice and interventions were required. They told us that in their opinion staff followed their advice so as to help maintain people's health and wellbeing and they had no concerns.

Requires Improvement

Is the service caring?

Our findings

People's comments about the care and support they received were variable. As already stated within the main text of the report, the majority of negative comments related to insufficient staff and the lack of availability of bathrooms to meet people's personal hygiene requirements and comfort preferences. The impact of this meant that the majority of interactions between staff and the people they supported was routine based and task orientated, for example, providing people with personal care, providing people with a drink and assisting people to eat. People confirmed that the majority of staff did not sit and talk with them for significant periods of time.

Although the above was highlighted people were encouraged and supported to make day-to-day choices and their independence was promoted and helped where appropriate and according to their abilities. For example, several people at lunchtime were supported to maintain their independence to eat their meal and some people confirmed that they were able to manage some aspects of their personal care with limited staff support. People told us that they were treated with respect and dignity. One person told us, "Oh, the staff always treat me nicely. If I need help, they [staff] ensure that I am covered up and nothing that shouldn't be is showing." We saw that staff knocked on people's doors before entering and staff were observed to use the term of address favoured by the individual. In addition, we saw that people were supported to maintain their personal appearance so as to ensure their self-esteem and sense of self-worth. People were supported to wear clothes they liked, that suited their individual needs and were colour co-ordinated. People were observed to wear jewellery and watches.

Staff demonstrated a reasonable understanding and knowledge of peoples' individual care and support needs, including their personal past history, likes, dislikes and preferences. Where interactions were observed, relationships between staff and the people they supported was seen to be positive. Staff were seen to provide care and support that was kind and caring and people were seen to welcome and enjoy this.

People were supported to maintain relationships with others. People's relatives and those acting on their behalf visited at any time. Staff told us that people's friends and family were welcome at all times. Relatives confirmed that there were no restrictions when they visited and that they were always made to feel welcome. Relatives told us that they always felt welcomed when they visited the service and could stay as long as they wanted.

Requires Improvement

Is the service responsive?

Our findings

Our inspection highlighted that people did not always receive care that was responsive to their needs. This was because staff shortages at times meant that staff's approach was primarily task focused and routine based rather than person-centred.

People's needs were not given due consideration to ensure their personal hygiene requirements and comfort preferences could be met. People told us that they were unable to have a bath or shower at a time of their choosing as there were not always enough staff available to offer them the opportunity and there was a shortage of baths in use within the service. One person told us, "I have not had a bath for god knows. Staff have told me there are no baths. It is disgusting they are not working. I am not always offered a shower and if you ask staff they say that they are short staffed. You can't win." The person's care plan recorded that their personal preference was to have a bath rather than a shower. Their hygiene records recorded that their last bath was in February 2016 and they last received a shower in May 2016. At all other times they had received an assisted wash. Another person told us, "I can't tell you how long it has been since I had a bath, I have not had a bath for months. I prefer to have a bath." The person's care plan recorded that their personal preference was to have a bath and their hygiene records recorded that they last received a shower in May 2016 and at all other times they received an assisted wash. A third person told us when asked if they had regular opportunities to have a bath or shower, "I would like to have a bath once a week. I rarely get my wish." Staff confirmed that there were only two working showers within the service and that no baths were functioning at the time of the inspection. We discussed this with the registered manager and the provider's representative. The latter confirmed that none of the bathrooms had been operational since 18 June 2016. They told us that approval for the works to be completed had been agreed by the provider on 23 August 2016. We spoke with the provider's representative following the inspection and they confirmed that some of the works to the bathrooms had been completed but it was envisaged that all bathrooms would be 'fit for purpose' by the 30 September 2016.

Arrangements were in place to assess the needs of people prior to admission. This ensured that the service was able to meet the person's needs.

Although some people's care plans provided sufficient detail to give staff the information they needed to provide personalised care and support that was consistent and responsive to their individual needs, others were not as fully reflective or accurate of people's care needs as they should be. This meant that there was a risk that relevant information was not captured for use by other care staff and professionals or provided sufficient evidence to show that appropriate care was being provided and delivered. For example, where people were assessed as living with dementia, information relating to how this affected all activities of their daily living were not clearly recorded. Additionally, not all care plans had been reviewed and updated to reflect the most up-to-date information. For example, although the care plan for one person highlighted that they were at very high risk of developing pressure ulcers, this was not updated to reflect that they had developed a grade two pressure ulcer.

Staff told us that there were some people who could become anxious or distressed. Improvements were

required to ensure that the care plans for these people considered the reasons for people becoming anxious and the steps staff should take to comfort and reassure them. Guidance and directions on the best ways to support the person required reviewing so that staff had the information required to provide appropriate care. Specific incidents had been recorded where people had become anxious and distressed, however improvements were required detailing staff's interventions and outcomes.

This is a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they had the choice as to whether or not they joined in with social activities at the service. Some people confirmed that they preferred to spend time in their room or the communal lounge rather than join in with the social activities provided. This referred specifically to the Main Unit and Simes Unit.

Although the service employed two members of staff to provide social activities to people living at the service, our observations throughout the inspection showed that there were few opportunities provided for people to join in, particularly for people living with more advanced stages of dementia and who required more support to benefit from occupation and stimulation. This referred specifically to Parkview Unit. Staff confirmed and records demonstrated that the majority of people living within this unit 'relaxed in the lounge' and rarely took part in other more stimulating activities. Observations on the second and third day of inspection showed that staff on Parkview Unit supported and enabled three people to participate in activities of daily living, such as, setting tables and helping with laundry. One person told us, "It makes me feel useful."

Information on how to make a complaint was available for people to access. People spoken with knew how to make a complaint and who to complain to. People and their relatives told us that if they had any worries or concerns they would discuss these with the management team and staff on duty. Staff told us that they were aware of the complaints procedure and knew how to respond to people's concerns.

Complaint records showed there had been seven complaints since 21 January 2016. Although a record had been maintained of each complaint and there was documented evidence to show that each one had been responded to by the registered manager or the provider's representative, further improvements were required. For example, not all complaints evidenced fully how conclusions had been reached and actions followed up. Additionally, it was not clear if the complainant was happy with the outcome. A record of compliments was maintained to evidence the service's achievements. One compliment from a relative of a person who lived at Chaplin Lodge recorded 'We can't begin to thank you all so much for the love and care you showed to our relative and us. It has been an incredibly difficult journey and knowing that you were taking the best care possible of our relative made the journey easier for us to cope with.'

Requires Improvement

Is the service well-led?

Our findings

Chaplin Lodge was registered with a new provider on 21 January 2016. However, the registered manager, other members of the management team and some of the staff had been employed at the service for some considerable time. The provider was able to demonstrate to us the arrangements in place to regularly assess and monitor the quality of the service provided. This included the use of questionnaires for people who used the service and those acting on their behalf. In addition to this the management team monitored the quality of the service through the completion of a number of audits, for example medication, health and safety, infection control and clinical audits relating to pressure ulcers and skin tears, falls and people's weight loss and gain. This also included an internal review by the provider's representative at regular intervals. These showed that arrangements were available for the gathering, recording and evaluation of information about the quality and safety of the care and support the service provides, and its outcomes.

Although these systems were in place, they did not identify all of the issues identified during our inspection. The arrangements had not recognised where people were either put at risk of harm or where their health and wellbeing was compromised. There was evidence to show that because of this some people did not always experience positive outcomes and the lack of robust quality monitoring meant that there was a lack of consistency in how well the service was managed and led.

Monthly medication audits had not picked up that some people who used the service had not always received their prescribed medication or that the recording on the medication administration records required improvement. Although the provider's representative told us that they were aware of shortfalls relating to the service's care planning and risk assessment processes, further improvements were required to ensure all of a person's care and support needs were recorded, risks identified and appropriate action taken. Additionally, improvements were required to ensure that the provider had effective arrangements in place to protect people from abuse. Appropriate measures were also required to ensure that the premises were properly maintained and equipment available for people using the service. Suitable procedures were required to make sure that sufficient staff were deployed to cover both unforeseen emergencies and the day- to-day routines of the service. Improvements were also required to ensure that staff employed received a proper induction, regular supervision and an appraisal. This meant that the provider's quality monitoring processes were not robust and working as effectively as they should be so as to demonstrate compliance and to drive improvement.

Where audits were in place these did not always provide an account of the actions to be taken or confirm actions taken where shortfalls were identified. For example, the health and safety audit undertaken in July 2016 demonstrated that there were several features of the audit that required addressing. However, it was not possible to determine if these had been actioned or remained outstanding. We discussed this with the provider's representative and they advised that the health and safety audit had been undertaken by an external source and the compiled report had only been received at the service on 12 August 2016. An assurance was provided that an action plan would be devised and implemented.

Staff did not feel that the overall culture across the service was as open and inclusive as it should be. Staff

told us that communication between the management team and staff and between individual staff team members required improvement. Staff told us that 'staff morale' was not good and this primarily related to a lack of teamwork between individual staff members and not always feeling listened to and supported. We discussed this with the registered manager and the provider's representative. An assurance was provided that efforts would be made to address staffs comments for the future.

Staff's comments about the support provided from the registered manager and management team were mixed with both positive and negative comments. One member of staff told us, "The registered manager is lovely, they do listen and they try to sort things out. However, what they do is not always effective. I am sure they are not supported by the organisation." Another member of staff told us, "[Name of registered manager] is lovely but I don't feel they have the authority." When questioned further the member of staff clarified that in their opinion the registered manager was often taken advantage of by other members of staff and was not firm in their approach. We discussed this with the registered manager and they confirmed that they always tried to be firm but fair.

The provider confirmed that the views of people who used the service, those acting on their behalf and staff had been sought in March 2016. The feedback summary report detailed that a response was received from 10 people who used the service and 16 members of staff employed at the service. The responses were collated and presented in a 'bar chart' format with the collected data. The majority of findings were positive and although a summary of actions from the questionnaires had been completed, these had not highlighted all comments made. For example, between 10 and 20 percent of people surveyed stated there was a lack of choices offered, such as for meals and drinks. This was not recorded as an action to be addressed. No actual comments from people using the service or staff were recorded to put the above percentage figures into context. This meant that lessons could not be learnt where improvements were required.

Although staff meetings were held at regular intervals which gave the staff the opportunity to express their views and opinions on the quality of the service, they did not show that discussions held were always acted on. Minutes of these meetings were available and confirmed the topics raised and discussed. However, where actions had been highlighted, there was not always an action plan completed to evidence the service's accomplishments and the dates these were concluded.

This is a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager confirmed that the service was part of the Promoting Safer Provision of Care for Elderly Residents (PROSPER) project in relation to falls, urinary tract infections and pressure ulcers management. This is a project that aims to improve safety, reduce harm and reduce emergency hospital admissions for people living in care homes across Essex by developing the skills of staff employed within the service. The registered manager confirmed that the data had yet to be analysed to evidence how Chaplin Lodge compared to other care services in the surrounding area that were of a similar size.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care Assessments of people's care did not include all of their care and support needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance People who use services were not supported by the providers systems and processes to assess and monitor the quality of service provided. The arrangements in place were not effective in identifying where quality or safety was compromised.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing We found that the registered provider had not ensured that there were sufficient numbers of staff deployed so as to make sure that they can meet people's care and treatment needs. The provider had not ensured that staff received appropriate learning and development needs that supported them to fulfil the requirements of their role to meet people's needs. Staff had not received on-going or periodic supervision.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Not all care and treatment was provided in a safe way for people using the service. Risks were not always mitigated to ensure people's safety and the arrangements for medicines management were poor.

The enforcement action we took:

Warning Notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment People using the service were not protected from abuse and improper treatment. Suitable measures were not in place to safeguard people from the risk of restraint.

The enforcement action we took:

Warning Notice