Leonard Cheshire Disability

Shore Lodge - Care Home Learning Disabilities

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 was carried out on 20 and 21 July 2015. The inspection was unannounced.

Shore Lodge provides accommodation for up to ten adults. It is part of the Leonard Cheshire Disability (LCD) organisation. The home is situated on the outskirts of Dartford in Kent. At the time of inspection, the home was fully occupied. People had a variety of complex needs including learning, physical disabilities and were limited in their ability to communicate verbally. During our inspection we found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider was not providing care in a safe way, Safe hygiene standards were not maintained, and staff training and supervision was not effective. Meals and mealtimes did not promote people's wellbeing. People's health care was not planned or delivered effectively. People were not treated with dignity and respect or provided with personalised care. Staff were not responsive to people's needs or choices. People were not provided with meaningful activities. There was an instructional culture and reactive leadership style at the service.

Summary of findings

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

Before our inspection we received information of concern from the local authority safeguarding team. Relatives made complimentary comments about the service their family members received. However, our own observations and the records we looked at did not always match the positive descriptions relatives had given us.

Systems to assess, monitor and improve the quality and safety of the service or identify and manage all the risks to people's safety were not effective. Unsafe practice meant that people were at risk of harm.

People were not always treated with respect or with regard for their privacy and dignity. They were not offered choices or consulted with about the care provided to them.

The provider did not have a clear system to assess how many staff were required to meet people's needs and to ensure there were enough staff to be on duty at all times. The approach to care was task focussed rather than person centred. Staff were under pressure to carry out a variety of tasks including household tasks in addition to providing care and activities for people. This meant they were not able to spend quality time with people.

People were not involved in planning their care or consulted about how their care was delivered. There was not enough information in care plans to make sure staff knew how to care for people's physical, emotional and social needs. People were provided with opportunities to take part in a range of activities.

Staff were supported by the management team. New staff received induction training. Not all staff had essential training or opportunities for additional training. Staff were not trained to deliver safe and appropriate care to each person. Although staff received regular supervision this was not effective in ensuring staff understood and practiced good values and behaviours. Staff did not recognise or understand how to safeguarded people from abuse.

There was a system for managing complaints about the service. The complaints procedure was provided in pictorial format so that people were helped to understand how to make a complaint.

People were supported to maintain their relationships with people who mattered to them. Visitors were welcomed at the service at any reasonable time. People were asked about their views through the provider's 'Have your Say' forms. Recent results were good and showed people were 'happy' or very happy with the overall service.

People received their medicines as prescribed. Medicines were stored securely to ensure people's safety.

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

The overall rating for this provider is 'Inadequate'. This means that it has been placed into 'Special measures' by CQC. The purpose of special measures is to:

• Ensure that providers found to be providing inadequate care significantly improve.

• Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.

Services placed in special measures will be inspected again within six months. The service will be kept under review and if needed could be escalated to urgent enforcement action.

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

Risks to people's safety and welfare were not well managed to make sure they were protected from harm.

The provider did not have an effective system in place to ensure that there were enough staff deployed in the home to meet people's needs and cover unplanned absence.

Because staff did not recognise abuse they did not know how to safeguard people effectively.

People's medicines were stored and administered safely to make sure people received the medicines they needed. The provider operated safe recruitment procedures.

Is the service effective?

Inadequate

The service was not effective.

Staff did not have all the essential and specific training and updates they needed, supervision was not effective to make sure staff modelled appropriate values and behaviours.

Meals and mealtimes did not promote people's wellbeing.

Health action plans were ineffective in providing the information and guidance staff needed to meet people's health care needs.

Staff were aware of the Mental Capacity Act 2015 but did not seek permission before they provided care to people. Where people's freedom was restricted Deprivation of Liberties safeguards were in place

Is the service caring?

Inadequate

The service was not caring

People were not treated with dignity and respect. Staff spoke to people in a demeaning manner.

People were not consulted about how they wanted their care delivered.

People were supported to attend a local church.

Is the service responsive?

Inadequate

The service was not responsive.

People's care was not planned or delivered in a personalised way.

People were not provided with a choice of meaningful activities.

People were supported to maintain their relationships with people who mattered to them.

Complaints were managed effectively and responded to appropriately.

Summary of findings

Is the service well-led?

Inadequate 

The service was not well led.

There was an institutional culture and the leadership style was reactive rather than proactive.

Systems to monitor the quality of the service and identify and mitigate risks to people's health, safety and welfare were not effective.

Records relating to people's care and the management of the service were not well organised or complete.

Shore Lodge - Care Home Learning Disabilities

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 the 20 and 21 July 2015 and was unannounced. This was a comprehensive inspection to look at how the provider was meeting the regulations relating to the fundamental standards of care. At our last inspection on 10 February 2014 there were no breaches of the regulations we looked at.

The inspection team included one inspector and an expert-by-experience who had personal experience of caring for family members with disabilities. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We gathered and reviewed information about the service before the inspection including information from the local authority, which included information from health and social care professionals.

During our inspection we observed care in communal areas. We examined records including staff rotas; three staff files, management records, medicine records and care records for three people. We looked around the premises and spoke with four care staff, a senior staff member, the registered manager and the Head of Operations. We spoke with two health and social care professionals and four relatives following our visit.

Inadequate

Is the service safe?

Our findings

People were not able to tell us if they felt safe. Relatives told us they felt their family members were safe and well looked after.

Each person had a moving and handling risk assessment. There were no risks assessments for continence, pressure sores, and specific conditions which affected people such as sight impairment, malnutrition and dehydration. This meant that staff did not have all the information and guidance they needed to protect people from risk of harm or how to manage these conditions to reduce the risk of harm.

People who were not able to move around independently were supported by staff. We observed people being helped to move in an unsafe way. Physiotherapists who worked with people at Shore Lodge expressed concern about the way staff moved people.

Staff used a standing hoist and a handling belt to move one person from a chair to a wheelchair. Two members of staff secured the handling belt around the person's chest and used the standing hoist to lift them up. Standing hoists are intended to assist people who can stand, bearing their own weight. They tried to get the person to hold on to the bars of the standing hoist. This person was not able to stand or hold on during the manoeuvre. This meant that all of their weight was supported with the handling belt under their arms which meant their arms were forced backwards into an awkward position over their head placing considerable strain their shoulders. Staff who were using the equipment said the person had good days and bad days and that they were able to stand most of the time.

The registered manager had updated the person's moving and handling risk assessment on 12 January 2015. This risk assessment stated, 'at present (the person's name) is not weight bearing at all. He is supported with a standing hoist and ceiling track hoist all the time'. The person was moved to their bed room in their wheelchair. The standing hoist was used and two members of staff, instructed by the registered manager, physically positioned the person on the bed. One of the support staff climbed onto the person's bed to complete this manoeuvre. There was no slide sheet available to assist staff to position the person safely. A slide sheet is a piece of equipment used by staff to support people safely move on a flat surface such as a bed. The ceiling track hoist above the person's bed was not used at all. This meant the person was at risk of harm through unsafe moving and handling practice. We reported our observations and concerns about this person's safety to the local authority safeguarding team.

The examples above showed the provider was not assessing or mitigating risks to people's safety effectively. This was a breach of Regulation 12 (1) (2) (a) & (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A number of concerns had been expressed by healthcare professionals involved in the care of people who lived at Shore lodge about people's safety: Equipment was being used that was not suitable for some people. For example, a standing hoist was being used without any advice from occupational therapists or physiotherapists. A sling had been ordered that was not suitable for the person it was used for. Concerns had also been expressed about unsafe moving and handling techniques being used on people who were unable to stand unaided. This supported what we observed at our inspection.

One person had moved to the home on 13 July 2015. A large mirror was resting on top of a storage box and leaning against the wall without being secured. Electrical items were stored in an open box and on the floor of the room. The lamp was plugged in and in use. None of these electrical items had been tested to make sure they were safe to use. On the second day of our visit the registered manager confirmed they had arranged for all items to be PAT (Portable Appliance Tested), and this had been completed.

The examples above showed the provider was not assessing or mitigating risks to people's safety effectively. This was a breach of Regulation 12 (1) (2) (e) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The premises had not been cleaned effectively. There was dirt and lime scale build-up around sinks and taps in bathrooms and toilets. The undersides of seats used over toilets and in showers were stained because they had not been cleaned effectively after use. Floors were not clean, particularly at the edges and in the corners of rooms where there was a build-up of dirt and debris. This meant that people were not protected from the risk of infection because safe hygiene standards were not maintained.

Inadequate

Is the service safe?

Staff were not using personal protective equipment (PPE) in a way that ensured people were protected from risk of cross infection. We observed staff leaving toilets, where they had been supporting people with their personal care needs, wearing protective gloves. This meant that surfaces they came into contact with around the home could be contaminated which placed people at risk from cross infection.

The examples above showed the provider was not assessing or mitigating risks to people's safety effectively. This was a breach of Regulation 12 (1) (2) (h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not safeguarded from abuse. Although ninety four per cent of staff had completed safeguarding training and attended an update, the staff did not recognise abuse through unsafe practice or inappropriate speech and language which demeaned people. There were posters displayed providing guidance to staff about how to report a case of suspected abuse. This included contact details for the local safeguarding authority. Staff told us they would report any incidents of abuse and felt confident that the management team would deal with any cases of suspected abuse appropriately. Although staff were aware of their roles in terms of reporting abuse, they were not aware of their responsibilities to ensure their own practice was safe and their speech and language was appropriate.

This was a breach of Regulation 13 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff did not spend time with people unless they were helping them with a task. People were left unsupervised in communal areas. Staff did not have time to sit and talk to people because they only had time to attend to people's immediate physical care needs. In addition to caring for people, support staff were also required to complete household tasks including cooking, cleaning laundry. There was no evidence that the time spent carrying out this work was factored into decisions about the number of staff deployed on each shift.

On 20 July 2015 the atmosphere in the service was chaotic. Staff were rushing to complete care tasks. People were not able to attend their day centre activities because staff were running late. This was partly because a member of staff had phoned in sick in the morning. There was no effective system in place to cover for absence or sickness. Staff said they had phoned colleagues but were unable to find a member of staff to cover the shift.

There were no waking night staff at Shore Lodge. There was a nurse call system for people to alert staff, who were asleep on the premises at night, if they were unwell or needed assistance. Some people had a mat next to their bed which alerted staff if they got out of, or fell from their bed. There was no risk assessment in place in relation to the decision not to deploy waking night staff to make sure people were safe through the night and to meet their needs. The registered manager had not reviewed night staffing arrangements for two years although people's needs had changed in that time.

The examples above showed the provider was not deploying sufficient numbers of staff or taking a systematic approach to determine the number of staff required to meet people's needs. This was a breach of Regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were safe systems in place for the management and administration of medicines. People's individual medicine records were up to date. Medicines were stored safely to make sure people were protected from risk of harm. When medicines were not in use they were stored securely in a locked trolley in a clinical room. Medicines that needed to be kept cool were stored appropriately in a locked refrigerator. There was a chart to record the temperature for the refrigerator and clinical room daily to make sure medicines were stored safely, at the correct temperature.

The provider operated safe recruitment procedures to ensure that staff were suitable and safe to work with people. Staff were required to complete an application form and attend an interview as part of the recruitment process at the service. We reviewed the files of three staff who had been recently recruited by the provider. These contained evidence that identity and Disclosure and Barring Service (DBS) checks had been carried out, employment histories had been checked and references had been received to make sure that staff were suitable to work with people at Shore Lodge.

Procedures were in place to ensure people were evacuated safely in the event of an emergency. Staff were aware of the procedures and knew what to do and who to report to.

Inadequate

Is the service safe?

Each person had a personal emergency evacuation plan. Fire safety equipment was in place and checked regularly.

Regular safety checks were carried out on gas and electrical installations. The provider carried out a comprehensive health and safety audit of the premises every two years.

Inadequate

Is the service effective?

Our findings

People were not able to tell us if they felt the service was effective. Relatives told us staff were, "Charming", "The staff are very, very good" and "They do a good job".

Staff were not appropriately trained or supported to meet people's needs. Staff training records dated 29 June 2015 listed all the required training courses. The record showed that not all staff had received an annual competency check for medication administration. Less than half of the staff had received training in managing risk of choking although some people were at risk. The percentage of staff who had completed other required training ranged from 83% to 94%. Two of the 16 'required' courses showed 100% of staff had completed them.

The registered manager told us they were responsible for delivering moving and handling training and had done a 'train the trainers' course. Our observations of unsafe practice in moving and handling people demonstrated that the training provided by the registered manager was not effective and placed people at risk of harm.

People at Shore Lodge had particular conditions which impacted on their daily lives. These included mental ill health and severe sight impairment. Several people were not able to communicate verbally. Staff had not received specific training to enable them to support people with their individual needs effectively. Staff did not have the knowledge of people's conditions to be able to recognise if their health had deteriorated. Staff did not understand how to communicate with people effectively. They did not make eye contact with people at their level or explain what they were going to do before moving people or carrying out care tasks.

We spoke with four members of support staff. One member of staff struggled to understand as English was not their first language. The staff team's knowledge and understanding about people's conditions varied. Staff were confused in their understanding of some conditions. There was no evidence that staff had received any training in mental ill health. Staff were not able to describe the effect of people's conditions or how to identify any deterioration in their health condition.

Staff supervision was not effective. We observed some poor practice and staff behaviours which was not being addressed. The registered manager told us they had identified that the approach of staff was, "Task focussed rather than person centred". The registered manager said that they had begun to address this through staff meetings. Minutes of monthly staff meetings since January 2015 showed no evidence of this. We observed staff were working hard but they were focussed on care and household tasks which meant they had little time to spend with people other than when they were supporting them with a personal care task.

The examples above showed the provider was not ensuring staff received the training and supervision they needed to care for people or addressing poor practice they had identified effectively. This was a breach of Regulation 18 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We observed that mealtimes were not a pleasant or relaxing experience for people. We observed the breakfast and lunchtime meal. People were not offered choices of what they wanted to eat and drink. At lunchtime a senior member of staff took four cans of spaghetti hoops from a kitchen cupboard, gave them to a member of staff instructing them to, "Heat them up"'. People were not involved in the choice of meal despite the menu displayed stating, 'Service users choice' for lunch. The picture menu board did not show the lunch that was actually served. The picture board was placed at a height that may not have been visible to everyone. People could not reach the picture menu board in order to be involved in choosing their meal. This meant that people were not supported effectively to choose what they wanted to eat and drink in ways that were appropriate for them.

Breakfast was delayed for one person. At 09.45 we observed this person asleep in the lounge while other people were eating their breakfast. The senior member of staff said, "He needs to be fed now, I'll bring the others through to the lounge now". Staff told us that this person had last eaten at 21.30 the evening before when they had a yoghurt. The senior member of staff said, "Only four or five can sit at the table together for a meal so (the person's name) will go to the table afterwards". There was another dining room which could sit five or six people which was not being used that morning. The person was then moved to the middle of the lounge in their wheel chair without explanation while other people were brought back to the

lounge. It was 10.07 before the person was supported to eat breakfast. This meant that one person waited a long time between their last meal of the day and breakfast the following morning.

People's meals were interrupted when staff who were supporting people to eat and drink were called away. Part way through one person's meal the senior member of staff who was supporting them went away to answer the telephone without explaining to the person why their meal was interrupted.

Some people required 'Soft diets' because they were at risk of choking. At 13.00 plates with an unidentifiable orange mixture were placed in front of five people who were sitting at the dining table. Two other people were also served this meal. The unappetizing mixture consisted of spaghetti hoops and waffles blended together. The registered manager later confirmed that not all these people required a soft diet. The registered manager did not know why the meal had been blended together rather than kept separate so people could recognise the components of the meal. This meant that people were not provided with food that was appropriate for them.

When the lunch time meal was served it was rushed. Three people were given buttered toast with grated cheese inside. The cheese fell out as the sandwich was lifted to be eaten. There were no second helpings or dessert offered. A drink was placed on the table for each person. One person was told, "Come on drink up". Everyone was served drinks in plastic cups. No reason for this was recorded in people's care plans. This showed that people's wellbeing was not promoted at mealtimes.

Four people were identified as at risk of malnutrition and dehydration. People did not have individual care plans which provided clear guidance for staff to follow to ensure they understood how to meet people's nutrition and hydration needs. Records were kept of the meals each person ate but no quantities were recorded to make sure the amount they ate was sufficient to maintain their health. Information from health professionals showed that a high number of people had experienced urinary tract infections. The amount people drank was not monitored effectively to make sure they were provided with enough to drink to protect them from the risk of dehydration or infection.

Speech and language therapists were concerned that staff at Shore Lodge were not checking the guidelines and following advice about eating and drinking for people who were at risk of choking.

The examples above showed that people's nutrition and hydration needs were not met in a way that promoted peoples' wellbeing. This was a breach of Regulation 9 (3) (i) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were supported with their health care needs by community health professionals including GPs, speech and language therapists, dieticians, podiatrists, physiotherapists and dentists. However, referrals were not made in a timely manner and staff did not recognise when a referral needed to be made.

Occupational Therapists and Physiotherapists were concerned that referrals to professionals were slow and that people were often referred when they were at their worst despite constant reminders to the management team at Shore Lodge of the importance of making a referral at the earliest moment. Staff do not recognise when clients need to be referred.

People had documents in their care files called health action plans. These contained some information about people's medical conditions, they were not plans about how to manage or promote people's health and did not provide guidance for staff about how to support people's specific health needs such as arthritis, mental ill health or pain management.

There was no tool for staff to use to assess if people were experiencing pain and at what level, to enable staff to identify or manage people's pain effectively. We observed that one person was uncomfortable; they indicated to us that their head hurt. We alerted staff that the person was experiencing pain.

The examples above showed that the provider had not planned people's health care, in collaboration with competent health professionals, effectively to make sure they received appropriate care and treatment. This was a breach of Regulation 9 (1) (a) & (3) (b) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Although staff were able to describe the requirements of the Mental Capacity Act 2005, they did not relate this

Inadequate

Is the service effective?

knowledge to the way they delivered care to people. They did not ask for permission before they carried out care tasks such as placing clothing protectors around people's necks or removing them. Moving people from the dining room to the lounge and back again. One person was sitting in the lounge and enjoying cool air from a fan that was placed next to them. A member of staff took the fan away saying, "I'm going to move the fan towards (name of person) as he is sweating and you are not". Clothing protectors were placed around people's necks without any explanation or conversation with them. People were told what to do rather than asked, "Come on, shoes on, we are going out." and "Come. We go to the lounge". This meant that people did not have control over their own lives and decisions were made for them rather than in consultation with them.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. People were not always able to make important decisions for themselves because of their disabilities. The premises were secure which meant people could not go out in the community without supervision. We saw evidence in people's care files that applications had been made to the local authority in accordance with DoLS guidance to make sure no one was deprived of their liberty without authorisation from the relevant authority.

The environment was suitable to meet the people's needs. Accommodation was at ground level and side corridors and doorways provided easy access for people who used wheelchairs. There were assisted bathing facilities.

Inadequate

Is the service caring?

Our findings

People were not able to tell us if they felt the service was caring. Relatives told us they were satisfied their family members were well cared for.

We observed that the management team and staff at Shore Lodge did not treat people with respect or promote their dignity. There was an institutional approach to care which demeaned people.

One person had moved to the home on 13 July 2015. This person's room had been decorated in pink before they moved in because the registered manager knew they liked pink in an effort to make them feel more at home. However they were not provided with suitable furniture to store their possessions. Their personal effects were in boxes and on the floor of their room. This did not promote their dignity or support them to settle in and feel at home. There was a discussion between the Head of Operations and the registered manager about the failure to provide suitable furniture for the person. The registered manager said they were waiting for information about the person's finances so the person could purchase a chest of drawers. The registered manager was not aware that it was the provider's responsibility to provide this, and other necessary items of furniture.

Staff did not treat people with respect. When we arrived at the service we asked the senior member of staff to introduce us to people and explain who we were. Five people were sitting in the dining room. The senior member of staff told the inspector personal information about people in the presence of other people. The senior member of staff instructed one person in a loud voice to, "Say good morning (name of person)". The senior member of staff repeated this instruction three times because the person did not respond, after the third time the person said, "Shut up". The senior member of staff told them off saying, "Don't say shut up, it's not nice". This showed the language that staff and senior staff used was demeaning towards people.

We heard and observed a number of interactions between staff and people which were not respectful or kind. A senior staff member was supporting a person with their personal care needs in one of the bathrooms. We heard them say, "You're not a boy, you're a man, don't do that" and later, "Stand up we're going to clean your bum now. Stand up".

Staff were not discreet in their conversations about people. Staff talked to each other over the heads of people while they were assisting them with their care needs or activities, sometimes about people. A senior staff member said, "(The person) is in the toilet as (the person) needs to open (the person's) bowels so we'll leave (the person) for a while", and to another member of staff, "We have to change (the person's name) next". These conversations took place in communal areas with other people present. The interactions we observed showed that people's privacy was not being respected.

Staff rushed through a series of tasks leaving little time to interact appropriately with, or offer explanation or choices to people. Staff and the management team did things to people rather than with them, often without warning or explanation. People were touched or physically moved without warning. We observed the senior member of staff leaning over from behind and pushing a person's elbows in who they were pushing in their wheelchair, whilst at the same time saying, "Mind your arms". We observed a member of support staff do the same thing to another person whilst pushing their wheelchair through a doorway.

People were ignored on two occasions when they requested drinks or activities. At 09.53 the senior member of staff told one person. "I'll take you for a cigarette soon". The cigarette was eventually provided after lunch, in the afternoon. Another person was walking around the home from one lounge to the other. Staff cut across their path several times without acknowledging them or saying "Excuse me". People were not being treated with respect.

The examples above showed that there was an institutional approach to care which demeaned people. The staff training record showed that 94% of staff had completed a 'required' course about 'Working in an empowering way'. This training was intended to provide staff with the knowledge and competencies to work with people in a way that gave them as much control as possible over their own lives. We found that this training was not effective. There was an institutional culture at the service which meant that people were disempowered and did not have control over their own lives because staff made decisions for them rather than with them. Staff spoke to people in a demeaning manner, telling them what to do rather than engaging people in conversation. Staff did not ask people what they wanted to do. Staff did not ask

Inadequate

Is the service caring?

people's permission or explain what was going to happen before carrying out care tasks with them. This showed that people were not supported to have control over their own lives as far as possible, to maximise their independence.

The examples above showed that the provider was not ensuring that people were treated with dignity and respect. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were encouraged to maintain their relationships with people who mattered to them. There were no restrictions on visitors to the service. Relatives told us they always felt welcome when they visited the service. People were supported to attend a local church.

Inadequate

Is the service responsive?

Our findings

People were not able to tell us if they felt the service was responsive to their needs. Relatives told us that they were kept informed about their family members. One relative said, "They keep me informed by email of what's going on. They took them to Butlin's the other week for a holiday, I thought that was wonderful". Another relative told us, "I have no complaints whatsoever, they are very good".

One person moved to Shore Lodge on 13 July 2015. The registered manager had visited the person before they moved and recorded an assessment of their needs. A care plan had not been drawn up to provide guidance for staff about how to meet their needs or understand their preferences. Staff told us they were getting to know the person. Information from the local authority safeguarding team showed there had been a discussion with the registered manager about the person's wish to go on two long walks each day. There was no plan in place to ensure this happened and daily records did not evidence the activity had taken place twice each day. Staff were not provided with, or did not follow individual guidance about how to communicate with and involve people in the planning and delivery of their care.

Routines were not flexible to accommodate people's individual choices. One person who had been walking around for most of the morning, sat down at the dining table with the inspector and indicated to staff that they would like a drink, pointing to the inspector's cup of coffee. The inspector pointed this out to staff who said they would be making drinks for everyone soon and walked away.

Another person saw that a member of the inspection team was given a cup of coffee. The person, who had been colouring, stopped their activity and said, "I want some as well". Staff did not acknowledge their request. Staff told us, "I'm going to make for them anyway; this is their time for drinks". A few minutes later staff came into the lounge and placed a clothing protector on the person. A few minutes after that the person was given a drink of blackcurrant. Staff had neither acknowledged nor responded to the person's request for coffee. Staff were focussed on completing tasks rather than providing personalised care to people.

Five people were not supported to take part in their planned activities during our visit. The activities programme showed that five people were due to go to out to a day activities centre at 10:30. By 11.00 staff explained to the registered manager that they were running late. The registered manager told staff it was too late to go and instructed staff to, "Take them for a walk", indicating two people who were able to walk independently. This conversation took place between staff and the registered manager in the dining room over the heads of these two people. They were not involved in the conversation, offered choices or consulted in any way about what they wanted to do. These two people were not able to communicate verbally but were able to indicate their choices. Health and social care professionals shared the same concerns that personal care needs were not being met in a person centred way or time taken to ensure that the people knew what was happening.

On hearing the conversation about the walk, the person who had asked for a drink left the dining room and went to wait by the front door. A member of staff then told the registered manager they were making drinks for everyone. The person was then taken to the dining room to wait for their drink and had a clothing protector put on. Shortly afterwards another member of staff removed the person's clothing protector, despite their drink not arriving. The member of staff said, "Naughty (person's name). Come on shoes on, we're going out". At that point the senior member of staff arrived with the person's drink but took it away again saying, "You can have tea in the canteen, tea and cake". The person was rushed through the process of getting ready to go out without any opportunity to choose what they wanted to wear. After waiting for 30 minutes with their coats on, the two people were taken out for a walk with two staff and another person.

People who required assistance were 'toileted' before lunch. There were no individual continence care plans. People were brought to the table between 12.45 and 13.00. One person was supported to transfer to a dining chair then pushed closer to the table with no verbal warning that this was about to happen. Another person wandered away from the table but was told to return by a member of staff who said "Go back to your place now please". They had already waited at the table for 15 minutes with nothing to do.

The atmosphere at Shore Lodge on the first day of the inspection was chaotic and stressful for people. Staff told people what was going to happen but then did not follow

Inadequate

Is the service responsive?

through to ensure it did happen. Before the decision was made not to take people to their day activities centre, they were repeatedly asked by staff if they still wanted to, "Go to college/one direction/all direction". Different words were used by staff for the same activity. The activity did not take place.

There was an activities programme which showed planned activities each week. These included activities away from Shore Lodge including going to the day activities centre, swimming food shopping and meals out. Some people attended a local church on Sundays. In house activities included reminiscence sessions, sensory or aromatherapy sessions, movement to music and having a takeaway and relaxing watching TV on Saturdays. Our observations and daily records showed that people were not always supported to access their programmed activities.

People were not offered any choice of activities during our inspection. Staff told us they knew what people liked to do. Staff described how one person liked colouring and another liked their 'bricks', (Lego). These preferences were recorded in their 'service user profiles'. The person who liked Lego repeatedly indicated they wanted someone to spend time with them doing this activity. Most of the time staff were too busy. The television was on in one of the lounges with the sound off. The person who liked colouring was taken to the lounge and a table was placed in front of them with crayons and colouring books suitable for small children. Most of the pages were already completed. People who were quiet received little attention other than when staff needed to carry out personal care tasks.

Occupational Therapists had concerns about whether activities were meaningful for people.

Activities did not reflect what people may have wished to do because the provider or registered manager had not ensured they understood and met people's needs or preferences.

The examples above showed that the provider was not providing care or activities for people in a responsive or person centred way. This was a breach of Regulation 9 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff described how they supported people to choose holidays. Records showed how one person visited the travel agent to collect brochures. They had then chosen their holiday and returned to the travel agents with staff to make their booking.

Relatives told us they had no complaints about the service their family members received. They told us they would speak with the manager if they had any concerns. There was a complaints procedure displayed in pictorial format in the hallway. This illustrated how people could make a complaint and how their complaint would be addressed. The registered manager showed us records of a recent complaint a relative had made. The record showed that the complaint was taken seriously and action was taken to address their concerns to their satisfaction. The registered manager did not have a system in place to record or monitor when people expressed unhappiness or dissatisfaction with the service they received. This meant that trends and patterns were not identified to ensure that improvements were made and people's views were taken into account.

Inadequate

Is the service well-led?

Our findings

People were not able to tell us if they felt the service was well led. Relatives told us they felt the service was well led. They said, "Very impressed, It's well run and they are nice people" and "I can't praise them enough for what they do".

There was an institutional culture at Shore Lodge. The registered manager told us they had recognised that staff adopted a task focussed rather than a person centred approach to caring for people. The registered manager told us they had started to address this in staff meetings. There was no evidence of this in the monthly staff meeting minutes since January 2015.

The leadership style was reactive rather than proactive in identifying and addressing issues that impacted the quality of life people experienced. The management team did not always seek or act on feedback from relevant persons such as health and social care professionals, for the purposes of continually evaluating and improving the service. Occupational therapists, physiotherapists, local authority care managers and speech and language therapists had raised a number of concerns with the registered manager and senior staff. These included concerns about unsafe moving and handling practice; unsuitable diets; late referrals for professional advice; unsuitable equipment; not providing meaningful activities or following advice and guidance from health and social care professionals, and inadequate care planning and record keeping. The management team had not addressed these issues.

The registered manager did not demonstrate effective leadership by modelling best practice. We observed the registered manager walk behind people on three occasions touching the backs of their heads in passing. People could not see who was touching them. On one occasion one person was eating their meal when the registered manager did this. The registered manager was surprised when we expressed concern that he was modelling inappropriate behaviour by this action. The registered manager told us he did it, "To provide reassurance". On other occasions he issued instructions to staff about tasks with people. He did not include the people concerned in the conversation even though they were present. This showed a lack of understanding about how to provide a service that promoted dignity and respect for people.

Although the registered manager told us that poor practice was being addressed with the staff through supervision and staff meetings, their attitudes towards people had not changed. The provider's performance management was not effective in ensuring people were consistently treated with respect and had as much control over their own lives as possible.

The provider had not carried out a quality assurance audit at the service since 2012. Therefore, the provider was not aware of the quality concerns within the service and had not identified the issues that we found during the inspection. The service manager told us this was because the provider had stopped doing these audits, "When CQC stopped asking for Regulation 26 reports". There were no effective action or improvement plans to make sure that people received a good service.

The registered manager was not operating effective quality assurance systems to assess, monitor and mitigate risks relating to people's health safety and welfare. Risks to people through unsafe moving and handling and poor hygiene and hygiene practices were not identified through effective management systems. This meant that people were at risk of harm.

The leadership of this service did not follow best practice guidance in infection prevention and control for care homes. The registered manager told us they were the infection control lead at Shore Lodge. We looked at four 'Premises Audit Checklists' the registered manager had completed between 18 March 2015 and 12 June 2015. These were tick box forms. No concerns were identified in relation to the cleanliness or maintenance of the premises. The registered manager acknowledged that they had not carried out a thorough inspection in relation to hygiene standards which meant people were at risk of infection.

The provider did not have an effective system to assess the number of staff required or cover for absence to ensure there were enough staff deployed to meet people's needs. There was no overall, up to date analysis of people's needs on which the numbers of staff needed was calculated. This meant staff did not have time to provide personalised care and people were not always able to attend their programmed activities.

An accurate, complete and contemporaneous record was not being maintained for each person. People's records were stored in a number of different locations which made

Inadequate

Is the service well-led?

information difficult to find. People had an individual care files which were stored in unlocked cupboards in communal areas. There was also a care file in the office for each person. Different information was stored in each of these files. Out of date information was mixed up with current information which meant there was a risk that people could receive inappropriate or unsafe care. Each person had a 'service user profile' document in their files which contained a short summary of the kind of support they needed and how it should be delivered. The registered manager told us the 'service user profile' had superseded support plans which were previously used. There were no care plans to provide guidance to staff about how to manage continence, communication, eating and drinking, sight impairment and other aspects of people's daily lives and care. This meant that staff did not have access to the information they needed to enable them to provide a good service to people.

Communication between management and the staff team was not effective. Staff had a handover between shifts. We observed the afternoon handover. Each person was briefly reported on. Reference was made to food, continence and one person's visit to hydrotherapy. No other information was passed on about the morning shift. There was no shift plan discussed or recorded to make sure staff understood their allocated roles and responsibilities to people during the next shift.

Staff meetings were held each month. The minutes did not evidence opportunities for staff to raise concerns, provide feedback or make suggestions about the service. Minutes were mainly reminders to staff about a variety of tasks or behaviours such as not using mobile phones or leaving early.

The examples above showed the provider and registered manager were not exercising effective leadership to ensure that people received a good service. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was a whistleblowing policy. Staff were aware of the policy and said they would go to the registered managers or senior staff if they had any concerns. However our observations showed that staff did not always recognise abuse or poor practice.

People and/or their relatives were asked for their views about the service through a customer satisfaction survey called 'Have Your Say. The results of the survey were evaluated and the report sent to the service shortly before our inspection on 7 July 2015. The overall result of the provider's survey showed that 100% of those who responded were 'Happy' or 'Very Happy' with the service. However, our own observations and the records we looked at did not always match the positive descriptions relatives had given us.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent **People were not asked for their permission before care tasks or day to day activities were carried out.**

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 were not protected from abuse or improper treatment.**

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care The provider had not ensured that people received appropriate care that met their needs and reflected their preferences.

The enforcement action we took:
We issued a warning notice in respect of this breach of regulation.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect People were not treated with respect and dignity.

The enforcement action we took:
We issued a warning notice in respect of this breach of regulation.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment People who use services were not protected against the risks of unsafe care and treatment

The enforcement action we took:
We issued a warning notice in respect of this breach of regulation.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance

This section is primarily information for the provider

Enforcement actions

The provider had not ensured that leadership and quality assurance systems were effective to make sure people were safe and they received a good service.

The enforcement action we took:
We issued a warning notice in respect of this breach of regulation.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing The provider had not ensured that the management team and staff were suitably trained and competent to provide safe and appropriate care. Regulation 18(2)

The enforcement action we took:
We issued a warning notice in respect of this breach of regulation.