Reason Care Limited

Elm Lodge Care Home

Inspection report

Stand Road
Chesterfield
Derbyshire
S41 8SJ

Tel: 01246456755

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

Summary of findings

Overall summary

This inspection took place on 6 December 2018 and was unannounced. The inspection was carried out following significant and ongoing concerns about the safety and effectiveness of people's care; shared with us by local care commissioners and external health care providers involved in people's care at the service.

Elm Lodge Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. The Care Quality Commission [CQC] regulates both the premises and the care provided, and both were looked at during this inspection. Single use accommodation and personal care is provided at this service in one adapted building over two floors, for up to 46 older people who may be living with dementia. Both floors of the building provide a dining room and two communal lounges. A secure garden area provided level access for people. At the time of our inspection there were 30 people using the service. All were older adults living with dementia, including many with other chronic health conditions, and some with sensory physical disability needs.

There was no registered manager for the service since November 2018. A registered manager is a person who has registered with the CQC to manage the regulated activities provided at the service. Like registered providers, they are 'registered persons'. Registered persons have a legal responsibility for meeting the requirements of the Health and Social Care Act (HSCA) 2008 and associated Regulations about how the service is run.

At our previous inspection in January 2018, we rated the service as Requires Improvement for the third consecutive time. People were not always protected from risks associated with unsafe, ineffective or inappropriate care that did not meet with their needs and preferences. The provider also did not operate effective governance systems at the service to consistently ensure the quality and safety of people's care. These were respective breaches of Regulations 9 and 17 of the HSCA 2008 (Regulated Activities) Regulations 2014. We asked the provider to send us a written report, to tell us what action they were taking to make the improvement required to rectify the breaches and to improve the service to a rating of a least Good. At this inspection we found these improvements were not made.

The provider did not operate effective systems for governance and oversight of the service, or demonstrate lessons learned when required, to ensure the quality and safety of people's care at the service. Pro-active, sustained and ongoing care and service improvement was not consistently ensured for people's health and welfare.

The provider did not always tell us or others with an interest in people's care when things went wrong at the service; or regularly consult with relevant parties help inform or improve people's care.

Records relating to people's welfare and the management of the service were not accurately maintained. National guidance was not always followed or reviewed for people's care.

People who could tell us felt generally safe at the service. People's safety was not consistently ensured. Risks to people's safety were not always effectively accounted for, managed or mitigated and people's medicines were not always safely managed.

There were not always enough staff to provide people's care and staff were not always safely recruited. The provider's subsequent improvement actions, which helped to mitigate the risk to people from unsafe staffing arrangements, needed to be demonstrated as continued and sustained.

Staff were trained and generally knew how to recognise and report abuse. Staff and management did not always recognise or act on discriminatory practice, to fully ensure people's rights, needs and choices in their care.

The service was mostly clean and hygienic but this was not consistently ensured, to fully protect people from the risk of an acquired health infection through cross contamination. A number of environmental adaptations helped to support people's independence and orientation needs, but this was not fully considered or optimised for people's benefit.

People did not always receive effective or accurately informed care, which met their needs and preferences and for their wellbeing. The provider's staffing, communication and care plan record keeping systems were not effective to consistently ensure this. e

Staff felt they received the training they needed but people's care was not always provided in line with national legislation, standards or guidance. Staff often followed the Mental Capacity Act when required. Where people were subject to any Deprivation of Liberty Safeguards, the provider did not always ensure staff followed any related conditions specified for people's care in their best interests.

People felt overall, staff were kind, caring and had good relationships with them, which we often saw. Staff's capacity to consistently ensure people's equality, rights, choice, comfort and independence were often compromised by the provider's ineffective care management, communication and staffing systems.

People's care was organised in a task orientated way and was not always person centred, timely, or appropriate to people's needs and preferences. The Accessible Information Standard was not fully considered to ensure this was met to benefit people living at the service

People were often confident to raise concerns if they needed to. Concerns and complaints were not always effectively accounted for, or used to inform or make care improvements when needed.

Nationally recognised standards concerned with end of life care were not formally sought, implemented or understood; to best inform people's care and to ensure their dignity, comfort and choice, when required at the end stage of life.

The service was not well led. Staff were not consistently informed or supported to help ensure people's care was consistently safe, effective, caring or responsive. Staff, external authorities and health professionals concerned with people's care at the service, were positive about the new acting manager, who they felt was trying to make a difference. However, confidence in provider and senior management to make the required care improvements was low.

We found four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This included two new breaches and two repeated breaches from our previous inspection in January 2018. Full

information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

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

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not consistently safe.

Peoples safety needs relating to their health condition, environment and care equipment, were not consistently accounted for, safely managed or mitigated when required. People's medicines were not always safely managed. Lessons were often not demonstrated as learned, or improvements made when things went wrong at the service.

Staff were trained and knew how to recognise and report abuse. Discriminatory practice was not always recognised or acted on to ensure people's rights, needs and choices in their care.

There were not enough staff to provide people's care and staff were not always safely recruited. Subsequent remedial actions by the provider, helped to mitigate any associated risks to people from this. However, this was not yet fully demonstrated as sustained for people's safety.

Is the service effective?

Inadequate

The service was not always effective.

People were not consistently supported to maintain or improve their health and nutrition.

People did not consistently received effective, appropriate or accurately informed care, which met their needs and preferences for their wellbeing.

Staff did not always demonstrate effective skills or knowledge; or consistently deliver people's care in a way that met with current legislation, standards and practice guidance.

Is the service caring?

Requires Improvement

The service was not always caring.

People felt overall staff were kind, caring and had good relationships with them. Staffs' capacity to consistently ensure people's equality, choice, independence and rights in their care were often compromised by ineffective management staffing systems.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's care was often not person centred, timely or appropriate to their needs and preferences. People's rights to accessible information in relation to their care, was not fully considered, to benefit people living with a disability or sensory impairment.

People knew and were confident to raise concerns but concerns and complaints received, were not effectively accounted for.

Nationally recognised standards concerned with end of life care were not formally sought or considered to ensure best practice for people's end of life care.

Is the service well-led?

Inadequate

The service was not well led.

The provider did not operate effective systems for the governance and oversight of the service, to consistently ensure the quality and safety of people's care. Pro-active, sustained and ongoing care and service development was not ensured for people's health and welfare.

The provider often did not tell us when things went wrong at the service, or consult with relevant parties to help inform and improve people's care when needed. Arrangements for communication, record keeping systems partnership working, were not sufficient to accurately and effectively inform people's care.

Elm Lodge Care Home

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.

Our last comprehensive inspection was undertaken on the 23 June 2016 and the provider was meeting the Regulations that we checked. However, we found that further improvements were needed in the quality of people's care. We rated the safe, responsive and well led domain as requires improvement. At this inspection we found improvements had been made in this area, but some further improvements were required.

Elm Lodge is a care home. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Elm Lodge is registered to provide accommodation and personal care support for up to 46 older people across two floors; each providing separate adapted single bedroom accommodation and communal living facilities. There were 30 people using the service at the time of our inspection. All were older adults living with dementia, including many with other chronic health conditions, including sensory and disability needs.

This comprehensive inspection took place on 6 December 2018 and was unannounced. The inspection visit was carried out by three inspectors. On this occasion we did not ask the provider to send us provider information return (PIR) prior to the inspection. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We offered the provider opportunity to share any relevant information about the service with us. We also reviewed information we held about the service. This included information from the local authority regarding their care commissioning, quality monitoring and safeguarding activities at the service. We also checked any statutory notifications from the provider. A statutory notification is information about important events that may happen at the service, which the provider is required to send to us by law. We used this information to help us plan our inspection.

We spoke with six people and spent time in communal areas of the service, observing how staff interacted with and provided people's care, including their meals and drinks. We spoke with the deputy manager, two senior and five care staff, a cook and the operations manager, who is also the nominated individual for the provider. We looked at eight peoples' care plans, to check some of the agreed arrangements for their care. We also looked at a range of other records relating to people's care and for the management of the service. This included medicines and staffing records and the provider's management checks of the quality and safety of people's care. This helped us to understand people's care experience at the service.

Inadequate

Is the service safe?

Our findings

People were not always protected from the risk of harm or abuse. Before our inspection local authority care commissioners had shared their concerns with us about the safety of people's care at the service. The local authority told us they had suspended their care commissioning with the provider at Elm Lodge Care Home, following a high number of safeguarding concerns; reported either through own contract monitoring activities or from visiting external health professionals, concerned with people's care at the service. The outcomes of subsequent safeguarding investigations, shared with us by the local authority, often identified neglect, including through repeated acts of omission and poor record keeping. This resulted in an increase of health incidents, injury or harm to some people that were considered avoidable; such as body weight loss and skin damage, including pressure sore occurrence.

People who could tell us said they generally felt safe at the service. However, we found people's safety was not always ensured.

Risks to people's safety associated with their health conditions, medicines, environment and care equipment, which were not always accurately recorded or safely managed. We saw that staff did not always follow people's care plans. Care plans did not always show sufficient information regarding the care steps required to optimise people's safety. This meant people were placed at increased risk of avoidable harm when this occurred. For example, harm from malnutrition or skin damage, associated with care that is not consistently informed or safe.

We observed fourteen people seated in various lounge areas, who remained there throughout the morning, up to and during lunch, which they also ate there. Some were not supported to move or reposition within at least four hours or more and none were given the opportunity to eat their meal in the dining room. Because of their health conditions, all of those people needed staff to help them to move safely. For some people, this included the use of equipment, such as a hoist. Related care records we sampled identified risks to two people's safety from prolonged body pressure, which could result in people's skin damage such as pressure sore occurrence or moisture lesions. Two people's related care plan instructions we looked at showed, 'For regular body repositioning'. This did not provide sufficient detail to show what this meant for people's care, such as what and how often and staff did not follow the instruction, to ensure people's safety.

Some people were wearing cushioned pressure relieving 'bootees'. Staff said this was advised by relevant external nursing professionals involved with people's care; 'to help prevent sores' [from skin damage to people's heels from excessive body pressure]. We saw the 'bootees' were not always fitted correctly, being either loose or with trailing straps, thereby reducing their potential efficacy and increasing risk to people from falls. During our inspection, one person with limited mobility, stood up from their chair in the lounge and tried to walk, unaided. The 'bootees' they were wearing were very loose on one foot and not fitted correctly, the person become unsafe and fell backwards, into their comfortable chair. We alerted a care staff member to this, who told us they were unsure about the correct fitting of the 'bootees' and said, "There is some confusion amongst staff and no guidance about how to fit them correctly."

People were not consistently protected from risks associated with the unsafe management of medicines. We looked at the provider's arrangements for the management and administration of people's medicines. This included the arrangements for five people's medicines, which we looked at in detail. We found medical instructions for the administration of people's medicines were not always being followed by staff responsible. People did not always receive their medicines as prescribed. Medicines administration records did not always show people were being given their medicines as prescribed, or the reasons whey these had not been given. The medicines needed to be consistently and safely given, for the treatment of health conditions, such as for infection, to reduce the risk of stroke from blood clots, or for people's mental health. Staff responsible for people's medicines did have relevant, up to date or accessible recognised medicines guidance to help inform them about people's medicines.

One person was prescribed medicines that needed to be given covertly to ensure their health and wellbeing, if they refused their medicines when offered to them. Staff understood and followed the person's care plan to ensure they received their medicines in this was, only as a last resort; thereby ensuring least restrictive care. However, there was no record of any consultation with the community pharmacist, regarding the chosen methods to give the medicines covertly. This is necessary, to ensure there are no contra-indications in relation to ensuring the efficacy and safe use of medicines. The provider's operational medicines policy guidance, which met with nationally recognised guidance concerned with the administration of medicines to be given covertly, was therefore not being followed to ensure the safety and effectiveness of the service user's medicines. There was a failure in management safety checks of medicines, as part of a robust auditing system. Medicines omissions and related safety concerns we found, had not been addressed by the provider before our inspection.

Information we therefore received before and during our inspection from relevant health and social care professionals, along with our related inspection findings; told us people's care and treatment was not always provided in a safe way. Risks to people's safety were not always effectively identified, managed or mitigated and people's medicines were not always safely managed. Lessons were not always learned to ensure timely care improvements for people's safety when things went wrong at the service. This meant people were not always protected from the risks associated with unsafe care and treatment, because the provider's systems, process and practices did not always effectively ensure this. The provider had also not notified us about many of the recent safeguarding concerns when required, to help us check to ensure people's safety at the service.

These were breaches of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were not enough staff to consistently ensure people's safety. We observed this to have a greater impact on people living on the ground floor at the service, many of whom had reduced mobility. Two people we spoke with together said, "You have to wait a lot"; and "Yes, we do; staff are always so busy; I don't think there's enough of them". Another person said, "It should be better now because we've got some new staff, but there are times when it's pretty tight."

Staff told us they were frustrated because there were not always sufficient staff to provide people's care, which included the day of our inspection. One care staff said, "There's not enough staff, it's not safe." Another said, "Everything is bothering us, they have cut staff hours; there's not enough hours and not enough staff." Another told us, "They don't take account of needs; just numbers. We were just about fully staffed again, but it doesn't last long before they reduce it. They have reduced it to five and three at night; we need seven in the day at least." Staff told us this often resulted in care delays, which meant people often had to wait too long for assistance, such as to go to the toilet, or eat and drink. One staff said, "It's always doing

tasks quickly from one to another, there's no time for anyone, it's all rushed." Another said, "I feel awful, I knew when [person] was waiting to go to the toilet this morning, but there was so much to do at the same time." A visiting external health professional told us, "People are often left in wet or soiled continence pads; This had improved lately, but not completely."

We saw that staff were often rushed whilst trying to balance peoples care with supporting others, such as visiting health professionals. Care was task orientated and staff had little time to spend with people, who were often left unsupervised or waiting for long periods when they needed assistance. This was because there were not enough staff to ensure continuity and completion of care without interruption.

People did not always receive timely support when they needed it, to fully ensure their safety, or the safety of others. This included, to enable people to move regularly and safely and to eat, drink and express themselves safely. We saw one person spilling a potentially hot drink on themselves whose care plan showed they needed to be supervised with hot drinks. At the main meal of the day, served at tea time, one person became frustrated whilst waiting for assistance. The person tried unsuccessfully for some time, to eat with another person's knife, subsequently dropping a significant amount of their food on to the floor. We saw another person seated at a dining table with others, who vomited a large amount of undigested food, with no intervention from staff to clean this up, for over 20 minutes.

We saw people becoming visibly agitated, who then engaged in destructive activities, such as shouting at others, throwing drinks and crockery, picking paint off walls and repetitively pulling at corridor handrails and radiator covers. Staff often ignored, passed by, or did not have sufficient time to offer relevant positive care interventions. Opportunities to engage people in home life and with others by way of meaningful occupational activities were not provided. When we spoke with the nominated individual who was also the operations manager for the provider about our findings, they initially said, "There are enough staff; the activities person is on holiday." This showed a complete lack of insight on their part, to proactively ensure people's needs could be consistently met by sufficient staffing arrangements.

This was a breach of Regulation 18(1) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Following our inspection, the provider sent us their revised staff rotas from 10 December 2018 planned to 2 January 2019, which showed increased staffing provision to help ensure sufficient, safe staffing levels. This helped to mitigate risks to people's safety from insufficient staffing, but the provider needed to demonstrate this could be consistently delivered and ensured.

Safe staff recruitment procedures had not always been followed before new staff commenced employment at the service. The new acting manager, told us they had recently found ten care staff employed at the service during 2018, who did not have all the required information on record to support their safe recruitment. For example, for two of the 10 care staff, there was no evidence of their previous employment references, and for another no criminal record check. This meant the provider could not always be sure staff were of good character, competent or safe to provide people's care. The acting manager showed us their action to obtain the missing staff recruitment information and ensure staff identified, either did not work unsupervised with people or provide people's care as required for their safety.

Staff we spoke with understood how to recognise and report abuse and had received training and related policy guidance for this. This included how to report any concerns to relevant external authorities concerned with people's care at the service, including local authority safeguarding. However, staff told us they didn't always feel supported or listened to by the provider. This mainly related to raising general concerns about to

people' safety, in relation to staffing levels.

Staff did not always recognise discriminatory care practice. We found people's bedroom doors were locked. With the expectation of one person, who had their own room key, this prevented their independent access. When we asked staff and management about this, they told us this was because, 'Some people often went into other people's rooms uninvited, sometimes removing their personal belongings, or making a mess there.' Alternative non discriminatory care, including positive behaviour strategies to prevent this, had not been considered or identified for people's benefit and safety.

Overall we observed the environment and equipment was mostly clean and hygienic. The provider's inspection history with us and recent feedback from the local authority before our inspection, told us the service was not always kept clean and hygienic. Care staff at the service also confirmed this. One care staff said, "There's been a lot of scrubbing and cleaning lately to improve." The acting manager said, "I have instigated a thorough cleaning regime to ensure this; we have reviewed the cleaning schedules and checks to make sure this is consistently followed." They also showed us a report from the local environmental health officer, following their re-inspection of the kitchen premises, food hygiene and handling at the service in October 2018. This found the provider had made improvements to achieve a four star [good] rating, from a previous one star [poor] rating.

However, in one person's room, there was a strong malodour. The related daily cleaning schedule record we looked at for the person's room, was not recorded to show this was being regularly completed. In one bathroom, we saw hoist slings were left on the floor and therefore not safely stored. Stand aid equipment in the bathroom was dirty and in need of a deep clean and the plastic coating on a rise and fall bath seat was cracked and splitting, which could be difficult to clean and an increased risk of harbour to germs. Clean commode pots were not safely stored, as they were left on the floor along with soiled pots in the dirty sluice room. This meant there was an increased risk to people from an acquired health infection through cross contamination. We discussed our findings with the acting manager, who agreed to take the action needed to rectify this, to ensure related cleanliness and hygiene.

Inadequate

Is the service effective?

Our findings

Before our inspection, information shared with us from local authority safeguarding investigations concerned with people's care at the service, found areas of neglect for 14 people's care, relating to their skin and nutritional care, or their positive behavioural support. Seven included insufficient care plan record keeping for staff to follow, lack of timely referral to relevant external health professionals or not following their instructions for people's care when needed.

People were not always effectively supported to maintain or improve their health. One person with limited mobility, told us they needed to regularly elevate one of their legs on their footstool when sitting; to help relieve swelling and discomfort from their related health condition. This was not been provided to the person whilst they sat in the lounge during the morning of our inspection. The person told us they were experiencing discomfort from their leg and said, "I am supposed to put my leg up on my footstool." A visiting health professional also confirmed this. The person went on to say [about their footstool], "Half the time it's not available; I don't know where it is." Staff told us they would, 'look it out' but did not subsequently act to ensure this. The person's related care plan did not show staff the frequency and duration the person's leg was to be elevated. Staff we spoke with were unable to confirm this. The person's care was therefore not effectively informed or followed for their health.

Visiting health professionals we spoke with told us, staff communication and understanding of people's care needs relating to their health, was variable. Two felt communication but had improved over recent weeks. Care staff we spoke with told us communication relating to people's care was poor. Their comments included, "There's no communication; I don't get to know about any care changes, unless a senior 'decides' to tell us. We don't get a care handover when we come on shift, it's just senior to senior only." And, "We are not kept sufficiently informed; I don't have a clue unless I come across something and ask; it puts me in a difficult position." And, "Communication is so hit and miss, there is no consistent approach. " Another told us, "Quite frankly, communication is appalling. We need a proper handover; it's supposed to be written in people's daily records, but we don't have time to trawl through; when you come on shift, there's too much to do.

Staff told us about one person who was at risk of skin sores from prolonged body pressure because of their health condition. We saw the person was provided with an electronic pressure relieving air mattress on their bed, to help prevent this. We noted the air mattress was on a 'low' setting following the person's rest there. When we checked with staff, they told us the setting should have been turned to 'high' for it to be effective. We looked at the person's related care plan for their skin care and pressure sore prevention. This did not give any instructions to show the correct air pressure mattress setting to be effective for the person's size and body weight. This placed the person at an increased risk of harm to their health from skin damage or soreness associated with incorrect equipment use.

Another person's care plan for their nutrition showed they needed a normal diet with 'support from staff'. Staff said this was to ensure the person received sufficient food intake, to maintain a health body weight. The minimum monthly care plan reviews for this recorded two entries during August 2018, which showed

the person's body weight loss, significant to trigger their referral to a community dietician for assessment and advice. A letter archived in the back of the person's care file, showed the referral and outcome advice for a fortified diet to be provided. Staff we spoke with knew to ensure this but the person's related care plan had not been updated with the health professional's instructions, provided three months before our inspection. This meant the person was placed at risk of receiving inconsistent, ineffective nutrition because of inaccurate care plan record keeping.

One person was under care and investigation from their GP for vomiting symptoms at mealtimes. Their care records showed the initial medical instructions from the GP for staff to follow. This stated the person was to be given 'small portions of food more often' and 'staff to monitor this, to ensure the person has sufficient amounts of food.' The actual type, portion amount and frequency of food to be given were not specified, to help accurately inform their related care needs. At the main meal of the day, staff did not follow the GP's instructions and gave the person a full sized dinner. The person ate this very quickly, then subsequently vomited.

People did not always receive timely support to eat and drink meals of their choice or liking. Meals were provided to people in a range of dining and communal lounges. Lunch and tea time meals we observed were not well organised for people and difficult for staff to manage. We saw staff often had to interchange from providing personal care, to supporting people with meals and drinks, which resulted in care delays, including for people's meal time support. At lunchtime, three people in one lounge area were given food, which they left most of because it that was not of their choice or liking, which they openly commented on. People located there also complained of being given cold tea and coffee at mid morning drinks served, or drinks with sugar in or vice versa, which they didn't like.

Lunchtime was a lighter meal with the main meal of the day served at tea time. The main meal served at tea time had mixed reviews. One person said, "It was awful." Another person told us they always enjoyed the meals provided at the service and said, 'There's always plenty, they will do something else for you, if you don't like the choice." We saw people were often left waiting for long periods for their meals to be served or for support from staff to eat and drink. For example, one person was left waiting in the dining room with their main meal in front of them, for over half an hour before staff returned to help to eat their meal. During this time the person became distressed having tried to eat their meal unsuccessfully with someone else's knife. Staff did not know what was for dessert but found this out from the kitchen. There was nothing recorded on the menu board displayed in the dining room to help inform people. Whilst some people did receive sufficient meals they enjoyed and chose, this was not consistently ensured in a timely manner.

Staff we spoke with generally understood the principles the Mental Capacity Act 2005 (MCA) but this was not always followed when required for people's care. The MCA provides a legal framework, for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We found people's consent or appropriate authorisation for their care was sought and obtained in line with legislation and guidance. However, formal authorisations for DoLS were not always effectively followed. required.

We looked at the records of formal authorisation for two people's DoLS, issued to the provider by the relevant local authority responsible for this. Both DoLS specified conditions to be met to ensure people

received care that was lawful, in their rights and best interests. For one person, a specified condition relating to their medicines administration were not followed by staff responsible, without considerable delay; until an external health professional concerned with the person's care at the service noted this. The other person's DoLS authorisation showed a restriction to their freedom, to live at the care home for their safety and welfare needs associated with their mental health condition. Discussions with staff and a review of the person's related care records, showed the specified condition of the DoLS authorisation, was not and had never been met. The provider had not not ensured relevant management checks, to make sure this was followed. The condition was to ensure the person was regularly supported to access the local community to shop and visit places of their interest and choice. We discussed our findings with the provider's nominated individual, who told us they would act to rectify this, to ensure the condition was met.

People therefore, did not always received effective care and support that met their needs or preferences. Staff were not consistently informed about people's care needs; and they did not always follow people's care plans, or seek and follow instructions from relevant external health professionals for people's care when needed. People's care plans were not always kept up to date and did not always contain sufficient information for staff to follow to ensure they receive effective, accurately informed care that met with their needs and preferences. This showed people did not always receive effective or accurately informed care, which met their needs and preferences and for their wellbeing.

These were breaches of Regulation 9 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Staff we spoke with felt they received the training they needed, along with relevant competency assessments when required, to enable them to perform their role and responsibilities for people's care. However, our inspection found people's personal care was not always provided in line with current legislation, standards or guidance. This meant people were placed at risk of unsafe or ineffective care. We discussed our findings with senior management and asked for a copy of the staff training matrix record. They advised us staff were trained to provide people's care, but said the training matrix 'needed updating'. They did not subsequently provide this following our inspection as we requested.

A number of environmental adaptations helped to support people's independence and orientation needs but this this was not fully considered to optimise people's related care experience. People were able to move around the home, which provided sufficient space for any equipment they needed to use, such as walking frames. There was level access to an enclosed garden with seating overlooking garden allotments, which two people said they liked to view. People we spoke with said they were happy with the environment and their own rooms.

Requires Improvement

Is the service caring?

Our findings

Overall, people felt staff were kind, caring and had good relationships with them. One person said, "The staff are very good, nothing is too much trouble." Another person told us, "Staff are pretty good; I get on fine with them." Another said, " I have a key to my door and can drop the catch if I want to for privacy. The staff always tap on the door, even if they have just left and come back in; they are very courteous and respectful."

We observed some positive caring interaction with people from staff. For example, gentle encouragement and reassurance whilst supporting one person to move to use the hoist. Staff also understood the principles of good care, to ensure people's dignity, choice, independence and rights. However, they were not always able to ensure or optimise this for people, because the provider's communication, care planning, staffing and management arrangements for people's care were not sufficient or effective to ensure this.

For example, staff were often rushed to provide people's care, which was a source of expressed concern and frustration for them. This often resulted in people's freedom, choice, comfort, dignity and independence being compromised or restricted. We saw people were left eating their main meal in the direct vicinity where one person had vomited, for some 20 minutes before staff had time to clear this away. Staff did not always respond when needed, if people verbalised or showed any discomfort or emotional distress. Staff were rushed and did not always check with people they were comfortable before leaving them to assist others. People were given drinks and meals that were sometimes cold, or not of their choice or liking. Most people were restricted from independently accessing their own rooms, which were kept locked. Some people were confined, because staff did not always have time to regularly support people's movement, including for their comfort and to other areas of the home.

People's views about their care and support were not actively sought to inform their care plans for staff to follow. Staff were not consistently informed regarding people's care routines, preferences and daily living choices. One person said, "I've never seen a care plan or been given opportunity to discuss it." Another said, "I'm sure there must be one but I've not talked to anyone about it." We saw that a standardised care planning format was in place in people's care files we looked at, which included a section with standardised prompts for staff to follow for completion. This aimed to ensure people's involvement or that of their representatives, to obtain and record people's individual care and daily living choices. In all of the care plans we looked at, this section was left blank and did not show any involvement of people or their representative.

Staff often understood and knew how to communicate with people in the way they preferred and understood. However, staff felt they needed further support and advice, to help them understand and communicate with one person living with dementia, who had reverted to their mother language; which staff did not understand. One care staff member in particular, was trying with best intent to support the person and communicate with them. However, advice from any relevant external agencies that may inform and support staffs' effective communication with the person, had not been considered or sought. There was also no information to show how people's choices were sought and considered, in relation to their preferred term of personal address, or for the provision of male or female care staff for their personal care. One person

said, "No, I don't recall being asked if I have a preference; I am happy to received care from either; they are all nice and gentle."

People and relatives were not routinely provided with information about how to access independent lay advocacy services, if people needed someone to speak up on their behalf. There was also no information visibly displayed to support this. The nominated individual for the provider, told us service information could be made available in large print for people if they needed this. They also said they had recently developed a policy for the service against the Accessible Information Standard (AIS). The AIS was introduced by the government in 2016 to make sure that people with a disability or sensory loss are given information in a way they can understand. However, when we discussed this with them, the policy was not available and they had not assessed the service against the AIS to ensure this was met for people living there.

Requires Improvement

Is the service responsive?

Our findings

At our last inspection of the service in January 2018, we found people did not always receive appropriate care that met their needs and preferences. This was because people were not consistently supported to engage in home life and with others, in a way that was meaningful to them. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Following that inspection the provider sent us their improvement plan to tell us what action they were taking to rectify this. At this inspection the required improvements had not been made.

People's care was often not individualised or responsive to their needs. Most people were sitting in lounges with the television on, which many were not watching. One person said, "The activities person is on holiday; there's not much to do." Another said, "[Activities co-ordinator] does quite a bit, but it's not for everyone. It's a bit basic and some can't join in. [Activities co-ordinator] does their best to make it like home." Another person said, "It's all a bit hit and miss; I don't think there's enough staff to organise things. I like the quizzes and singing."

Senior management confirmed that the activities co-ordinator was on leave and that care staff were responsible for providing activities. Staff told us they did not have enough time to organise meaningful activities for people to engage in at service, or within the local community. Some staff felt they were not skilled or sufficient supported to do this. One person's records specified legally agreed conditions for their care at the service, which showed they were to be regularly supported by staff to access the local community. The person, staff and related care records we looked at confirmed this had never been achieved. The provider had therefore not ensured time or additional staffing resources, to consistently ensure structured, appropriate activities for people that met their needs and preferences

This meant people did not always receive care that was appropriate to meet their needs and preferences. This evidence has been taken account of in the Effective domain of this report, to support the related breach of regulation identified there.

People said they were confident and knew who to speak with if they needed to raise a concern, or make a complaint about the service. One person said, "The acting manager is very approachable; issues I have raised with them have been dealt with quickly; only minor things." Another person said, "Oh, I complain all the time, I let certainly let them know; if you don't tell them they don't know; they taken it in good stead."

We were advised by senior management that the provider's complaints procedure was displayed in the main entrance area. This was not visibly displayed when we checked. The operations manager told us they were aware of two complaints. There were no records made of these complaints including their investigation and outcomes, or of any related management checks in relation to complaints received. This meant the provider was unable to account for any complaints about the service. The new manager told us about their action to rectify this, to ensure complaints received are effectively accounted for.

At the time of our inspection, there was no person living at the service, who was at the end stage of their life.

One person, with an terminal advanced medical health condition, had been prescribed anticipatory medicines for their physical comfort, but had not yet needed to use them due to recent a health improvement. Anticipatory medicines help to ensure people's comfort from pain or emotional distress at the end stage of life and prevent any unnecessary hospital admission.

Staff were not knowledgeable about recognised national standards concerned with end of life care. People's recorded needs assessments we looked did contain a brief prompt for staff to record people's 'end of life care wishes'. However, these were mostly blank, or with no information to show relevant discussion or assessment with people and their representatives; to support people's end of life care and treatment decisions and wishes, including after death body care. For example, one person's related care record dated May 2015 following their admission to the service showed, "Staff will have to contact family to discuss." There were no further entries made in the record. This showed that nationally recognised standards for end of life care had not been formally sought or considered for people's care at the service in any event.

Inadequate

Is the service well-led?

Our findings

At our last inspection in January 2018 effective systems were not operated to consistently ensure the quality of people's care. This was a breach of Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014. Following that inspection the provider sent us their improvement plan to tell us what actions they were taking to rectify this.

At this inspection the required improvements had not been made to ensure this. We found both repeated and further breaches at this inspection, with shortfalls across all of the areas we look at when we inspect services.

A senior operations manager for the provider, told us the previous registered manager was responsible for carrying out regular care and service audits, to check the quality and safety of people's care at the service. The operations manager was not able to locate any related records for this. However, they provided two copies of their updated Service Improvement Plan (SIP) of May 2018, reviewed in September and November 2018. The SIP was initially prompted and agreed following a concerns meeting held with the provider, by the local authority.

The provider's SIP review dated September 2018, showed 64 of their specified improvement actions were completed and considered as concluded. This review showed there was 'a robust governance system in operation at the service', to check and ensure the quality and safety of people's care. This did not match our inspection findings, which found many areas of concern, such as in relation to the quality, safety and effectiveness of people's care. For example, in relation to communication and record keeping, equipment servicing and maintenance and staffing. The revised SIP from this dated 5 November 2018, showed 38 service improvement actions were still needed, as originally identified in May 2018. A further four actions were signed off as completed on this SIP. These included, ensuring person centred care, safe medicines management and infection control and effective care approaches at the service. This did not match our inspection findings where we found significant related concerns. The improvement actions not completed, since May 2018, often reflected areas of concern we found at this inspection, in relation to the quality and safety of peoples' care at the service.

The provider did not consistently ensure safe staffing or effective communication, reporting and record keeping arrangements for people's care at the service. Robust systems were not effectively established, operated or sufficient to consistently ensure this. People's medicines, environment and equipment used for their care were not always safely managed. This included environmental cleanliness and the servicing and maintenance of equipment.

Records required for the management and running of the service and for people's care were not always ensured, accurately maintained or robust. Existing records for emergency lighting, fire safety risk assessment, nurse call system and portable appliance testing were out of date between five and 12 months. Documentary evidence to show regular servicing and any maintenance of the passenger lift at the service, was not available. The operations manager advised this work had been carried out, but was unable to

evidence this with the relevant certificates of maintenance.

The provider had not always told us or people's relatives when things went wrong at the service when required. For example, the provider did not always send us required written notifications, to enable us to check and ensure people's safety at the service, when needed. Records showed, this included a minimum of four incidents resulting in people needing medical intervention and one where a person attempted to injure another person with a hot drink. People and relatives were not formally consulted on a regular basis, in order to seek their views about the quality of people's care; to help inform any care and service improvements. For example, such as through regular meetings or care questionnaire surveys.

The provider did not ensure regular formal consultation, with people and relatives, such as through meetings or care surveys, to help inform and improve peoples' care when needed.

This meant people were placed at ongoing risk of receiving unsafe or ineffective care, or care that did not always meeting with their needs and preferences. The provider did not operate effective systems for governance and oversight of the service, or demonstrate lessons learned for people's care when required. Pro-active, sustained and ongoing care and service improvement was not consistently ensured for people's health and welfare.

These were breaches of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service was not well led. There was no registered manager for the service. Although a new manager had recently commenced. The nominated individual for the service was also the operations manager.

Since our last inspection, management of the service was often ineffective. For example, the service inspection history and information shared with us from local partnership agencies and care professionals, shows a cycle of operational and management failure at the service. External professionals involved with people's care at the service, including care commissioners told us the new acting manager was working hard to forge improved relationships with them.

Staff did not always either understand or follow their role and responsibilities for people's care and sometimes both. Most staff felt they were not consistently supported or informed to always provide people's care in a safe, effective, caring and responsive manner. All of the staff we spoke with made positive comments about the new acting manager. These included, "Positive and approachable'; "Trying their best to make a difference"; and "[Acting manager] listens and has already started to try and sort out our supervisions; when I told her I've never had one."

The provider had ensured to visibly display their most recent inspection rating for the service, at the service and on their website, as required to do so.

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 People who used the service were not always protected against risks associated with ineffective care. This was because people's care was not always person centred or appropriate, to ensure their needs and preferences. Regulation 9(1)(a)(b) & (c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing People who used the service were not protected against risks to their safety associated with unsafe staffing. This was because staffing arrangements were not always safe or sufficient for people's care. Regulation 18(1).

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 Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2014 Safe Care and Treatment. How the regulation was not being met: People who used the service were not protected against the risks associated with unsafe care or treatment. This was because risks to people's safety associated with their health condition, environment or any equipment use for their care, were not always effectively identified, managed or mitigated when needed. Regulation 12(1) & (2)(a)(b)(c)(d)(e)(g)

The enforcement action we took:

Urgent Notice of Decision issued 13/12/2018 - Restrictive conditions imposed on provider registration until further notice. To prevent further service user admissions to Elm Lodge Care Home. With immediate effect.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance People who used the service, were not always protected from risks associated with ineffective governance. This was because the provider did not ensure safe and effective operations for the management and oversight of the service, or communication and record keeping for people's care; to ensure timely, pro-active, sustained and ongoing care and service improvement. Regulation 17(1) & (2) (a), (b) (c)(d).

The enforcement action we took:

Urgent Notice of Decision issued 13/12/2018 - Restrictive conditions imposed on the provider's registration until further notice.To prevent further service user admissions to Elm Lodge Care Home. With immediate effect.