GCH (Heath Lodge) Limited

Heath Lodge

Inspection report

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Date of inspection visit:
16 May 2016
25 May 2016

Date of publication:
21 September 2016

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

Heath Lodge is registered to provide accommodation and personal care for up 67 older people some of whom live with dementia. At the time of our inspection 48 people were living at Heath Lodge.

The inspection took place on 16 and 25 May and was unannounced.

Since our last inspection there had been changes within the senior management team and new ways of working at senior level were being implemented. The manager who was registered at Heath Lodge had recently been transferred to another home owned by the provider. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. Heath Lodge was being managed by an interim management team and a newly appointed manager was due to register with CQC as required.

We previously inspected Heath Lodge on 13, 14 and 16 January 2015 and identified breaches of Regulations 09 Person Centred Care, 11 Need for Consent, 17, Good Governance and 18, Staffing of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We rated the home as requiring improvement. The provider sent us an action plan setting out how they would meet the requirements of the regulations. We carried out a comprehensive inspection of Heath Lodge on 16 and 25 May 2016. This inspection was triggered by concerning information we received that related to staffing, communication difficulties, and the care people received in Heath Lodge. At this inspection we found that the provider had not made the required improvements they told us they would implement. We also identified breaches of Regulations 09, 10, 11, 12, 13, 14, 17 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we took at the back of our report.

The service had staff vacancies and as a result was using high level of agency staff. Some staff recruited by the provider were not able to demonstrate to us a good understanding about their roles and responsibilities regarding the care they delivered to people using the service. People experienced delays in getting assistance and also receiving care when they needed it. We observed examples of people not receiving safe care.

There was a lack of leadership on each of the floors of the home and the permanent senior staff who were responsible were expected to provide leadership with limited support and training. The staffing issues had impacted on care delivery, maintenance of records, the management of medicines and people's access to health care professionals.

At this inspection we found that there were not always sufficient numbers of staff deployed to meet people`s needs at all times. Risks to people's health and well-being were not consistently identified and responded to positively. People's medicines were not administered at the times indicated by the prescriber.

The environment people lived in was not effectively maintained and cleaned. We found unpleasant odours in people`s bedrooms and communal areas which persisted the whole day of the inspection. People were not supported by staff who had undergone robust recruitment processes to help ensure they were of sufficiently good character to provide care to people.

Staff told us they did not feel supported and many were unaware of who was managing the home. Training had not been provided in a manner that supported staff's understanding of how to provide care.

People's nutritional needs were not consistently met and monitored. People were not freely able to choose what they ate and people did not always have access to a range of health professionals and were not always referred when they needed to be. This was confirmed by the professionals we spoke with.

Individual staff members spoke and interacted with people in a kind and friendly manner, and none of the staff observed lacked a caring approach to people. However staff did not always ensure people's social needs were met and people did not always received care at the time they needed it.

People did not always receive high quality care that was well led. The action plan submitted to us following our previous inspection had not been completed and issues identified following local authority reviews of the care had also not been actioned. The service improvement plan in place was not sufficiently robust and the provider had not sought to constantly monitor and review the quality and safety of care people received. Care records, and records relating to the management of the service were incomplete and in the care of care records at times illegible.

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 are 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.

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 safe.

People were not supported by enough staff meaning they experienced a delay when they needed assistance.

People were not supported by staff, who had undergone robust recruitment checks prior to starting work.

People were not protected from the risk of harm. Not all staff were aware of how to identify and respond to avoidable harm occurring.

People's medicines were not managed safely, and people did not always receive their medicines as intended by the prescriber.

People did not always live in a clean and hygienic environment.

Is the service effective?

Requires Improvement

The service was not effective.

Staff were not supported and had not received sufficient training to develop skills to meet people's needs effectively.

There were few development opportunities and support for staff to enable them to carry out their role safely

Mental capacity assessments and best interest decisions had not been carried out for those people who may have lacked capacity to take their own decisions.

People's nutritional needs were not thoroughly reviewed, assessed and responded to.

People were not routinely referred for specialist support when their health needs deteriorated.

Is the service caring?

Requires Improvement

The service was not always caring.

People's privacy and dignity was not always maintained.

People were not always supported in a manner that met their individual needs.

Staff had not understood the needs of people living with dementia.

People were not involved in decisions about their care.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People did not always receive personalised care from staff.

People were not provided with the opportunity to pursue their hobbies and interests.

People told us they felt able to raise concerns or complaints with staff but did not feel confident in the interim management arrangements that their concerns would be dealt with.

Is the service well-led?

Inadequate

The service was not well led.

There were not effective systems to monitor and improve the quality and safety of the service provided. Previous areas of concern identified at our last inspection had not been improved or acted upon.

The manager was not able to demonstrate through a robust system of governance that staffing levels matched the level of needs of the people.

The manager had not ensured the records reflected people`s needs and these were not regularly updated.

The manager had not ensured the service met the fundamental standards.

People told us they had poor communication with the management. They were unaware of the recent management changes in the home.

Heath Lodge

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place at Heath Lodge on 16 and 25 May 2016 and was unannounced. On 27 May 2016 we received further feedback from health professionals and people's relatives about the service provided. The inspection was carried out by two inspectors.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed information we held about the service including statutory notifications that had been submitted. Statutory notifications include information about important events which the provider is required to send us.

During the inspection we observed staff supporting people who used the service; we spoke with four people who used the service and relatives of two people. We spoke with nine staff members, the interim management team, a representative of the provider, the newly appointed regional manager and two visiting health professionals.

We also reviewed the findings of a service monitoring audit carried out by the local authority. We sought feedback from the social care professional who carried out this visit from the commissioning team. We also used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We reviewed care records relating to seven people who used the service and other documents central to people's health and well-being. These included staff training records, medication records and associated management records.

Inadequate

Is the service safe?

Our findings

At our previous inspection on 13, 14, and 16th of January 2015 we found that there were insufficient numbers of staff deployed to meet people's needs. The Registered Manager sent an action plan that addressed how the provider would ensure they met the requirements of the regulations. At this inspection we found the required improvements had not been made.

We found there continued to be insufficient numbers of staff deployed to meet people's needs. We saw that on one unit two care staff were allocated to work with people with varying dependency needs. Seven people required assistance from two staff to help them with and personal care and changing position. When either staff member went on their break or went for lunch, this left the other staff member alone. On the day of the inspection due to staffing needs elsewhere in the home, one member of staff was deployed to a different area in the home leaving just one staff member on this unit. This meant that people were required to wait for assistance with their personal care needs and people who were cared for in bed had to wait to be assisted to change position.

We saw on two units that the morning medicines round on the first day of our inspection continued beyond eleven o'clock in the morning. On the second day of our inspection we saw improvements had not been made and medicines were still being administered after ten o'clock. This meant that people were not receiving their medicines as prescribed. We asked one staff member on our second day why medicines were late. They told us, "Today we are just late, breakfast should be finished by nine but we are late, it was only me and one permanent [staff] today and they [manager] took the permanent away, there should be me and two carers."

Throughout both days of the inspection we saw that staff were rushed. The care provided to people was delivered in a task orientated manner rather than tailored to people's individual needs and preferences.

The provider's quality improvement team told us that the dependency tools had not been used as required by the provider's policy by the previous registered manager. They told us they were completing this to understand the staffing needs in the home. Staff we spoke with told us there was a shortage of staff and they were continually on the go, with little support from the management team. A visiting professional told us, "Staff here are physically worn out." We were told that one unit leader finished their shift at eleven o'clock the previous evening. They worked five consecutive 12 hours shifts and after each shift they had a two hours' drive to get home to their family. The provider asked them to return to work the following day in the morning, the day of the inspection, due to staff shortages. This meant the team leader worked 60 hours in five consecutive days and was asked to return for another 12 hours shift where they were expected to adhere to their role including giving medicines to people.

The daily allocations sheets that the unit managers used to plan the staffing for each unit were inaccurate. Although records of staff allocation indicated there were sufficient staff allocated to each unit in the home we found this was not the case. Two staff members were running late, others were moved around to different units where they had no experience of working and were not aware of people's specific needs.

When we spoke with one staff member they said, "I was supposed to be downstairs (Daffodil) but they [unit leader] move me here to be next to you [inspector], I don't know where I go next." A second staff member said, "There are times when we work short and there are times when there is a lot of agency staff or even just agency staff on the units." They continued to say, "Often we don't have a senior on each unit. We don't get a lot of support from seniors because they are all over the place doing medication or other things. This unit we have 12 people, two require the assistance of two staff so we are late every day to get them up and do other stuff." Our observations throughout the inspection confirmed that staff were rushing to meet people`s needs.

We spoke with two staff members and asked them to explain to us the roles and responsibilities they had when delivering care to people using the service. Both staff members told us they were responsible for meeting people`s basic care needs like personal care, offering food and drinks. They also told us they had some training when they commenced employment for the provider, however they could not recall any specific training. They were not able to tell us if they had safeguarding training, mental capacity and deprivation of liberty or infection control training. They told us even if they had these trainings they could not recall anything they learnt.

The lack of suitably skilled staff was a continued breach of Regulation 18 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found that recruitment checks for staff were not thorough or comprehensive. We checked four recruitment records for staff employed recently. Only one of these files was complete. We found for one staff member gaps in their employment and handwritten references had not been checked and verified to ensure authenticity. For another member of staff we found no evidence of a criminal records check or if references were received.

We looked at the recruitment profiles for the agency workers providing care to people on a temporary basis. For two of the staff working on the two days of our inspection we found no agency profile listing their training, skills and competencies or documentary evidence to show they undergone a criminal records check. The provider said they will ask for these, however agency staff were already working in the home. The provider had no proof that the agency staff supporting people in the home had the required skills or were of sufficiently good character to do so.

This was a breach of Regulation 19 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We received mixed feedback from people living at Heath Lodge about whether they felt the service was safe. Some people we spoke with told us they did feel safe living at Heath Lodge. One person said, "It's a lovely house, I feel very comfortable with everyone around me." However another person said, "No, not all the time it's not peaceful or calm like at home and I always feel scared something's going to happen to me." We spoke with a visiting health professional who told us they were concerned about the safety of people living in the home. They said, "There are a high number of skin tears, lack of equipment for moving and handling and high staff turnover. Staff don't know who they are caring for."

Not all the staff we spoke with were able to tell us what constituted abuse, and what actions they would take if they suspected a person was at risk of harm. For example, we spoke with one staff member, who was not able to tell us anything about what safeguarding meant, or to demonstrate their understanding of how to identify or report any potential signs of abuse. We clarified our question; however they remained unable to explain clearly what this meant.

We found that staff awareness about safeguarding procedures varied throughout the home. Some of the staff were able to explain to us how they documented in people's records incidents or injuries and then completed an incident form which they reported to the senior staff on duty. However, other staff were unaware of the procedures, did not know the signs of potential abuse and were not aware of their responsibilities to safeguard people. For example, we spoke to an agency night worker who worked regularly in the home. When asked about abuse and reporting, they were unable to tell us and said, "Sorry I just don't know." Most of the staff we spoke with were unaware of how to report concerns outside of Heath Lodge and were not aware of local organisations such as the local authority or CQC.

We looked at the training provided to staff for safeguarding adults. This demonstrated to us that staff had received training in this area, albeit with the exception of five of these staff members whose training had elapsed. However, staff knowledge in this area was inconsistent. The provider had not checked staff knowledge following the training

We asked a staff member about a person who had developed two pressure ulcers whilst living at the home. They acquired two pressure ulcers in one day. Staff told us that on one occasion, prior to our inspection there was one day when only agency staff were allocated to work on that unit. The staff member told us that agency staff failed to reposition the person who required repositioning frequently. An agency staff member told us, "[Person] was bed bound and had wounds. I think they came from sleeping on one side and not being turned." This incident was reported by the provider to the local safeguarding team at the local authority and was being investigated.

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

We observed people being assisted to move using a hoist by staff who were not sufficiently trained to do so. Staff were seen using unsafe practices. On one unit we saw one person hoisted by two care staff. The sling they used to sit the person in was far too big, they rushed when carrying out the procedure, and we saw the person slip in the sling and nearly tip over backwards. On a second unit we saw one person assisted by two staff using a stand aid hoist. They fitted the sling and instructed them to be ready and lifted them up. The person was not able to hold on to the bars of the stand aid to support their weight when they were lifted up. Their weight was sustained by the sling which pulled them up from under their arms, placing them at risk of bruising or skin tears.

We spoke with the unit leader and asked them who was responsible for assessing the use of equipment for people. They told us they were responsible for assessing this and they took the decision about what equipment people should use. However, when we looked at the training for the unit leaders we found that none of the three employed were qualified as moving and handling assessors. Prior to our inspection it was identified by the local authority that there was insufficient equipment for assisting people. The provider purchased two further hoists, however we saw staff assisting people with stand aid hoists when a full hoist was required.

When we arrived at Heath Lodge, we saw one person with a large cut to the front of their leg. We enquired with three staff who were unable to tell us how this occurred. We spoke with the unit leader who told us it had occurred approximately two weeks prior to our inspection while the person had been assisted to transfer with a stand aid hoist. The unit leader told us the stand aid hoist had been changed but there had been no reassessment of this person mobility needs. This left the person at risk of further harm.

People had not had risks to their health and welfare assessed and care plans to mitigate risks were not

always in place. The interim manager told us that in their opinion the needs of some people living at Heath Lodge had increased to such an extent that they were no longer residential needs but nursing. They told us, "There are social workers in and out of here all the time now, but people haven't been assessed or reviewed for over 18 months." However, the previous Registered Manager had not informed social work teams of the need to review people whose needs may have become too much for a residential home to manage.

People's medicines were not managed safely, or administered when people required them. We checked ten people's medicine administration records (MAR) and found that there were gaps and errors. For example, on 15 May 2016 at night, one person's medicine was left blank, indicating it had not been given. When the unit leader administered the medicine at breakfast time the following day, they did not check to see if the person had missed their medicine or not. They administered the medicines for that time without investigating or reporting the error. , Staff had not documented the reason for when medicines were refused or destroyed on the rear of the MAR as required. Where people's medicines were administered covertly, for example by being crushed and mixed with food, staff had sought the approval of a GP. However, they had not sought a pharmacist's advice on whether the medicine was suitable for crushing, or whether there was an alternative such as liquid medicine.

Throughout our inspection on 16 May 2016 we noted that the home had an unpleasant odour throughout the day. This was present in both communal areas and in people's rooms, and also from some people`s clothes. We saw that chairs were stained in numerous places, food stuff was on the floor and floors and walls were heavily marked. We looked in people's rooms and in two people's en-suites we found soiled underwear on the floor. When we returned on 25 May we found some improvements had been made, however the home remained unclean in many areas.

The lack of risk assessment and mitigation; unsafe medicine management; unsafe care delivery and poor infection control was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

Requires Improvement

Is the service effective?

Our findings

We looked at how the registered manager had supported and developed staff through continual coaching, mentoring and training. We found that not all staff received training in areas they required to enable them to carry out their role effectively. Staff told us they received training at the beginning of their employment, however when we asked them to tell us what training topics they had done they could not remember. After prompting two staff confirmed they have done safeguarding training and moving and handling. The staff members we talked to could not remember if they had training about the Mental Capacity Act and Deprivation of Liberty Safeguards.
We looked at 31 staff training records. These confirmed that not all staff had received training in infection control; mental capacity; or dementia awareness. Staff had received training in food hygiene, but there was no evidence to demonstrate staff had undertaken training and were knowledgeable in understanding people`s nutritional needs or care planning which included assessment tools such as nutritional screening tools, waterlow assessments and mobility assessments.

The unit managers who were responsible for reviewing and assessing people's changing needs, developing care plans and referring them for specialist healthcare services had not received the training necessary to enable them to carry this out competently. Staff had been promoted internally without the training necessary to develop skills and an understanding of their new role. We found numerous examples where the unit managers had not been sufficiently supported either by direction from the management team, or with accessing appropriate development opportunities. For example the unit leaders felt it was their responsibility to assess people's changing mobility needs and the use of equipment without having the qualification to do so. They were also responsible for updating people's care plans but did this as a routine once a month but not if people`s needs changed during the month.

We observed a team leader on the day of the inspection administering medicines for people on two units, helping staff with the use of equipment to move people and being asked to sit in a review for a person with their social worker. All these events happened between 10 am and 12 pm. One of the unit leaders told us, "I am trying to support staff, do my job but at times I am just not getting the time to do my job properly."

The unit managers were observed attempting to manage two units with no direct management support. One unit manager had been promoted twice over the past year from care staff member to unit manager. They had received no additional training or development to enable them to carry out this role confidently and told us they felt they were undertaking responsibilities that they were not sufficiently trained to manage.

Staff we spoke with told us that they had not had supervision or appraisal regularly. We confirmed this with the interim manager who told us that staff had not received any face to face supervision recently; however they had plans to re-commence this. Records confirmed that staff had no face to face supervision with their line manager since early in 2015. We saw staff worked diligently but had been unsupported. One staff member said, "I feel I am doing far more than I should in my position. I cover more than one unit in my shift because [there are] no staff."

The failure to ensure there were suitably qualified, competent, skilled and experienced staff was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). At the time of the inspection applications to deprive people of their liberty had been made for some but not all the people living in the home. The interim manager had recognised this and requested these to be done. On the day of the inspection an assessment was being carried out for a person who required a DoLS application.

One person had a Do Not Attempt Cardio Pulmonary Resuscitation decision (DNACPR) in place, this listed that it was their decision not to be resuscitated and to be cared for in the home and not in hospital. There had been no mental capacity assessment completed about this decision. Staff we spoke with told us that this person finds it difficult to make decisions as they were not able to retain the information they were given long enough to make a decision. This person had been diagnosed and lived with dementia. One staff member said, "[Person] will only say `yes` or `no`, they don't have capacity." Therefore the decision on the DNACPR may have been incorrect and could have had a serious impact on the person`s life.

We identified further examples were people did not have capacity assessed in line with the requirements of the MCA. For example we observed some people had bed rails fitted and used on their beds. Staff could not tell us if this was in people`s best interest. There were no records about a best interest process and mental capacity assessment to demonstrate how these restrictions were in people`s best interest. At the time of the inspection the interim manager told us they were reviewing these assessments; however these had not been completed at the time of inspection.

People who were assessed as requiring their medicines to be administered covertly had not had the appropriate assessments carried out as required by the MCA 2005. Where some people had their medicines administered in this way, staff had not carried out an assessment of capacity or sought alternative methods of administration that meant disguising medicines in food were not necessary. We saw the GP had authorised the use of covert administration, however, the views of people, families, or any other relevant person had not been sought.

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

People had mixed views about the food provided at Heath Lodge. One person said, "The tucker is great, I love it and look forward to the hot dinners." A second person said, "It's fair to middling really, not what I want to eat mostly, but it will do." A third person said, "Can't really choose, we just get what we are given, and when we say what we want they [staff] don't listen."

Staff were not aware of people's preferences and did always offer people choice of food. For example, we observed a person walking along the corridor on the way to have breakfast accompanied by a staff member. They were excited about going for breakfast in the dining room and repeatedly told us about having a bowl of porridge which was their favourite. The staff member assisted the person to sit and left another staff member to serve their breakfast. The staff member who was preparing people's breakfast did not ask the

person what they wanted; they placed a bowl of rice krispies in front of them. The person visually sank in their chair and was dismayed and confused. This was further compounded when the staff gave the person sitting next to them a bowl of porridge. The person picked at their cereal but left most of it without any prompting or querying by the staff as to why they were not eating their breakfast.

We saw a second person at 11:20 eating their porridge with a cup of tea. They asked a volunteer befriender for egg and bacon. The volunteer went to the kitchen to ask but returned saying, "I am afraid I have to give you bad news. The kitchen staff can't do egg and bacon now they are in the middle of preparing lunch." The person then told us, "I ask [care staff] to get me my breakfast egg and bacon, but this is as far as it gets."

On another unit, at breakfast, staff were taking people their meals to either their bedrooms or communal areas; however, staff were not able to sit with people for any meaningful period of time to support them with eating. One person at breakfast had been brought to the table before their breakfast was prepared or ready for them. They were seen to become agitated, getting up and down from the table, whilst their breakfast was getting cold. Staff were not available to intervene and support them; subsequently they left their breakfast, and walked away. They were not encouraged to return to the table and as they left the dining area their breakfast was thrown in the bin.

People who found it difficult to sit for long enough to eat a meal were not offered snacks between main meal times. Tables were not laid to support a warm and pleasant environment. Staff did not use visual aids to assist people with selecting their meal; menus were hand written on a white board in the dining areas. This meant that people with memory or sight problems were unable to decipher what the options were when selecting their meal.

Referrals to health professionals were not consistently carried out, and when they did occur were prompted by those health professionals being in the home and identifying people themselves. One visiting health care professional told us, "I'm only meant to be here for half an hour, but lately I've been spending up to three hours because we see more and more people we don't know about and find out when we are here." Even where people were identified as requiring a referral to either the GP, Tissue Viability Nurse, psychiatrist, mental health team, dietician this did not occur consistently.

We found numerous examples where people were not referred for issues such as weight management, dietary needs, and mental health concerns. For example, we found an entry in one person's daily records to say the skin on their bottom was "not looking good" and was "coming off". Records did not demonstrate that the district nurse had been requested to assess the person and when we spoke with the unit manager they confirmed this saying that staff just applied cream to the area.

Assessments were done by staff to identify if people were at risk from poor nutrition or hydration however people's weights were not regularly monitored to identify any weight loss. Where people were identified as losing weight staff had not ensured their nutritional care plans and assessments were reviewed and up to date. As a consequence health professionals were not consistently involved at an early stage where weight loss was identified. For example, when calculating people's body mass index, staff did not use exact data and people`s height was estimated. One person's weight records showed they had lost 3.8 kilograms between March and April 2016, no more recent weight had been taken. When we asked what actions had been taken the unit manager told us, "They don't need a food and fluid chart; they are putting weight on and have a good appetite." This was a contradiction of what the weight records noted, and demonstrated that the unit manager was not aware about the person`s needs. The Malnutrition Universal Assessment Tool (MUST) had been completed incorrectly with no record of weight loss noted for March or April. Where the MUST asked staff to complete the amount of weight the person had lost, they recorded zero, meaning this

did not trigger an action or referral to a health professional and placed the person at risk of malnutrition.

For another person identified as losing weight staff had been monitoring their weights weekly. However their food and fluid intake was not monitored which meant that staff were not able to effectively review what the person had eaten over the previous week. The MUST had been incorrectly completed suggesting they had zero weight loss over several months which was not the case. For example they had lost 800 grams in one week which was in addition to further documented weight loss over previous weeks. When we spoke with the unit manager about actions they had taken because of this sustained weight loss, and whether they considered monitoring the person more closely they told us there was no need for the person to be closely monitored because they had a good appetite. This meant that people's nutritional needs were not met, monitored or reviewed by staff. Staff were not knowledgeable about the correct use and completion of the MUST which if completed correctly should have identified if people were at risk of malnutrition. Staff were not aware of people`s changing nutritional and dietary needs.

This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service caring?

Our findings

People's privacy and dignity was not always maintained. For example, we observed staff on one unit hoisting a person from the chair to their wheelchair. In doing so, staff spoke to each other, with minimal discussion with the person to allay their anxieties of being hoisted. Staff did not protect the person's dignity while in the hoist, allowing them to slip in the sling exposing their underwear to a room full of people. Staff did not attempt to cover the person and continued to transfer them to their wheelchair.

When we arrived at Heath Lodge, some people were not dressed in clean clothing. People's hair was uncombed, and their finger nails had dirt underneath that had not been cleaned. One person was sitting in their sling in the lounge with an unpleasant odour coming from them due to being incontinent. People who ate both breakfast and lunch were left in clothing with food that had spilt either over the front of them or into their laps.

Some people had their bedroom doors left open when they were still in bed. Staff were not able to tell us if people preferred their door open or not. This was not documented in the care plans. We heard staff knocking on bedroom doors and greeting people where people were able to communicate verbally. However, where people were not always able to voice their needs, staff did not always knock before entering people's rooms.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's care records contained some assessments in relation to people's needs. We saw that one assessment was to capture what was important to people, and how they would like their care to be provided. These assessments sought to understand people's life history, previous employment, and interests and how they liked to spend their days. It also captured the times people liked to get up or go to bed, and whether they had preferences around the gender of the staff that assisted them. We saw that some of these had not been completed and for those that had been completed the staff we spoke with were unaware of people's specific requirements.

We observed throughout our inspection staff approached people in a manner that sought to reassure people and offer help. However, due to staff being rushed, they were not taking the time to understand what people wanted and this caused frustrations and misunderstandings. For example, we saw that one person living with dementia was distressed and constantly walking through the corridors looking for someone. One staff member approached them asking them what was wrong. The person attempted to tell them they were looking for [Relative] and did not know where they were. However the staff member being in a rush misunderstood and not communicated with the person to find any suitable distraction. The person continued throughout the day to be unsettled and anxious. When we spoke with this member of staff and asked them about this person, they did not understand the grief the person was experiencing for their relative. They told us that the person wanted to have a cup of tea and they had tried to get them to accompany them to the kitchen, but the person kept leaving.

Requires Improvement

Is the service responsive?

Our findings

People we spoke with told us some of the staff listened to them and their views and wishes mattered. One person said, "Its fine with the ones who can understand me or who I can understand." A second person said, "Not all of the carers, but some of them just look at me and make me think they just don't understand." A visiting health professional said, "One of the carers is writing notes for another because they don't understand English. Others just can't express what the concerns are so how can they possibly be responsive when they don't understand. It's not that they are poor carers, quite the opposite, but it is just not safe for people."

Care plans we looked at relating to personal care matters and social activity had been written in a person centred manner and in many examples contained information about people regarding likes and dislikes, activities and daily living. For example, the care plans detailed people's preferences around areas such as eating, drinking, sleeping, and mobility. The care plans when completed documented how the person wished to receive support for each of these identified areas. However the delivery of the care was not carried out in a manner that reflected these identified needs and preferences.

Where it had been documented in people's care plan that they liked to rise early in the morning, or eat breakfast in the communal areas, staff were not always able to help people achieve this. Staff confirmed this and told us that, "This unit we have 12 people, 2 requires assistance of 2 so we are late every day to get them up and do other stuff." People told us that the care they received was task based, meaning there was little time to support them in a personalised way. One person said, "They [Care staff] do their upmost best all the time to help, but it has to be their way because of the time they have, so things are a bit like an assembly line at times."

The activities we saw on both days of the inspection offered little stimulation to people. There was a lack of meaningful activities offered to people by staff. For example on the first day we saw the hairdresser was in the home. Only one person was encouraged to visit them. However, care plans we looked at stated that issues like appearance for females was important. We had seen that people's hair had been ungroomed.

On the second day of our inspection visit there was a movie afternoon held. However, for people who were unable to leave their beds there was nothing organised. Some people who did attend the movie afternoon quickly lost interest and left. We saw people walking around the home in a confused state. The one group activity we did observe involved people being able to try a range of different continental foods. People were heard to comment "This is something new, and how did you get the idea to do this?" Another person said, "We never done this before, who came up with this?" and a third person said, "Do I have to taste all this? I have never done it before." This clearly was not an activity that people were used to. Staff did not have time to spend with people on a one to one basis to support them to pursue their own hobbies and interests.

Most people we saw throughout the inspection were sitting in communal lounges watching television or in their rooms. People told us that staff did not have the time to spend time with and that conversations were mostly around their care needs and help they required. One person said, "I miss the spark of a good chat

with the carers, we used to have it a while ago, but not now, there either isn't enough of them to spare me the time, or I can't understand them and they can't understand me." A second person said, "Don't believe all the posters or promises, this place is dull and lifeless and not a shadow of how it was."

People received care which was not necessarily how they preferred, was not individualised and did not reflect their choices and this was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us that they felt that decisions about their needs were taken by the staff, and the outcome of this presented to them. One person said, "I don't know what`s happened but it seems sometimes that I'm at the end of the queue to be told but it has only been like that recently and I think this is because the manager has gone off." People and relatives told us that the staff used to involve them in developing a plan of support that addressed and managed their needs, however recently this had not happened as often. They told us that staff also used to regularly update them with the outcome of appointments or any health related matters; however this also had been less consistent in recent months.

People we spoke with told us they were aware of how to raise a complaint and had been provided with information from the provider. However, people also said that they didn't know who they could take a complaint to if they had one due to the changes in managers. One person said, "I can go to the carer or the senior but if it's something more personal or a bit more important, then who I go to." We looked at the log of complaints received, and saw that these were investigated, responded to and communicated in line with the provider's policy. The registered manager had dealt with each complaint they received appropriately and ensured they communicated to people the outcome of their complaint. However, at the time of the inspection, it was difficult to see how complaints were managed as people were unclear about the management arrangements.

Inadequate

Is the service well-led?

Our findings

The registered manager for Heath Lodge had moved to another of the providers home's however had not applied to deregister at the time of our inspection. When they moved to another home, they had not handed over matters regarding the management of the home to the interim manager or the quality improvement team to aid them in identifying and rectifying numerous issues previously found by the provider.

On the first day of the inspection we sought assurances from the regional manager about management arrangements. They told us they have a team of managers with different responsibilities allocated to make improvements to the service; however they had not appointed one person to oversee the whole management of the home and give leadership and clear direction to the team. For example two members of the management team were updating and re-writing care plans to be more `user friendly`. Another member of the management team was observing care practices; however they did not intervene or take action in relation to the areas of concern we identified. There was no cohesion or stability within the management team, and no one manager had assumed overall responsibility to deliver on the identified shortfalls.

At the time of the inspection, six managers had been involved in supporting the home, all of whom had their own responsibility; however there was no shared action plan or review of progress. When we asked at the end of the first day of the inspection for an audit tool to be sent to us, this was not done by the agreed deadline. On the second day of the inspection, when we asked why this was not sent, it was clear that each manager had thought the other had completed this. This demonstrated to us that management arrangements in the home were not sufficient to ensure consistency and continuity. One staff member told us, "Who's who and what's what here because none of us know. The home is up and down all the time, there are too many changes around." A second staff member said, "It's just madness at the moment, there are so many managers here but I don't know what they are doing, they haven't said what they need to do but if they just asked and spoke to us then we could help."

When we spoke with the provider about our concerns regarding the management of the home they were unaware of some of the concerns. On the second day of our inspection the provider had appointed a new manager who told us they would register with CQC as they are required to do. However the management arrangements in the home were not robust, there was a lack of overall leadership and governance to ensure people received safe and effective care. At the time of the inspection people we spoke with were unaware of the management changes, and some staff were unaware of who was in charge of the home whilst a replacement manager was recruited. When staff were informed about the recruitment of the manager they voiced their concern that they may not remain in post. One staff member said, "I don't know who really the manager is at present. They all just come and go so we [staff] do our best."

We asked staff about staff meetings and they told us these had not been held regularly. One staff member said, "They happened in the past but have not been held for a long time." The interim manager had begun resuming staff meetings however not all staff had been able to attend or receive feedback from these.

Following our inspection in February 2015 the provider completed an action plan and returned this to us on the 14 May 2015. They told us in this document that they would ensure they met the requirements of the breached regulations identified at the previous inspection by 31 July 2015. In this action plan they told us they would achieve this by ensuring that they would complete monthly reviews of people's dependency levels, they would review this with the regional manager to ensure they reflected the staffing requirements in the home. This had not been completed, and people's dependency needs had not been assessed by the previous manager. Staffing in the home had not been assessed as required. We identified staffing levels as a breach in this inspection. People continued to be at risk because systems did not seek to identify, address or mitigate the risks of insufficient staff deployed to meet their needs.

We asked to see how both the management team and provider monitored staffing levels following our previous inspection. The action plan submitted to us following our previous inspection noted that each person's dependency would be reviewed and monitored, and staffing hours would be amended accordingly to people's changing needs. However, when we asked to see a copy of the required staffing levels for the home there was no evidence made available to us of any reviews of staffing hours.

Neither the provider nor the registered manager had continually reviewed and assessed people's needs in relation to their mobility or nutritional needs. Assessments of people's needs were not reviewed to ensure people had the correct care plan in place or equipment to mitigate the risks to people's health and well-being. Specialist healthcare professionals had informed the previous registered manager and the current interim management team of the need to order equipment to assist people such as slings and hoists, and had also brought in their own assessor to review people who were at high risk of falls. When staff calculated people's BMI, they did not use the appropriate methods, and this had not been identified through the provider`s quality auditing and assessments. When we arrived at Heath Lodge we asked for a copy of a service improvement plan. The interim quality management team had developed a brief plan that outlined some of the key areas in need of improvement, however had not yet addressed or remedied some of the identified concerns.

Regular audits of key areas of service delivery had not been robustly completed in areas such as training, supervisions, care planning, staffing, and incidents or injuries. The provider had not identified or acted on risks to people using the service. Risks of injury to people had been identified by external visitors and other professionals and not identified through both robust care planning and effective review through governance arrangements. Incidents and accidents had not been reviewed by management for any recurrent trends to identify whether these occurred at particular times of the day or may be attributed to a lack of staff for example.

The interim management team informed us that they were not familiar with the current reporting arrangements in the home. They told us they were in the process of carrying out an audit using a new set of tools to monitor the home, and were implementing this on the first day of our inspection. We asked for this to be sent to us once completed at the end of the week, which they agreed to do. However, we did not receive this as requested. The provider sent us a series of new monitoring tools that they were implementing, however they did not address or identify any areas of improvement needed in the home.

Care records did not clearly identify people's needs and why they were receiving particular levels of care. For example, staff told us one person stopped eating well and stopped walking from one day to another. They said that after a few days the person was unsafe sitting in an armchair because they were sliding off. They said that a GP was called and they commenced an end of life care plan and cared for the person in bed. When we looked in the care plan there were no risk assessments, care plans, professional contacts or referrals to verify this, only what staff told us. This meant that this person may have not received the correct

care they had been assessed as requiring because staff had not completed the records.

Assessments of people's moving and handling needs were incomplete and incorrectly completed. For example, one person who had previously used a stand hoist was assessed to require a full body hoist; however staff continued to use the stand hoist. The care plan continued to refer to the use of a stand hoist, increasing the risk of injury and harm to the person by being assisted with the wrong equipment.

When we reviewed the content of people`s care records we found that these varied in both quality and ease of reading. Some staff that completed people's daily records had done so concisely, which made reviewing those simple and straight forward to read and understand. However, other entries were either barely legible or written by people who had a poor understanding of writing in English. We asked one staff member about the lack of accurate recording in people's care plans. They told us that nobody on the unit will update the care plans and usually it is only done after the 15th of each month, not when needed due to a change in people's condition. This meant an accurate and contemporaneous record of a person's care and support needs had not been maintained to ensure they received the care they required safely.

The lack of effective monitoring of the quality of care provided to people together with the poor maintenance of accurate records meant that people had received care that did not meet their needs and protected their health and well-being. The interim arrangements had helped minimise imminent risks to people and ensured some oversight was being provided, however this was not effective at all times.

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

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 Regulation 9 (1) (2) (3) (a) (b) Person Centred Care The registered person did not ensure they consistently carried out, collaboratively an assessment of people`s needs and preferences and ensuring that care was provided with a view to achieving people's preferences and ensuring their needs were met.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect Regulation 10 (1) People were not treated with dignity and respect.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs Regulation 14 Meeting nutritional and hydration needs. People were not adequately supported to receive suitable and nutritious food and hydration and to be referred for specialist support when their needs changed.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Regulation 17 (1) (2) (a) (b) (c) Good Governance The provider did not ensure people received safe care because a robust system of monitoring and responding to identified areas of concern was not effective. Records relating to people's care were not accurately maintained or updated when required.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider failed to carry out the necessary pre-employment checks to ensure staff working at the service were of good character and had the competence, skills and experience necessary to deliver care to meet people`s needs safely and effectively.

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 (1) (1) (a) (b) (c) (e) (g) (h) The provider did not ensure that: i) Assessments to the risks to the health and safety of service users of receiving the care or treatment were carried out when required. ii) Persons providing care or treatment to service users have the qualifications, competence, skills and experience to do so safely. iii) People lived in a clean and hygienic environment. iv) People's medicines were managed safely.

The enforcement action we took:

The Registered Provider must not admit any service users to Heath Lodge without the prior authorisation of the Commission.

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 and improper treatment because systems were not used and monitored to identify people who were at risk of harm, and actions were not taken to mitigate the risk of harm when identified. The provider had also not done all that is reasonable to protect people from harm from staff who were unable to communicate effectively with them.

The enforcement action we took:

The Registered Provider must not admit any service users to Heath Lodge without the prior agreement of the Commission.

Regulated activity	Regulation
Accommodation for persons who require nursing or	Regulation 18 HSCA RA Regulations 2014 Staffing

personal care	The provider did not ensure there were sufficient numbers of staff deployed to safely provide care to people when they required this. Staff were not supported through professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform. The provider did not ensure that staff employed were of sufficiently good character

The enforcement action we took:

The Registered Provider must not admit any service users to Heath Lodge without the prior written agreement of the Commission.