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Cherry Lodge

Inspection report

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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

The inspection took place on 29 and 30 June 2017, and was unannounced.

Cherry Lodge residential home provides accommodation and personal care for up to 19 people. At the time of this inspection, there were 19 people using the service, some of whom were living with dementia. Three of the 19 people were receiving respite care for a temporary period of time.

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

During this inspection we found significant shortfalls in the quality of the care being provided. We found the registered provider to be in breach of five regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We took urgent enforcement action to impose conditions on the providers registration which stipulated that no new admissions to the service should be permitted without the written consent of the Care Quality Commission. We also asked the provider to inform us in writing by 10 July 2017, that they had assessed and reviewed every person living in the service, including those people receiving respite care, in relation to their risk of the development and management of pressure ulcers, malnutrition, falls, and choking. This condition continues on a monthly basis, whereby the provider informs us of actions which have or are being taken to mitigate identified risks. We decided to impose these conditions on the providers registration because people may be exposed to the risk of harm.

People's health, safety and well-being were at risk because the registered manager and provider had failed to identify where safety was being compromised. Risks in relation to falls, malnutrition and pressure area care were not being adequately assessed or monitored to ensure people were cared for in a safe way. There was limited guidance for staff about how to manage or reduce risk.

We found shortfalls in the way that medicines were recorded and stored. Documentation showed that people did not always receive the correct medicines as prescribed. Some medicines were not checked to ensure they were stored at a safe temperature.

We found that care plans that did not reflect people's current needs. Care plans were not personalised to the individual. This meant that staff did not always have up-to date and clear guidance to help them support people in a way that took into account their preferences.

Robust quality assurance systems and audits were not in place to monitor the service provided to people, and so the provider was unable to identify shortfalls in the safety and quality of the service. The provider had not undertaken regular checks to ensure the quality of care or to use this to drive improvement. The registered manager had not notified us of serious injuries which had occurred in the service, which is

required by law.

Staffing levels were not sufficient in order to meet the needs of people and keep them safe at all times. The number of staff required to meet people's needs was not calculated based on the needs of people using the service.

Continuous supervision and control, combined with lack of freedom to leave, indicate a deprivation of liberty, and the provider had not applied for this to be authorised under DoLS. People were not supported to have maximum choice and control of their lives to support them in the least restrictive way possible.

The dining experience was not consistently conducive to an enjoyable mealtime and opportunity for social interactions, and we have made a recommendation about improving the dining experience for people.

The provision of activity was not sufficient to meet individual and specialist needs. However, the provider had taken steps to improve this.

Not all staff had received necessary training updates. Training sessions were being sought in areas such as safeguarding, risk management, fire safety, and dementia awareness. Staff told us that they had not received training in behaviour which challenges, and we have made a recommendation about this whilst appropriate training is sought.

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 safe.

Risks to people's health, safety and welfare were not identified and managed so as to ensure people's safety and wellbeing.

There were not sufficient staff available to meet people's needs safely.

Clear and accurate records were not being kept of medicines administered by staff. This meant we could not be sure people were always given their prescribed medicines.

Staff were aware of types of abuse they may come across in their work, but were not always aware of who to refer concerns to outside of the service.

Is the service effective?

Requires Improvement

The service was not consistently effective.

The provider had not applied for Deprivation of Liberty Safeguards when people who lacked capacity to consent, had their liberty restricted.

Staff held qualifications in care, but not all staff were up to date with their mandatory training to ensure good practice.

People were not always supported to maintain good health and have timely access to healthcare support.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Care was hurried and task focussed.

People's privacy and dignity was not always respected.

People were not routinely involved in the planning of their care.

People were supported to see their relatives and friends.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Care records did not provide staff with the information they needed to provide individualised care. People's care plans did not always reflect their current needs.

The provision of activity for people was not sufficient to meet the individual and specialist needs of all people using the service.

People and their relatives felt able to complain if they had concerns they wanted to raise.

Is the service well-led?

Inadequate

The service was not well led.

The registered provider had not ensured that the service was operating effectively to ensure that people were receiving safe and effective care at all times.

Communication between the management team was not effective.

Quality assurance systems were not robust and had not identified where quality and safety had been compromised. This placed people at risk of harm.

The service had not notified us of serious injuries that occurred in the service.

Cherry 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.

The inspection took place on 29 and 30 June 2017, was unannounced and undertaken by two inspectors and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before our 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. Prior to the inspection we reviewed information we had received about the service such as notifications. This is information about important events which the provider is required to send us by law. We also spoke with the local council contracts and quality assurance team.

During the inspection visit we spoke with seven people living at the service, three relatives, and two health professionals. Following the inspection visit we spoke to a third health professional and a member of the medicines optimisation team. We spoke with the registered manager, two representatives of the provider, and five members of care and catering staff. We also observed the interactions between staff and people.

To help us assess how people's care needs were being met we reviewed four people's care records and other information, including risk assessments and medicines records. We reviewed three staff recruitment files, maintenance files and a selection of records which monitored the safety and quality of the service.

Inadequate

Is the service safe?

Our findings

We found that people living in the service were at risk of harm because risks had not been identified and appropriate actions put in place to reduce the risk to people.

For example, we found that the service was not taking action to reduce the risk of people falling. Whilst some people had been identified as at risk, there was limited care planning around how staff should support the person to reduce their falls and remain safe. Where there was care planning in place, we observed that this was not being followed. For example, one person's care plan stated their walking frame should be placed close to them at all times. We observed this was not the case and staff did not take action to make sure this was within the person's reach.

The service had not actively made referrals to the Falls Prevention Team to obtain advice or guidance on how to support people with falls reduction. A health professional raised concerns with us about the number of falls people sustained at the service. They told us that on occasions people they visited had injuries but staff could not explain how they had sustained these.

One person had fallen a total of 16 times in a four month period but the service had not made a referral to the falls prevention team. Incident records showed that the person had fallen 35 times between 2 January 2017 and 18 June 2017. This included five days where the person had fallen multiple times in a day. The service had not recorded this person's falls in such a way that meant they could monitor them for trends, such as the time of day the person was falling. In April 2017 the person sustained a head injury following a fall and was referred to the falls prevention team by the ambulance service. During our visit, the falls prevention team came to assess the person. They told us they were concerned that the service had not made the referral to them earlier. They also told us they were concerned that basic adjustments to the person's equipment, such as getting them a lowered bed, had not been considered. During our inspection we were told that this person had sustained another serious head injury in the week prior to our visit, which had required hospital treatment.

We identified that wardrobes in people's bedrooms were unsteady and not secured to the wall, which posed an accident and injury risk. One person's incident records showed that they had been found with items of furniture on top of them following a fall. No action had been taken to reduce the risk of possible injury as far as possible.

We saw that personal emergency evacuation plans (PEEP's) were completed for people who lived in the service. Such evacuation plans help to ensure effective evacuation of the home in the event of an emergency. However, we found that information recorded in these had not always been updated where people's needs changed. For example, one person who could previously mobilise with a walking frame now needed the support of two staff to mobilise. This was not reflected in their evacuation plan. Another person had moved to a bedroom in another part of the service, but their evacuation plan had not been updated to reflect this. Having inaccurate information in these plans put people at risk in the event of an emergency situation.

We were concerned that people's dietary needs were not being met. The service was using the MUST (Malnutrition Universal Screening Tool) to assess people's risk of becoming malnourished. However, the service did not follow best practice guidance when people were assessed as at risk. For example, they were not weighing people and re-assessing people weekly. Weighing people at risk of malnutrition more regularly means that further reductions in weight can be addressed quickly before they become significant and the person becomes malnourished.

There was limited care planning around the nutrition of people who had a low weight and were at risk of malnutrition. One person who was underweight had no care plan in place to instruct staff on how to support them to reach and maintain a healthy weight. Staff told us this person was having supplements to increase their weight, but these were not referred to in their care records. There were no records to support that this person had been referred to a dietician who could provide specialist guidance to the service on how to reduce the person's risk of malnutrition. We reviewed the person's food charts and found that whilst these were being completed, they did not evidence that the service was encouraging the person to eat extra snacks in between meals to boost their intake. Staff told us they did not actively offer people extra snacks but that people were offered tea and biscuits at a scheduled time every morning. We spoke with the cook who also told us that people were not actively offered snacks. However, they said that there were biscuits and crisps available if people requested them. It was unclear how some people living with dementia would know these were available to them.

A member of staff told us that one person was having thickened fluids to reduce their risk of choking. Their nutritional care plan stated they had 'no specific requirements'. This meant there was a risk that the person may receive fluids which were not thickened and put them at risk of choking. Staff were unable to tell us what other arrangements were in place to ensure the person received food of an appropriate consistency to reduce their risk of choking.

Where people were at risk of developing pressure ulcers, these risks were not being safely or appropriately managed. A health professional raised concerns with us about the way the service assessed and managed people's pressure care. They told us they were concerned about the lack of procedures in place to reduce the risk of people developing pressure areas, for example, regular repositioning. We found that where the service identified people as at risk of developing a pressure area, there was no adequate accompanying care planning to guide staff on how to reduce this risk. Care records around people's skin integrity were generic and were not personalised to specify actions that would be appropriate in reducing the risk to the individual. One person was being cared for in bed and was at high risk of developing a pressure area. Their care records stated staff should carry out a daily assessment of the person's skin, however, there was no information about how this should be done or where it should be recorded. Staff we spoke with were not aware of any assessment of a person's skin that they should complete, and stated that whilst they looked out for any changes in a person's skin, they did not actively carry out regular checks to look for these changes. There was no evidence that the service had considered how they could reduce the risk to people whose mobility was poor. For example, they had not considered whether supporting people to change their position regularly would reduce their risk of developing a pressure area.

The service was not keeping appropriate records where people had current pressure ulcers that required input from the district nurse. For example, a visiting health professional told us one person had a 'particularly nasty' pressure ulcer at present. However, this was not recorded in the persons care record.

There were no checks in place to ensure pressure relieving equipment was maintained effectively. The registered manager told us these were checked daily by staff delivering people's care. However, we found one person's pressure relieving cushion had deflated.

The lack of effective communication between staff and the management of the service meant people were placed at risk of harm. A health professional raised concerns with us about poor communication between staff and other professionals. They said that the service did not always inform them in a timely manner when people needed input from them. For example, they said they had visited one person during our inspection who they found had a head injury with stitches. They told us that their team would be required to remove the stitches, however, they had not been informed that the person had sustained this injury or informed of when the hospital advised the stitches should be removed. We observed that staff were unsure of this when asked, and were unable to locate the discharge paperwork which would contain this information. Had this person not already been receiving support from this health professional, it is unclear whether the service would have ensured their stitches were removed at the correct time to ensure the appropriate healing of their wound.

The health professional also raised concerns with us about staff not acting on the advice or guidance they gave during their visits. For example, they told us that there had been occasions where they had asked staff to call the GP for people but on their next visit they found this had not been done. This put people at risk of not receiving the medical care they required to protect their health, safety and welfare.

We reviewed the systems in place for managing people's medicines and found that these systems did not consistently ensure people received their medicines safely. Prior to our inspection, the service had been visited by the Medicines Team from the local Clinical Commissioning Group (CCG). They identified some areas for improvement and the service had plans in place to make these improvements at the time of our visit. However, we found that there continued to be significant shortfalls in the medicines administration practices at the service which put people at risk of harm.

We found that there were discrepancies in Medicines Administration Records (MAR's) which showed that people had not received their medicines in line with the instructions of the prescriber. For example, one person had been administered a tablet to reduce agitation. They were then inappropriately administered a further tablet three hours later. The persons GP told us that they should not have been administered more than one dose in a 12 hour period. In addition to an overdose in this medicine, the person was also inappropriately administered a sleeping tablet which should not have been taken alongside the medicine for agitation. This had not been independently identified by the service and therefore no medical advice had been sought for this person. There was limited guidance for staff on when it would be appropriate to administer the above medicines and the frequency doses could be safely administered. This put the person at risk of harm.

We found that where medicines should be prescribed at certain times of the day or when the person was seated upright, records did not evidence that these medicines were consistently administered in this way. There was no guidance for staff available to instruct them on how to safely administer these medicines.

Where people were prescribed 'as and when' (PRN) medicines, appropriate guidance was not always in place to instruct staff on the intended purpose of these medicines and when they should be administered.

We observed the medicines round and found that staff were not always following best practice. For example, we observed that on occasions medicines were left unsecured and unattended whilst the staff member administered medicines to people. This meant that these medicines could be removed inappropriately or there was the potential for someone living with dementia to take these in error.

We found that where issues in the practice of staff administering medicines had been identified, robust action was not always taken to protect people from harm. For example, we found that a number of concerns

had been raised about a particular staff member's practice. The registered manager was aware of poor practice displayed by this staff member but had not stopped them carrying out these duties. This put people at risk of coming to harm.

All of the above constitutes a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Staff and a visiting health professional raised concerns with us about the number of staff available to meet people's needs. During our inspection there were two members of care staff and one member of senior care staff available to support people. The senior member of care staff was responsible for administering medicines, which meant they were not always available to support the other members of staff with carrying out care tasks such as supporting people to go to the toilet. We were told that there were two members of care staff available at night to support people. The registered manager had not assessed the number of staff required based on the dependency of the people using the service. The service has an unusual layout and is set over three floors, however, the registered manager had not taken this into account when considering the number of staff required to meet people's needs.

The registered manager told us that there were three to four people who required the support of two members of staff in order to have their needs met. We observed that people often had to wait for staff support because staff were helping other people. We observed that people on the top floor of the service waited the longest, with one person not receiving support for 20 minutes after they rang their call bell. Due to the high number of falls in the service, we were concerned that had someone rang their call bell because they had fallen, staff may not be able to react quickly enough to protect them from further harm.

The registered manager told us they had already identified a need for a third member of care staff during the day and were waiting for newly recruited staff to start. However, they had not considered the use of agency staff to address this shortfall in the interim. This meant people continued to be put at risk of not having their needs met in a timely manner.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Manual handling equipment, such as hoists, had been serviced, and there were systems in place to monitor the safety of water systems and the prevention of legionella bacteria. Electrical systems had been tested, and portable fire-fighting equipment had been recently inspected. The service carried out a fire alarm test on a weekly basis.

We spoke with staff about their knowledge and understanding of safeguarding procedures and how to report any concerns. We found that whilst staff knew the various types of safeguarding they may come across in their work, such as physical and financial abuse, not all staff knew who to report their concerns to outside of the service. The registered manager told us it had not been possible to determine when staff had last completed safeguarding training, but we saw they had booked a training session in July 2017 for all staff working in the service. This will help staff to understand the correct procedures and who they should raise concerns to in the future.

People were protected by procedures for the recruitment of new care workers. Checks on new care workers had been carried out with the Disclosure and Barring Service (DBS). The DBS identifies people who are barred from working with children and vulnerable adults and informs the service provider of any criminal convictions noted against the applicant.

Requires Improvement

Is the service effective?

Our findings

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 decision 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). The MCA DoLS requires providers to submit applications to a 'Supervisory Body' for authority to restrict people's liberty.

Some people in the service were living with dementia and may not be able to make some decisions that affected their daily life. People's care records lacked reference to their ability to make decisions, or where appropriate, for others to make decisions in their best interests. The service had not carried out assessments of people's capacity under the Mental Capacity Act (MCA) where they believed the person may have limited or deteriorating capacity. Care records did not make clear what decisions people could make for themselves. For example, decisions about meals or drinks, and therefore did not place focus on encouraging independent decision making even at a basic level.

The registered manager did not demonstrate to us in discussions that they had a full understanding of the MCA and Deprivation of Liberty Safeguards (DoLS). This meant we were concerned that people could have their rights infringed or be deprived of their liberty inappropriately. For example, one person had been asked to sign a 'disclaimer' which stated that they chose to ignore the advice of the registered manager and go out unaccompanied without telling them of their whereabouts. Staff told us this person had capacity, and there was no information in their care plans to evidence they did not have capacity to make these decisions. It was unclear why the registered manager felt this person should inform staff of where they were going at all times. Another person spoke with us about leaving the service and said "I get out every day. You have to tell them where you are going though, they aren't happy if you don't." There was no information in this persons care records to indicate they would be unsafe visiting the community unaccompanied without telling staff of their whereabouts. There was the potential that people's right to privacy and independence was infringed as a result of this.

The registered manager had not made DoLS applications for people where these would have been appropriate. There were people living with dementia, under constant supervision and unable to leave the service where DoLS applications should have been made. This meant that we could not be confident that the provider was aware of their duties and responsibilities under the deprivation of liberty safeguards and that people's human rights were respected.

Whilst staff told us they understood the principles of the MCA and obtaining consent, they told us they had not received recent mental capacity training. This meant we could not be confident that the service was

ensuring staff had up to date knowledge of MCA and were kept up to date with best practice.

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

People's health needs were not always met in a timely manner. Poor records were kept of the input people received from health professionals and there were inadequate systems in place to communicate this between care staff at shift changes. A health professional told us that communication between them and the service was often poor. They said that where people required support from them, staff did not always let them know of this requirement in a timely manner. For example, a district nurse had visited to see one person in relation to their pressure ulcer, but they had not been informed about another nursing task they needed to carry out for the person. This meant that people may not receive the care they require in a timely manner which could be detrimental to their health and wellbeing.

All of the above constitutes a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

We asked people their views about the staff providing their care. One person said, "Oh yes, the staff know what they're doing. When I need help, the staff are there. They [staff] give me a full body wash as I'm not able to bath at the moment." Another said, "Very confident. They [staff] do things for you so well. I have walking difficulties and have a frame as well as this wider wheelchair now which, as I say, is much more comfortable. They're [staff] very good." A third told us, "The staff are perfectly okay. I'm happy with the staff."

The registered manager told us that they had recently reviewed the training records of all staff, and had developed a training matrix which they showed us. They were aware that refresher training for staff was behind, and due to this they had carried out work based observations of staff working in the service to ensure their practice was safe.

They told us, and records showed, that refresher training had been provided in medicines management recently by them, but they had also requested a pharmacist based training session, and sessions from the medicines team. We found that all staff were overdue update training in fire safety and safeguarding adults, but we saw this had been booked.

Staff told us that they had not received training in behaviours which challenge. Some people using the service displayed behaviour that challenged staff. Training in this area would support staff to better understand techniques for de-escalation and supporting people who display behaviours that may challenge. The registered manager told us they had contacted the Alzheimer's society to request training in dementia care, including behaviours which challenge.

We recommend that the service explores current guidance from a reputable source in relation to supporting staff to effectively manage the specialist needs of people living with dementia, and the range of approaches and interventions which can be considered in meeting people's individual needs.

Staff new to the service completed an induction which involved shadowing more experienced staff over a period of three days depending on their level of experience. The registered manager had plans in place to ensure new staff were trained in relevant subjects linked to people's needs. One staff member told us, "I started last year and my induction was good. I had time to do my training, and I was supported in my role." Where new staff did not hold relevant qualifications in care, they were expected to complete the Care Certificate. The Care Certificate is an identified set of standards that health and social care workers adhere

to in their work.

Records showed that staff were provided with one to one supervision meetings every four to six months. Supervision provides staff with a forum to discuss the way they worked, identify training needs, and receive feedback on their practice. The registered manager told us that they were aware that some staff were overdue supervision. Supervision records showed that staff were provided with the opportunity to discuss the way that they were working, their training needs and achievements.

We asked people if they enjoyed the food. One person told us, "They [staff] ask us what we want for lunch. We get two choices which are generally okay. We have a roast and fish on a Friday, as I expect they do everywhere. We have shepherd's pie and lasagne which I like. There's enough to eat and they [staff] bring around a trolley with coffee and tea and biscuits in the morning." Another said, "The portions are fine. We have ample [food]. I stay in here [own room] as I like my own company. I eat all my meals in here. They [staff] will do you something else if you don't like what's on the menu. The drinks trolley comes in the morning about 10:30am."

We observed the lunchtime meal on both days of our inspection. Five people were seated in the dining area (with four separate tables) and four people ate in the adjoining lounge area. Lunch trays were also taken to some people in their rooms. We observed that people were not given a choice of what they would like to drink with their meal. Care staff poured everyone the same drink prior to them coming to sit at the table.

Staff were not present in the dining area whilst people were eating their meals, as they were busy supporting people to eat in their bedrooms. Whilst no one required support with their meal during our observation, they did not have any way to request support from staff if needed.

Requires Improvement

Is the service caring?

Our findings

Despite the failings we identified in the service, people told us that staff were kind and caring. One person told us, "The staff are kind and considerate, they're very good." Another said, "The staff are very good. They [staff] have got to know me and we've got a routine. They [staff] ask me if I'm comfortable. They [staff] would do anything for you." A relative said, "The staff are very good. There's lots of friendly banter."

We observed that staff were intuitively caring in nature. However, this culture of caring was not promoted consistently by the service. For example, the management of the service had not ensured there were enough care staff to meet people's social and emotional needs, and this meant people were left alone with no interaction for long periods of time which could lead to them feeling isolated. The lack of care staff available to support people meant that the care delivered to people was task focussed. Socialisation with people was attached to care tasks because staff did not have time to spend interacting with people in a meaningful way.

People told us that staff did protect their privacy. One person told us, "The staff are very kind. I normally have my door open but when they're sorting me out it always gets closed. They [staff] are careful about privacy." Another said, "They're [staff] kind and caring. They help me bath. They help me take my clothes off and cover me up as I'm getting out. My dignity is looked after." However, we saw some practices' which compromised people's privacy and dignity. For example, shortly after our arrival to the service we observed one person sitting on a commode in their room as their door had been left open. We also observed another person receiving personal care in their room with their door open. The language we observed some staff use to describe people did not promote their dignity and respect. For example, some staff described people by their needs rather than by their name.

We asked people if they knew that they had a care plan, and if they were involved in their care. One person said, "Care plan? No I don't know about that, they [staff] do all that for me." Another said, "I've never been asked for my views about that." We found little evidence that people had been involved with creating their care plans and people's views and preferences with regard to their care were not reflected in their care records. This meant that that people could be receiving care which was not in line with their individual wishes and preferences.

There was limited information available for staff about people's personal histories, preferences, hobbies and interests. Some people using the service were living with dementia and were unable to independently recall these details for themselves. Whilst some staff demonstrated a knowledge of this information, new staff had recently started working at the service and there were further new staff due to start after our inspection. These newer members of staff would not have access to this information which could guide them on how to better understand the people using the service.

In addition to the above, there was limited information available about how people could communicate with staff. Where people had limited verbal communication, there was no information on other ways they may communicate their feelings, such as facial expressions. This information could help staff to

communicate with people in a way they understood and to support them to communicate their preferences.

Whilst some people's care plans made limited reference to tasks they could carry out independently, there was not a focus on encouraging people to live as independently as possible. For example, some people's care plans stated they were able to eat their meals without support but did not set out what other aspects of their care they could manage independently. The management of the service and care staff did not encourage people to access the community independently where they were able. There was not an understanding of 'positive risk' and how enabling people to take some day to day risks could promote a sense of autonomy and independence.

Relatives were able to visit as they chose, and there were no restrictions. One relative said, "I come in on a regular basis. I can just come and go.

Requires Improvement

Is the service responsive?

Our findings

People's care plans did not consistently reflect their current needs, preferences and wishes. Records stated people's care plans had been reviewed monthly. However, the information within these care plans had not been updated where people's needs had changed. This meant that these reviews were ineffective in ensuring staff had accurate and up to date information on people's needs to refer to. For example, one person's care records stated they mobilised independently with a frame. However, we were told and observed that this person now needed the support of two carers to mobilise. This meant that people could be at risk of receiving inappropriate care which did not meet their needs or put them at risk of harm.

Care records did not identify the support people required to engage in meaningful activity or continue their individual hobbies and interests. We observed that there was little activity taking place in the service during our visit. The management of the service had not calculated the staffing level in such a way that took into account people's need for meaningful engagement, and this meant that staff did not have time to support people with this. One person said, "The staff only really talk when they're passing. They're [staff] always so busy." We observed throughout the day that people seated in a communal area of the service were disengaged with their surroundings. The television was on, but this was on a shopping channel for most of the day and people in this area did not appear to be watching it. The television remote was not available to people so they were unable to choose what they wished to watch. A visiting health professional raised concerns with us about the level of activity within the service and said they did not see activity taking place when they visited.

Care plans did not include sufficient information about people's backgrounds, personal histories, hobbies or interests which would help staff to engage with them. There was limited information about what brought wellbeing to people's lives, particularly for people living with dementia, or for people who may spend most of their time in bed due to frailty or illness. By documenting a person's past life events and developing an individual biography of that person, it enables others to develop a better understanding of the person's past experiences.

A member of care staff spoke with us about one person living with dementia who was experiencing a high number of falls. They described the person as having had a very busy life prior to coming to live in the service, and said they thought the person might be feeling frustrated because they were unable to do as much now. They said they felt this might be why the person often tried to stand unaided and fell. The care records for this person did not provide information on the person's life history or their hobbies and interests. The service had not considered how providing the person with support to engage in meaningful activity could help to keep them busy and distract them from mobilising independently and falling.

All of the above constitutes a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Plans were in place to improve the availability of activity for people. An activity coordinator had begun working at the service shortly before our inspection and had carried out initial discussions with people using

the service about what interested them. They had put together a plan of the activities they would do with each person using the service based on these preferences. One person said, "I have to say I'm looking forward to the new person coming in to read to me. I don't go into the lounge as I don't feel comfortable with some of them [people]." Another said, "I hear we are having someone new to do activities from Monday. There's to be painting, and exercise, one-to-one in our rooms." The registered manager told us the activity co-ordinator will begin working two days per week, but acknowledged this may not be sufficient to meet everyone's needs, so it would be kept under review. It was unclear how the service would promote activity and engagement outside of these times.

The service had a complaints procedure in place. Details of how to complain which were displayed in the service held the incorrect contact details, and the registered manager said they would correct this. People and relatives told us they would report any concerns and complain if needed. One person said, "I talk to the [provider] regularly. If I have anything concerning me I talk to [provider] or [registered manager]." Another told us, "I complained about a carer being a bit short. It all got sorted out." A relative said, "I haven't complained, but if we needed to, we would see [registered manager]."

Inadequate

Is the service well-led?

Our findings

There was no effective oversight of the quality of the service from the provider, registered manager and deputy manager.

The provider did not have a system in place to monitor the quality and safety of the service. The provider had not been carrying out any checks on the quality of the service which meant there was a lack of oversight which led to a failure to recognise shortfalls that placed people at risk of harm.

Where areas for improvement had been identified, action was not always taken in a timely manner to ensure there was no impact on the quality or safety of the care provided. For example, the management of the service had identified that they required more staff to meet the needs of people using the service. However, no immediate action was taken to increase the staffing level whilst recruitment for new permanent staff was completed. This meant that people continued to be put at risk of not having their needs met.

The registered manager had started working at the service in January 2017 and had put in place an improvement plan. However, they had not independently identified all the issues we identified which put people at serious risk of harm. The registered manager had failed to focus their attentions on making improvements in the area's which affected people most, such as ensuring care plans reflected people's current needs. There was a culture of blame amongst the management team, and a lack of accountability when we raised issues which had not been addressed.

Monitoring procedures did not effectively assess, monitor and mitigate risks to people including their health, safety and welfare. For example, where accidents and incidents were being recorded, no analysis had been undertaken to identify themes and recurring trends thereby limiting future occurrences. We noted that for one person, 35 incidents relating to falls had been logged, but no analysis had been carried out. When we analysed the information, we found that there was a pattern at particular times of the day when the person would fall. If the service had identified this independently, they could have considered distraction techniques or engagement in an activity as a method of reducing falls during these times. Recording practices of incidents were not robust, and we found that some falls had not been logged.

Providers are required by law to send the CQC statutory notifications to inform of certain incidents, events and changes that happen. This includes notifying us of serious injuries which been sustained by people living in the service. The registered manager told us they had not submitted any notifications to us in relation to serious injuries.

We found that there was a delay in referring safeguarding concerns to the local authority. The registered manager was aware of an incident which would bring into question a staff member's integrity. They had not made a safeguarding referral in respect of this incident, nor notified the Disclosure and Barring Service of the situation. We found another incident which had occurred in relation to an administration error with a person's medicines. This had not been reported to the safeguarding team. Additionally the staff member who made the error had not been suspended from administering medicines, despite there already being a

concern about their competency. This was contrary to NICE (National Institute for Health and Care Excellence) guidelines which state, "Care home providers must ensure that staff who do not have the skills to administer medicines, despite completing the required training, are not allowed to administer medicines to residents."

The above evidence has demonstrated failings which have exposed people to the risk of harm.
The provider and registered manager had failed to recognise potential harm to people using the service, and their non-compliance with regulatory requirements.

All of the above constitutes a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some staff told us they felt well supported and confident in the way the registered manager ran the service. Staff said they could approach the manager with any concerns and felt they would deal with concerns appropriately. One staff member told us, "[Registered manager] is okay. They share information with us [staff] and they do listen." Another said, [Registered manager] is good, the only thing I would say is that we need more structure. Things need to be better. We [staff] work hard, and share the workload, we work really well as a team, but credit needs to be given more often."

People told us they knew who the registered manager was. One person said, "Yes [registered manager] comes and speaks to me regularly, sees how I am." Another said, "I do know the manager, can't remember their name, but we [people] do see them around the place a lot."

We saw that staff meetings had taken place in the service to share information with the staff team. We saw that relevant information had been discussed, for example, life history books needing to be completed, provision of activity, allocation of keyworkers, training, care plans and catering. This ensured that staff were aware of key issues arising in the service.

We saw that feedback was sought from staff and people living in the service via surveys in November 2016. However, we were not confident that feedback had been used effectively. For example, in November 2016, two people raised that the provision of activity was not adequate, and this improvement was still 'in progress' when we inspected. The registered manager told us they were looking to improve the way in which they gained feedback from people and others, and on a more frequent basis. We saw that a 'compliments and concerns' document was available at the front entrance for visitors or people to use if needed.

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's care plans did not consistently reflect their current needs, preferences and wishes. Staff did not have accurate and up to date information on people's needs to refer to. Care plans did not include sufficient information about people's backgrounds, personal histories, hobbies or interests. 9 (1) (a) (b) (c) (3) (a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider did not have appropriate arrangements in place for obtaining and acting in accordance with people's consent in line with MCA 2005 DoLS safeguards. 11 (1) (3)

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 Risks to people's health, safety and welfare were not identified and managed so as to ensure people's safety and wellbeing. Clear and accurate records were not being kept of medicines administered by staff. This meant we could not be sure people were always given their prescribed medicines. 12 (1) (2) (a) (b) (g)

The enforcement action we took:

Notice of Decision

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have a system in place to monitor the quality and safety of the service. Where areas for improvement had been identified, action was not always taken in a timely manner to ensure there was no impact on the quality or safety of the care provided. Monitoring procedures did not effectively assess, monitor and mitigate risks to people. 17 (1) (2) (a) (b)

The enforcement action we took:

Notice of Decision

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

personal care	Staffing levels were not sufficient to ensure that people's needs were met at all times. 18 (1)

The enforcement action we took:

Notice of Decision