Ernehale Lodge Care Home Limited

Ernehale Lodge Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We inspected Ernehale Lodge Care Home on 5 and 6 June 2017. The inspection was unannounced. The home is a situated in Arnold in Nottinghamshire and is operated by Ernehale Lodge Care Home Limited. The service is registered to provide accommodation for a maximum of 30 older people. The service has 20 bedrooms, ten of which are intended for shared use. There were 24 people living at the home on the days of our inspection visit.

Ernehale Lodge had been taken over by a new provider at the start of April 2017. The registered manager and staff team had been transferred over from the previous provider.

The service had a registered manager in place at the time of our inspection. 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 our inspection we found the systems in place to reduce the risks associated with people's care and support were not always effective. People were not protected from risks associated with the environment and the service was not clean and hygienic in all areas. People received their medicines as prescribed; however medicines were not always stored or managed safely.

There was a risk that people may not receive the support they required as there were not always sufficient numbers of staff deployed. Safe recruitment practices were not always followed. Staff did not always receive suitable training or support to enable them carry out their duties effectively and meet people's individual needs. Staff were provided with regular supervision.

People's rights under the Mental Capacity Act (2005) were not respected at all times. In addition, people could not be assured that they would be supported in the least restrictive way possible. Where people had capacity they were enabled to make decisions and their choices were respected.

People were not protected from the risk of dehydration and malnutrition as people's food and fluid intake was not always appropriately monitored. However people told us they enjoyed the food and had enough to eat and drink. People had access to healthcare and their health needs were monitored and responded to.

People's right to privacy was not respected at all times and they were not always treated in a dignified manner.

Staff were kind and caring and had an understanding of what was important to people living at the home. People felt involved making choices relating to their care and were supported to maintain their independence. People were supported to maintain relationships with family and friends and visitors were

welcomed into the home.

People could not be assured that they would receive the support they required as care plans did not always contain accurate, up to date information. People were not consistently provided with the opportunity for meaningful activity. However there were plans in place to make improvements in this area.

People were supported to raise issues and concerns and there were systems in place to respond to complaints. People and staff were involved in giving their views on how the service was run.

Systems in place to monitor and improve the quality and safety of the service were not effective. Action had not been taken to review and update important policies and documents relating to the running of the home. Sensitive personal information was not always stored securely. The provider had plans in place to improve some aspects of the service.

The above concerns in relation to the quality and safety of the service resulted in us finding multiple breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These breaches were in relation to privacy and dignity, safe care and treatment, staffing, consent and good governance. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

Systems in place to reduce the risks associated with people's care and support were not always effective.

People were not protected from risks associated with the environment and the service was not clean and hygienic in all areas.

There was a risk that people may not receive the support they required as there were not always sufficient numbers of staff deployed. Safe recruitment practices were not always followed.

People received their medicines as prescribed; however medicines were not always stored or managed safely.

Is the service effective?

Requires Improvement

The service was not always effective.

People's rights under the Mental Capacity Act (2005) were not respected at all times. People could not be assured that they would be supported in the least restrictive way possible. Where people had capacity they were enabled to make decisions and their choices were respected.

Staff did not always receive suitable training or support to enable them carry out their duties effectively and meet people's individual needs. Staff were provided with regular supervision.

People were not protected from the risk of dehydration and malnutrition as systems in place to monitor this were not being used as intended. People told us they enjoyed the food and said they had enough to eat and drink.

People had access to healthcare and their health needs were monitored and responded to.

Is the service caring?

Requires Improvement

The service was not always caring.

People's right to privacy was not respected at all times and they were not always treated in a dignified manner.

People felt involved making choices relating to their care and were supported to maintain their independence.

Staff were kind and caring and had an understanding of what was important to people living at the home.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People could not be assured that they would receive the support they required as care plans did not all contain accurate, up to date information.

People were not consistently provided with the opportunity for meaningful activity, there were plans in place to make improvements in this area.

People were supported to maintain relationships with family and friends and visitors were welcomed into the home.

People were supported to raise issues and concerns and there were systems in place to respond to complaints.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

Systems in place to monitor and improve the quality and safety of the service were not effective.

Action had not been taken to review and update important policies and documents relating to the running of the home. Sensitive personal information was not always stored securely.

People and staff were involved in giving their views on how the service was run.

The provider had plans in place to improve some aspects of the service.

Ernehale Lodge Care Home

Detailed findings

Background to this inspection

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

We inspected the service on 5 and 6 June 2017. The inspection was unannounced. The inspection team consisted of one inspector 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.

Prior to our inspection we reviewed information we held about the service. This included information received from local health and social care organisations and statutory notifications. A notification is information about important events which the provider is required to send us by law such as such as allegations of abuse and serious injuries . We also contacted commissioners of the service and asked them for their views. We used this information to help us to plan the inspection.

During our inspection visit we spoke with five people who used the service and three people's relatives. We spoke with five members of care staff, two members of the domestic team, a member of the catering team, the clinical lead nurse, the deputy manager and the registered manager. We also spoke with a representative of the provider and the nominated individual. A nominated individual is a person who is nominated to represent the organisation.

We carried out general observations of care and support also looked at the interactions between staff and people. In addition to this we used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

To help us assess how people's care needs were being met we reviewed five people's care records and other information, for example their risk assessments. We also looked the medicines records of six people, three staff recruitment files, training records and a range of records relating to the management of the service, for example audits and complaints.

Requires Improvement

Is the service safe?

Our findings

Risks associated with people's care and support were not always effectively assessed or managed. For example, records showed that one person had a recurring grade four pressure ulcer and this had been the case for a significant period of time. A specialist mattress was in place to reduce the risk of further skin damage and promote healing. However we found that the mattress was not set appropriately, which may have reduced its efficiency. We also found that recommendations made to aid the healing of this person's pressure ulcer were not followed. Their care plan provided details of specific dietary requirements to promote healing, however the catering team were not aware of this and confirmed that the recommended diet was not being provided. This put the person at risk of further deterioration of their pressure ulcer.

People's food and fluid intake was not always appropriately monitored where there was a risk of poor nutrition or hydration. For example one person had recently lost weight and as a result the staff team were monitoring the person's food intake. However these charts were not always fully completed which meant there was a risk that staff may not identify if the person's appetite had further decreased. Another person was at risk of dehydration and staff were monitoring their fluid intake. However charts were not always fully completed and action was not taken when records showed fluid intake significantly under recommended levels. This meant that people were not protected from the risk of dehydration or poor nutrition. We spoke with the registered manager who was not aware of the concerns we found in relation to these recording issues, they told us that action would be taken to address this.

People were not adequately protected from risks associated with the environment. We identified risks in relation to legionella, this is a bacteria that can develop in stagnant water and can lead to a fatal form of pneumonia. There was no legionella risk assessment in place and checks and maintenance of the water system had not been recently conducted. This meant that not all steps had been taken to reduce the risk of legionella developing in the water supply. This was exacerbated due to the age of the building, number of empty rooms and in addition, people living at the home were at increased risk of developing Legionnaires disease due to their age. In addition to this other safety checks, such as fire system and equipment checks, had not been completed. This meant that people could not be assured that measures such as emergency lighting and fire-fighting equipment were functioning effectively. We discussed the above with the registered manager and provider who told us that a legionella risk assessment would be arranged and that all safety checks would be completed by the recently recruited maintenance person.

In addition to the above people were at risk of scalding themselves due to hot water temperatures in some basins being above the recommended safe level. There were no systems in place to check the temperature of the water in sinks which were accessible to people who used the service and we found water temperatures to be significantly in excess of the recommended level of 43°C. This meant that people were put at risk of sustaining an injury from hot water. We shared our concerns with the registered manager who told us that they would look into this.

People could not be assured that their medicines were stored safely to ensure they were at their most effective. There were no recent records to demonstrate monitoring of the temperature of the room where

the medicines trolleys were stored. On the day of our inspection visit the temperature of the room was 25°C, which is the recommended upper limit for safe storage. This meant there was a risk that variations in temperature may not be detected which could have had an impact on the efficiency of medicines. We spoke with the clinical lead nurse who told us that recording had not taken place "as often as they would have liked." They told us they would start monitoring this.

When people were prescribed medicines to be taken 'as and when required' there was not always guidance in place detailing what these medicines had been prescribed for or when they should be taken. This meant that staff did not always have clear information about when to give people these medicines and posed a risk that they may not be administered when needed. When people were prescribed creams for topical application there were not clear details of how, where and why these creams should be applied and staff did not consistently record the application of these creams. This meant we could not be assured that people's creams were applied as required and there was a risk of people developing sore or injured skin.

The above information was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they received their medicines on time and as prescribed. One person said, "My medication is done properly three times a day." Another person told us, "I need to take my medication four times a day. The staff give me my medication and they do it all correctly." Other than the above cited issues medicines were organised and medicine records were completed accurately.

People could not always be assured that there would be staff available to meet their needs. People had mixed views regarding staffing levels. Some people we spoke with told us there were enough staff available to meet their needs. One person told us, "There's always someone here for me. When I need to call for help I have a pendant, the staff respond day and night. They are there 24 hours a day seven days a week." However other people commented that they could that "they could do with more staff" and told us staff were always "so busy." Staff had mixed views on staffing levels. Whilst some staff told us that there were normally enough staff on shift, others told us that there were times when the service was not staffed at the level specified by the provider. One member of staff told us that this resulted in staff "cutting corners and having insufficient time to complete tasks." They told us they felt that this sometimes resulted in people waiting for longer than normal for support to change position and access the toilet. The registered manager told us that they made decisions about staffing levels based upon the needs of the people who used the service. We reviewed staffing rotas and found occasions where these staffing levels were not achieved. This put people at risk of not receiving the support they required in a timely manner. We spoke with the registered manager and provider about this who told us that they had identified this as an area for improvement and had recently recruited new staff to ensure enough staff were employed.

People could not be assured that good hygiene practices were consistently followed. Effective cleaning procedures were not in place for some items of equipment used in people's care and support. For example we observed staff using communal wheel chairs with communal pressure cushions during our inspection visit. This equipment was not routinely cleaned between different people using it. This was an unhygienic practice which meant that people were potentially using equipment which was not clean. In addition some areas of the home had unpleasant odours and other areas such as the underside of dining tables were not clean. The service had very recently had an audit conducted by the local infection control team which had identified a significant number of areas for improvement and the management team were working towards improving the cleanliness of the home.

People and their relatives told us they felt that they or their family members were safe at Ernehale Lodge

Care Home. One person told us, "Yes I feel safe. The people here know how to treat you. I couldn't say anything against it. I find it very safe." Another person said, "I'm safe and well looked after. Everything is good here. If I was worried about something here I would speak to my family." The relative of one person commented, "[Relation] is definitely safe." There were systems and processes in place to minimise the risk of abuse and staff had received training in protecting people from abuse and avoidable harm. Staff we spoke with understood how to recognise and report allegations of abuse and knew how to escalate concerns to external agencies if needed. Staff were confident that any concerns about people's safety were dealt with appropriately by the management team. Although no recent safeguarding referrals had been made the registered manager assured understood their responsibility to escalate concerns to the Local authority if required. This meant there were systems and processes in place to safeguard people from harm and abuse.

People could be assured that safe recruitment practices were followed. Before staff were employed criminal records checks were undertaken through the Disclosure and Barring Service (DBS). These checks are used to assist employers to make safer recruitment decisions. We also saw that proof of identity and appropriate references had been obtained prior to employment and were retained by the provider. This meant that the necessary steps had been taken to ensure people were protected from staff that may not be fit and safe to support them.

Requires Improvement

Is the service effective?

Our findings

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

People's rights under the MCA were not always protected as the Act had not always been applied to ensure that decisions were made in people's best interests. People's care plans did not always contain information about whether they had the capacity to make their own decisions. For example, a number of people who used the service shared a bedroom, three of these people's care plans documented that they lacked the capacity to make a decision of this nature. Despite this there was no documentation in place to demonstrate that the decision to share a bedroom with a person unknown to them had been considered as part of a best interests decision making process. The relative of one person commented, "[Relation] shares a room with someone else. I don't like that but to be fair [relation] doesn't even know that they are sharing a room." This meant people rights under the MCA were not always respected.

Staff we spoke with demonstrated a mixed understanding of the MCA. Two staff members were able to explain how the act should be applied and how a person's understanding and capacity may vary. However other staff had a very limited working knowledge of the MCA and DoLS or how it should be applied. One member of staff told us, "DoLS, I'm not sure (what that is), I heard someone has one." This limited knowledge could expose people to the risk of receiving care and support that did not reflect their wishes and staff making decisions that may not be in their best interests.

The above information was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. The registered manager had made applications for DoLS where appropriate and these had been granted. There were no conditions specified on the DoLS authorisations that we reviewed.

One person who used the service told us, "They (staff) always ask me what I want. I feel listened to. The staff explain to me what they are doing. They do ask for my permission before coming into my room and helping me." Another person told us, "The staff explain what they have come to do and they always ask me if it's OK." Where people had capacity we saw staff supporting people to make choices and decisions and staff gained their consent before providing care and support. For example a nurse supporting someone to take their medicines explained what each medicine was and its purpose to enable the person to make a choice. This meant that where people were had capacity, they were involved in decisions relating to their support.

People who used the service told us that they felt that staff were competent and skilled. One person told us, "The staff know what they are doing. They are well trained. I'm supported very well." Another person said, "They staff know what they are doing as far as I can make out." The relative of one person told us that they felt staff had the required skills and commented, "I think that the staff cope very well with the resident's. I've never seen anything happen to make me think that they can't." Training records showed that almost all staff had completed the training identified as compulsory by the provider. This included; safeguarding, moving and handling, equality and diversity and first aid. Staff who had not yet completed these courses were booked to attend future dates. However, during our inspection the staff we spoke with told us that they felt that they did not have the training required to support people whose behaviour could be challenging at times. We discussed this with the registered manager and provide who informed us that they would arrange training.

Although staff received regular supervision to discuss their practice we found that staff did not always receive adequate support following incidents. Two members of staff explained that they sometimes supported people experiencing periods of heightened anxiety and agitation which sometimes resulted in staff being physically hurt. Staff were not offered any formal support or debrief following these incidents. This meant that opportunities for staff to reflect upon practice and improve support to people who used the service may have been missed.

The clinical lead nurse provided professional supervision to the nurses employed by the home. However, the clinical lead nurse did not have access to clinical supervision to reflect upon their own practice and ensure their ongoing competency. This meant there was a risk that people may be supported by staff who did not have the necessary skills to carry out their role effectively.

People were positive about the food at Ernehale Lodge Care Home and told us that they had enough to eat and drink. One person told us, "I chose what I want to eat and I never change my mind. For me there's enough to eat and drink. I can get a drink, and food, when I feel like I need it. The food is good." Another person said, "I chose what I want to eat and I can change my mind if I want to. I get enough to eat and drink and I can ask for food at any time of the day and night. The food is really nice actually." The relative of one person told us, "There is enough for [relation] to drink throughout the day. There's also enough food." During our visit we observed two meal times and saw that people were offered a choice and appeared to enjoy their meals, some people requested additional servings which were provided. Staff supported people who required assistance with their meal in a calm and unhurried way and the atmosphere was generally relaxed and pleasant. The majority of food was attractively presented with the exception of the pureed diet. We saw that people had access to drinks and snacks throughout the day.

People were supported to attend appointments and access healthcare and this was reflected in the comments of people living at the home. One person told us, "They are very good at spotting when there's a problem for example if you're ill. If I'm ill I do get the chance to see a doctor." Another person told us, "If I need a doctor I just ask. The doctor will come to see me here. The optician visits me here too." The outcomes of appointments with professionals including GP's, nurses and other specialist health professionals were recorded in people's care plans. We spoke with the clinical lead nurse who told us that they had developed relationship with the local GP surgery who now conducted weekly surgeries at the home to enable people to access the services of the GP as needed. The clinical lead told us that they hoped this initiative would help to prevent unnecessary hospital admissions. Staff made contact with relevant healthcare professionals when there was a deterioration in a person's health or well-being. For example, staff had recently identified that one person was showing signs that they may have an infection and had contacted the person's GP for advice. People's specific health conditions were documented in their care plans and included guidance for staff on how to recognise that their health condition may be worsening.

This meant that people were supported by staff to maintain their physical health and well-being.

Requires Improvement

Is the service caring?

Our findings

The design and layout of the building did not promote people's privacy or dignity. A number of the bedrooms at Ernehale Lodge Care Home were intended for two people to share and during our inspection visit seven of these rooms were being occupied by two people. We found the beds in these rooms were surrounded by a 'privacy curtain' which staff told us were drawn when supporting people with intimate personal care in order to protect their dignity. Some of the people who were sharing bedrooms did not access communal toilets, which meant that they used a commode which was located in their bedroom. We asked staff how they would ensure a person's privacy when using the commode in a shared room and they told us they would draw the privacy curtain around the other person. This did not promote people's dignity or respect their right to privacy. Shared rooms also meant that people had very limited opportunities to spend time alone.

People and their relatives commented on the lack of space within the home and told us that this also had an impact on their privacy. The relatives of one person commented, "Our only room for improvement is that there's no privacy in the public areas. The lounge is too cramped. We're visiting [relation] and we always have to move to allow a wheelchair to pass or we have to get out of the way because someone needs the hoist."

Staff did not always respect people's right to privacy and confidentiality. Although staff understood the need to respect and promote people's privacy and could give us examples of how they did this our observations demonstrated that this knowledge was not put into practice. For example we heard staff openly discussing sensitive personal information about one person's health needs in the communal lounge. This could be overheard by others in the room. We also observed occasions where staff members held conversations between themselves whilst assisting people. For example one person was being supported to transfer into their wheelchair using a hoist. Three members of staff were present and talked to each other, not the person when providing this assistance. This did not promote the person's dignity.

Language used by staff was not always respectful or empowering. For example, we heard examples of people being described as "the walkers" to describe people who did not need support to mobilise and "the feeders" to describe people who needed assistance to eat. We heard staff using outdated, disempowering language such as referring to "toileting" people. This language did not promote respectful, dignified support.

Mealtimes were not a dignified experience for some people. The food served to people who required their diet to be served of a pureed consistency was not appetising and did not promote a dignified dining experience. We observed that all of their food, was blended together in what the home called a 'smoothie' and was then served in a plastic cup. Care had not been taken to blend food separately nor had any consideration been given to the presentation of the food. We shared this feedback with the registered manager who informed us that they would take action to ensure the presentation of food for people on modified diets was improved.

All of the above information was a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Despite the above information people and their relatives were positive about the staff team at Ernehale Lodge Care Home. One person told us, "The staff here are lovely, very caring. We're all treated the same I haven't witnessed the staff being unkind to anyone." Another person said, "They (staff) all go above and beyond the call of duty here." The relative of one person told us, "They are kind and caring and very professional. I can't speak highly enough of them." Another relative told us, "The staff are excellent I couldn't fault them. The care and support is excellent too." The staff we spoke with told us that they felt that they provided a caring service. One member of staff told us, "The care here is second to none, staff are here because they care about people."

People also commented on their relationships with staff and told us that staff knew them well. One person told us, "They (staff) know me well. They know what I like and don't like. They know what I like to do. They listen to me." Another person said, "The staff know me and my family. They know what I like." People's care plans contained information about the person's history, important relationships and their individual preferences. Although none of the people living at the home could recall any recent involvement in their care plans the registered manager told us that these plans had been developed with the person and their relatives where possible. People also had reminiscence books and we saw that these were used by staff to have conversations with people about their past. The relative of one person commented on how the staff took care of their loved one's appearance, they told us "[Relation] always has their own clothes on. They always look nice. [Relation]'s clothes are clean and colour co-ordinated."

People told us that they felt involved in day to day decisions about their support and this was reflected in people's comments. One person told us, "I'm involved in my care, they (staff) talk to me and they ask me." A second person said, "I am listened to, I feel like I can have my say." People explained that they were supported to make decisions in areas such as how they spent their time, what they wore and the food they ate. The relatives of people living at Ernehale Lodge Care Home commented that they felt involved in decisions relating to the care of their loved ones and told us communication was good. The relative of one person told us, "We're always kept informed about [relation]. Even when [relation] had had the slightest tiniest bruise they will call us to let us know."

People had access to an advocate if they wished to use one. There was information about advocacy displayed in the service. Advocates are trained professionals who support, enable and empower people to speak up. The registered manager told us that no one was using an advocate at the time of our inspection but explained they would make a referral for advocacy should they need to.

Staff told us they aimed to promote people's independence and this was reflected in the comments of people living in the home. One person said, "They (staff) encourage me to do as much as I can for myself – I am able to put some of my clothes on but I can't do the buttons up. They help me to get to where I need to be and then they leave me to do things for myself. They are always there for me." Another person told us, "I can't walk anymore but I can do most things for myself. The carer will wash my hair and then I will do my own shave. I prefer to do things for myself." There was information in people's care plans about what people were able to do for themselves and areas in which they needed prompting or assistance. People's families told us there were no restrictions on them visiting their loved ones.

Requires Improvement

Is the service responsive?

Our findings

Information in people's care plans was not consistently accurate or up to date. Each person who lived at the service had a care plan, these contained information about people's preferences, details of support they required and any risks associated with their care and support. Whilst some care plans were adequate and contained up to date information other care plans lacked detail and were out of date. For example one person's support needs had changed significantly in the weeks prior to our inspection but their care plan had not been amended to reflect this. Their care plan stated they were independent in many aspects of their care, but we spoke with two members of staff who confirmed that the person was now reliant upon staff for most aspects of their care. Another person often behaved in a way that put them and others at risk. However we found that their care plan did not contain clear details of how to support them in this area and staff we spoke with were unable to clearly describe how to safely support the person. As care plans were not always accurate or up to date this meant there was a risk that staff did not have access to up to date information about people's needs.

In addition to the above people could not be assured that they would receive the support they required as staff did not routinely use care plans to inform care and support. Staff told us told us they did not always find time to read care plans. One recently recruited member of staff told us that care plans were "not really used that much" and that staff learnt about people's needs in staff handover and from other staff members. This put people at risk of receiving care that inconsistent care that did not meet their needs. We discussed this with the registered manager who told us that staff had access to a brief summary of people's support needs and were provided with a daily handover. However this did not assure us that staff consistently had an adequate level of knowledge to ensure people received support to meet their individual needs.

People could not always be assured that they would receive responsive support that was based upon their individual needs. We were informed by staff that some people were unable to access the bath or shower as there was not the appropriate equipment available to ensure their safety. This had resulted in a significant number of people not having had a bath or shower for a number of months. Furthermore we found that some routines were in place to suit the needs of the service rather than the individuals living at the home. For example we were informed by the staff that there were specific times for things such as assisting people to use the toilet. This meant that people may not receive support that was based upon their individual needs and preferences. We discussed this with the registered manager who told us that service routines were flexible and assured us that they were looking into equipment to enable people to shower and bathe safely.

People were provided with limited opportunity for social activity. People we spoke with commented on the lack of opportunity for meaningful occupation. One person told us, "I don't join in any of the activities. I do feel a bit isolated here. I would like to read but I can't do that so easily now." Another person told us, "During the day we chat to the staff. There are no activities here." A new activities coordinator had been recruited recently and was due to start work at the service in the near future. In the interim, care staff took responsibility for ensuring that people had the opportunity for meaningful occupation. Staff commented that although they put music and films on for people they often struggled to spend meaningful time with

people as they were frequently interrupted by the need to provide personal care. Records we looked and our observations confirmed what we were told. During our inspection visit we observed staff initiated a music and movement activity. We saw this activity was interrupted after ten minutes as staff were required elsewhere in the service. People were not informed that the activity was over and were left holding the instruments. During our visit several people spent a significant amount of time unoccupied and we saw that much of the communication with staff, although friendly, was functional and task focused. People's routines were dominated by meals and personal care and the remainder of the time people listened to music, watched TV or slept. A number of people spent long periods of time in their bedrooms alone and staff made little attempt to interact with people socially or provide the opportunity for occupation.

People were supported to maintain relationships with family and friends. During our visit we saw people's relatives and friends visiting. People spent time together in communal areas and appeared to feel comfortable and relaxed.

There were a number of ways for people and their families to provide feedback on the service provided at Ernehale Care Home. We observed a comments and suggestions box was available in the foyer along with cards advertising ways to share feedback online. People told us that they felt able to make a complaint and added that they had no cause to complaint. One person told us, "I don't have any complaints about this home. I've never had a complaint while I've been here." Another person told us, "I don't have any complaints, but if I did I would go straight to the manager." The relative of one person told us, "We would feel comfortable making a complaint if we had a complaint, but there is nothing to complain about." The registered manager told us there not been any formal complaints however we found there were systems in place to ensure that complaints were appropriately managed and responded to in a timely manner. Staff we spoke with were aware of their role in recording any concerns received and communicating these to the management team.

Requires Improvement

Is the service well-led?

Our findings

The service was not consistently well led. We identified a number of shortfalls in the way the service was managed, this included concerns related to the safety of the service, the implementation of the Mental Capacity Act and the privacy and dignity of people who used the service. This led to breaches of a number of the regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider did not have sufficient systems in place to check people's care and support was carried out safely or in a way that met their needs. For example, information on food and fluid intake was not being checked for those people who were at risk of poor nutrition or hydration to ensure they were being given sufficient to eat and drink. This meant the provider was not assuring themselves that people's care was being delivered safely or in line with their needs and preferences. The provider was not ensuring that people's care plans were kept up to date to ensure staff had accurate information regarding people's needs and risks. The lack of effective systems to check on the quality and consistency of the service meant there was a risk that people's care was not being delivered safely and in line with the regulations.

Systems in place to monitor and improve the quality of the service were not consistently effective. Although there was an audit system in place, this had not been effective in identifying or addressing the issues we found during our inspection visit. For example, a monthly clinical audit, had not picked up concerns such as those relating to medicines management found during our inspection. Where areas for improvement had been identified, such as the recording of application of topical creams effective action had not been taken to address the issues and during our inspection we found a continued failure to record the application of creams. This resulted in people being placed at risk as medicines were not always managed safely and there were insufficient systems in place to ensure the safe management of medicines.

We spoke with the provider who told us they had undertaken an informal audit of the service when they took over the running of the service. Following our inspection visit the provider shared an improvement plan with us which was based upon their initial evaluation of the service. This focused primarily on improvement of the physical environment and staffing and did not identify or address the concerns relating to the safety and quality of the service found during our inspection visit.

In addition to the above we also found concerns about other areas of governance during our inspection. Sensitive personal information was not stored securely. We found that cupboards containing care plans were left unlocked throughout the duration of the first day of our inspection visit. This meant that information relating to people's health and support needs could be accessed by people who used the service and visitors, this was a particular risk as the care plan were stored in a room in the foyer of the service close to the entrance. Despite sharing this feedback with the registered manager and provider on the first day of our inspection visit on the second day of our inspection we found that care plans were still not stored securely.

The registered manager told us that the service was still using policies and governance documents from the previous provider. Although the provider informed us that they were working on implementing a system to

enable the development of new policies and procedures we were concerned that some key documents had not been updated to reflect changes to the provider. For example we reviewed the business continuity plan, which detailed the action to be taken in the event of an emergency such as flood or utility failure. We found that this not been updated and still contained contact details of staff employed by the previous provider. We discussed this with the registered manager who took action to update the business continuity plan during our inspection visit. However we remained concerned that action had not been taken to identify and update key documents prior to our inspection.

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

Despite the concerns identified during our inspection visit, people we spoke with told us they were happy living at Ernehale Lodge Care Home and said that they felt the home had a good atmosphere. One person told us, "This is a good place to live, I like living here. The manager is kind, caring and chatty. All of the staff are very nice." Another person told us, "The staff here are excellent – they work very hard." The relative of a third person commented, "I think that everything's been excellent. I don't have any complaints what so ever."

There was a registered manager in post at the time of our inspection visit. The registered manager told us that they attended local managers forums in order to keep up to date with good practice. Some people who used the service provided positive feedback about the approach of the registered manager. One person told us "The (registered) manager is very good here." The relative of another person said, "We do know the (registered) manager she's very helpful. The (registered) manager helped us to sort a problem out – we were very grateful to her for that." However a number of other people, and relatives of people told us they did not know, or did not regularly see the registered manager. One person told us, "We don't see the (registered) manager to talk to enough," another person commented, "I don't know the (registered) manager." One person's relative told us, "I know the (registered) manager. She seems to stay in the office. I don't speak to her much." This meant people could not always be assured they could access the registered manager should they wish to discuss their care and support.

People who used the service and their families had the opportunity to be involved in some aspects of the running and development of the home such as the food and the environment. For example some people who used the service and people's relatives provided feedback about the physical environment and decoration of the home. The provider had listened to this feedback and developed a plan for making improvements to the building and environment. The registered manager also told us of their plans to increase opportunities for people and their relatives to provide feedback such as the introduction of regular meetings and the development of a new satisfaction survey. This showed us that there were systems in place to collate feedback from people and the provider was using these to drive improvements.

We received mixed feedback from staff about the support they received form the management team. A number of staff we spoke with told us that the transition to the new provider had been a difficult period and that they had not felt supported throughout the process. These staff also told us that they were dissatisfied with recent changes made to the service and this had resulted in low morale in the staff team. In contrast other staff we spoke with were positive about the management team and told us that they felt well supported and listened to. We discussed this with the registered manager and provider who informed us that they were currently working with the staff team to try to improve communication and morale. We saw records which showed that the new providers had met with the staff team to introduce themselves and offer reassurances to the team.

We checked our records which showed that the registered manager had notified us of events in the service. A notification is information about important events which the provider is required to send us by law such as serious injuries and allegations of abuse.

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 10 HSCA RA Regulations 2014 Dignity and respect People were not always treated with dignity and respect. People's right to privacy was not always respected. 10 (1) (2) (a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent People's rights under the MCA were not always protected as the principles of the Mental Capacity Act (2005) were not consistently adhered to. Regulation 11 (1) (3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People who used the service were not protected against the risks associated with their care and support as risk assessments were not always in place as required, some were incomplete and staff did not always follow guidance. People were not protected from risks associated with the environment.

	Medicines were not always managed or stored safely. Regulation 12 (1) (2) (a) (b) (g)
Regulated activity	**Regulation**
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems in place to monitor and improve the quality and safety of the service were not effective. Sensitive personal information was not always stored securely. 17 (1) (2) (a) (b) (c) (f)