HC-One Oval Limited

Godden Lodge Care Home

Inspection report

57 Hart Road
Benfleet
Essex
SS7 3GL

Tel: 01268792227

Date of inspection visit:
09 December 2019
10 December 2019

Date of publication:
04 March 2021

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Godden Lodge is a residential care home providing personal and nursing care for people aged 65 and over. Some people have dementia related needs and some people require palliative and end of life care. The service consists of four houses: Victoria House, Cephas House, Boyce House and Murrelle House. The service can support up to 133 people and at the time of our inspection there were 87 people living at the service.

People's experience of using this service and what we found
Information relating to people's individual risks was not always recorded or did not provide enough assurance that people were safe. Suitable arrangements were not in place to ensure the proper and safe use of medicines. The incidence of medication errors at the service were high. Not all medication errors had been investigated and where these had been investigated, they were not as thorough as they should be.

Required recruitment checks on staff were not robust enough to ensure staff were suitable to work at the service. This referred specifically to agency staff used at the service. Lessons were not learned, and improvements were not made when things went wrong.
People were protected by the prevention and control of infection but where stringent infection control measures were required for specific people, information was not recorded within their care plan.

Not all staff employed at the service had received mandatory or refresher training. Not all agency staff working at the service [Boyce and Murrelle Houses] had received or completed an 'orientation' induction when undertaking their first shift at the service. Where staff had been promoted to a more senior role, there was no evidence of an induction having been completed. Staff had received regular formal supervision. Not all staff spoken with felt supported or valued by the organisation or management team.

Where people were moved from one house to another house, people and those acting on their behalf confirmed they had not always been consulted, given enough notice or provided with a rationale for the transfer. People were not supported to have maximum choice and control of their lives. Best interest decisions were not always recorded where people had bedrails in place or a sensor alarm fitted to alert staff if they got out of bed and mobilised within their room.

People's comments about the food they received was variable. People at risk of poor nutrition and hydration were not properly and accurately assessed. People's nutritional and hydration needs were not properly monitored and recorded to ensure unnecessary dehydration.

Although the service worked with other organisations to ensure they delivered joined-up care and support, records suggested people did not always have access to healthcare services when needed. No-one spoken with had seen their own or their family member's care plan. Relatives did not know what information was available for them to access.

People did not always feel they were treated with care and kindness or feel listened too. People's comments about the level of care they received was variable across the service. This was attributed to inadequate staffing levels, staff regularly being moved between the individual house's, high usage of agency staff and staff not having the time to spend with them. Many interactions by staff remained task and routine led.

Not all care plans contained enough information to ensure staff knew how to deliver appropriate person-centred care and treatment based on people's needs and preferences. Where information was recorded relating to specific incidents, evidence of staff interventions to demonstrate the support provided and outcomes was not always recorded or appropriate. End of life care plans were in place but provided limited information to guide staff on how to provide care to a person who was at the end stages of their life.

People were not supported or enabled to take part in regular social activities that met their needs. Arrangements were in place to record, investigate and respond to any complaints raised with the service. However, there was a lack of evidence to demonstrate lessons learned and learning outcomes.

The leadership, management and governance arrangements did not provide assurance that the service was well-led, that people were safe, and their care and support needs could be met. Quality assurance and governance arrangements at the service were not reliable or effective in identifying shortfalls in the service. There was a lack of understanding of the risks and issues and the potential impact on people using the service. The lack of effective oversight of the service has resulted in continued breaches of regulatory requirements.

Rating at last inspection
The inspection was prompted in part by notification of a specific incident due to concerns received about the care people using the service received. The Care Quality Commission were also aware that the Local Authority had on-going concerns about the service. A decision was made for us to inspect and examine those risks and we found significant improvements were required.

The rating at last inspection was requires improvement (published June 2019). There were three breaches of regulation. These related to breaches of Regulation 12 [Safe care and treatment], Regulation 17 [Good governance] and Regulation 18 [Staffing].

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

Follow up
We will meet with the provider and request an action plan to understand what they will do to improve the standards of quality and safety. We will work alongside the provider, Local Authority and CCG to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within six months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions 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.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not safe.

Details are in our safe findings below.

Inadequate

Is the service effective?

The service was not effective.

Details are in our effective findings below.

Inadequate

Is the service caring?

The service was not caring.

Details are in our caring findings below.

Inadequate

Is the service responsive?

The service was not always responsive.

Details are in our responsive findings below.

Requires Improvement

Is the service well-led?

The service was not well-led.

Details are in our well-Led findings below.

Inadequate

Godden Lodge Care Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
The inspection team consisted of three inspectors and one assistant inspector on both days of inspection. Additionally, inspectors were accompanied by two Experts by Experience on the first day of the inspection. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service. An NHS Prescribing Support Consultant Dietician who specialises in the nutritional needs of older people, also supported the inspection team on the first day. This was because prior to our inspection, the Local Authority had visited Godden Lodge Care Home and raised concerns about how the service was meeting service users' nutritional and hydration needs.

Service and service type
Godden Lodge Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service did not have a manager registered with the Care Quality Commission. An application to be registered with the Care Quality Commission had been submitted to us on 18 November 2019 and this was being processed. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
The provider was not asked to complete a provider information return prior to this inspection. This is

information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

During the inspection-
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.

We spoke with 17 people who used the service and 10 relatives about their experience of the care provided. We spoke with 20 members of staff including; house manager's, qualified nurses, nurse assistants and care staff, the service's chef, one staff member responsible for facilitating social activities, the manager and area director. We also spoke with five visiting healthcare professionals. We reviewed 14 people's care files and six staff personnel files and requested sight of agency staff profiles. We also looked at a sample of the service's quality assurance systems, the provider's arrangements for managing medication, staff training and supervision records, complaint and compliment records.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has deteriorated to Inadequate. This meant people were not safe and were at risk of avoidable harm.

At our last inspection to the service in April 2019, the registered provider had not always provided care and support for people in a safe way. Risks to people were not always recorded and mitigated and medication practices at the service required improvement. This was a breach of Regulation 12 [Safe care and treatment] of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014. We found not enough improvement had been made and they were still in breach of regulation.

Assessing risk, safety monitoring and management; Using medicines safely; Preventing and controlling infection

• Not all risks to people's safety and wellbeing were assessed and recorded. For example, one person who experienced seizures had a risk assessment completed, however this did not include information relating to prolonged seizures, the risk of these recurring, or the measures in place to reduce the risk. A care plan was in place relating to the administration of emergency medication should the person experience a seizure, but this was not linked to their risk assessment and was placed at the back of the care plan folder, which would not be easy to locate in an emergency.

• Not all bedrail assessments had been fully completed to reflect all areas of risk, such as the risk of entrapment and other associated risks.

• Not all manual handling assessments reflected the type of equipment needed, for example, the specific type of hoist to be used, size of sling and safe loop configuration to safely transfer a person.

• On Cephas House there was an incident whereby a person fell out of bed. Observations showed there was no sensor alarm mat in place, but the bed was placed at its lowest position. A review of the person's care plan recorded bedrails should be in place to reduce the risk of falls, but these were not in place at the time of our inspection. The qualified nurse was asked to provide a rationale for this omission, but no explanation was provided. The qualified nurse responded by stating they would get bedrails fitted for this person with immediate effect but without completion of an appropriate risk assessment to ensure this item of equipment was suitable. This placed the person at risk of harm as there was a potential risk they could climb or roll over the bedrails.

• Medication Administration Records [MAR] showed not all people using the service received their prescribed medication. The MAR forms for 18 out of 87 people were viewed. We found 10 out of 18 demonstrated there were occasions when people had not always had their medication administered. The MAR for one person detailed they were prescribed an inhaler four times a day, to help them breathe. Between 1 December 2019 and 10 December 2019 inclusive, there were five occasions whereby this was not administered at midday.

• Eight out of 10 MAR forms demonstrated people's topical and/or medicated cream were not always applied by staff. The MAR form for one person recorded them as requiring two topical creams to be administered twice and three times daily but this did not routinely happen. For example, out of a possible 29

applications, one of their topical creams was not administered on 16 occasions.
• On day one of the inspection on Cephas House, the agency nurse was still administering people's morning medication at 11.45am. This was the agency nurse's first shift working on Cephas House and the nursing assistant was unable to support them due to a staffing shortfall. The agency nurse went to give one person their eye drops but found they had run out. Action had not been taken by staff to ensure there was a sufficient supply of medication for this person.
• Two relatives expressed concern about the administration of medication at the service. One relative raised concern because their family member had recently been given the wrong medication. The second relative told us there was an occasion whereby they had found their family member's medication on the floor and another time their medication had been left on their bedside cabinet for them to take but they required supervision as they could knock them over.
• The incidence of medication errors at the service were high as noted from the incident report forms completed for November 2019. Not all medication errors had been investigated and not all investigations were robust to demonstrate lessons learned.
• Not all staff who administered medication had had their competency reassessed in line with the provider's expectations.

At our last inspection to the service in April 2018, suitable arrangements were not in place to ensure enough numbers of staff were deployed to meet people's care and support needs. This was a breach of Regulation 18 [Staffing] of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014. We found not enough improvement had been made and they were still in breach of regulation.

Staffing and recruitment
• Suitable arrangements were not in place to ensure there were enough staff to give people the care and support they needed. We found people received personal care later than they wished and some people were left in bed for no apparent reason.
• On the first day of inspection on Murrelle House, three people were not supported to get up for lunch because staff had run out of time. Staff told us, "There would usually have been another four people in the lounge eating, we ran out of time with X, X and X, so they stayed in bed. I feel we are failing these people, X has been washed, the other two haven't, we just haven't had the time." Staff also confirmed they hadn't completed people's hourly checks, had struggled to reposition people who were at risk of developing pressure ulcers and no-one had had a shower or bath. Staff did not get the time to read people's care plan. A relative on Boyce House told us they had recently arrived to visit their family at 11.45am, only to find them still in bed, having not been washed or dressed.
• Staff on Victoria House told us they were frequently concerned about staffing levels and the impact this had on people using the service. Staff told us it was hard to provide a good standard of care and they felt people were being neglected. This referred specifically to people having to wait for their comfort needs to be met.
• People and their relative's comments about staffing levels across the service were variable. One person told us, "Sometimes, I wait a long time for help, they [staff] say they're with somebody else. I don't know if they need more staff? When I've asked for help. I worry that staff have forgotten me, and I get worked up. It's better at night, if I press my buzzer, staff normally come quite quickly then." A second person told us, "The buzzer takes such a long time to get answered, one hour sometimes, when staff are helping other residents. If there was an emergency, I don't know what I would do, as I need their help to move."
• A relative told us staff were always being moved between the houses, which made it difficult for people to build a rapport with staff. They said, "It really upsets [person] and if affects the standard of care, [person] has to start all over again with someone else." We were told this had been raised with the manager, but nothing had changed, and they had not been given a satisfactory explanation as to why staff had moved around so much. Following the inspection the registered provider wrote to us stating on occasions staff

were moved between the houses but only in the best interests of people using the service. Permanent staff were moved to provide support where agency are used. This ensures there is an even number of permanent staff to agency used.
• People's comments about night staff were more favourable than day staff. One person told us, "The night staff here are brilliant. They have the time to sit and talk with you, if they see I'm awake, they come in and sit and have a chat with me. It's very comforting when you're feeling down."
• People felt reliance on agency staff had a negative impact on the service. One person told us, "They [organisation] use agency staff here quite often, they're useless. They stand around not knowing what to do and have to be told by permanent staff what to do." One relative told us, "At weekends there are more agency staff, and it's not as good then, they don't know people, obviously."
• Staff told us they regularly felt stretched and under pressure, with the focus on completing tasks rather than providing person-centred care and support. Staff told us it felt like a 'conveyer belt' when providing care and support to meet people's personal care and comfort needs.
• Staff recruitment records for five permanent members of staff were viewed. Relevant checks were completed before a new member of staff started working at the service. However, profiles for agency staff, were not in place to evidence they were of good character and fit to work with vulnerable service users, including the outcome of enhanced Disclosure and Barring Service [DBS] checks and the right to remain and work in the UK.

Learning lessons when things go wrong
• The inspection highlighted lessons had not been learned and improvements made when things went wrong. Concerns highlighted at our previous inspection in April 2019 remained outstanding.
• Actions highlighted following an audit conducted by the Local Authority in March 2019 and November 2019, had not been actioned by the provider and remained outstanding.

Systems and processes to safeguard people from the risk of abuse
• Most people told us they felt safe. One person told us, "I do feel safe here, staff are looking after me, I'm not worried, but I'm not happy either." When asked why this was, they told us they did not know how to use their call alarm facility. We noted someone had provided written instructions on how to use the call alarm, but this did not appear to have assured them. They told us, "I'll just shout if I need them [staff] or go to find them." Another person told us, "Yes, I can say I feel safe. The staff are pleasant, but I do feel locked in, there's not much to do here." A relative told us they had no concerns about their family member's safety.
• The manager told us safeguarding incidents were discussed as part of daily 'flash' meetings with a representative from each house and various heads of department to ensure lessons were learnt. The meeting minutes from 'flash' meetings for November 2019 were reviewed and showed no evidence to suggest safeguarding incidents were routinely discussed.
• A safeguarding log was in place, however it failed to clearly identify the specific detail and circumstances of safeguarding incidents raised, the outcome of investigation undertaken, actions taken, and an overview of lessons learned to monitor possible themes and trends.
• Staff had a good understanding of what to do to make sure people were protected from harm or abuse. Staff confirmed they would escalate concerns to the care coordinator and external agencies, such as the Local Authority or Care Quality Commission.

Inadequate

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has deteriorated to Inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Ensuring consent to care and treatment in line with law and guidance

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA.

In care homes, and some hospitals, this is usually through MCA application procedures 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 had the appropriate legal authority and were being met.

• Where people were moved from one house to another house, people and those acting on their behalf confirmed they had not always been consulted, given enough notice or provided with a rationale for the transfer. One person told us, "I don't know why they [organisation] moved me, it was a surprise. I think they could talk to us more." One relative told us, "They moved [person] from [X to X] without telling me what was happening. The first I knew, [person] had been moved, and I was pretty annoyed I can tell you, as I wasn't involved."
• Staff confirmed four people were moved from Murrelle House to Boyce House. In two people's care records there was no evidence to show the next of kin had been advised of the move. There was also nothing in place to demonstrate the rationale for the transfer, that the provider had sought people's consent prior to the move.
• A formal complaint was raised with the management team relating to the above. A person using the service was taken out for the day by a friend. When they returned to Godden Lodge Care Home, they were unable to access their bedroom as a new person had been admitted and were now occupying their room. The person using the service had not been consulted about this and was upset about the transfer. The complaint records detailed people who acted on their person's behalf were retrospectively advised of the transfer nine

days later.

Consent had not always been sought for people using the service and those acting on their behalf. This demonstrated a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

• People's capacity to make decisions had been assessed and these were individual to the person. However, best interest decisions were not always recorded where people had bedrails in place or a sensor alarm fitted to alert staff if they got out of bed and mobilised within their room.
• Where people were deprived of their liberty, applications had been made to the Local Authority for DoLS assessments to be considered for approval and authorisation.

Supporting people to eat and drink enough to maintain a balanced diet
• People's comments about the food they received was variable. Some comments included, "The food here is lovely, I'm never hungry or thirsty", "The food is very good, look at all this food [showed meal to us], then we'll have cake this afternoon, that's my favourite" and, "The food is fine, I like it." However, other comments were less than favourable, and people told us there was little variation in the meals. One person said, "Chicken, we have too much chicken here, I think they've [organisation] got a chicken farm and a wartime supply of carrots." Another person told us, "The food is tasteless, too much chicken and not cooked well. I have food brought in and drinks." Following the inspection the provider submitted a rolling four-week menu. Although people perceived a lack of variety with the meals provided, the menus demonstrated people were offered a varied diet throughout the day.
• People at risk of poor nutrition and hydration were not adequately assessed. The Malnutrition Universal Screening Tool [MUST] for three out of four people was incorrect. MUST is a screening tool used to identify adults who are malnourished, at risk of malnutrition or obese. Not all staff had received specific training relating to the completion of the MUST tool. The chef confirmed they were not informed of service users MUST scores.
• We spoke to the chef about food fortification, this is a nutrition support strategy used for people who are either malnourished or at risk of malnutrition. The chef told us they fortified people's porridge with skimmed milk powder each day, but staff fortified all other meals. They were unaware how this was completed by staff. Several people's food on Boyce House was fortified, using high fat and sugar ingredients. However, it was unclear how staff identified who required their food to be fortified, as care plans did not make this requirement clear.
• People's nutritional and hydration needs were not being properly monitored and recorded to ensure unnecessary dehydration and weight loss. Where people were cared for in bed, fluid intake was not routinely recorded. For example, on the 10 December 2019 on Cephas House, one person was observed to be lying in bed at 12.45pm. There was no chart in place to monitor their fluid intake, but their 'Daily Record of Care' was completed. This showed they had declined fluid at 9.40am. No other record was available to evidence how staff were supporting them to remain hydrated. The 'Daily Record of Care' from 1 December to 8 December 2019 inclusive was viewed. This recorded a minimum of 200 millilitres of fluid only on 2 December 2019 up to a maximum of 600 millilitres of fluid on 3 December 2019. The person's care plan provided no evidence relating to how their hydration needs were to be met, particularly as this could be inadequate on some days. This was not an isolated case.
• Though some people were assisted and supported to eat and drink by staff, people did not always receive their meal in a timely manner. For example, the lunch trolley arrived on Murrelle House at 12.41pm, the last person to be supported did not receive their meal until 1.30pm. On Boyce House, the last person to be supported received their meal between 1.50pm and 2.00pm as advised by staff.

Improvements were required to ensure people's nutritional and hydration needs were met. This

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

• People were not rushed to eat their meal. The meals provided were in enough quantities and looked appetising. People had access to fruit and cakes were provided most afternoons for people to enjoy.

At our last inspection to the service in April 2018, not all staff received appropriate training, induction or supervision to fulfil the requirements of their role. This was a breach of Regulation 18 [Staffing] of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014. We found not enough improvement had been made and they were still in breach of regulation.

Staff support: induction, training, skills and experience
• Staff training records showed not all staff employed at the service had received mandatory or refresher training in line with the organisation's expectations. This referred specifically to safeguarding, safer people handling or moving inanimate objects, nutrition awareness and basic life support. A healthcare professional told us not all staff had a good knowledge and understanding of the needs of people living with dementia.
• Not all agency staff used at the service [Boyce and Murrelle Houses] had received or completed an 'orientation' introduction when undertaking their first shift at the service. We found there was no evidence of training or introduction for 21 out of 37 agency staff used at Godden Lodge Care Home between 25 October and 10 December 2019. Furthermore, the profile for one agency member of staff showed all training had expired in March 2019. There was no evidence available to show the service had contacted the external employment agency to check if the above information remained accurate.
• Where staff had been promoted to a more senior role, there was no evidence of an induction having been completed.
• Staff had received regular formal supervision. Not all staff spoken with felt supported or valued by the organisation or management team.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
• Although the service worked with other organisations to ensure they delivered joined-up care and support, records suggested people did not always have access to healthcare services when needed. Prior to our inspection, information received by us indicated concerns about the management of people's healthcare needs, including seeking medical advice at the earliest opportunity. This inspection examined those risks and improvements were required.
• People's oral healthcare needs were assessed but lacked detail. The manager was aware of the Care Quality Commission's review ['Smiling Matters'] on the state of oral health care in care homes in England which was published in June 2019 but had not yet read the document.
• The service was part of the 'Red Bag Care Home Scheme'. This is a national initiative which aims to promote and improve communication and relationships between the care service, ambulance crews and NHS Hospital; enabling relevant healthcare information about a person to be shared.

We recommend the provider seeks advice and guidance on best practice for working with external professionals and organisations to ensure effective collaborative working and better healthcare for people.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
• People's needs were assessed prior to their admission to the service. People's protected characteristics under the Equalities Act 2010, such as age, disability, religion and ethnicity were identified as part of their need's assessment. Staff knew about people's individual characteristics.

Adapting service, design, decoration to meet people's needs

• Godden Lodge Care Home is a purpose-built care home consisting of four individual houses. People had access to a small garden and this was adjacent to each house.

• There were enough dining and communal lounge areas for people to use and choose from within the service. People had personalised rooms which supported their individual needs and preferences.

• Improvements to the service were required to make this more 'dementia friendly'. There was a lack of visual clues and prompts, including accent colours, signs using both pictures and texts to promote people's orientation.

Inadequate

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has deteriorated to Inadequate. This meant people were not treated with compassion and there were breaches of dignity; staff caring attitudes had significant shortfalls.

Ensuring people are well treated and supported; respecting equality and diversity; Respecting and promoting people's privacy, dignity and independence

• People did not always feel they were treated with care and kindness or felt listened too. This was attributed to inadequate staffing levels, staff regularly being moved between the individual house's, high usage of agency staff and staff not having the time to spend with them. People told us they did not always receive proper personal care, regular baths or showers. Information available suggested people's comments were accurate.

• Many interactions by staff remained task and routine led. This referred to staff providing drinks, supporting people to eat their meals and assisting people with their personal care and comfort needs. There was an over reliance on the television despite some people being asleep or disengaged with their surroundings and not watching the television.

• People and relative's comments about the quality of care and support they received was variable. Positive comments included, "They're [staff] kind and caring girls, they never make you feel you're a nuisance", "Most staff are quite pleasant and helpful to me" and, "I'm quite satisfied with them [staff], they're okay to me." One relative told us, "Staff are all very friendly and really helpful. I genuinely feel staff do care about [person], they're quite a character and I think they like them."

• Where less favourable comments were made, one person told us, "I get frightened to ask anybody for help, staff just say it's not their job." The person clarified this further by telling us some staff could refuse their request for help and to find another member of staff who could help them. They told us this made them feel anxious and often they just kept quiet. The same person stated, "I'd really like staff to explain things to me more, the staff don't talk to you, you don't get to know them. Some staff are okay, but I get terrible pain in my back." They told us when they raised this with a member of staff, they were told, "You're not the only one here." The person did not know the staff member's name and told us they tried to avoid them whenever they could.

• Another person told us, "They [staff] just give you a look, they don't really talk to you, it makes me feel terrible. Staff should be trained to be able to talk to people." The person added, when walking along the corridor, staff rarely stopped to talk or say hello and were always in a hurry. The person was asked by us if they felt staff cared about them, tearfully they told us, "No, not really."

• People and those acting on their behalf were not always treated with respect and dignity. As already highlighted in 'Effective', where people were moved from one house to another house, people confirmed they had not always been consulted, given enough notice or a provided with a rationale for the transfer. This demonstrated communication with people was not always respectful as it did not respect the person's right to engage or consider their personal preferences.

Not all people using the service received person-centred care and treatment that was appropriate to meet their needs. This demonstrated a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

• Where positive interactions took place, we observed support provided by staff as caring and kind. During these exchanges people were noted to have a good rapport with staff and there was much good humour and banter.
• People were supported to maintain and develop relationships with those close to them. Relatives confirmed there were no restrictions when they visited.

Supporting people to express their views and be involved in making decisions about their care
• No-one spoken with had seen their or their family member's care plan. Relatives did not know what information was available for them to access. One relative told us, "I always check [person's] notes which are left in their room, because I like to know what is going on, but I didn't know there were other records elsewhere." A second relative told us, "I've not seen [person's] care plan, and was not sure about it, or whether I could ask to see it. We haven't been offered or involved to see it to my knowledge." Following the inspection the provider wrote to us stating that whilst this was reported by relatives, specific questions relating to their involvement were examined as part of the registered provider's quality assurance arrangements.
• People and those acting on their behalf had been given the opportunity to provide feedback about the service through the completion of questionnaires.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has remained the same. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; End of life care and support

• Staffing shortfalls and high usage of agency staff resulted in people's needs not being consistently met.

• Not all care plans contained enough information to ensure staff knew how to deliver appropriate person-centred care and treatment based on people's needs and preferences. For example, although one person had a seven-day care plan in place following their admission to the service at the beginning of November 2019, a full care plan depicting their needs and the care to be delivered was not completed when we inspected on 9 and 10 December 2019. This meant not all of the person's care needs were assessed and recorded to guide staff on their current care, treatment and support needs.

• Where people could be anxious and distressed and exhibit inappropriate behaviours towards others, information relating to known triggers and specific guidance for staff on how best to support individuals was not recorded. Where information was recorded relating to specific incidents, evidence of staff interventions to demonstrate the support provided and outcomes was not always recorded or appropriate.

• Though service user care plans had been reviewed, information recorded did not always reflect up-to-date information.

• People's care plans had limited information about their wishes and preferred priorities, such as their spiritual and cultural needs at the end of their life. Without this information, staff would be unable to ensure people's wishes at the end of their life were respected. The provider had produced a seven-day plan to assess and monitor people's care, treatment and wellbeing at the end stages of their life, however these were not routinely completed.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

• We found some people were not always supported or enabled to take part in regular social activities that met their needs. This included group activities and one-to-one support. For example, on both days of inspection on Boyce House, people were not supported to take part in social activities.

• Comments from people using the service were not favourable and included, "When I first came here, staff used to have time for a chat, but not now. So, I go to my room in the afternoon to watch quizzes on the television", "I feel I should be doing more, like playing games, doing something to keep me alert, but there's nothing to do" and, "It's boring here, nothing going on. I used to read a newspaper, but I don't get one now."

• Relatives comments were variable. One relative told us, "The activities person here is so good. They got to know [person] very well, they found out [person] used to play bowls. They got a small grass carpet and some balls, and they were bowling together the other day." A second relative told us, "I think they have enough entertainers in, [person] likes them, likes to join in." This contrasted with another relative's comments, "You don't see much going on these days."

• People's care and support plans did not show how the service responded to their differing needs in terms of interests, social activity and stimulation. Activity records provided little information to confirm activities offered, refused and the level of engagement undertaken. For example, one person's activity record evidenced nine occasions between 4 September 2019 and 10 December 2019, whereby the person engaged in social activities.
• People's personal history was sparse and therefore staff were not provided with a good understanding of the person's past life to help understand them and initiate conversation. One person told us about their past employment history, but said, "I don't think any of the staff know that." Numerous people told us they did not think staff knew any details of their past lives, careers, families and interests."

People's assessments did not include all of their care needs and people were not supported to have their social needs met. This demonstrated a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Meeting people's communication needs
Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.
• We did not see enough evidence of how AIS had been applied. The activity programme and menu were not in an easy read or large print format to enable people with a disability, living with dementia or sensory loss to understand the information.

Improving care quality in response to complaints or concerns
• Arrangements were in place to record, investigate and respond to any complaints raised with the service. Since May 2019, the complaints log showed the service had received 10 complaints. These related to concerns about the level of care people received, poor medicines management, staffing shortfalls, lack of social activities for people using the service and missing laundry. Each complaint had been investigated and responded to. However, there was a lack of evidence to demonstrate lessons learned and learning outcomes.
• People told us they knew how to raise a concern if they had any worries. One person told us, "I would go and knock on the office [individual house] door. I'm sure they'd [staff] listen to me." Another person told us, "I always used to talk to X [previous house manager name] if I had any problems, they were always very helpful. Today a new one's started, but I'm sure I could still go to them."
• Five compliments relating to the quality of care people received at Godden Lodge Care Home were recorded on a well-known external website.

Inadequate

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has deteriorated to Inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

At our last inspection to the service in April 2018, effective arrangements were not in place to assess and monitor the quality of care provided, to ensure compliance with regulations. This was a breach of Regulation 17 [Good governance] of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014. We found not enough improvement had been made and they were still in breach of regulation.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Continuous learning and improving care

- Quality assurance arrangements were not reliable or effective to make the required improvements. The lack of effective oversight and governance of the service had resulted in continued breaches of regulatory requirements highlighted at our previous inspection in April 2019. This demonstrated lessons had not been learned to drive improvement and ensure the quality and safety of the service.
- In March 2019, the Local Authority completed a quality audit of Godden Lodge Care Home. This is an assessment tool, to help the Local Authority assess the quality of care delivered by providers of adult social services. The outcome of the audit recorded a rating of, 'Requires Improvement'. Numerous actions were required to be addressed as detailed within an action plan submitted to the provider by the Local Authority. On 27 November 2019, the Local Authority returned to Godden Lodge Care Home to assess the action plan and found none of the actions recorded had been addressed. This demonstrated lessons had not been learned to drive improvement and ensure the quality and safety of the service.
- The provider's governance framework 'Cornerstone' had identified where improvements were needed, however, the required improvements had not been made. An action plan was not completed to demonstrate what action had been taken to improve and mitigate risks.
- Bi-monthly 'Home Visit Reports' by either the area director, area quality director or both, were viewed for the period September 2019 to December 2019. Visits had been conducted on three occasions, and though actions required were recorded an action plan was not completed detailing how this was to be monitored and addressed. The reports had not identified the issues highlighted by the Local Authority or by the Commission. This demonstrated arrangements to assess and monitor the quality and safety of the service provided was not effective.
- The provider had a tool to determine the number of staff required to meet people's needs. We asked the manager for evidence of this, but they could not tell us if this had been completed. We discussed this with the area manager and area director at the time of our inspection and requested evidence of this tool for the period April to November 2019. Evidence of the completed staffing tool in line with people's dependency needs was not provided at the time or following our inspection.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong;
• An incident occurred whereby a culture of openness and transparency was not followed by staff and this led to the person's end of life wishes not being respected. An incident report and subsequent investigation was not completed to ensure lessons were learned. Staff had not followed the provider's policies and procedures relating to the duty of candour.

This was a breach of Regulation 20 [Duty of candour] of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements
• At this inspection there was no registered manager in post. An application to be registered with the Care Quality Commission was submitted on 18 November 2019 and was being processed. The manager commenced in post on 2 September 2019 and had completed the provider's corporate induction.
• The manager told us they received appropriate support from the area director and area quality director. However, the manager had received one supervision since their appointment on 18 October 2019, despite being new in post, the service having an overall quality rating of 'Requires Improvement' following our inspection in April 2019 and scrutiny by the Local Authority because of on-going concerns. There was no evidence to suggest this supervision covered an understanding of the risks and issues facing the service.
• Not all staff had effective role models to provide support and guidance to enable them to effectively carry out their roles.
• The Care Quality Commission shared concerns relating to planned impending cover for the manager whilst they had a period of absence from the service. Because of this, alternative cover arrangements were made, with the area quality director managing and overseeing the service in the manager's absence.
• Not all staff spoken with were aware of the provider's vision and values. For example, one member of staff when asked what these were, stated, "Kind care company." Another member of staff spoken with was unable to tell us what these were.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
• Arrangements were in place for gathering people's and relatives' views of the quality of service provided through the completion of a questionnaire.
• Staff meetings were held to give the management team and staff the opportunity to express their views and opinions on the day-to-day running of the service. However, not all staff felt they had a 'voice' or felt empowered and able to discuss topics. Not all staff felt listened to. Staff told us they had regularly spoken to the manager about staffing shortfalls at the service but felt these had been dismissed.
• Meetings were held for people using the service and for those acting on their behalf, to enable them to have a 'voice', however these were not always well attended. On the first day of inspection a relatives meeting was held, attendance included 1 person using the service and six relatives.

Working in partnership with others
• There was limited engagement with other organisations, agencies or networks to share best practice, expertise or resources to improve the service and deliver a good experience of care for people.

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 11 HSCA RA Regulations 2014 Need for consent Consent had not always been sought for people using the service and those acting on their behalf.

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 9 HSCA RA Regulations 2014 Person-centred care People did not receive person centred care and treatment that was appropriate to meet their needs. Assessments did not include all of a person's care needs and people were not supported to have their social care needs met.

The enforcement action we took:

Conditions imposed on provider's registration

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 were not recorded and mitigated. Medication practices required improvement.

The enforcement action we took:

Conditions imposed on provider's registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs Not all people's nutritional and hydration needs were being met.

The enforcement action we took:

Conditions imposed on provider's registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Effective arrangements were not in place to assess and monitor the quality of care provided.

The enforcement action we took:

Conditions imposed on provider's registration

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care	Regulation 20 HSCA RA Regulations 2014 Duty of candour A culture of openness and transparency was not followed by staff and they had not followed the provider's policies and procedures relating to the duty of candour.

The enforcement action we took:

Conditions imposed on provider's registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Suitable arrangements were not in place to ensure enough members of staff were deployed to meet people's care and support needs to a satisfactory standard.

The enforcement action we took:

Conditions imposed on provider's registration