Gerald William Butcher

# Earlfield Lodge

## Inspection report

21-31 Trewartha Park
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Tel: 01934417934

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23 November 2017

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## Ratings

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|---|---|
| Overall rating for this service | Requires Improvement |

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

# Summary of findings

## Overall summary

We undertook an unannounced inspection of Earlfield Lodge on 21 and 23 November 2017. At the last comprehensive inspection of the service in September 2016 one breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 was identified. This was in regards to Regulation 12, safe care and treatment. People who used the service were at risk due to the management of medicines. This breach was followed up as part of our inspection. You can read the report from our last comprehensive inspection, by selecting the 'All reports' link for Earlfield Lodge, on our website at www.cqc.org.uk. The service was rated requires improvement.

Earlfield Lodge provides accommodation and personal care for up to 65 older people, some of whom are living with dementia. At the time of our inspection the service was providing accommodation and personal care to 59 people.

A registered manager was in post 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.

The service was not well-led. Quality audits were in place but did not monitor and review all areas of the service. Therefore the extensive failure to meet the regulations found at this inspection had not been identified by the registered person. The current management structure was ineffective as all quality oversight was delegated to senior staff. Notifications had not been sent to the Commission as legally required to inform of significant events such as Deprivation of Liberty Safeguards authorisations and events that stop the service.

The service was not safe. Medicines administration was not being managed safely and areas previously highlighted to the provider had not been addressed. Environmental risk assessments were not in place and regular checks of all areas were not conducted to keep people safe. Recruitment procedures were not followed in line with the provider's policy. This meant effective checks were not completed before new staff began their employment.

People were not always being deprived of their liberty in accordance with legislation and guidance. Food and fluid records were not being consistently maintained. Staff were not supported through regular supervision and training. This meant that staff development needs were not always being identified and staff may not have had sufficient training in particular areas of their role.

Care plans were not always person centred as people's background and histories were not consistently completed. Mixed feedback was received about the provision of activities at the service. The service was fully staffed. However, observations were made that staff were not always responsive to people's needs in a timely manner.

Staff completed an induction when they started at the service, which orientated them to systems, processes and people. People had access to healthcare and the provider had good relationships with other health professionals. People and relatives knew how to raise concerns and complaints and felt comfortable to do so. Complaints were investigated and responded to. Staff were aware how the Mental Capacity Act (MCA) 2005 applied to their role.

People received care and support from staff that were kind and caring. Family and friends were welcomed at the service. People's independence was encouraged and promoted. People, relatives and staff's views were sought through different methods, such as meetings and questionnaires. Effective communication systems were in place.

We found seven breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and one breach of the Care Quality Commission (Registration) Regulations 2009. You can see what action we told the provider to take at the back of this 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 home was not always safe.

Medicines were not managed and administered safely.

Safe recruitment procedures were not always followed.

Premises and equipment had not been properly assessed or maintained.

### Is the service effective?

**Requires Improvement**

The service was not always effective.

Staff were not supported by regular supervision and training.

The service was not meeting the requirements of the Deprivation of Liberty Safeguards.

People's nutrition and hydration needs were not fully supported as records were inconsistent.

People's healthcare needs were supported.

### Is the service caring?

**Good**

The service was caring.

People were supported by staff who were kind and caring.

People had good relationships with staff.

People's visitors were welcomed and supported by the service.

### Is the service responsive?

**Requires Improvement**

The service was not always responsive.

Staff deployment was not always responsive to people's needs.

Care records were not person centred.

Feedback around activity provision was mixed.

## Is the service well-led?

**Inadequate**

The service was not always well-led.

Notifications had not been sent to the Commission as required.

Systems in place to monitor the quality of care and support were not effective.

Communication systems were in place for staff and relatives.

Meetings and surveys were facilitated to gain feedback.

# Earlfield Lodge

**Detailed findings**

## Background to this inspection

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

This inspection took place on 21 and 23 November 2017 and was unannounced. The inspection was carried out by two inspectors and one expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give key information about the service, what the service does well and improvements they plan to make. We reviewed the PIR and other information we had about the service including statutory notifications. Notifications are information about specific events that the service is legally required to send us.

Some people at the service may not be able to tell us about their experiences. We used a number of different methods such as undertaking observations to help us understand people's experiences of the home. As part of our observations we used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the needs of people who could not speak with us.

During the inspection we spoke with 14 people living at the home, 5 relatives and 11 staff members, this included senior staff, and the registered manager. We also spoke with one health professional. We reviewed 15 people's care and support records and four staff files. We also looked at records relating to the management of the service such as incident and accident records, meeting minutes, recruitment and training records, policies, audits and complaints.

Requires Improvement

# Is the service safe?

## Our findings

At the last inspection in September 2016 people were at risk as Medicine Administration Records (MAR) were not being consistently completed, people who self-administered their medicines did not have risk assessments in place and medicines were not always being stored as directed. At this inspection we found not all of these areas had been addressed and the provider continued to not meet this regulation.

MARs had gaps where staff had not signed to indicate they had administered the medicines as prescribed. Staff responsible for medicines confirmed that these had been given to people but not signed for. For example, one person's MAR had seven gaps on two different days where staff had not signed. There was a chart in place for staff to sign to confirm they had checked the MAR's for any gaps, but these had not been completed consistently. Additionally, on one occasion staff had signed the chart to confirm they had checked the MAR's, and there was nothing documented to indicate that staff had noted the gaps that were present.

Some people were prescribed additional medicines on an as required basis. Although there were some protocols in place for the use of these additional medicines, they were not in place for all. For example, some people had been prescribed medicines for agitation, but there were no protocols in place to inform staff of the signs people might display, or of the steps staff should take to relieve the agitation prior to resorting to the use of medicines. Although these medicines had been administered, staff had not documented on the reverse of the MAR the reasons for administration. This meant it would be difficult for staff to identify triggers or trends.

Some people had been prescribed creams and lotions. Topical medicine administration charts (TMARs) were in place, including body maps to inform care staff where they needed to be applied and how often. This information had not always been transcribed correctly; for example, one person had a TMAR in place and the body map had been shaded to indicate it should be applied to the person's hips and knees. However, the written instructions informed staff to apply only to the person's knees. We looked at the TMARs for four other people and all the charts had significant gaps where staff had not signed to indicate the creams had been applied. Staff told us they had been given. For example, one person had been prescribed a cream twice a day, but the chart had only been signed 14 times during between 1 November 2017 and 21 November 2017. This meant there was a risk that people did not always have their creams and lotions administered as prescribed.

One person was self-administering their medicines. The person had signed a form to indicate they took responsibility for administering their own medicines. However, the provider's medicines policy referred to a risk assessment being completed for people who wished to self-administer their medicines, but this was not in place. This had been highlighted to the provider at the last inspection of the service. Additionally, the policy stated 'Self-medicating service users will be clearly monitored to ensure they are taking the correct doses at the correct time.' Staff said they did not undertake stock checks of this person's medicines which meant the provider's policy was not being followed.

When medicine incidents or errors occurred they were not reported through the provider's incident reporting procedures. For example, one person had been prescribed an antibiotic which staff had administered for six days longer than the prescribed period. This had been noted in a medicines audit that the amount given to the person must have been incorrect for the error to have occurred. The incident had been noted on 31/10/2017 but had not been reported as a medicine error. The provider's Medication Errors policy stated that incident reports should be completed and that incidents would be investigated and recorded. As the provider's policy had not been followed, it was difficult to assess whether the incident had been investigated or whether actions had been considered in order to prevent a recurrence.

Some of the MAR charts had photographs in place to assist staff to recognise people, but photographs were not in place for everybody. Some people's preferences in relation to how they preferred to take their medicines had been documented, but these were not in place for everybody. This had been highlighted to the provider at the last inspection.
Medicines that required storage in accordance with legal requirements had been identified and stored appropriately. Registers of these medicines matched the stock numbers held. However regular stock checks were not carried out by the service. The provider's 'Administration of Medicines Policy' was incorrect. It made reference to two nurses being required for the administration of controlled medicines; however, there were no registered nurses employed at the service.

At the last inspection medicines were not always stored as directed. At this inspection we found improvements had been made. The temperature of the medicines store room and the medicines fridge was monitored and records showed temperatures were within recommended ranges.

This was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff administering medicines to people took their time and did not rush people. Staff checked people had a drink and ensured medicines had been swallowed before signing the MAR chart. They asked people if they needed any additional medicines, such as pain relief.

The service did not follow an effective recruitment process before new staff began their employment. All stages of the recruitment process as outlined in the provider's policy had not been adhered to. For example, one file we reviewed did not contain photographic verification of the person's identity, which the provider's policy stated, 'to include photographic evidence.' In addition the person had changed their surname and there was no formal verification of this. Disclosure and Barring Service checks (DBS) had not been always been completed by the provider before new staff began working at the service. A DBS check helps employers to make safer recruitment decisions by providing information about a person's criminal record and whether they are barred from working with certain groups of people. The provider was not clear on current guidance on DBS and we saw in one staff file that a DBS from a previous employer had been used. References for new employees had not been sought in line with the provider's policy; this had been highlighted to the provider at the last inspection of the service. We found that references obtained for staff did not always confirm the dates of their previous employment. Therefore it was not always corroborated when people had left previous employment and any gaps in employment could not be investigated. In one staff record the dates of employment stated on their application form did not match the reference sought and this information had not been identified or followed up. For another staff member a second reference had not been obtained so this had been provided by a friend who was also employed at the service.

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

There were no environmental risk assessments in place. These assessments review the environment for potential risks and outline guidance on how to keep risks to a minimum. We found areas of the service that were in need of redecoration and repair. For example, bath sides that were split and cracked, ceilings that were also cracked, wallpaper that was torn, paintwork that was chipped, carpet that was stained, plaster that was falling away from the walls and nails sticking out of the wall. A redecoration plan and refurbishment plan was reviewed for 2016. However, there was not a plan in place for 2017. This meant that areas that needed maintenance and repair were not always being addressed. During our inspection, we used the lift. The lift did not open at the correct level and opened to a brick wall. The provider acknowledged that the lift needed upgrading. One staff member said, "That happens sometimes." We reviewed the environmental checks that were currently in place. The only checks available to view were from October 2017, no previous checks were documented. These checks consisted of a brief note being written of any actions needed in regards to people's rooms. These had been ticked off, to indicate they had been completed. No checks had been conducted of the communal areas, windows and external environment.

Checks of electrical equipment, gas safety and water had been conducted. Some checks of other equipment such as mobility aids and wheelchairs had been completed monthly. However, it was not clear what equipment was in use, what had been checked and what actions had been taken following these checks. For example, the checks completed on wheelchairs, ticked they had been done and stated, 'All'. We were told by a staff member that several wheelchairs had been taken to have their tyres replaced, this action was not indicated on the checklist.

This was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff were knowledgeable about how to report incidents and accidents. However, on people's care records the actions taken following an incident or accident was often limited or not completed. We reviewed one incident in October 2017 where staff had sought additional healthcare advice following an incident. When contact was unable to be established this had not been followed up or an alternative source contacted. Therefore the records did not clearly indicate if the person's health needs following this incident had been addressed. Actions staff should take or measures implemented to minimise the risk were not clear on records held. For example, one person had fallen seven times during June 2017, but the analysis that had been carried out did not make any recommendations, adjustments to the care plan, identify any learning or suggest preventative measure to avoid recurrence. Another person had choked during a mealtime in July 2017 the actions recorded showed how the situation was well managed at the time but did not show actions taken to reduce the risk of it happening again and this was not reflected in the person's care plan.

Care records contained risk assessments for people in areas such as skin integrity, malnutrition and falls. However, the guidance for staff in risk management was inconsistent. Some care records we reviewed had clear and detailed guidance for staff in how to support the person in reducing identified risks. For example, for one person we reviewed their care plan guided staff in the mobility equipment to use and when this may be appropriate. However, for another person at risk of falls the guidance for staff was limited.

The provider had policies and procedures in place for safeguarding vulnerable adults. Staff were aware of the signs of abuse and the process to follow if they had any concerns. One staff member said, "I would report to a senior and record in people's daily file." We found that staff filled in body maps to record any bruising or injuries, but these were not always reported. For example, we looked at a body map that had been filled in for one person in September 2017. Staff had documented, 'Noticed bruise on wrist when assisting with personal care – unknown origin.' However, as this had not been reported, no investigation into the potential cause had been undertaken. Patterns and trends may not be established. Senior managers immediately

addressed this and by the second day of the inspection systems were in place to report and analyse and bruising that may occur.

People had a personal evacuation in place, which detailed the individual support they would require in an emergency situation. The fire procedure indicated a colour coded system which showed staff quickly what type of support people required. A business continuity plan was in place, which gave procedures and guidance to follow should an evacuation of the building be required following an incidence such as a fire. However, the plan did not cover other eventualities such as severe weather or a water leak. A senior manager said this would be addressed.

The service was currently fully staffed. People, relatives and staff told us there was enough staff. One relative said, "There seems to be enough staff around all of the time." A staff member said, "If we are all in it is fine, it is when staff are off sick we struggle." The service did not use agency staff and covered any sickness and holiday with existing staff members. However, we observed that people's care and support needs were not always met in a timely manner. We have reported on this in the responsive domain.

A fire risk assessment was in place. Regular checks of fire safety equipment had been conducted such as emergency lighting and fire alarms. However, it was not always clear what equipment was in place and where it was located. Practice fire drills had been undertaken. Staff were clear on the procedure they should follow in such a circumstance.

Staff were observed wearing personal protective equipment where appropriate. A dedicated team was responsible for ensuring the service was kept clean and hygienic.

People told us they felt safe. One person said, "Yes I always feel safe." Another person said, "I am looked after here." A relative said, "[Name of person] is kept as safe as houses here."

Requires Improvement

# Is the service effective?

## Our findings

Staff did not receive supervision as frequently as the provider's policy indicated to support them to deliver effective care. Supervision is where staff meet with their line manager to discuss their performance and development. The provider's policy stated that staff should receive supervision every three months. The supervision matrix we reviewed showed 12 members of staff had not received supervision since at least 2015, some were as long ago as 2013. We reviewed 12 staff members' supervision records. All of these staff members had only received one supervision in 2017. It had often been up to 12 months since their last supervision. This meant staff's performance in their role was not regularly being monitored and training and development needs were not being identified. We received mixed feedback from staff around their supervision. One staff member said, "It is hit or miss if we receive supervision." Another staff member said, "Yes I have regular supervision." When staff had received supervision the meeting covered areas such as attendance, training, reflective practice and understanding their role. A staff member said when they had supervision they found it, "Useful."

We reviewed the staff training records and saw that staff received training in areas such as moving and handling, food hygiene and fire safety. However, in some areas such as The Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards over half the care staff had not completed any training in this area. In other areas such as first aid and safeguarding vulnerable adults staff had not received regular training. Staff had not always completed the training at all or had completed it between 2012 and 2014. This means that legislation and guidance may have changed since this time and staff may not be up to date in their skills and knowledge.

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

Records to monitor people who were having their food or fluid intake monitored had not been consistently completed. Records did not always demonstrate that people had enough to eat and drink. One person had lost weight and it was documented that they should be encouraged to have a fortified diet, regular high calorie nutritional foods and lots of snacks. A health professional was due to assess their food and fluid for the previous week. The charts for the previous five days did not demonstrate that the recommended guidance had been followed. For example, on 16 November 2017 it had been documented that the person had, '2 x tea' to drink. No food intake had been recorded. On 17 November 2017, it had been documented the person had 150mls to drink and no food intake. On 18 and 19 November 2017, food and fluid intake had been documented that showed the person ate and drank as recommended. On 20 November 2017 no food or fluid had been recorded. Staff told us they were responsible for checking the charts had been completed, but that this did not seem to work. Other food and fluid charts we reviewed also demonstrated that people's recommended intake had not been achieved. There was nothing documented to indicate that staff had noted when people had a poor food or fluid intake or that it was escalated. This meant that people nutrition and hydration needs may not always be met. The service did regularly monitor people's weights and identify any loss or gain. However, over the past months there had been an issue with the equipment which had meant that people's weights taken were not always accurate. The provider had taken action to repair the

equipment.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager had not always met their responsibilities with regard to the Deprivation of Liberty Safeguards (DoLS). DoLS is a framework to approve the deprivation of liberty for a person when they lack the mental capacity to consent to treatment or care and need protecting from harm. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the Mental Capacity Act 2005 (MCA). We found that for three people their authorisations had expired but their assessed needs had not changed. There were significant delays before another application was submitted to the local authority. For example, for one person their DoLS authorisation expired on 01/12/15. However, another authorisation was not applied for until 24/01/17. In addition some people were being supported in a way that may restrict their liberty without the necessary authorisation in place to do so. In one person's care record, it said, 'To try and ensure [Name of person] does not leave the home.' The person did not have a DoLS in place and had been assessed as lacking the capacity to consent to reside at the service.

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

Staff demonstrated a good understanding of the MCA and explained how they used their knowledge in their work practice. One staff member said, "I always ask people what they want and gain people's consent." Staff described how they used different methods of communication to support people in making their own choices. One staff member told us about a person who used hand signs to indicate their decisions. The service had a well-documented process for capacity assessments. This showed what area of capacity was being assessed, and how the outcome was established. When a best interest decision was needed, these were decision specific. The documentation showed how the person and other relevant people had been involved in the decision making process, other options that had been considered and why the outcome was the least restrictive. However, this assessment process had not extended to people who may require a DoLS application. We found that people who may be assessed as requiring a DoLS application had not always been identified.

The services' layout could be disorientating for people. There was little direction to guide people or orientate people to where they were within the service. We observed that information to aid people was not always correct. For example, several clocks were not displaying the correct time. In two different areas of the service the day and date displayed was incorrect. This could be confusing for people who were living with dementia in particular.

New staff completed an induction process. We reviewed the induction staff completed. This took staff through systems and processes within the service, working with people in a respectful and dignified way and through the services policies and procedures. All staff we spoke with had completed an induction. Staff spoke positively about the induction process. One staff member said, "Yes the induction was good, you got to know the staff and residents." Another staff member said, "The induction was thorough. I shadowed another staff member." The induction was not yet aligned with the Care Certificate or similar. The Care certificate is a modular induction which introduces staff new to health and social care to a minimum set of standards. The service was working towards this and had identified a staff member to progress this.

The feedback about the food provided at the service was generally positive. One person said, "The food is

marvellous." Another person said, "The food is terrific, you would not get better in restaurant." A relative commented, "The choice of food is wonderful." However, one person said, "The food is just passable." Some concerns were raised with us around the quality of the food at particular times. This was brought to the attention of senior staff members who said they would take actions to address. We observed that staff offered people choices at mealtimes and showed people options to support them in their decisions. People enjoyed their meals at their own pace and chose where in the service they preferred to eat. Staff members regularly offered people drinks. Additional requests for food and drinks were accommodated. One person who asked for a particular type of biscuit which was brought from the kitchen straight away said, "Nothing is too much trouble." Fresh fruit was available for people to help themselves to around the service.

People told us they had good access to healthcare and were supported by the service. One person said, "I go to the hospital to see the doctor." Another person said, "I have to go to the hospital, I don't know how often, the staff let me know when I need to go." Relatives commented the changes in people's health needs were identified and actions taken. A health professional said, "There is a good working relationship." The health professional commented that the service took the recommended actions in regards to people's health needs.

The service was trialling new movement sensor beams in people's room. The service was reviewing if this equipment was more effective and less intrusive to support people in remaining safe within their rooms. The provider's statement of purpose ensured that people were welcomed to the service and that care and support was given equally and individually. This was monitored through the surveys conducted by the service.

Good

# Is the service caring?

## Our findings

People told us they were supported by staff who were kind and caring. One person said, "Everyone [referring to staff] are so caring." Another person said, "The management is kind and caring." A relative said, "They [staff] do a wonderful job."

People told us they had good relationships with staff. One person said, "I get on with everybody here." Another person said, "Everything is wonderful here. Nothing is too much trouble, everyone is so caring." We observed a staff member say to people, "I'm just going to put the lunch on". One person asked, "Shall I stay for something to eat?" The staff member replied, "Oh please do. I'd love you to stay."

People were offered comfort and support when appropriate. We observed one person who was becoming agitated. A staff member sat with them, held their hand and explained what would be changed within the environment to alleviate their distress. The staff knew the person well and what was important to them. We observed another member of staff talking to one person. The person's hair had fallen into their eyes and the member of staff said, "Your hair is in your eyes; let me help you." The staff member gently moved their hair away from their eyes. One person said, "All the staff here are fantastic. They're really good and really on the ball".

People were encouraged to maintain their independence. We observed at mealtimes that people were offered support but were encouraged to do things for themselves. People had their own room key if they wished. One person said, "I have my own key."

The service had received a number of positive compliments since January 2017. One compliment said, 'How grateful and touched I have been with your staff. They both went above and beyond.' Another compliment read, 'A big thank-you to you all for the care and kindness.' Another compliment described a celebration. Staff had facilitated this event to be personal and the person said how much this had meant to them.

Family and friends could visit when they wished. There were no restrictions on visitors. Relatives said they were always welcomed when they visit and staff ensured they were spoken with. One relative said, "I visit at all times of the day and they always make me feel welcome." Another relative told us how they liked to visit and have meals with their relative. The service would set up a private dining area so they could eat together. The relative said, "This is very nice." A family member told us about when they relative had been unwell, "The staff kept me up to date in changes in their condition. They supported me as well when I was upset and tearful."

We observed two staff members support a person to transfer safely using appropriate equipment. The staff members spoke calmly to the person, explaining what was happening and checking that the person was comfortable and felt safe. They reassured the person through the process. The person smiled and chatted with the staff members. Staff upheld people's dignity. A person was asleep in a communal area and staff put a blanket across their lap.

People were able to spend time in communal areas or in the privacy of their own room. We spoke to a group of people who told us they enjoyed having their breakfast together. We observed people enjoying a sensory area of the service when they wished.

Regular meetings were held with people. We reviewed recent minutes and saw that information was communicated about new staff to the service, food service, sensors in rooms and keyworker roles. People raised and discussed items such as security and staff uniforms. Decisions were made, for example to improve the lighting at the front of the building. Staff went through the fire procedure, to ensure people were aware of the systems in place.

Requires Improvement

# Is the service responsive?

## Our findings

The service was not always responsive. We observed that staff deployment was not always responsive to people's needs. For example, we observed a person who had informed a staff member they needed to use the bathroom. The person said to staff, "I really need to go." It took 15 minutes before staff members accommodated this request. The Short Observational Framework for Inspection (SOFI) we conducted demonstrated that staff were not always available and responsive to people during a mealtime. One person tried to move their mobility aid and was asking for assistance but had to wait for staff as there were none present. We monitored the call bell system. We found that call bells were continuingly sounding for long periods of time. One person's call bell was ringing for 27 minutes before being answered. Another person's was ringing for 17 minutes. We went to check on their well-being, they said, "I have been ringing for over 10 minutes." We went and asked a member of staff to attend to them. The provider said they were exploring a new call bell system which would be less intrusive to people as would alert staff rather than sound over the whole building. Senior managers said they would investigate how staff responded and ensure staff for attended to people promptly.

Care plans were not always person centred. The personal history section of people's care plans, were not consistently completed. Out of eight care records we reviewed only three were completed. This meant that information about people's families, past employment, culture and interests were not always documented. This may mean that areas important to people are not facilitated. For example in regards to people's religious needs. People's preferences in relation to their preferred routines and things that were important to them had been documented but these were often limited to a summary of people's needs and did not continue throughout the plans. For example, personal care plans guided staff to, 'Encourage personal choice' but did not always specify people's preferences for a bath or shower, or the clothes they preferred to wear. Activities that people enjoyed engaging in were not always documented. Care plans around specific health needs such diabetes or catheter care were not always in place or lacked specific guidance for staff.

Communication plans did not always guide staff in appropriate strategies. In one person's care record it documented that they chose not to wear their hearing aid, but did not detail how staff should communicate with them. However, staff we spoke with were aware of people's communication preferences. For example, a staff member told us how one person preferred communication method was writing things down which they respected and responded to using the same method.

We received mixed feedback about the activity provision. A relative said, "There is always something to do." People told us about the snooker club they attended at the service and another person said they enjoyed playing bingo. We observed a person independently going to town in a taxi and they told us they enjoyed this. We observed people enjoying their time with the hairdresser who regularly attended the service. There was a lot of conversation and laughter. Colouring books and pencils were available for people to use as they wished. We observed a member of staff ask a person if they wanted their colouring. The person replied, "Yes." The staff we spoke with all said that activities could be improved and more individual activities would be beneficial to people. One staff member said, "We could do more activities." Another staff member said, "Activities could be improved." There was a brief scheduled programme of activities. On the first day of our

inspection the scheduled activity of bingo did not take place. On the second day of our inspection senior managers had revised the activity programme taking into account the suggestions made by people into the activities they wished to participate in.

The service accommodated people's end of life wishes dependent on the individual circumstances where plans had been made. The provider had sought to gain people's end of life wishes, some people had chosen to detail this. The service supported people's relatives and people close to them by ensuring families had the space to spend time with people.

The service had received two complaints since January 2017. These had both been investigated and responded to. Actions had been taken following these concerns being raised. Relatives told us they were aware of the complaints procedures. One relative said, "I know how to make a complaint should the need arise." People said that management were available should they need to raise any concerns. One person said, "I see them every day." One family member said their relative had raised a concern and, "It was sorted out straight away."

In areas of the service there were memorabilia and pictures displayed which may be of interest to people. For example, pictures of the Royal family and important historical events. In other areas of the service displays had been made of photographs of sports and entertainment. However, some of these pictures had been removed for some time and had left marks over the walls. Other pictures had been there for a long period of time and were discoloured. This showed that the environment had not been reviewed or changed to adapt to the interests and needs of people currently living there. Items were available for people to explore and use such as different wool, musical instruments and play equipment.

Inadequate

# Is the service well-led?

## Our findings

In 2015 we recommended to the service that they improve their systems for monitoring and assessing the quality of the service. At the last inspection in 2016 the service had made changes and improvements. However, medicine audits were found to be ineffective as they failed to identify issues that could place people at risk. At this inspection we found the governance systems in place had not mitigated the risk to people in regards to medicines management. For example, when issues had been identified such as gaps on TMARs in audits from April 2017 effective measures had not resolved the issue and were still continuing. This meant that improvements to medicines management had not been achieved and the service continued to be in breach of this regulation.

The registered manager, who was also the nominated individual of the service delegated the daily operation and running of the service to senior staff members. Senior staff operated systems to monitor and review the quality of the service. This included audits of falls, accidents and incidents, medicines and people's weights. Emergency call bell alerts were audited and this showed clearly what the situation was and the action that had been taken. However, there were no regular audits of daily call bells. Therefore it had not been identified that at times call bells were not being answered in a timely manner. Senior staff did however, analyse call bell alerts in regards to observed situations with particular people when appropriate. Action plans were completed following the service's monthly audits. However, many actions were, 'Ongoing', which did not fully explain if actions taken previously had been effective or required adjustment.

The registered manager and provider who has legal responsibility for meeting the regulations did not have any additional systems in place to ensure effective oversight of the service. This meant that areas of the service that we found during this inspection that presented risks to people and the extensive failure to meet regulations were not identified. For example, environmental risks, DoLS, recruitment and notifications. Therefore resources had not been allocated to address these shortfalls or a plan of action to make improvements. The current management structure was ineffective. Since this inspection, the management arrangements have been reviewed and changes implemented. We will review the effectiveness of these changes at the next inspection.

The provider had undertaken an opinion survey of staff members in August 2017. The results had given the provider a depth of information and showed there was a mix of opinions in most areas. There were comments indicating when staff had felt supported and satisfied within their role. For example, 'My managers are supportive.' The survey indicated where improvements could be made around leadership, staff morale, staff attendance and activities. For example, one comment said, 'Staff morale is good but could be better.' An action plan to address these areas had not been completed. On the second day of our inspection an action plan had been devised, showing what changes would be made and by when.

A survey had been undertaken with people and relatives in 2017. Overall the results were positive. With scores such as 92% of people saying they were happy with their room and 76% of staff respected their privacy by knocking on their doors before entering. However, we were unable to view any actions taken as a result of this survey to continuously improve the service provided.

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Notifications had not always been submitted to the Commission as required. Notifications are information about specific events that the service is legally required to send us. We found three DoLS notifications had not been submitted in 2017, a notification about an event that stopped the service in July 2017 and a safeguarding incident in October 2017 had not been submitted, 'without delay.'

This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009

The registered manager was regularly at the service. However, senior staff members undertook the day to day running of the service. One staff member said senior staff were, "Personable and approachable." Another staff member said, "The senior management are very supportive towards the staff both on a professional level and in a pastoral care way, this is something they do particularly, well." One person said, "The management is wonderful." Another person said, "They [management] are very nice and listen to me." One relative said, "The management is very approachable and you can see them anytime."

Staff comments around the support they received were mixed. One staff member said, "I am not well supported." However, another member of told us how they were very well supported and the provider had made adjustments to enable them to be successful in their role.

Staff and people commented on the positive atmosphere at the service. One staff member said, "The atmosphere is really good." Another staff member commented that they worked well as a team.

Staff told us about the systems in place to communicate information to them. A verbal handover occurred before each shift started. A diary detailed people's appointments so plans could be made accordingly. The computer system used enabled all staff to receive messages and alerts which related to changes in people's care and support needs. One staff member said, "I feel well informed when I come onto my shift."

Senior staff facilitated regular meetings. Meetings occurred with care, housekeeping, kitchen, and night staff. Information was communicated to staff about changes in the service such as staffing arrangements. Staff discussed different areas of people's care and support. One staff member said, "We are encouraged to share ideas." Another member of staff said, "The management listen to what you say." However, we highlighted to senior staff members that no clear actions were taken as a result of the meetings.

Relatives told us they were kept well informed. Letters were sent communicating important dates and events. For example, a letter had been sent detailing events across the festive season. Relatives told us they were invited to the services' meetings, which were held regularly. One relative said, "They always keep me informed if [Name of person] is not so well. I come in every day but I know I will be called if needed."

The provider facilitated staff members to engage in further recognised qualifications in health and social care and had developed positive links with a local college. Senior managers had attended a national care conference and local provider meetings to advance their knowledge and experience. The registered manager had completed and returned the Provider Information Return (PIR) within the timeframe allocated and explained what the service was doing well and the areas it planned to improve upon.

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 18 Registration Regulations 2009 Notifications of other incidents<br><br>Regulation 18 (2) (c)<br><br>The provider had failed to send notifications to the Commission as required. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 9 HSCA RA Regulations 2014 Person-centred care<br><br>Regulation 9 (1)(3)(b)<br><br>The provider had not always ensured that people received suitable nutrition and hydration to meet their needs as records were not consistently kept. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment<br><br>Regulation 13 (5)<br><br>The provider had not ensured people were being deprived of their liberty with lawful authority. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 15 HSCA RA Regulations 2014 Premises and equipment<br><br>Regulation 15 (1) (d) (e) |

| | |
|---|---|
| | The provider had not ensured the equipment and premises was properly maintained. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>Regulation 17 (1)(2)(a)(b)(e)(f)<br><br>Quality monitoring systems were not fully effective. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed<br><br>Regulation 19 (1) (2)<br><br>The provider had not ensured that recruitment procedures were operated effectively. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 18 HSCA RA Regulations 2014 Staffing<br><br>Regulation 18 (2)(a)<br><br>The provider had not ensured staff had received appropriate supervision within their role.<br><br>The provider had not ensured that staff had completed or had regular training to be effective in their role. |

This section is primarily information for the provider

# Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

| Regulated activity | Regulation |
| --- | --- |
| Accommodation for persons who require nursing or personal care | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>Regulation 12 (2)(g)<br><br>People who used the service were not protected from the proper and safe management of medicines. |

**The enforcement action we took:**

We issued a warning notice