Bupa Care Homes (CFHCare) Limited

Godden Lodge Residential and Nursing Home

Inspection report

57 Hart Road
Thundersley
Benfleet
Essex
SS7 3GL

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06 January 2016
07 January 2016

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

Godden Lodge Nursing and Residential Home provides accommodation, personal care and nursing care for up to 133 older people. The service consists of five separate houses; Boyce House and Murrelle House for people living with dementia and who have nursing needs, Cephas House for people who require nursing and palliative care, Appleton House for people living with dementia and who require residential care and Victoria House for people who require residential care. At the time of the inspection we were advised that Appleton House and Victoria House had merged.

The inspection was completed on 5 January 2016, 6 January 2016 and 7 January 2016. There were 102 people living at the service when we inspected.

The overall rating for this provider is 'Inadequate'. This means that it has been placed into 'Special measures' by CQC. The purpose of special measures is to:

- Ensure that providers found to be providing inadequate care significantly improve.
- Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.
- Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.

Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will be kept under review and if needed could be escalated to urgent enforcement action.

A registered manager was not in post at the time of the 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 managed on a day-to-day basis by one of the provider's Regional Support Managers. In addition they were supported by a Clinical Service Manager and Relief Home Manager.

At our previous inspection on 29 September 2015 improvements had been made and the service was rated 'requires improvement' but at this inspection we found that improvements across the service had not been sustained and people were placed at risk.

Arrangements were in place to inform the provider of what was going on in the service, but these were not

effective and there was a lack of provider and managerial oversight of the service as a whole. Lessons had not been learned and any improvements had not been sustained in the longer term. There was a reactive rather than proactive approach by the management team which meant that people did not receive a consistent safe and appropriate service.

Checks were not effective to monitor medication practices and ensure that people received their prescribed medication as required. Additionally, systems were not in place to ensure that people always received appropriate care to meet their needs or care that was responsive to their individual needs and preferences. Records were not properly maintained, for example, in relation to staff recruitment, staff induction, staff supervision, food and fluid monitoring and end of life care.

Risks were not appropriately managed or mitigated so as to ensure people's safety and wellbeing in relation to staffing levels, care planning, management of care and arrangements to respond to emergencies.

Staffing levels were not always appropriate to meet people's needs and this impacted at times on the level of care and support they received by staff. The deployment of staff, particularly on Cephas House and Victoria House was not always appropriate to meet the needs of people who used the service. Staff did not always have enough time to spend with people to meet their needs or to respond to people's changing needs.

Staff told us that they did not feel supported by the provider or the management team. Not all staff had received regular formal supervision or an annual appraisal. However, staff told us and records showed that there was a positive approach to staff's general learning and development needs including induction.

People's comments were variable about the care and support provided. The majority of interactions by staff were routine and task orientated and we could not be assured that people received appropriate care to meet their needs. Some aspects of care practices required improvements. These related to assisting people to eat and drink, communication with people living at the service and care and support to be less routine and task focused.

The dining experience for people was positive and people were complimentary about the quality of meals provided. Suitable arrangements were in place to ensure that the service was clean, hygienic and free from offensive odours.

Appropriate assessments had been carried out where people living at the service were not able to make decisions for themselves and to help ensure their rights were protected. Peoples privacy and dignity needs were maintained.

You can see what actions we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

The management of medicines was not safe as people did not always receive them as prescribed.

Risks were not appropriately managed or mitigated so as to ensure people's safety and wellbeing.

Steps were not in place to ensure that there were sufficient numbers of staff available at all times for the health and wellbeing of people using the service. The deployment of staff was not always appropriate to support people safely.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff felt unsupported by management and did not receive regular formal supervision or an annual appraisal. However, they were complimentary about their induction and training at the service.

Monitoring and management of people's nutritional and hydration needs required improvement as we could not be assured that people received a satisfactory diet or fluid intake.

Staff had a basic knowledge and understanding of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. Where people lacked capacity, decisions had been made in their best interests.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Although some people stated that staff treated them with care and kindness, care provided was often task and routine focused.

People did not always receive appropriate care and support and some staff's communication with people was poor.

People's end of life wishes and the care to be provided was not recorded to an appropriate standard.

Is the service responsive?

Inadequate

The service was not responsive.

People's experience of care and treatment was that it was not always responsive to their individual needs and preferences.

People were not always engaged in meaningful activities and supported to pursue pastimes that interested them, particularly for people living with dementia.

People's care plans were not regularly reviewed or reassessed. Not all people's care records were sufficiently detailed or accurate.

Concerns and complaints were always taken seriously and responded to in good time.

Is the service well-led?

Inadequate

The service was not well-led.

There was a lack of managerial oversight of the service as a whole. There was a reactive rather than proactive approach by the management team which meant that people did not receive a consistent safe and appropriate service.

The quality assurance system was not effective because it had not identified the areas of concern that we found and improvements previously made had not been sustained and used a learning opportunity to improve care across the service.

Records were not properly maintained to ensure that information was available to all staff in an up to date and appropriate format or to show that management of the service were governing effectively across the service.

Godden Lodge Residential and Nursing Home

Detailed findings

Background to this inspection

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

This inspection took place on 5 January 2016, 6 Janauary 2016 and 7 January 2016 and was unannounced. Following the inspection, additional documents as requested by the Care Quality Commission were forwarded to us between 8 January 2016 and 14 January 2016.

The inspection team over the three days of inspection consisted of two inspectors. A Specialist Advisor whose specialist area of expertise related to pressure ulcers, wound management and end of life care joined the inspectors on day two of the inspection. Additionally on day one and day three of the inspection, the inspectors were accompanied by an expert by experience. An expert by experience is a person who has personal experience of caring for older people and people living with dementia.

We reviewed the information we held about the service including safeguarding alerts and other notifications. This refers specifically to incidents, events and changes the provider and manager are required to notify us about by law. During the inspection the provider was requested to provide additional documents relating to our inspection. These were forwarded to us as requested.

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 28 people who used the service, 14 relatives, four house managers, 19 members of staff, the Regional Support Manager, the Clinical Service Manager, Relief Home Manager and the Area Manager.

We reviewed 15 people's care plans and care records. We looked at the service's staff support records for 10 members of staff. We also looked at the service's arrangements for the management of medicines, complaints and compliments information and quality monitoring and audit information.

Inadequate

Is the service safe?

Our findings

At our last inspection on 21, 22 and 24 July 2015 we identified concerns relating to poor medicines management. We found that medicines on Cephas House were not stored securely and not all people had been given their medication in line with the prescriber's instructions. We also found that people were not protected against the risk of receiving support that was inappropriate or unsafe as there were not always enough staff to support them. People and those acting on their behalf told us that there was not enough staff on Murrelle House to support them and this was confirmed by our own observations. We asked the provider to send us an action plan which outlined the actions to be taken to make the necessary improvements. In response, the provider shared with us at regular intervals between August 2015 and January 2016 their action plan detailing their progress to meet regulatory requirements. We found that the improvements they told us they would make had not been sustained.

Although people told us they received their medication as they should and at the times they needed them, the arrangements for the management of medicines were inconsistent and unsafe. Whilst medicines were stored safely for the protection of people who used the service, we identified that nine out of 21 people's medication on both Cephas House, Victoria House and Appleton House had not been appropriately managed to ensure their safety. This was of specific concern as a lot of people for whom we found medication issues could not verbalise their needs due to their health and medical conditions.

We found unexplained gaps on the Medication Administration Record [MAR] forms, giving no indication of whether people had received their medicines or not, and if not, the reason why it was not recorded. Not everyone had received their prescribed medication as it was 'out of stock'. For example, the MAR forms for one person showed that they had not received up to 17 possible doses of pain relief medication between 3 January 2017 and 7 January 2017 and two doses of another medication as 'out of stock'. In addition, not everyone had received their medication in line with the prescriber's instructions. For example, one person's pain relief gel was recorded on their MAR form to be administered three to four times daily. However, the MAR form showed that this was only administered twice daily for the period 28 December 2015 to 6 January 2016 inclusive. The house manager was unable to provide a rationale for why the prescriber's instruction was not being followed. There were numerical discrepancies in the MAR form for one person which meant we were unable to ascertain if the person had received their medication in line with the instructions of the prescriber. The house manager was unable to provide a rationale for the discrepancy and when discussed with the registered nurse they too were unable to clarify why this had happened.

Observation of the medication rounds on Victoria House, Appleton House and Cephas House showed this was completed with due regard to people's dignity and personal choice. However, the checklists used by staff to evidence the start and finish times of the medication round on Cephas House were not accurate. For example, the teatime round on Cephas House was recorded as having commenced at 19.00 and completed at 19.30 on 6 January 2016. Our observations showed that the registered nurse was still undertaking the medication round at 19.40 and when asked they confirmed that several people still required their teatime medication to be administered. This showed that the medication checklist was inaccurate and could not be relied upon to provide an accurate account of the times when medication had been administered. We could

not be assured that people using the service received their medication when they should and at suitable intervals between each dose.

Where people were anxious or distressed and were prescribed PRN [as and when required] medication, the MAR forms detailing when medication had been given to ease their anxiety and distress did not always tally with incident reports. For example, the daily care records on 30 December 2015 for one person recorded that they had been given medication at 14.35 as they had become anxious and distressed. This was not recorded within the person's MAR form. The MAR form showed that on 31 December 2015 and 1 January 2016 the same person had received the same medication however, no incidents were recorded to show that the person had been anxious or distressed. This meant that there was no rationale recorded detailing why the person's PRN medication had been administered. This suggested that there were times when the person received medication when they did not need it.

Although intuitively staff knew the people they supported and some risks were identified and recorded relating to people's health and wellbeing, for example, the risk of poor nutrition, poor mobility and the risk of developing pressure ulcers, however, this was inconsistently applied. Additionally where risks were identified, suitable control measures were not put in place to mitigate the risk or potential risk of harm for people using the service.

For example, one person on Cephas House had a significant pressure ulcer. We found that the person's pressure ulcer management was not appropriate or safe. We spoke with the registered nurse and they confirmed during the morning of 6 January 2016 they had changed the dressing on the person's pressure ulcer that morning. However, the registered nurse confirmed that no sterile dressing pack had been used. In addition, the registered nurse confirmed that they had not worn a sterile apron or gloves. When questioned further as to how the pressure ulcer wound had been cleaned, the registered nurse told us that they had used water and stated, "I kept it as clean as possible." The registered nurse confirmed that sterile dressing packs were not available on Cephas House or within other houses at Godden Lodge. No rationale was provided as to why no attempt had been made to request sterile dressing packs, aprons and gloves. This showed that unsafe practices were being carried out which could ultimately lead to a higher risk of infection, especially considering the depth and grade of the pressure ulcer.

Our observations on 6 January 2016 on Cephas House showed that one person was assessed as at high risk of developing pressure ulcers. We checked the setting of their pressure relieving mattress and found that the equipment was incorrectly set in relation to the person's weight. For example, the setting was observed to be above 60 [60 KG] and yet the person's actual weight when last recorded in November 2015 showed 52.2 KG and should have been on setting 50 or 55. This meant that the amount of support the person received through their pressure mattress was incorrect and would not aid the prevention of pressure ulcers developing or deteriorating further. We discussed this with the Clinical Service Manager on 6 January 2016. However, when we returned to Cephas House on 7 January 2016 and inspected the pressure relieving equipment for this person, we found that the setting had not been rectified and remained inaccurate in relation to their weight. Actions to mitigate any risks to the person had not been addressed.

Reasonable steps to ensure peoples' and staff's health and safety were not always considered. On 6 January 2016 we were made aware that where staff lone-worked on Appleton House, there were no effective systems in place for staff to summon assistance as the call alarm facility could only be heard on Appleton House and did not alert staff on Victoria House which was adjoined. This meant if there was an accident or serious unforeseen incident, there was no effective system available for staff to summon assistance and this could place people at risk of delayed care and treatment. We brought this to the Regional Support Manager's attention at the time of the inspection. Following the inspection the Regional Support Manager wrote to us

and confirmed that pendant alarms for staff had been purchased.

These failings are a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Comments about staffing levels on Murrelle House from people using the service and those acting on their behalf were generally positive. People told us that staffing levels were much improved and appropriate to meet their needs or their relative's needs. However, this was in contrast to what we were told on Victoria House, Appleton House, Boyce House and Cephas House. There was not enough staff to meet people's needs in a timely manner and in line with their prefences and personal needs.

On Victoria House one person who used the service and their relative told us, "They [the service] don't have enough staff and the staff are run off their feet." Another person told us, "They [the service] are definitely short staffed." When asked how this impacted on them, they told us, "I could not get a shower last week for seven days. It was solely due to staffing levels. It was a bad time for me." They further stated that they had requested a shower on at least four separate occasions, but staff had told them that they were too busy and there were no staff available to support them with this request. We spoke with the house manager and three members of staff. They confirmed that the above account was accurate and was due to staff telephoning at the last moment to say that they would not be coming in and staff sickness. In addition, the house manager told us that one person required three members of staff to deliver personal care and this impacted on the numbers of staff available to support others living within the same house. A third person told us, "In the mornings they [staff] are all tied up. I get myself up because I get fed up waiting. I've fallen twice. They definitely need more staff." This was confirmed by the person's relative. Another person told us, "It was terribly stressful for staff on Christmas Eve and the atmosphere wasn't Christmassy at all. There was no fun, no atmosphere on Christmas Day; there wasn't enough staff for that." It was difficult to determine if this was an isolated case or systemic of the service, as most people's daily care records provided no information to indicate how people had spent Christmas Day or New Years Eve.

Nine members of staff told us that staffing levels, as told to us by the registered provider, had not always been maintained. Staff confirmed that they did not have time to sit and talk with people using the service and that people often had to wait for long periods of time for care and support to be provided. For example, one member of staff stated that when people asked to go to bed, often they had to wait because there were not enough staff available to help everyone to bed at their preferred time. They told us, "They [people using the service] are not happy, but what can we do?" They also told us that at times the care provided for people using the service could be rushed. On Cephas House one person who used the service confirmed this and told us, "They're short-staffed. Some of them [staff] tell me, but I can tell anyway. Sometimes I feel very rushed by them [staff]." A relative told us that in their opinion there were not enough staff available and they were concerned that their relative had lost a lot of weight in recent months because there were not sufficient staff available to support them with their nutritional and hydration needs. Records viewed confirmed this.

Our observations during the inspection showed that staff did not always have enough time to spend with people to meet their needs and this was primarily evident on Cephas House and Victoria House. The care and support provided was routine and task orientated and this was evident from our observations. The deployment of staff was not always suitable to meet people's needs, for example, we noted that there were times when the main communal lounge areas within both houses were left without staff support for between 10 and 20 minutes. Staff rosters for the period 4 December 2015 to 7 January 2016 inclusive were viewed for each house. These showed that staffing levels as told to us by staff were not always maintained and suggested that there were not always sufficient numbers of staff rostered to provide care and support to people using the service. We discussed this with the Regional Support Manager and Area Manager and were

advised that measures were in place to deploy staff where appropriate with 'bank' staff or agency staff. However, we found that the staff rosters were not accurate and did not always include 'bank' staff or agency staff used. Therefore it was not always possible to determine if staffing levels were appropriate or not but taking into account the discrepancies in service rotas, our observations, staff and people's voice we judged the service to be lacking sufficient staff to effectively deploy resources across the site to support people safely and to meet their individual needs and preferences.

Although people's level of dependency was assessed and recorded each month, there was no systematic approach to determine the number of staff required, to review the service's staffing levels and to ensure that the deployment of staff met peoples changing needs and circumstances. In addition, the dependency needs of people did not always accurately reflect the provider's 'Resident Care Need Banding.' For example, one person's banding was graded as 'Band 3', however staff and the Clinical Service Manager confirmed that their banding was incorrect and this should have been 'Band 4'. We discussed this with the Regional Support Manager and Area Manager and they confirmed that several peoples' 'Resident Care Need Banding' required reviewing.

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

Not all staff had been recruited properly and in accordance with the provider's own policy. We found that satisfactory evidence of conduct in one person's previous employment, in the form of references, had not been received prior to their employment at this service, these had not been sought and remained outstanding. In addition, we found that one staff member's Disclosure and Barring Service certificate was received after they had commenced employment. We asked to see evidence of profiles for four agency members of staff utilised at the service however these were not available. The provider could not be assured that people were protected by their staff recruitment process and improvements were required.

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

Staff had attended training in safeguarding people. Staff were able to demonstrate a good understanding and awareness of the different types of abuse and how to respond appropriately where abuse was suspected. Staff confirmed they would report any concerns to external agencies such as the Local Authority or the Care Quality Commission if required. Staff confirmed they would do this without hesitation in order to promote people's safety and wellbeing. Staff were confident that the provider and the management team would act appropriately on people's behalf. There was a consistent approach to safeguarding and any concerns had been dealt with promptly and both the Local Authority and the Care Quality Commission had been notified.

We looked around the premises and found that all areas of the home environment were clean and there were no unpleasant odours. We found that there were sufficient supplies of personal protective equipment for staff usage. These were for single use only and discarded after personal care with a person who used the service had been delivered so as to prevent the transfer of infection from one person to another. Records showed that infection prevention and control audits had been completed. The audits indicated that areas for corrective action had been highlighted in December 2015. Although action plans had yet to be developed and actioned at Boyce House and Murrelle House. We found that daily cleaning schedules were in place for all areas of the home environment. Records showed that these were completed each day by the service's house-keeping staff. We found that the laundry facilities were sited so that soiled clothing and infected linen were not carried through areas where food was stored and prepared and did not infringe on people's rooms

or communal areas. We found that there were suitable arrangements in place so that dirty laundry was handled with care and reduced the potential spread of infection.

Requires Improvement

Is the service effective?

Our findings

At our last inspection on 21, 22 and 24 July 2015 we identified concerns relating to poor nutrition and hydration on Murrelle House. The dining experience for people was variable and not always appropriate to meet peoples' individual nutritional needs. We also found that the implementation of staff training was not effective in all the houses to ensure that staff knew how to apply their training and provide safe and effective care to people using the service. We asked the provider to send us an action plan which outlined the actions to be taken to make the necessary improvements. In response, the provider shared with us at regular intervals between August 2015 and January 2016 their action plan detailing their progress to meet regulatory requirements. We found that the improvements they told us they would make had been sustained on Murrelle House and Boyce House.

Improvements were needed to ensure staff had a structured opportunity to discuss their practice and development to ensure that they continued to deliver care effectively for the people they supported. The majority of staff told us that they did not feel supported and valued by members of the management team or the organisation. When questioned further staff told us that they had not received formal supervision at regular intervals or an annual review of their overall performance for the preceeding 12 months. We found that this was accurate and not happening in line with the provider's own policy and procedure which stated that all employees should have a minimum of four one-to-one supervisions, including an annual appraisal over a 12 month period. Not all staff were able to tell us when they had last received supervision and some staff told us that they had not received supervision in 2015. In records we reviewed five out of 11 members of staff had not received supervision within the last 12 months. Additionally seven out of 11 members of staff had not received an annual appraisal. We discussed this with the Regional Support Manager and they confirmed that shortfalls had been identified in relation to staff supervision and annual appraisals had not been completed in 2015.

Staff told us they received an induction when first newly employed at the service. This included a standardised induction about the organisation, five day workplace induction appropriate to an employee's role, which included an 'orientation' induction of the premises, observation of practice and opportunities to shadow a more experienced member of staff for several shifts. In addition, it was the provider's expectation that all staff must complete all mandatory training as part of the induction process. The induction records for two out of three staff were evident and showed that the induction process had been robust and in line with the Care Certificate framework induction programme. However, no induction record was recorded as having been completed for the third member of staff. This meant that we could not be assured that all staff had received a thorough induction that provides them with the skills and confidence to carry out their role and responsibilities effectively.

People told us that they felt that staff employed at the service were competent. Staff were very complimentary about the quality of the training provided. One member of staff told us, "They [provider] are really hot about training." Another member of staff told us, "We get regular up-dated and refresher training. I think the training here covers what we [staff] need." Staff told us that they received regular training opportunities in a range of subjects and this provided them with the skills and knowledge to undertake their

role and responsibilities and to meet people's needs to an appropriate standard. Following our inspection a summary report dated December 2015 relating to mandatory training for all staff employed at the service was forwarded to us. This provided both numerical and statistical information and confirmed that nearly 98% compliance with mandatory training had been completed by staff.

In general staff were aware of who might need additional support or encouragement to eat and drink and the majority of staff had a good understanding of each person's nutritional needs and how these were to be met. Although people's nutritional requirements had been identified, assessed and documented, where people were at risk of poor nutrition, appropriate actions had not always been taken so as to ensure that people's nutrition and hydration needs were met. Where appropriate, referrals had not always been made to a suitable healthcare professional, such as, dietician or the Speech and Language Team [SALT] for advice and support.

We could not be assured that people on Cephas House received sufficient nutrition and hydration to meet their needs. Peoples' nutrition and hydration records provided insufficient detail to enable any person inspecting the record to determine whether their needs were being met to an acceptable level. For example, one person was observed to be nursed in bed as they required end of life care. Daily care records evidenced that the person's nutritional and hydration intake was poor and weight records showed that they had lost a total of seven kilograms in weight over a two month period. We asked the Clinical Service Manager for evidence of food and fluid intake records for this person for the period 1 December 2015 to 6 January 2016 inclusive. The Clinical Service Manager advised us that no food and fluid intake records had been maintained as they were stopped on 30 November 2015. The Clinical Service Manager when asked was unable to provide a rationale for this decision. The Clinical Service Manager confirmed that fluid intake records had commenced on 4 January 2016. However, these showed that the person only received a total of 480 millilitres on 4 January 2016 and 5 January 2016 and by 12.25 on 6 January 2016 had received only 240 millilitres. The person's care plan relating to eating and drinking had not been reviewed and updated to reflect a change to their nutritional and hydration circumstances. In addition, there was no evidence that the above had been discussed with a healthcare professional, such as, GP or dietician, for involvement or advice.

Where people refused a meal, there was limited evidence to show that alternatives to the menu were routinely offered and/or provided by staff. For example, the nutritional records for one person showed that whilst the person generally ate breakfast most mornings, the midday and teatime meals were not always eaten. No alternatives to the menu were recorded as being offered and staff were unable to tell us if they had. Additionally, we found that an instruction from a healthcare professional recorded that staff should make a referral for the person to be seen by a dietician as they were concerned about the person's medical condition. No record was available to show that a referral to a dietician had been made and neither the registered nurse on duty or the Clinical Service Manager was able to provide a rationale for this oversight.

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

People's comments about the quality of the meals provided were generally positive. One person told us, "The food here is very good. I like it all. If I do want something different then it is provided. I cannot complain." Another person told us, "The food is always good." However, one person told us, "The food's OK, but it's always swimming in gravy and I don't like it. I wish they'd offer it [gravy] to us at the table. It would make it a bit more personal." Relatives were asked for their views on the meals provided for their member of family. One relative told us, "The food looks very nice, there is a good choice of meals and the portions are good." Another relative told us, "I have not eaten here but the food looks good and my relative seems to

enjoy it."

We found that the dining experience for people was generally positive and people were supported to enjoy a choice of food and drinks that met their nutritional needs. People were supported to use suitable aids to eat and drink as independently as possible, for example, to eat their meal using a spoon, use of specialist beakers and plate guards. This showed that people were enabled and empowered to maintain their independence and skills where appropriate. Where people required assistance from staff to eat and drink, this was provided in a sensitive and dignified manner, for example, people were not rushed to eat their meal and positive encouragement to eat and drink was provided.

Although people told us that their healthcare needs were well managed, we found that some peoples' healthcare needs were not recorded as well as they should be or included evidence of staff interventions and the outcomes of healthcare appointments. This meant that we could not be assured of the actions taken by staff to act on issues identified so as to ensure the best possible healthcare outcomes for the people they supported.

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. We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

Staff told us that they had received Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) training. Staff were able in most cases to demonstrate a basic understanding of MCA and DoLS, how people's ability to make informed decisions can change and fluctuate from time to time and when these should be applied. Records showed that where appropriate people who used the service had had their capacity to make decisions assessed. This meant that people's ability to make some decisions, or the decisions that they may need help with and the reason as to why it was in the person's best interests had been recorded. Appropriate Deprivation of Liberty applications had been made to the Local Authority for their consideration and authorisation.

We found that the arrangements for the administration of covert medication for people using the service was in accordance with the Mental Capacity Act (MCA) 2005. 'Covert' refers to where medicines are administered in a disguised format without the knowledge or consent of the person receiving them, for example, in food or in drink.

Requires Improvement

Is the service caring?

Our findings

The service needed to improve the way they delivered personalised care to people in a caring and compassionate way. This included areas such as end of life care, communication, care provision and understanding people as individuals including their lives and histories.

People's preferences and choices for their end of life care were not clearly recorded, communicated and kept under review. We found that the needs of people approaching the end of their life and associated records relating to their end of life care needs were either not up-to-date or not recorded. For example, the care plans provided little or no information detailing people's pain management arrangements and the care to be provided so as to provide comfort to the person. No information was recorded to identify who may have a few months, weeks or days to live; in order to aid care planning arrangements and discussions with the person and those acting on their behalf. In addition, no Preferred Priorities for Care [PPC] documents were in use. This is designed to help people prepare for the future and gives them an opportunity to think about, talk about and write down their preferences and priorities for care at the end of their life. This may lead to inappropriate hospital admissions or people's wishes not being followed. This meant that people's 'end of life' wishes were not in line with the Gold Standard Framework in End of Life Care or new guidelines issued by the National Institute for Health and Care Excellence [NICE]. The latter places emphasis for a more individualised approach to 'end of life' care.

No information explaining what treatment should be provided for people's health if they were no longer able to make decisions for themselves was recorded (Advanced Directive). This meant that we could not evidence that people and those acting on their behalf were involved in the assessment and planning for their end of life care or supported to make choices and decisions about their preferred options.

People's comments about the care provided by staff was variable. One person told us, "They [staff] treat us very well and they're very caring." Another person told us, "I'm treated very well. If you ask for anything, they'll [staff] do it for you. They [staff] do a good job]." Less than favourable comments were made and people told us that they did not always find staff to be kind and caring. One person told us, "Some [staff] are excellent, but some [staff] are not as caring. They can be a bit dismissive." Another person told us, "Some of the staff are marvellous. The senior staff are good however the younger ones are not so good. They haven't the patience or understanding." They advised us that they recently asked a younger member of staff for some brown bread, they told them that there wasn't any. The person stated that they knew this was not true and felt the staff member did not care enough to fulfil her request. Additionally relatives comments about the care and support provided for their member of family was also variable. One relative told us, "I don't worry about my relative's care when I'm at home – they [staff] do care about them." Another relative told us that they worried about their relative's care as staff did not always notice if their clothes were wet and required changing or if their member of family had not eaten well.

We found that some members of staff lacked knowledge of people as individuals and were not familiar with the people they were caring for. For example, on Boyce House we were made aware that it was one person's birthday. The deputy house manager and two members of staff were unable to tell us how old the person

was or other essential information relating to the person's life history. Although staff suggested to us that the person was unable to tell us their age, we sat with them and after a while they told us when and where they were born and other information relating to their personal life story. Staff looked at the person's care plan and confirmed to us that the information we were told was accurate. Whilst this was happening a member of staff had gone out to purchase a birthday cake and a birthday present for the person. However, we later discovered that the present had been a bottle of shower gel and a tube of steradent. Although the gesture was well meant, these were everyday personal care items routinely purchased for the person and no thought had gone into the gift or what might be meaningful for the person. We also asked staff about other people in their care, including information about the things that were important to them in their lives, for example, members of their family, key events, hobbies and personal interests. We found that some staff were unable to give us any information but confirmed that they would in future obtain this information from visiting relatives. This lack of staff knowledge and attention to people's lives and histories meant that care could not be truly person centred and individualised.

Staff interactions with people were variable with some interactions positive and others routine and task focused, for example, some staff only spoke with people or interacted with them when providing personal care or assisting them to eat and drink. Staff's communication with people living at the service was also variable, for example, some staff were seen to kneel down beside the person to talk to them or to sit next to them and staff provided clear explanations to people about the care and support to be provided in an appropriate way. Other members of staff were observed to have difficulty communicating with people and understanding their needs, such as, not enabling people the opportunity to make choices or providing clear explanations to a person prior to undertaking a specific task. Where interactions were positive, staff rapport with people living at the service was observed to be friendly and cheerful. This was clearly enjoyed by people and there was positive chit-chat between both parties.

The majority of people told us that they were treated with respect and dignity. Our observations showed that staff respected people's privacy and dignity, such as, we saw that staff knocked on people's doors before entering and staff were observed to use the term of address favoured by the individual. In addition, we saw that people were supported to wear clothes they liked and that suited their individual needs.

The manager told us that where some people did not have family or friends to support them, arrangements could be made for them to receive support from a local advocacy service. Information about local advocacy services and other useful information for people and those acting on their behalf to access were displayed on a noticeboard within each house. People were supported to maintain contact with family and friends and relatives told us that they were always welcomed and that there were no restrictions on visiting times.

Inadequate

Is the service responsive?

Our findings

Our inspection highlighted that people did not always receive care that was responsive to their needs or care that was carried out in a person centred way. As already highlighted within the main text of this report, this was because staff shortages at times meant that staff's approach was often task focused and routine based. In addition, our findings showed that where some people required specific equipment to help aid their physical wellbeing, recommendations and instructions from visiting professionals had not always been followed and referrals had not always been made. For example, on Cephas House in December 2015, a healthcare professional advised staff that one person who had a pressure ulcer and was being nursed in bed, required '24/7' bed rest until a vital piece of equipment was in place. Once available the person could be sat in a comfortable chair for up to two hours maximum each day. On the second day of inspection our observations showed that the equipment had still not been provided and staff had failed to follow this up. The person's daily care records over a three week period showed that the person remained in bed each day, except when they had been admitted to hospital. We asked the person if they wished to get out of bed. They told us that although there were periods whereby they required a lot of sleep, there were also occasions when they wanted to get up. This showed that staff had not been responsive to the person's needs and had not considered the person's preferences.

On the first two days of the inspection staff made us aware that there was a lack of hot water supply on Appleton House to wash and bathe people who were living within this house. Staff confirmed that this was a regular occurrence and it could take up to 30 minutes on some occasions for the water to reach a suitable temperature. For example, two people confirmed that they were regularly washed and/or bathed in cold or luke warm water. We checked this and found that five out of six wash hand basins within Appleton House did not provide a supply of hot water after we had run each hot water supply for a timed period of 10 minutes. Maintenance records showed that this had been highlighted on several occasions, however effective steps had not been taken to remedy the problem in the long-term. This showed that the provider was not response to meet peoples' basic care and support needs. We discussed this with the provider and an assurance was provided that the issues relating to a lack of supply of hot water would be dealt with as a matter of priority.

These failings are a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Arrangements were in place to assess the needs of people prior to admission. This ensured that the service was able to meet the person's needs. However, limited evidence was available to show that where appropriate this had been conducted with the person or those acting on their behalf and how alternative ways were sought to gain those people's views who were unable to communicate them because of their high level of needs. Therefore the provider could not be assured in all cases that they had all the information they needed to provide person centered care.

We found inconsistencies across the service in the quality of the information included within people's care records. Some provided sufficient detail to give staff the information they needed to provide personalised

care and support that was consistent and responsive to their individual needs. However, others were not fully reflective or accurate of people's care needs. For those people who could not communicate their needs the accuracy of their records were imperitive in ensuring appropriate care and support was delivered. For example, one person was recorded as having a grade three pressure ulcer to one of their heel's. Limited information was recorded within the care plan detailing the care and treatment to be provided by staff. Although the house manager confirmed there was involvement of a healthcare professional, no information was recorded relating to the person's pressure ulcer and the on-going care and treatment to be provided. In addition, where instructions were recorded detailing that a photograph of the pressure ulcer should be taken at regular intervals so as to show progress with the care and treatment provided by staff, these had not been completed or were confusing. For example, three photographs were evident for the above person but two of the photographs related to others using the service. It was unclear as to who these were as the photographs were unnamed and not dated. On Cephas House we found that where people had a topical cream applied to their skin to keep it from drying out or to help aid and maintain good skin integrity, records to confirm that the topical cream had been applied by staff were either not available or were incomplete.

Staff told us that there were some people who could become anxious or distressed. Improvements were required to ensure that the care plans for these people considered the reasons for people becoming anxious and the steps staff should take to comfort and reassure them. Guidance and directions on the best ways to support the person required reviewing so that staff had the information required to provide appropriate care. Although specific incidents had been recorded where people could become anxious and distressed, little quantitative information was recorded detailing staff's interventions and outcomes. Therefore we could not be assured that the person was receiving the appropriate support in regards to their anxieties and distress to ensure their wellbeing.

People's comments about social activities provided at the service were variable. One person told us that their relative's anxious and distressed behaviours had recently decreased as a result of staff engaging their relative in the activity of colouring. Others told us that they were often bored because there was nothing to do. One person told us, "I go to sleep because I'm bored. I think the others do too. I think they could do with one or two new staff. They [Staff] could then sit and chat to us maybe." Another person told us, "There is no computer access here. I would definitely use it, even if other's didn't." One relative told us, "They [staff] just put some music on and called it an activity.There definitely needs to be more organisaed things planned, to stimulate and break up the day."

Improvements were needed in the way the service and staff supported people to lead meaningful lives and to participate in social activities of their choice and according to their abilities. The Regional Support Manager confirmed that four members of staff who were responsible for supporting people to partcipate in social activities had been newly appointed to the service. Our observations showed that there was a lack of social stimulation available for people, particularly for people living with dementia and people who were nursed in bed or predominately remained in bed throughout the day. Where activities were viewed these were short lived and not always provided at a suitable time, for example on Boyce House we witnessed a karaoke session starting 15 minutes before the lunch time meal was served at 12.30. One of the members of staff responsible for providing social activities told us that as a newly formed team the activities programme was being revised. They told us of their plans to provide both group and one-to-one support for people using the service. It was evident from our discussions with them, that they and the rest of the team were enthusiastic and keen to improve peoples' participation in a range of social activities and were initially spending time with individual's so that they could get to know their personal preferences, likes and dislikes, past hobbies and interests. However, their monthly budget of £150.00 to pay for materials and external entertainers is small for a service of this size.

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

The service had a complaints process and procedure in place that identified how people could raise concerns and what would happen. People living at the service and those acting on their behalf confirmed that they would feel comfortable and able to make a complaint if the need arose. Comments included, "I know I can complain but, so far, I have been able to get things sorted out with the staff so have not needed to complain" and, "I've never needed to make a complaint as any issues we have had have been dealt with immediately."

The Regional Support Manager confirmed that since 1 August 2015 there had been three formal complaints. A record was maintained detailing the specific nature of each complaint, including evidence of the investigation, action taken and proof of how decisions and conclusions had been reached.

Inadequate

Is the service well-led?

Our findings

At our last inspection on 21, 22 and 24 July 2015 we found that the provider's quality assurance systems were not effective and there was a lack of managerial oversight of the service as a whole. As a result of our concerns Warning Notices were issued on 21 August 2015. A focussed inspection was completed on 29 September 2015 to check compliance with the Warning Notices. We found that compliance had been achieved however, further improvements were required to ensure that changes and improvements were embedded and sustained over time to ensure that people were provided with a consistently safe and effective service. We asked the provider to send us an action plan which outlined the actions to be taken to make the necessary improvements. In response, the provider shared with us at regular intervals between August 2015 and January 2016 their action plan detailing their progress to meet regulatory requirements. A suspension of placements by the Local Authority was compulsory following our inspection in July 2015 and this was lifted in December 2015.

The provider confirmed that following our last inspection concerns raised by us had been taken seriously and additional support had been provided to ensure future compliance with regulatory requirements. The service did not have a registered manager in post and the service was being managed on a day-to-day basis by a Regional Support Manager. They confirmed that a 'relief' home manager was also supporting the service and a Clinical Service Manager had been appointed in October 2015. Our findings at this inspection showed that although the management team of the service were visible at all levels, had an understanding of their key roles and responsibilities and had resources and support available to drive improvement; the management of the service was ineffectual to do what was required of them to deliver a quality service for people using the service.

There was a lack of managerial oversight of the service as a whole as each house was managed in isolation by individual 'house' managers. We concluded that not all house managers managed their respective houses effectively and in line with best practice guidance or in line with the provider's own policies and procedures. The Regional Support Manager was unable to demonstrate how they ensured the house managers were performing their role effectively. Although there was a formal system in place to monitor their performance, where concerns were highlighted relating to individual house manager's, steps had not always been taken to address these. For example, the Regional Support Manager and Clinical Service Manager confirmed that they were concerned about one house manager's performance. However, they confirmed that no formal supervisions had been undertaken with this member of staff to review their performance or to complete an action plan detailing the steps to be taken to agree the additional support required to enable them to be an effective house manager and role model.

Audits and quality assurance checks carried out by the Regional Support Manager, Clinical Service Manager and house managers did not identify the issues we identified during our inspection and had not identified where people were put at risk of harm or where their health and wellbeing was compromised. There was evidence to show that because of this people experienced poor care outcomes and the lack of robust quality monitoring meant that there was a lack of consistency in how well the service was managed and led. For example, as part of this inspection we found that the arrangements for the management of medicines

were inconsistently safe on Cephas House, Victoria House and Appleton House. We requested a copy of three months medication audits for each house for the period October 2015 to December 2015 inclusive. These were not available at the time of the inspection despite several requests and were forwarded to us seven days after our inspection. The Regional Support Manager confirmed that the filing systems were poor and the audits had not been easy to locate. No medication audits were available for Cephas House and no audits for Victoria House and Appleton House were completed in October 2015 or December 2015 due to the lack of time. This is of concern as the Quality Manager Home Visit and subsequent report undertaken in November 2015 and December 2015 highlighted that a full medication audit for Cephas House was completed on 30 November 2015 and this scored a 'red' rating. This demonstrated that controls in place to ensure the administration of medicines documentation and processes were not being adhered to. The report further detailed that the actions needed were handed over to the Regional Support Manager. No evidence of this was provided at the time of the inspection and there was no information to show that the actions highlighted had been addressed. In addition, the provider's monthly Quality Metrics Report showed that medication errors had not been reported to inform this report since September 2015.

The provider did not have robust records and data management systems in place to monitor what was happening within the service. Systems in place did not ensure people's safety or mitigate risks relating to their health, safety and welfare of people using the service. Where plans were in place it was evident that these were either not working or not being followed by staff. Following our last inspection in July 2015, action plans from the provider were submitted at regular intervals to us. These told us of the steps and actions being taken to ensure compliance with regulatory requirements. In addition, visits and subsequent reports by the provider's own Quality Assurance team highlighted where improvements and actions were required, including a 'Rag Rating' or 'traffic light' rating system as a visual cue of performance in some areas. For example, one care plan audit for December 2015 recorded a red 'traffic light' score of 57% and highlighted a number of areas that required action. At the time of this inspection, the Regional Support Manager and house manager confirmed that actions highlighted had not been addressed and remained outstanding.

Records relating to staff employed and people using the service were not properly maintained. This meant that robust recruitment systems were not in place to keep people safe. Systems were not in place to ensure to ensure that staff received regular opportunities for formal supervision and an annual appraisal. Our observations showed that responsibility by the registered nurses and house managers for leading each shift was inconsistent and staff were not always being supervised properly. The provider did not have an effective system in place to review staffing levels so as to determine that the deployment of staff was suitable to meet people's needs.

Staff meetings were held at regular intervals so as to give staff the opportunity to express their views and opinions on the day-to-day running and quality of the service. Minutes of some of the meetings undertaken to date were not readily available to confirm the matters raised and discussed or the actions highlighted.

The absence of robust quality monitoring was a contributory factor to the failure of the provider to recognise breaches or any risk of breaches with regulatory requirements sooner. The provider was unable to demonstrate how they intended to comply with the regulations as set out in the Health and Social Care Act 2008.

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

The Regional Support Manager confirmed that the views of people using the service, those acting on their

behalf and staff had been undertaken during Autumn 2015. A report of the findings had yet to be completed and they confirmed that this would be available February 2016.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care People who use services did not receive person-centred care and treatment that was appropriate to meet their needs. Assessments of people's care did not include all of their needs.

The enforcement action we took:

Notice of Decision to impose conditions on the provider to restrict admissions at Godden Lodge Residential and Nursing Home

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Not all care and treatment was provided in a safe way for people using the service. Risks were not always mitigated to ensure people's safety. Suitable arrangements were not in place for the proper and safe management of medicines.

The enforcement action we took:

Notice of Decision to impose conditions on the provider to restrict admissions at Godden Lodge Residential and Nursing Home

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs People who use services did not always have their nutritional or hydration needs met, regularly reviewed or responded to in good time.

The enforcement action we took:

Notice of Decision to impose conditions on the provider to restrict admissions at Godden Lodge Residential and Nursing Home

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance

Diagnostic and screening procedures Treatment of disease, disorder or injury	People who use services were not supported by the providers systems and processes to assess and monitor the quality of service provided. The arrangements in place were not effective in identifying where quality or safety were compromised.

The enforcement action we took:

Notice of Decision to impose conditions on the provider to restrict admissions at Godden Lodge Residential and Nursing Home

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed People who use services were not protected by the providers recruitment procedures.

The enforcement action we took:

Notice of Decision to impose conditions on the provider to restrict admissions at Godden Lodge Residential and Nursing Home

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing People who use services did not always have sufficient numbers of staff available to meet their needs. Staff employed did not always have an induction that prepared them for their role. Staff did not always receive on-going or periodic supervision.

The enforcement action we took:

Notice of Decision to impose conditions on the provider to restrict admissions at Godden Lodge Residential and Nursing Home