Beechcroft Care Homes Ltd

Cary Lodge

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This comprehensive inspection took place on 12 and 18 June 2018 and the first day was unannounced. We last inspected this service in June 2016 where it was rated 'Good' overall and 'Requires Improvement' in the Responsive key question. We recommended the provider find ways to improve the level of social interaction and meaningful activities within the home.

During this inspection in June 2018 we found the provider had not met our recommendation and identified a number of concerns relating to people's safety, staffing levels, people's needs not being met, people not always being treated with dignity and respect, and poor leadership.

Cary Lodge is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Cary Lodge is registered to accommodate up to 40 older people, some of whom are living with dementia.

The home is set over three floors with bedrooms on each floor. There is a lounge/dining room on the ground floor and the basement floor. On the basement floor is an area separated from the rest of the building by a keypad which leads to four rooms being used by people on intermediate care packages. These are care provided by the home when people are well enough to leave hospital but not yet well enough to go home. On the first day of our inspection there were 26 people living in the home and on the second day there were 25 (this was due to some changes in people receiving intermediate care and one person passing away).

The service had a registered manager. 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 people who lived in Cary Lodge were not always safe. Although we saw a number of good examples of risks to people being identified and well managed, we also identified a number of instances where risks had not been adequately assessed or mitigated. People were not adequately protected from others who posed risks relating to their behaviours. People had experienced being victims of assaults and inappropriate behaviours from others due to staff not being able to properly monitor or support people.

There were not enough staff to meet people's needs or keep them safe from harm. Staff were unable to properly monitor people or give people the time they needed to distract and otherwise occupy them. For example, on the day of our inspection one person had walked into another person's bedroom and had been physically assaulted.

Along with staffing numbers not being sufficient to protect people from risks, staff did not always have the guidance needed to ensure people were protected. For example, one person who posed a significant risk to

people because of their behaviours did not have a risk assessment or care support plan relating to these behaviours. When we spoke with staff we found some were not aware of the risks this person presented or how they should act to ensure people were protected.

People had been placed at risk in relation to medicine management practices. Night staff had not been adequately trained to administer medicines and therefore day staff had been pre-dispensing medicines. This is an unsafe practice and action was taken by the provider to stop this following our inspection.

People did not always have their individual needs met. People's needs relating to their mental health had not always been identified, planned for or appropriately responded to. There were not enough staff to allow them to spend time meeting people's needs when they were experiencing distress or anxiety. Therefore people spent very long periods of time in these states.

People's care plans did not contain detailed information about people's lives and interests to help staff understand ways to support them positively. People did not have access to adequate stimulation or activities to meet their social needs. Although there were some organised activities which took place at the home, these were not sufficient to engage people and provide stimulation. Creative measures had not been taken to ensure people had access to activities which met their individual preferences or their needs. Sufficient action was not taken to safeguard people from the actions of others. Incidents were not always reported to the safeguarding authorities as they should be to help protect people from harm. Processes in place were not effective in protecting people from abuse or ensuring incidents were reported and appropriately investigated.

We found a lack of understanding in relation to the Mental Capacity Act 2005 (MCA) and the five statutory principles of the MCA by the registered manager. Blanket decisions and restrictions had been applied to people without consideration of whether individuals might lack the capacity to make the decision. For example, each bedroom had been fitted with a sensor mat by the bed. This had been put in place without understanding that this restricted people's freedom to move around without being monitored. Whilst for some people this was appropriate, this was not the case for everyone.

People were not always treated with kindness and respect. We saw people were hardly spoken to by staff when being supported to eat and one person was not shown respect for their privacy and dignity when sitting in an exposed position. Although we found staff were individually caring, the culture at the service and the staffing arrangements did not ensure people were treated respectfully as they should be. We found the registered manager did not always demonstrate an understanding or a respect for people's need for contact and sexual expression as they grew older.

People enjoyed the food on offer at Cary Lodge. However, we found that people had to wait for long periods of time to be served their food. People were supported to sit at the dining tables or had their cutlery placed in front of them at their chairs up to 40 minutes before their meal was served. This caused some people living with dementia undue distress.

The culture at Cary Lodge did not put people first. People's needs were not being met and staff were task focused. Although the provider told us they had strong values and worked towards ensuring people were at the heart of the service, this was not demonstrated at the time of our inspection.

Improvements were being made to the service at the time of our inspection. People's care plans were being reviewed, staff were receiving training and there were plans to improve the environment. Cary Lodge was a well maintained home with a well-tended garden and pleasant rooms. Staff spoke about people with

respect and admiration for their individual personalities.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

We found seven breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These breaches related to people's individual needs not being met, people's rights under the MCA not being protected, people not always being safe from risks, safeguarding incidents not always being identified and reported, staff numbers not being adequate to meet people's needs, and ineffective quality assurance systems. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

People were not protected from risks relating to their safety and wellbeing as these had not always been identified or acted on.

Where accidents and incidents had occurred, actions were not always taken to ensure these did not happen again.

Incidents where people had been at risk of abuse had not always been identified and reported.

People were not supported by sufficient numbers of staff to meet their needs and keep them safe.

Night staff were not all trained in administering medicines, which placed people at risk.

Is the service effective?

Inadequate

The service was not always effective.

People's rights were not always respected under the Mental Capacity Act 2005.

Not all staff felt supported and regular supervisions were not taking place.

People had enough to eat and drink to meet their health needs. However, people's experience around mealtimes was poor.

Is the service caring?

Requires Improvement

The service was not always caring.

Staff did not always show respect for one person's dignity and privacy.

Staff missed opportunities to speak with people.

People were not always treated with respect when being supported to eat their meals.

Is the service responsive?

Requires Improvement

The service was not responsive.

People's social needs were not being met and they did not have sufficient opportunities to take part in meaningful activities.

People's care plans and risk assessments did not provide staff with sufficient information to meet people's needs.

People were encouraged to make complaints.

Is the service well-led?

Inadequate

The service was not well led.

There were systems in place to assess and monitor the safety and quality of care provided but these had failed to identify all the concerns raised in this inspection.

Where concerns had been identified, insufficient action had been taken to minimise risks and improve practice.

The service was not person centred.

The provider sought feedback but did not always act on it sufficiently.

Staff morale was poor and staff felt unsupported by the registered manager.

Cary 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 12 and 18 June 2018 and the first day was unannounced. One adult social care inspector carried out this inspection. Prior to the inspection we reviewed the information we had about the service, including notifications of events the service is required by law to send us.

We conducted a SOFI during this inspection. SOFI (Short Observational Framework for Inspection) is a specific way of observing care to help us understand the experience of people who are unable to talk to us.

We spoke with seven people who lived in Cary Lodge. We also spoke with seven members of staff, the chef, the facilities manager, the recruitment and training manager, the registered manager and one of the providers. During our inspection we spoke with three visiting healthcare professionals and sought feedback from the local authority quality and improvement team prior to and following our inspection.

We looked at the ways in which medicines were recorded, stored and administered to people. We also looked at the way in which meals were prepared and served and reviewed in detail the care provided to seven people, looking at their care files and other records. We reviewed the recruitment files for three staff members and other records relating to the operation of the service, such as risk assessments, complaints, accidents and incidents, policies and procedures.

Inadequate

Is the service safe?

Our findings

During our inspection we found people who lived in Cary Lodge were not always safe. We found concerns relating to the management of risks to people's welfare, inadequate staffing levels, and issues relating to safeguarding incidents not being reported as necessary, to help keep people safe.

We found risks to people relating to their mobility, falls, nutrition, hydration and skin integrity were identified, recorded, monitored and minimised. However, a number of people who lived in Cary Lodge had very advanced dementia and presented with behaviours that were challenging and posed risks to others. We found these risks were not well managed. People regularly walked into other people's rooms and records showed a number of incidents of aggression between people who lived in the home had taken place. People had not been adequately protected from aggression.

Staffing numbers were not adequate to meet people's needs or keep people safe from harm. Staff were unable to properly monitor people or have the time they needed to occupy them. For example, on the day of our inspection one person had walked into another person's bedroom and had been physically assaulted. Staff had responded to the person's shouts and had managed to remove them from the situation but this had left the person very distressed, with bruising and scratches. Staff told us they had not been able to monitor this person prior to them going into this bedroom as they were busy attending to other people.

People were also at risk from others during the night. For example, one person had recently been admitted to the home and had displayed behaviours which caused concern. Between the first and second day of our inspection this person had left their room in a state of undress and had attempted to climb into another person's bed. Staff had been alerted to this in time to protect the person whose room it was but this had caused the person who was in the bed the person tried to climb into to be very frightened and distressed. The staffing numbers available overnight did not ensure people were protected from this person should the staff be helping a person with repositioning for instance.

Although we found some good examples where risks to people had been identified, action had been taken and staff had been given clear guidance on how to minimise risks, we found this was not always the case. Along with staffing numbers not being sufficient to protect people from risks, staff did not always have the guidance needed to ensure people were protected. For example, one person who posed a significant risk to other people because of their behaviours did not have a risk assessment or support plan relating to these behaviours. When we spoke with staff we found some were not aware of the risks this person presented or how they would act to ensure people were protected.

All the people who lived in Cary Lodge needed help from staff to take their medicines. We found that night staff were not able to administer medicines to people due to not being trained. Prior to our inspection we received information about day staff 'potting up', or pre-dispensing medicines into pots, prior to leaving work, in order for the untrained night staff to administer it. This poses a significant risk to people. At the time of our inspection the registered manager had spoken with each person's GP and it had been agreed for people's night time medicines to be administered earlier, prior to the day staff finishing their shift. This

protected people from the risks relating to their prescribed medicines being pre-potted and administered by staff who did not have the right competencies. However, during our inspection, staff told us they were still pre-potting pain killers such as paracetamol, should people require them during the night. We shared this information with the provider and registered manager and they assured us this would no longer be happening. Following our inspection, the provider arranged for night staff to undertake medicine management training and shadowing.

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

Sufficient action was not taken to safeguard people from the actions of others. Incidents were not always reported to the safeguarding authorities as they should be to help protect people from harm. Records showed that one person had been assaulted by another by having their arm twisted, one person had another attempt to get into bed with them whilst in a state of undress and one person had made an allegation against two members of staff having undressed them against their will. Staff and the registered manager told us they had received training in safeguarding and knew how to recognise harm or abuse and how to report it. However, neither staff nor the registered manager had recognised these incidents as harm or potential abuse and had not reported them as required.

The processes in place were not effective in protecting people from abuse or ensuring incidents were reported and appropriately investigated. This meant the systems and processes in place to prevent, act on and report abuse were not effective.

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

The staffing levels at Cary Lodge were inadequate. At the time of our inspection there were 26 people living in the home on the first day and 25 people on the second day. The home was set on three floors. Each floor had bedrooms on and there was a lounge/dining room on the ground and basement floors. Staffing numbers in the home fluctuated. At the time of our inspection and prior to this, the provider had been seeking further funding from the local authority in order to increase the staffing levels at the home. Whilst they were waiting for reviews of people's needs, however, they had not ensured staffing levels were sufficient to meet people's needs. In response to recent staff complaints, the provider had added a 'floating' member of staff to the rota. This meant that between 2pm and 4pm, for example, there was one member of staff providing care to people on the ground floors, one staff member providing care to people on the basement floor, one senior carer completing their duties including the medicine round and one 'floater' to help should people require transferring. Staff told us there were six people who required two to one support from staff for all their transfers as they were non weight bearing and there were five people who required significant staff input because of their behaviours. Other people who lived in Cary Lodge required staff support in order to meet their emotional needs as they were regularly in distressed states due to their dementia. Staff were regularly required to manage challenging situations in the home between people as well as providing people with varying levels of personal care and supporting people with their anxieties. During the night time there were two members of staff to provide care to people.

These staffing numbers were not sufficient to ensure people were safe and their needs were met.

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

Recruitment practices at the service ensured that, as far as possible, only suitable staff were employed. Staff files showed the relevant checks had been completed. This included a disclosure and barring service check (police record check). Proof of identity and references were obtained as well as full employment histories, this protected people from the risks associated with employing unsuitable staff.

The premises and the equipment were well maintained to ensure people were kept safe. Regular checks were undertaken in relation to the environment and the maintenance and safety of equipment. Good infection control practices were in use and there were specific infection control measures used in the kitchens, the laundry rooms and in the delivery of people's personal care. There were fire extinguishers, fire protection equipment and clearly signposted fire exits to assist people in the event of a fire. Each person had a completed personal emergency evacuation plan which detailed how they needed to be supported in the event of an emergency evacuation from the building.

Inadequate

Is the service effective?

Our findings

There was a lack of understanding by the registered manager and staff in relation to the Mental Capacity Act 2005. We found that blanket rules had been applied to people without their consent first being sought.

Most of the people who lived in Cary Lodge had been diagnosed with a form of dementia. These conditions sometimes affected people's abilities to make specific decisions at specific times. We therefore checked whether the service was working within the principles of the Mental Capacity Act 2005 (MCA). The 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 found a lack of understanding in relation to the MCA and the five statutory principles of the MCA on behalf of the registered manager. The five principles of the MCA include that all individuals are presumed to have capacity; and action taken on behalf of a person must be in their best interests and regard must be had as to whether an act or decision is the least restrictive of a person's rights and freedoms.

The registered provider was not following these principles with regards to people who may lack capacity to make certain decisions. Blanket decisions and restrictions had been applied to people without consideration of whether individuals might lack the capacity to make the decision. Each bedroom had been fitted with a sensor mat by the bed. This had been put in place without understanding that this restricted people's freedom of movement without being monitored by staff via an alarm. Where people lacked capacity to make the decision to have the sensor mat turned on, the registered manager had not followed the required process to ensure that this restriction was in each person's best interests and was a proportionate response to risk.

This issue had been identified to the registered manager by the local authority quality team prior to our inspection and they told us they were working together towards undertaking mental capacity assessments for each person in relation to the sensors. However, the day prior to our first day of inspection a new person had been admitted to the home and a sensor mat was in place by their bed and they had a door alarm. When we asked the registered manager why this was they told us they had not sought consent from this person or completed any mental capacity assessments. They had failed to ensure they had the person's consent prior to using equipment to monitor their movements.

This was a breach of regulation 11 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). If a person is under continuous supervision and control, is not free to leave to live elsewhere and does not have the mental capacity to consent to these

arrangements, they are being deprived of their liberty. An application must be made to the local authority for legal authorisation. Most people who lived in Cary Lodge were under constant supervision and control and were deprived of their liberty in that they were unable to leave the home on their own. We saw the registered provider had made applications to the local authority where these were required.

Staff told us they did not feel supported by the registered manager but were provided with good training. They told us training was available when they wanted and could ask for more if they wanted. Comments from staff included; "We do get training. It's been really good." However, we found staff did not always have the training necessary to perform their role. For example, night staff had not been provided with the training, practical assessment or competency tests to administer medicines to people who needed them. This had led to some unsafe practices being implemented.

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

People were supported to have enough to eat and drink. During our inspection we observed two lunchtime meals. There was a full time cook working in the home who made meals based on people's preferences and need. We saw people were supported where needed and people enjoyed their food. Where people had lost weight staff had monitored their food intake and had discussed people's needs and support with the dietician or speech and language therapists (SALT).

However, we found that people had to wait for long periods of time to be served their food and that when people were supported to eat staff missed opportunities to speak with them. People were supported to sit at the dining tables or had their cutlery placed in front of them at their chairs up to 40 minutes before their meal was served. 20 minutes after people were all supported to the tables, four people's meals were served and they were supported by staff to eat. This meant all the other people in the dining room waited for a further 20 minutes whilst smelling the meals of these four others. We found this caused particular distress to people living with dementia. For example, one person became agitated and continued to bang their cutlery on the table. We heard another person saying, "I'm so hungry."

Mealtimes were not managed appropriately and did not meet the needs of the people who lived in the home, particularly those living with dementia.

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

There was a programme of supervisions, observations and appraisals for staff. During supervision, staff had the opportunity to sit down with the registered provider to talk about their job role and discuss any issues and further training wants and needs. The provider had recently employed a full time recruitment and training manager and we spoke to them during our inspection. They told us they supported staff through their induction and completed supervisions to ensure staff were putting their learning into practice. They also told us all new starters who were employed with no previous care experience undertook the care certificate. The care certificate is an identified set of standards used by the care industry to ensure staff provide compassionate, safe and high quality care and support. They told us this took the form of six classroom sessions and coursework which was overseen by the registered manager.

People were supported by staff to see healthcare professionals such as GPs, specialist nurses, psychologists, district nurses, occupational health practitioners, opticians and dentists. We found examples of staff identifying concerns or changes in people's needs, raising this with outside professionals and following their

guidance. We received feedback from one external professional during our inspection who had dealings with the service and they told us they had been contacted when needed.

During our inspection we spoke with the provider's facilities manager who told us about the recent changes made and the plans for the environment. There were a number of changes planned in order to make the environment more suitable for people living with dementia. At the time of our inspection improvements were required in order to help people orientate themselves within the home and find their way around more easily. These had been identified, however, and action was being taken to make these improvements. Cary Lodge was comfortable and clean and there was a well-tended garden and terrace area for people to go to if they wanted. All areas were accessible via a lift and people had pleasant rooms that were personalised.

Requires Improvement

Is the service caring?

Our findings

During our inspection we observed some kind and pleasant interactions between staff and people. However, we also saw a number of poor interactions and occasions where people were not treated with dignity and respect.

Staff did not always display respect, attention and kindness to people when supporting them to eat. During the lunchtime meal we observed two members of staff supporting people who needed help with eating. These staff members hardly spoke with the people they were supporting and the only words they spoke to them consisted of variations of "Open your mouth please." On one occasion we observed a member of staff using the spoon they were helping a person to eat with to wipe excess food from around their mouth. This did not demonstrate respect for them or treat them like an adult. During this meal, the other member of staff stopped feeding one person to go and support another with personal care. They did not tell the person they were leaving or ensure their food stayed warm. Around eight minutes later the second member of staff came over to support the person who had been left and simply said "Open your mouth for food" before helping them. They did not explain who they were, what they were doing, what the person was eating, check the temperature of their food was still appealing or apologise for them having had to wait.

We saw a number of occasions where staff missed opportunities to speak with people. For example, one person was sitting with a drink of juice when another person came up to them, poked them in the chest and took their cup away. A member of staff noticed this and brought the person another drink. However, they did so by leaning over the back of their chair, placing the drink in front of them and not saying a word to them. They did not check they were alright or acknowledge them at all.

We saw a lady who lived in the home sitting in the living room in a recliner chair sitting with their skirt and legs up and their underwear exposed. We looked around and found that within the living room there was a male resident and that a male delivery person from an external delivery company walked through this room to reach the lifts. We were concerned about this lady's dignity and asked a member of staff who was in the room about this. This member of staff had not made any effort to maintain the lady's modesty and privacy. When we raised this with the member of staff they told us the person's relatives did not buy them any trousers and therefore they had to wear skirts and they did this all the time. They then placed a blanket over their legs. Later on, we again saw this person's underwear exposed in the living room and it took a member of staff at least 15 minutes before they noticed and covered them. This did not demonstrate respect for maintaining this lady's dignity and privacy.

Each person who lived in the home had an electronic care plan which had some pre-programmed sections for staff to complete. One of these sections was entitled 'sexuality'. In the majority of care plans we looked at we saw this had been completed to read 'N/A' (Not applicable). We asked the registered manager about this and they said this was because it was not applicable to those people. This was dismissive of people's individual needs around sexuality and their personal expression. It did not demonstrate an understanding or a respect for people's need for contact and sexual expression as they grew older.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw positive exchanges between staff and people and staff told us they cared deeply for the people who lived in the home. Staff made comments including, "All staff genuinely care for our residents", "Because of staffing it's impossible for us to spend time with people. We would love to though because they're all so lovely" and "We have a lovely group of residents. Superb residents." Some staff told us how others had gone above and beyond for people by bringing in music CDs, coming in on their days off to support and spend time with people. Although we found staff were individually caring, the culture at the service and the staffing arrangements did not ensure people were treated respectfully as they should be.

The environment was homely and people's bedrooms were personalised to meet their preferences. Some artwork people had made was displayed on the walls which helped make Cary Lodge homely and increased people's pride in their work.

Requires Improvement

Is the service responsive?

Our findings

Following our inspection in June 2016 this key question had been rated as 'Requires Improvement'. We had identified some concerns relating to people not having access to sufficient social interaction or meaningful activity to promote their wellbeing. We made a recommendation for the provider to improve in this area. During this inspection in June 2018 we found the provider had made some improvements by appointing an activities coordinator for the group of homes and had identified some staff to lead activities within Cary Lodge. However, we found these actions had not been sufficient to improve people's experience.

Cary Lodge is registered with the CQC to provide care to people living with dementia, people with an eating disorder, people with mental health conditions, older people, people with physical disabilities and people with sensory impairments. We found people did not always have their individual needs met. People's needs relating to their mental health had not always been identified, planned for or appropriately responded to. For example, staff told us about one person who was experiencing severe depression and refused to engage with organised activities at the home and spent almost all of their time alone in their room. Staff did not have any information about how to best support this person with their depression and how to engage and encourage them. No steps were being taken to improve the person's outlook and find other ways to engage them and help them feel better.

Other people had needs relating to their mental health and dementia. Staff did not have any guidance on how to help people cope with distress and anxiety associated with their dementia. People's care plans did not contain detailed information about people's lives and interest to help staff distract them by finding topics to discuss or activities to take part in. For example, during the first day of our inspection we saw one person was extremely distressed for the majority of the day. They cried, walked up and down the hallway continuously and regularly told us they wanted their life to end. We observed staff approaching this person, briefly talking to them gently and kindly and either helping them to a chair or to get a drink. Although these interactions were positive, they were very short and did not give the person time to talk and be adequately supported. Staff did not distract the person with an activity or task. Therefore, their distressed behaviour was continuously repeated.

People did not have access to adequate stimulation or activities to meet their social needs. The home organised some activities for people which they enjoyed. For example, on the first day of our inspection staff sang songs with people and on the second day an external musician attended. People clearly enjoyed these. However, we found activities were not sufficient to engage people and provide stimulation. People had individual activity plans but these were very poor and did not contain enough information. For example, one person's activity plan stated they had previously enjoyed knitting but could no longer do this because of their hands. It therefore instructed staff to leave their bedroom door open so they could observe people and talk to them when passing. No effort had been made to explore what other activities the person may be able to enjoy other than knitting. Staff confirmed they did not spend time with people engaging them in stimulating activities. Staff made comments including, "We can only do basic needs. The residents are completely bored. They don't get opportunities to go out and they make comments like they want to die". Staff confirmed they were not encouraged to think of ways to distract and stimulate people. Comments

included, "We're not encouraged to give ideas about activities, activities are really lacking" and "We would like to explore people's histories and develop activities but it's not encouraged and we don't have time. Sometimes you don't find out about someone until their funeral."

People were not supported to take part in activities independently where able to do so. For example, a member of staff told us they had tried to do some colouring with a person on one occasion. During this activity they realised the person was unable to engage in this because they were unable to see. They looked at the person's care plan which stated they needed glasses. This member of staff had supported this person for three months without ever seeing them with glasses on or knowing they needed glasses. When they asked where the person's glasses were, they were told they had been lost. This meant the person had been unable to see properly, engage in activities, and could have been put at risk by not having access to their glasses. We asked the registered manager about this and they told us they would investigate the whereabouts of this person's glasses.

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

Staffing numbers did not allow for staff to spent time meeting people's needs when they were experiencing distress or anxiety and therefore people spent very long periods of time in these states. Staff made comments including, "We just don't have time to help her. If we did she wouldn't be as distressed", "(Name of person)'s anxiety is through the roof but we don't have the time to spend with her. We say "You're ok" and then run off and do something else", "We don't get a chance to properly distract people. There are not enough staff". We observed staff being very task driven and rushing to tend to people without fully meeting people's needs. Staffing numbers did not allow for staff to sit with people, talk to them, learn about their histories, preferences or interests.
The registered manager confirmed staffing issues had resulted in people not having all their needs met and reduced people's access to activities and stimulation. Although there had been a recent increase in staffing numbers these had not ensured people's needs were met.

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

A complaints policy was in place at the service. The registered manager told us they encouraged people, staff and relatives to make complaints should they wish to. Some staff told us they felt comfortable raising any concerns, others told us they did not feel these were listened to.

Where care plans had been completed, these contained clear information for staff to follow. Personal preferences and histories had been sought and where people had routines these were detailed and taken into account. People were given choices in an accessible way. For instance, people were shown meal choices in order to help them make a decision. This enabled people to make their own choices where possible.

The service was able to support people should their health decline and they required 'end of life' care. The registered manager said they were supported by the community nurses to ensure people's care needs could be met. Between the first and second day of our inspection one person receiving end of life care sadly passed away. We saw some cards received by Cary Lodge which had been sent by relatives of people who had received end of life care at the service. These were very complimentary of the care their loved ones had received.

Inadequate

Is the service well-led?

Our findings

Prior to our inspection concerns had been raised by the local authority quality team about the quality and safety of care provided at Cary Lodge. This had led to the local authority working with the management team at the home to identify issues and complete an improvement plan. This process was underway during our inspection and actions were being taken to respond to concerns raised. These related to improving care plans, improving the understanding of staff with regards to the Mental Capacity Act 2005 (MCA), ensuring staff were trained in manual handling practices and improving mealtimes. Although we found that action had been taken in these areas, we found these had not been sufficient to ensure people received safe, effective, caring, responsive and well led care.

We found widespread and significant shortfalls in leadership. The registered provider and the registered manager had failed to ensure people received high quality, safe care. During this inspection we identified a number of concerns and breaches of regulation. Some of the concerns we found had been identified previously by the local authority quality team but insufficient action had been taken. For instance, although staff and management had received training with regards to the MCA we found knowledge and understanding was still lacking and people's consent was still not being sought where necessary.

Other concerns we found had not been identified by the checks undertaken by the management at the service. The systems and processes in place to monitor the safety and quality of care at the home had not been effective. For example, although staffing checks were undertaken and a tool was being used to calculate the staffing numbers required, the seriousness of the staffing situation had not been identified. The systems had failed to identify that people were put at risk of harm from the staffing levels and that people's needs were not being met.

The leadership at Cary Lodge consisted of a registered manager, a deputy manager, team leaders and senior carers. Further management was provided by the providers and a recruitment and training manager who undertook audits and quality assurance checks. These looked at the environment, people's care plans, medicines, staff training, accidents and incidents.

People's records were not always up to date and accurate and therefore people were at risk of not receiving the care they required. For example, one person did not have a completed care plan after having lived in the home seven day. This person had a number of significant risks which had not been recorded and staff did not have access to guidance.

The culture at Cary Lodge did not put people first. People's needs were not being met and staff were task focused. Although the provider told us they had strong values and worked towards ensuring people were at the heart of the service, this was not demonstrated on the inspection. A number of staff members had recently left and the staff who remained at the home had very poor morale. They did not feel supported by the management team and did not feel action was taken when concerns were raised. We saw the results of a staff survey which had been completed in February 2018. In this survey staff had raised concerns relating to low staff morale, staffing levels, team work not being encouraged and the poor relationship between the

registered manager and staff, amongst others. Comments given by staff in the survey included, "I feel that there are not enough staff on duty to make being on the floor safe for the amount of difficulties our residents have." Although these concerns had been identified, recorded and some action was taken, this had not been sufficient to minimise risks, improve people's care and staff experiences and morale.

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

The registered manager was aware of their responsibility regarding duty of candour, that is, their honesty in reporting important events within the service, and their need to keep CQC up to date with important events within the service.

The provider and registered manager were part of a local network of care homes and regularly attended events in order to learn from others and find ideas for improvements.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People did not receive appropriate care that met their needs. Where meeting people's nutritional needs, the provider did not always have regard for people's well-being. 9(1)(a)(b)(2)(3)(i)

The enforcement action we took:

Notice of proposal to restrict admissions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People were not always treated with dignity and respect. 10(1)

The enforcement action we took:

Notice of proposal to restrict admissions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Consent was not always sought from people before care and treatment was provided. 11(1)

The enforcement action we took:

Notice of proposal to restrict admissions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks to people's safety had not always been assessed or mitigated. Medicines were not always managed safely. 12(1)

The enforcement action we took:

Notice of proposal to restrict admissions

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 People were not protected from assaults from others. Systems and processes to report incidents were not effective. 13(1)(2)(3)

The enforcement action we took:

Notice of proposal to restrict admissions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes had failed to adequately assess, monitor and improve the quality and safety of people. Records were not always accurate. 17(1)(2)(a)(b)(c)

The enforcement action we took:

Notice of proposal to restrict admissions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were not sufficient numbers of skilled staff deployed to keep people safe. 18(1)(2)(a)

The enforcement action we took:

Notice of proposal to restrict admissions