Mr & Mrs S Kejiou

Parsonage Lodge EMI

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?	**Inadequate**
Is the service responsive?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

This inspection took place on the 26 and 27 November 2015 and was unannounced.

Parsonage Lodge EMI provides care for up to 14 people who need support with their personal care. The service provides support for older people and people living with dementia. The service is a large, converted property. Accommodation is arranged over three floors. The service has single and double bedrooms. A passenger lift and stair lift are available to assist people to get to the upper floors. There is an enclosed garden to the rear of the property. At the time of our inspection there were 11 people living at the service.

A registered manager was working at the service at the time of the inspection; they are also one of the registered providers. 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 registered manager had delegated some responsibilities for the management of people's care to a manager.

At our two previous inspections we found that the provider was in breach of a number of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and breaches of the Care Quality Commission (Registration) Regulations 2009. At this inspection we found that the provider had not taken sufficient action to improve the quality of the service and breaches of Regulations continued.

The registered manager was not leading the staff team or managing the service on a day to day basis. They did not have the required level of oversight. The poor performance of staff went unchecked and people were not treated with the dignity and respect they deserved.

Staff did not understand the needs of people who were living with dementia and there was a risk that some people were the subject of abuse at times. People were not treated equally; staff listened to what some people had to say but ignored others. For example, people who asked for food or drinks were often told to "Wait your turn" or were told the drink was being made when it was not.

Staff knew the possible signs of abuse; but had not recognised that the way they spoke to some people was potentially abusive. Staff did not speak to people with respect and told people in loud abrupt tones to, "Stop shouting", "Be patient" and when one person asked for a cup of tea, they were told, "Not you, you've just had one". Staff leaned over people sitting in armchairs, rather than being at the same level when they spoke to them. We observed that one member of staff wagged a finger in a person's face as they spoke with them. The person shrank back from the staff member.

People were not treated with compassion and kindness at all times and their dignity was not respected. Staff working at the service had not taken time to build relationships with people and did not know them well. Communication between staff and people was not consistently good. People were not offered choices

in ways that they understood and staff did not take time to present options to people in ways that would not confuse them.

Staff recruitment systems were in place. Sufficient checks had not been completed to make sure that staff did not pose a risk to people using the service and to check they had suitable skills, knowledge and experience. Disclosure and Barring Service (DBS) criminal records checks were not in place for new staff. New staff had completed an induction. However, the registered manager was not following current good practice and staff had not started to work towards a Care Certificate.

Staff had completed some training since our last inspection but checks had not been completed to make sure that they used their new skills and knowledge to provide safe and consistent care and support. Training in dignity and respect and safeguarding people had not taken place. An analysis of staff training needs had been completed. Further training and competency assessment were required to make sure that staff had all the skills and knowledge they needed to provide good quality care and meet people's individual needs.

Emergency plans were in place but staff had not been trained to use equipment provided to evacuate people safely from the building.

The Care Quality Commission is required by law to monitor the operation of the Deprivation of Liberty Safeguards. The registered manager and manager were unclear about their responsibilities under the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS). Following our last inspection the registered manager had assessed people's risk of being deprived of their liberty and made applications to Supervisory bodies to lawfully deprive everyone living at the service of their liberty, including those they had not assessed as being at risk. Conditions placed on people's DoLS authorisations were not used to plan their care. Processes were not in operation to assess people's capacity and make decisions in their best interests.

People's needs had been assessed. Reviews of care plans had been completed, however changes in people's needs had not always been identified and the care they received had not been planned to make sure it met their needs. People and their relatives had not been asked about their preferences of care and people did not always receive their care in the way they preferred.

Some people needed to use special cushions or mattresses to reduce the risk of them developing pressure ulcers. Staff had not taken action to make sure that these were used safely when alarm lights came on. Mattresses were not always set at the correct pressure to provide people with the right support and maximum benefit. People were not supported to go to the toilet or to change their continence products regularly. Advice from community nurses was not being followed and this put people's skin at risk of damage.

Detailed guidance was not provided to staff about how to move and transfer people safely and the guidance that was in place was not changed when people's needs changed. One person was moved in a wheelchair without the footplates being used properly which put them at risk.

Medicines management processes were in place. There was a risk that people did not always receive the medicines they needed when they needed them to keep them safe and well. Some people were prescribed medicines when they needed them such as pain relief. Guidance was not in place for staff to make sure that they knew when to offer these medicines to people. The application of prescribed creams was not recorded and guidance had not been given to staff about how, when and where to apply the creams to make sure they were used to best effect.

Changes in people's health had been identified. Food was not prepared to meet some people's specialist dietary needs, including diabetics and people who were at risk of losing weight and people who were at risk of becoming unwell. Choices of food were limited and the second option was often the same choice, an omelette.

The activities on offer to people were very limited and we observed people sitting doing not very much and without any interaction from staff on a number of occasions.

The provider had a complaints policy in place; they told us they had not received any complaints since our last inspection.

Regular checks on the quality of the service provided had been completed, however the registered manager was not aware of the shortfalls in the quality of the service that were found at the inspection. Information from people about their experiences of the care had been obtained but the registered manager had not reviewed these to see if any action was required.

Records were kept about the care people received and about the day to day running of the service. These were not always accurate.

The registered provider had not taken action to notify the Care Quality Commission of significant events that happened at the service, such as the outcomes of DoLS applications and when people had died.

At the last comprehensive inspection this provider was placed into special measures by CQC. This inspection found that there was not enough improvement to take the provider out of special measures.

At this inspection we found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and breaches of the Care Quality Commission (Registration) Regulations 2009. CQC is now considering the appropriate regulatory response to resolve the problems we found.

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.

Staff knew the signs of abuse, but did not know that the way they spoke to and treated people might be abusive.

There were sufficient staff on duty, but they did not have the right skills and experience to consistently meet people's needs. Recruitment checks were not thorough.

Staff did not always move people safely. The registered manager had not given staff clear guidelines to follow about moving people safely.

Emergency plans were in place but staff did not know how to use equipment to help people leave the building safely in an emergency. Risks to people were not being managed safely.

There was a risk that people did not always have the medicines they needed to keep them well because staff had not been told when to give them to people.

Is the service effective?

Inadequate

The service was not effective.

People's ability to make decisions had not been assessed and they were not involved in making decisions about their care.

Staff did not have the skills and knowledge to meet people's needs. Staff were not trained to provide safe and appropriate care to people, including the care of people living with dementia.

Risks to people's health had been identified but action had not always been taken to keep people as healthy as possible.

People told us the food was 'OK'. People did not always get the food and drinks that they asked for and needed.

Is the service caring?

Inadequate

The service was not caring.

People were not treated with respect. Staff did not maintain people's privacy and dignity.

Staff did not take time to get to know people well and build relationships with them.

People were not always given information in ways that they understood. Staff did not take time to listen to what people had to say.

The routine of the service was designed so staff could complete tasks and was not flexible to suit people's needs and preferences.

Is the service responsive?

Inadequate

The service was not responsive.

Care plans had not been updated when people's needs changed.

People were not supported to take part in activities they enjoyed, inside and outside of the service.

The provider had a complaints procedure in place.

Is the service well-led?

Inadequate

The service was not well-led.

The provider and registered manager did not have a clear set of values, including involvement, equality and safety for the service.

There was no leadership. The registered manager was not managing the service on a daily basis.

Checks on the quality of the service had not found the shortfalls in the service..

The provider had not used the views of people and their relatives to improve the service people received.

The registered manager was not always able to find the records they needed when they needed them.

Parsonage Lodge EMI

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 was an unannounced inspection that took place on the 26 and 27 November 2015. The inspection was undertaken by two inspectors.

Before our last inspection we asked the provider to complete a Provider Information Record (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We did not receive the information we requested from the provider.

We contacted the local authority and health care professionals to obtain their views about the care people received and considered this with other information we held about the service, including previous inspection reports and information the provider sent to us immediately after the last inspection. The provider had not sent us any notifications since the last inspection even though there had been notifiable events. A notification is information about important events which the provider is required to tell us about by law.

We spoke with two people and one relative and looked at comments from other relatives. We looked at the care and support that people received. We looked at people's bedrooms, and other areas of the service including the laundry, bathrooms, and communal areas and observed the support provided to people in the lounge-dining room.

We looked at care records and associated risk assessments for five people. We observed medicines being administered and inspected medicine administration records (MAR). We looked at management records, five staff files including recruitment files, training and support records, health and safety checks for the building, staff meeting minutes, quality audits and policies and procedures.

We spoke with the registered manager, three members of staff, the cook and the handyman.

We last inspected Parsonage Lodge EMI in May 2015. At this time we found that the service was inadequate and CQC took enforcement action against the provider.

Inadequate

Is the service safe?

Our findings

Previously, we found that the provider had not taken action to make sure that people were safe at all times. At this inspection we found that the provider had still not taken adequate action to improve the safety of the service for people. People were not assured that they would be safe and protected from harm and abuse.

At the last inspection we found that the staff knew the signs of abuse and how to raise any concerns they had about people. At this inspection staff told us about the different types of abuse but had not recognised that people may be at risk from abuse at the service. One member of staff described verbal abuse to us as, "This could be the way you talk to a person and if you talk to them in an aggressive manner that's verbal abuse". We observed this staff member talking to people in an aggressive manner on a number of different occasions.

On one occasion a person called out for a cup of tea. The staff member responded by shouting back at the person, "There is no need to shout out to me about what you want. I will get to you". The member of staff then walked over to the person, wagged their finger at the person and repeated, "Don't shout at me. I will get to you". We had previously observed the same staff member saying to the person, "What have your family told you. You have to be nice to us". After this incident the person became subdued, they stopped talking and looked at the floor. We raised two safeguarding alerts to the local authority safeguarding team during the inspection.

Staff did not know how to support people if they became agitated or know how to resolve conflicts between people. Staff told us that when there was any conflict between people they told them to, "Stop it" and said they would tell people, "They could not do that". At lunch time, one person tried to take another person's meal, as they had not been given theirs yet. This resulted in a disagreement between them. Staff did not try to settle the situation or reassure each person. One person was 'told off' by staff, who said, "That is stealing, you mustn't steal other people's food". Staff did not support the person during their meal and there was a risk of further disagreement between the person and other people sharing the table.

Staff knew how to raise concerns with relevant people, such as the manager and the local authority safeguarding team, however the manager was not aware of the local authority safeguarding protocols for reporting and investigating any concerns that were identified. They told us it was their process to investigate any concerns that were raised and that they would not wait for instruction to do this from the local authority safeguarding team. Investigations completed by the manager into safeguarding allegations could compromise investigations by other agencies such as the police, and are not in line with the local authority safeguarding processes or best practice guidance. Not all staff had received training in how to recognise and respond to abuse.

People were not protected against the risk of abuse and improper treatment. Care and treatment was not always provided in a way that was not degrading to people. This was a breach of Regulation 13 (1)(2)(4)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not always moved safely. We observed staff moved one person in their wheelchair without using footplates to support their feet. The person was frail and their feet were dragging along the floor, this put them at risk of injuring their feet and ankles. Staff had not recognised this. We stopped the staff member from continuing with the unsafe practice and explained to them the risks that the person was at when they were moved in the wheelchair without using footplates. It is best practice to use footplates to support people's feet and prevent injury when using a wheelchair unless the use of footplates would place the person at a greater risk.

Detailed guidance had not been provided to staff about how to move and transfer people safely. One person's care plan instructed staff to use an 'oxford medium yellow sling', when they were hoisted. This sling was not used to hoist the person during the inspection. Another person's plan instructed staff to 'use a handling belt and encourage the person to stand'. However, the manager, who wrote and updated the moving and handling risk assessments, told us that the person was not able to stand and needed to be hoisted at all times. The person become very distressed when they were hoisted but was not comforted by staff. Staff told us the person always became distressed when they used the hoist. They needed to use the hoist several times a day to keep them safe. Staff had not tried to find out why the person became distressed or explored other methods of moving the person.

People's skin health had been assessed; some people were at a high risk of developing skin damage, such as pressure ulcers. These people needed to use special cushions or mattresses to reduce the risk of them developing pressure ulcers and this had been provided by the local community nursing team. People were not consistently supported to use this equipment safely. To offer people the maximum benefit, mattresses must be set at the correct setting for each person, for these mattresses this was the person's weight. One person's mattress was set to 30kg but the persons weight was double this. This meant that the person would not receive the maximum benefit from the mattress and there was a risk that the mattress would deflate when the person laid on it and they would not receive the correct support, increasing their risk of developing pressure ulcers. The low pressure red warning lights were lit on two people's mattresses, indicating that they were not functioning correctly. Staff had not checked the mattresses and did not know that these warning lights had been activated. The manager told us that the lights did this when the person was not lying on the mattresses, which was incorrect. Staff should have requested that an engineer visit to check the mattresses were working correctly when the warning lights activated. We shared our concerns about people's mattresses and the increased risks of them developing pressure ulcers with the local community nursing team.

Information was included in people's care records about the support health care professionals had recommended to keep people's skin as healthy as possible and heal any wounds. Some staff did not know what treatment had been recommended and people had not been supported to follow the advice given. For example, a community nurse had recommended that one person keep their legs elevated due to a medical condition. The person was not supported to elevate their legs for most the two day inspection apart from a couple hours during one afternoon. Risks to the person were not managed and they were not supported by staff to remain as safe and healthy as possible.

The special mattresses and cushions people needed to help keep their skin as healthy as possible were on loan from the local health service. The provider had been informed that the equipment would need to be returned to the health service as the system to loan equipment to people in care homes was changing. The provider did not have any plans in place to make sure that people had the equipment they needed to keep them safe when the loan equipment was returned and there was a risk that people would not have the equipment they needed.

External contractors carried out checks on equipment and appliances such as hoists, the lift, gas and electric. The lift had been serviced in September 2015. However, recommendations had been made about the maintenance of the lift. The report stated, 'Lift is very old and dated, advise consideration be given to the renewal of upgrading lift to comply with in date regulations'. The report further stated, 'Insulation on wire braids is perishing and causing live wire to become exposed'. We asked the registered manager what they had done about these recommendations and we were told that no action had been taken as yet, and the lift was in use on a daily basis.

The provider had failed to make sure that people received appropriate care and treatment to meet their needs at all times. Risks to people had not been mitigated and equipment was not used in a safe way. This was a breach of Regulation 12(1) (2)(b)(e) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Accidents involving people were recorded and the registered manager reviewed each one to see if any further action was required to keep people safe. They did not look for patterns and trends in accident reporting, such as if people were falling frequently or if accidents were happening at specific times or in specific places in order to take remedial action.

At the last inspection we found that safe staff recruitment processes were not always followed. This included a failure to obtain candidates full employment history, explore any gaps in employment and to obtain satisfactory references. Staff whose Disclosure and Barring Service (DBS) checks had not been received were working unsupervised with vulnerable people. The DBS checks help employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services.

The registered manager had recruited two staff since our last inspection. We looked at the recruitment checks they had completed for these two staff members which were still not robust. They had not obtained a full employment history or an explanation of a gap in the employment history for one staff member. They had also had not identified and discussed the factual differences in the information the staff member had given on their C.V. and their application form. There was not a valid DBS check for the second staff member. They had not ensured that they had all the information required and had not carried out all the checks they needed to make a safe decision to appoint the staff members.

Safe recruitment systems were still not in operation to protect people from staff who were not of good character. This was a breach of Regulation 19(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last inspection we found that the registered manager had not always deployed enough staff to meet people's care and welfare needs. At this inspection we found that the registered manager had not taken action to make sure there were enough staff available at all times to meet people's care and welfare needs. Care staffing levels had decreased since our last inspection; however, the needs of people receiving a service had not significantly changed. There were two members of care staff on duty throughout the day and night.

The registered manager told us, "Sometimes there is another member of staff who worked between 10.00am and 4.00pm", because, "It's a busier time". However, the registered manager was not able to tell us when this happened or how often an extra member of staff worked at the service. They also told us that they and the manager would, "Step in" when needed. However, this was not reliable and did not always happen leaving just the two care staff to support everyone.

Two of the 11 people using the service needed two staff members to help them move and provide their personal care. There was a risk that the remaining 10 people would not get the support they required to keep them safe, while the two staff on duty supported one person.

The registered manager had not considered people's needs and preferences when deciding how many staff to deploy on each shift. The layout of the building, including refurbishment of the bathroom on the first floor and peoples' changing needs had not been considered. Staffing levels were inconsistent over the week and people could not be assured that their needs would be met in the way they preferred by staff who knew them well at all times.

A cook worked at the service making the lunches and preparing some teatime meals during the week. When the cook was not on duty these cooking duties were covered by care staff, the manager or registered manager leaving less care staff available to support people.

The registered manager said "It's hard to recruit to this field" and there was always a, "Shortage of staff" available to employ. They told us they wanted to employ two more staff, but did not tell us how this was going to be achieved. Cover for staff sickness, leave and vacancies were provided by other staff members and occasionally by agency staff. The provider told us, "We use agency staff when we need them, mainly at night".

The provider had still not ensured that consistent numbers of suitably qualified, competent, skilled and experienced staff were deployed to keep people safe at all times This was a breach of Regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems were in operation to order, administer and dispose of prescribed medicines. Some people were prescribed medicines 'when required' (PRN), such as pain relief and to help them if they became anxious. A policy was in place for the administration of 'when required' medicines which stated, 'Staff administering PRN medication must ensure the medication is given as intended by recording in the specific short term medication plan in the resident's Care Plan'. The policy required the care plan to include the name of the medicine and the signs and symptoms that the person presented.

Staff were not following this policy and guidance had not been provided to staff about when to offer people their 'when required' medicines. Staff told us they knew the signs that people were in pain and may need pain relief but this was not recorded. There were no plans in place to make sure that other 'when required' medicines, including medicine to help people to feel less anxious, were given safely and when required. Some people were unable to ask for their medicines due to their conditions, so there was a risk that people would not receive their 'when required' medicines when they needed them.

At our last inspection we found that the management of prescribed creams had improved. However, at this inspection we found that these improvements had not been sustained. Guidance had not been provided to staff about how, when and where to apply creams to keep people's skin as healthy as possible. New systems that the manager said they had been planning to introduce including the recording of the administration of creams were not in operation and the application of creams was not being recorded. Staff could not check if peoples' creams had been administered or not.

Medicine administration record (MAR) charts were provided by the pharmacy and staff recorded the medicines people received. Medicines that were not recorded on the MAR had been added by hand. These records had not been checked to make sure that they were accurate and there was a risk that staff may not have copied the details accurately.

Most medicines prescribed to people were stored in lockable cabinets, however, medicines that people no longer needed were not locked away so were accessible to everyone. The manager lacked awareness about safe medicines management, For example, the manager did not know about the timescales for keeping medicines after a person's death.

Only staff who had been trained, administered medicines to people. The registered manager had not carried out ongoing checks of staff to ensure that they remained competent in medicines management. Daily checks on medicines stocks continued to make sure they were correct.

At our last inspection the manager had identified some improvements were needed to make sure people got their medicines when they preferred. Some people were prescribed medicines to be taken after they had gone to bed so the manager said they planned to talk to doctors about changing the times of these medicines. We found that this had not happened and people continued to be woken to have their medicines after they had gone to bed.

The provider had not made arrangements for the proper and safe management of all medicines This was a breach of Regulation 12(2)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last inspection each person had a personal emergency evacuation plan (PEEP). However these had been kept on a computer and were not available for staff to use in the event of an emergency. Previously, a list of people who used the service, which staff could 'grab' in the event of an emergency, was not up to date. At this inspection the PEEP's were now available and the list of people who used the service was up to date. These were accessible to staff so they had the information they needed if they had to evacuate the building. Staff knew what to do in the event of an emergency. Special equipment was in place to help people get down the stairs if the lift could not be used in an emergency. Staff had not been trained to use this safely. There was a risk that it would be used incorrectly or not used at all in the event of an emergency.

A new floor was being laid in a bathroom on the first floor. The workmen had stored items they had removed from the bathroom on the fire escape, which blocked the exit route. The registered manager told us that there was no one using their bedroom at the time. However, when we visited people's bedrooms, there was one person in their room. If there had been an emergency this person would not have been able to use the fire escape.

The gas safety check identified that there was no safety chain fitted to the kitchen cooker. The registered manager did not know that this work needed to be carried out and had not made sure this recommendation had been acted on.

The clinical waste bin, used for soiled items such as incontinence products was stored at the front of the building. It is a requirement that bins of this type are locked and secure at all times. At the beginning of our inspection the lid of the bin was not closed and the contents were accessible to people and animals. The registered manager and manager had both walked past this bin when they arrived at the service but had not taken action to secure the bin. We informed the registered manager of our concerns about the storage of clinical waste and they arranged for the bin to be locked.

Staff used the same sling to move different people rather than people having their own sling to suit their height and weight. The sling looked dirty. We pointed out to staff that the sling was not clean, so they could arrange for it to be washed.

The provider had failed to ensure that the premises were safe and risks of infection were assessed and

mitigated. This was a breach of Regulation 12(2)(d)(h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Previously, water temperatures had not been checked regularly and checks that had been carried out showed that the water from some taps was too hot leading to a risk of scalding. At this inspection water temperatures were now being checked regularly in each person's room and adjustments were made if temperatures were not within the guidelines.

Inadequate

Is the service effective?

Our findings

Our inspections of December 2014 and May 2015 found that the provider was not meeting the requirements of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). 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 MCA requires that as far as possible people make their own decisions and are helped to do so when needed. When people lack mental capacity to take particular decisions, any decisions made on their behalf must be in their best interests and as least restrictive as possible. Since the last inspection we have received concerns from social care professionals about the registered manager and manager's lack of understanding of the requirements of the MCA.

Staff remained unclear about their responsibilities to assess people's capacity to make decisions. There was no system in operation to assess people's ability to make particular decisions, when they needed to be made.

Assessments of people's capacity to make particular decisions had still not been completed since our last inspection. For example, one person was given a medicine without them knowing (covertly). An assessment of the person's capacity had not been completed and the person had not been involved in the decision to give them medicines covertly. Staff told us the person did not have capacity to make the decision and they had acted on the advice of a health care professional. The requirements of the MCA had not been followed as the decision had not been made by the person and by people who knew them well.

The registered manager and manager were not clear about who held legal powers to act on each person's behalf, such as a Lasting Power of Attorney. There was a risk that some people's families would be asked to make decisions or give consent on their relative's behalf without having the relevant authority. Decisions made on peoples' behalf had not been recorded to demonstrate how, who and why they had been made.

On occasions staff assumed that people had capacity to make decisions and had not supported them to make choices when they needed information or support. For example, many people living at the service had not had their hair cut for a while and their hair styles appeared to have 'grown out'. Staff told us that a hairdresser did not visit the service regularly and staff contacted them at people's request. Staff had not recognised that people may not know when they wanted or needed a haircut and did not offer people the opportunity to see a hairdresser on a regular basis but relied on people asking for an appointment. There was a risk that people would not be offered care and services that they needed because they could not ask for them.

Some people were able to make decisions for themselves about all areas of their life. We observed staff offering people choices and people who were able told staff what they wanted. However, staff did not always respect people's choices and ignored their basic requests such as asking for a drink or a biscuit.

Other people were not able to make complex decisions for themselves. Staff did not offer people choices in ways that suited them best. One staff member asked a person if they wanted a cake or a biscuit, the person

was unable to understand what the staff member was saying to them due to their condition. The staff member did not show the person the two items to help them understand and reduce the risk of confusion.

The provider had failed to comply with the Mental Capacity Act 2005 and to make sure that care was only provided with the consent of the relevant person. This was a continued breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the DoLS. We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

Since our last inspection the provider had assessed the risk of people, living at Parsonage Lodge EMI, being deprived of their liberty. Some people were assessed as not being at risk of being deprived of their liberty and so did not need an authorisation from a supervisory body. The registered manager had not acted on the outcome of these assessments appropriately and had applied to supervisory bodies for the authority to deprive everyone living at the service of their liberty. The supervisory bodies had assessed that some people were able to make decisions about living at the service and about the care and treatment they received and did not require a DoLS authorisation to be made. Staff did not involve them in decisions about their care even though they had the capacity to be involved.

Care had not been planned to make sure that the conditions of some DoLS authorisations, including, involving the person's appointed representative, were complied with.

The provider had not planned people's care to make conditions of some Deprivation of Liberty Safeguards authorisations were complied with. This was a breach of Regulation 13(5) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff did not always seek medical advice when peoples' needs changed. For example, one person had lost 11kg (approximately 1st 10lb) in 10 months. The person's doctor had advised staff in September 2015 that they were not concerned about the weight loss at that time. However, the person had continued to lose weight and staff had not contacted the person's doctor again for advice. Staff thought that one person was unwell shortly before the inspection and had contacted their doctor who visited them at the service and prescribed medicines for them.

Before our inspection we received concerns from local community nursing team that one person was not receiving the care they required to keep their skin healthy and had developed pressure ulcers. These concerns are being investigated by the local safeguarding team. During our inspection we found that advice from community nurses about how to support one person to heal a pressure ulcer was not being consistently followed.

Care had not been planned to keep people with diabetes as health as possible. When one person began using the service staff were given information about their diabetes, including that it was controlled by a special diet. Care had not been planned to make sure the person was supported to manage their diabetes and a special diet was not provided to the person.

People were offered regular sight tests and were supported to wear their glasses. Other regular health checks such as dental checks had not been offered to people.

People told us the food was "Ok" and "Alright" at Parsonage Lodge EMI. However, the provider had not taken action to make sure that everyone was offered food and drinks suitable for the needs and preferences.

People's risk of malnutrition had been assessed and some people were at 'very high' risk of losing weight and becoming malnourished. Care had not been planned to minimise the risks of people losing weight and some people had continued to lose weight. Each person was weighed once a month. People who were at a high risk of losing weight were not weighed more often to make sure that any weight loss was quickly identified.

Action had not been taken to provide people who were losing weight with high calorie foods and they had continued to lose weight. Some people were prescribed high calorie drinks to help them gain weight but staff had not considered providing them with a high calorie diet, including milky drinks and food fortified with extra calories. One person had lost more weight since starting to have the high calorie drinks and another person's weight went up and down but they remained at a high risk of malnutrition. A nutritious high calorie diet may have helped one person to recover from other health issues they had.

Food was not prepared to meet people's dietary requirements. For example, some people required a low sugar diet. Low sugar alternatives were not offered to these people and they ate the same food as everyone else, including biscuits, cakes and puddings. One person who needed a low sugar diet frequently requested drinks from staff. Staff had not recognised that this may be a sign that the person's blood sugar levels were too high and they were at risk of becoming unwell. The person was not always given a drink when they requested one leading to a risk that they may become dehydrated. Other people were not provided with food they asked for such as cakes or biscuits.

Food was not prepared to support people to eat on their own and remain independent. For example, one person's care plan stated that their food should be cut up into small pieces and they were to be supported to eat by themselves. On the day of the inspection the person was fed their meal by staff, who mixed it up together. The meal did not look appetising and the person would not have been able to taste the separate flavours of each food. Some people struggled to use cutlery but no special 'finger foods' were prepared for them and no adapted cutlery was provided.

Specialised crockery was not provided to help people remain independent at mealtimes. One person, who was unable to see well, did not require support from staff to help them eat. The person used a 'plate guard' to help stop their food from falling off their plate. Staff told us that the 'guard' should be placed in a certain position so the person knew where this was and would not spill their food. At the lunch time meal we observed that the plate guard was not put in this position and the person was not told where the plate guard was. This did not make it easy for the person to eat their meal.

Some people did not have teeth and did not use dentures. Staff had not recognised that one person had difficulty eating some foods. For example, one person was given two biscuits. They were not able to bite the custard cream biscuit and did not eat it.

People had not been offered suitable food and drink to meet their nutritional needs. People were not always supported to eat and drink. This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The cook told us that they tried to meet people's menu requests when they could. One person had requested rice pudding a few days before our inspection and this was on the menu during our inspection.

At our last two inspections we found that staff had not received the training they needed to provide safe and effective care. Following the last inspection the registered manager sent the Care Quality Commission (CQC) a training plan, which showed how they planned to address the shortfalls in staff training.

Since the last inspection staff had completed some training. However, observations showed that staff lacked the skills and competencies to consistently provide safe and effective care. For example, staff had received training in supporting people with dementia. Staff had also been given information about dementia care which they were expected to read. The registered manager planned to assess staff's knowledge and understanding of dementia care but had not completed these assessments at the time of the inspection.

Despite the training, staff lacked understanding about dementia and how to support people living with dementia. For example, one person was struggling to eat their meal and was using their knife incorrectly. A member of staff stood over the person and said, "Don't you remember what I told you yesterday? Yesterday I told you to use a spoon". The person did not reply and the member of staff walked away. The person was living with dementia and there was a likelihood that they had not remembered what they had been told the day before. Staff had not recognised that the person may no longer know the words for knife and spoon and did not support them to eat their meal.

Most staff had received training in moving and handling, but some staff did not always follow safe procedures when helping people to move. We observed that staff moved one person in their wheelchair, without using the footplates placing the person at risk of injury. On other occasions staff did not use the techniques and equipment detailed in the moving and handling plans, including the hoist slings. One staff member could not show us how they moved people using a particular sling. They told us they had not used the sling before our inspection as the person was not usually moved in the way they were on the day of the inspection. Before our inspection visiting health care professionals had raised concerns with us about moving and handling practices used at the service they considered to be unsafe. These were being investigated by the local safeguarding team.

People were not always treated in a caring and compassionate way. Training had been arranged for staff in how to treat people with dignity and respect but none of the staff had started the course. Observations made during the inspection showed that people were not always treated with dignity and respect. Staff had not received training in abuse and keeping people safe and had not recognised that the way some staff spoke to people could be abusive.

There was an in-house induction that was spread over four weeks. This included an introduction to the service, fire and other procedures and time to look at care plans. Following this staff completed an induction based on the Skills for Care common induction standards. These standards were replaced in April 2015 by the Care Certificate, an identified set of standards that social care workers must adhere to in their daily working life. The registered manager was not aware of the Care Certificate so the induction had not been adapted to meet best practice guidance.

The registered manager had started to take action to monitor and assess the training needs of the staff. A training needs analysis had been carried out for two members of staff, but required training identified as a result of this analysis had not taken place. Assessments of staff competencies and skills to complete specific tasks had started, through observations. However, these checks were incomplete and the competency of all staff had not been checked. The action the registered manager had taken had not improved the quality of the care and support people received.

Staff had not received appropriate training and development as was necessary to enable them to carry out

the duties they were employed to perform. This was a breach of Regulation 18 (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last inspection there was no supervision programme in place and staff were not receiving regular supervision. This had changed and staff were now receiving supervision on a regular basis. This included new members of staff. One staff member had requested some training at a supervision meeting and had been enrolled on a recognised qualification in care. Staff meetings were taking place on a regular basis which gave staff the opportunity to talk about training and events in the service. Staff told us that thought the support through supervisions and staff meetings was now, 'better'.

Inadequate

Is the service caring?

Our findings

One person's relative told us they were happy with the support their relative received. Another relative had returned a survey and stated, "Mum is loved here and well cared for". Staff sometimes treated people in a caring manner, but at other times staff were abrupt and dismissive to people.

At the last inspection we found that staff did not always treat people with dignity and respect. People were spoken to in a disrespectful manner and staff made inappropriate comments about people. The provider had not taken action to stop this happening and staff continued to speak to people in a disrespectful manner.

People were not asked about their care needs in a discreet and respectful manner. For example, staff asked one person in a loud voice, "Do you want to use the toilet?" The person did not respond and the staff member repeated the question twice. When the person did not respond, the staff turned to another member of staff and said, "Duh". The person who had not responded was led to the toilet by the staff member, who did not speak to them again.

Staff told us one person was, 'obsessed with food'. Staff supported the person to walk towards the dining room. The person stopped walking and staff laughed and told us the person had stopped because they had 'seen a cup on a table' as they walked past. Staff told us, "This is because [the person] thinks there is something in the cup and they want it". Staff did not attempt to move the cup or divert the person's attention to something else, such as a drink of their own. One staff member stated, "Look [the person] is scanning the place looking for food. They are always doing that". Another member of staff stated, "It's not fair the way that [the person] eats and never puts on weight". Staff then started laughing. They had not included the person in the conversation and spoke about them as if they were not present.

People were not supported to wear napkins or clothes protectors to protect their clothes when they were eating and drinking. On occasions people had accidents and spilled their food and drink. Staff did not support people to change their clothing after meals so they had clean clothes. One person was wearing a jumper that was soiled with their lunch and was not supported to change.

Staff did not treat people equally and did not speak to everyone in a kind and caring manner. Staff appeared impatient with two people. On several occasions we observed that staff did not answer two people's questions and gave them short answers such as, "Wait a minute" and, "It's not your turn". When giving people snacks, staff bent down in front of some people and said things like, "Here you are. I have some biscuits for you". When they gave snacks to other people they put the plates down in front of them without saying anything. One person wanted to change their biscuit and was told by the staff member, "You touched that one so you have to eat it now". They did give the person another biscuit but did not speak to them as they did this. On one occasion we observed a staff member walking around the lounge and asking people what they would like to drink. One person was asking the staff member for a cup of tea. The staff member responded by telling the person told, "Wait your turn" and served them their tea last.

Staff did not take time to get to know people, learn about what they had achieved in their life and what was important to them. One person had a book which contained pictures of people and events that were important to them. The book was damaged and some of the pages were torn. Before giving the person the book to look at one staff member held it in front of the person and appeared to reprimand them and said, "Who did this? Was it you by any chance? Who ripped this? Was it you? You're proud of yourself aren't you? You have spoiled your special book". The staff member gave the person the book and walked away. The person found it difficult to look at the book without help and accidently tore another page in the book. Staff did not spend time looking at the book with the person to support them to turn the pages and to remember why the people in the book were important to them. On another occasion the person began to tell a staff member about a company they had worked for a long time, the staff member appeared not listen to what the person was saying and walked away.

People's requests were not always listened to and responded to by staff. One person told a staff member they had not been to the toilet. The staff member told them, "You have been to the toilet. I waited outside while you were in there". The person repeated that they had not been to the toilet, and was again told that they had used the toilet. Staff did not recognise that the person may need to use the toilet again and did not support them to the toilet. Another person asked a member of staff a question and was told, "Patience. I will get to you in a minute".

Staff did not always give people the information they needed. For example, when people were given their meal they were not told what was on their plate. Some people were not able to see well. We asked staff how one person knew what was on their plate and where it was. They told us, "Oh they can find it". People did not always know what they were eating and could not chose which foods they wanted to eat and which foods they did not.

Some people needed to use specialist equipment such as a hoist to help them move safely. One person found this a distressing experience and shouted out and cried for help when the equipment was used. Staff made comments such as, "It's ok" and, "It's fine". This did not reassure the person and they became more distressed. Staff did not use their tone of voice, facial expressions of touch to offer the person more reassurance or explain why they were using the hoist to make sure the person feel more safe and secure. On another occasion two staff members, the manager and the registered manager stood around a person, talking about the person as they were moved. The person was upset and crying out while they were being moved but the staff and managers did not include the person in their conversation or give them any reassurance.

Information was not provided in ways that people, including those living with dementia, could easily understand, such as large print and pictures. The complaints procedure was only available in small print. There was a large whiteboard in the dining area and although this showed what the meals were for each day, staff did not support people to view this. Some clocks had stopped and others showed the wrong time, making it difficult for people to know what time of the day it was.

People were not treated with dignity and respect at all times. This was a breach of Regulation 10(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not always supported to spend time with people they liked or knew well. People were not able to choose who they sat with at mealtimes. Staff sat three people together at each meal who did not always appear to get along and the people argued at both lunchtime meals we observed.

Two people had known each other for a long time before they moved into the service. One person's care

plan said they enjoyed spending time with the other person. However, staff did not support the people to spend time together during the day, such as at meal times. Staff told us the people did not recognise each other and did not approach each other. We observed that on several occasions the two people chose to spend time together chatting and singing and showed affection for each other.

People's relatives were able to visit when they wanted to. A relative told us they could visit when they wanted to and felt they were always made welcome. The registered manager had arranged for some coffee mornings to take place and relatives had been invited to attend.

Inadequate

Is the service responsive?

Our findings

People's care plans did not contain people's preferences about how they liked their care and support to be provided. Staff told us they were gathering information about people's preferences likes and dislikes. Information was not available to staff about some peoples' backgrounds. One person was not able to tell staff what they liked and staff were waiting for the person's family to tell them. Basic information was available about other people's preferences such as 'appears to like most foods and drinks'.

Assessments of people's needs had been completed by the registered manager before people were offered a service. The information obtained during the assessment process was limited and only included people's basic physical needs. Information about how the person preferred their care and support to be provided, their life history, interests, likes and dislikes had not been obtained.

Further assessments of people's needs, such as assessments of their skin health and dietary needs had been completed once people began to use the service. These assessments had been reviewed but changes in the care and support people required had not been made. For example, one person's care plan instructed staff to support the person to remain independent at meal times and stated they needed 'occasional support at mealtimes'. Staff told us the person was unable to eat without assistance and so they fully supported them to eat their meals.

At the last inspection we found that people's care and support was not always provided in the ways they preferred. For example, the morning routine at the service had been planned to allow staff to complete tasks by a specific time and not to support people to get up when they wanted to.

At this inspection staff told us that everyone was got up, washed, dressed and had eaten their breakfast by 8:00am each morning. All the care plans we looked at stated that people chose to get up between 5:00am and 6:00am. Information provided to the registered manager before one person moved into the service stated that the person preferred to get up between 8:00am and 8:30am. Staff had not supported the person to follow their preferred routine. Several people sitting in the lounge were asleep when we arrived at 9:00am to complete the inspection.

Some people needed help from staff to go to the toilet and with their continence needs. At the last inspection we found that people were not supported to use the toilet on a regular basis. This had not changed and people were not supported to have their continence needs met. Community nurses had advised that people's continence products should be checked regularly during the day and night so they could be changed when they were at capacity. This advice depended on how much each person drank. Guidance was not provided to staff in people's care plans about how people would tell them if they needed to use the toilet or their continence products needed changing. Action had not been taken to monitor the amount people drank and staff did not know if people needed to go to the toilet at regular times each day.

The manager told us people's continence products were changed approximately every six hours. They told us that two people were prescribed four continence products for a 24 hour period, three for during the day

and 1 for the night. Night products have a greater capacity than day time products. The manager told us that people's products were changed when they got up at approximately 6:00am, after lunch at approximately 1:00 or 2:00pm and before they went to bed between 9:30 and 11:00pm. So, on occasions people's products were not changed for over 6 hours. We observed that people were not taken to the toilet regularly. There was a risk that people were not supported to change their products when they were wet or soiled and people were uncomfortable. A wet or soiled continence product touching a person's skin puts them at risk of developing sore or broken skin.

Guidance was not provided to staff about how to reassure people if they became anxious or upset. For example, one person's care plan stated the person 'Can present some verbal aggression when approached' and instructed staff to leave the person for 10/15 minutes. The care plan stated that, 'if the person did not calm', staff were to 'assist [the person] to their room and allow them time to compose themself'. The person was not able to walk and required staff to use equipment to move them safely. The person became very distressed when being moved with the equipment. Staff had not recognised that by removing the person to their room and so using the equipment would have increased their anxiety and distress.

People were not involved in the planning of their care. Reviews were completed by outside professionals on occasions and people's relatives were invited to attend these if they wanted to. People were not fully involved in this process to make sure that the care and support they were offered met their needs and preferences.

Assessments were not carried out with the person and include their preferences for care. Care was not designed and provided to achieve peoples' preferences and ensure their needs were met consistently. Care plans were not all updated with any changes in people's needs. Care was not provided to reflect people's preferences. This was a breach of Regulation 9(1)(3)(a)(b)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us that they found it very difficult to motivate people to take part in activities at the service. Other staff told us that people did not like taking part in activities. Information had not been obtained about the activities and pastimes people had enjoyed before they moved into the service and people were not supported to continue with these unless they made a specific request.

We observed that people spent long periods of time sitting in the lounge with little engagement from staff. The television was on but people did not appear to be watching it. Some people were not able to see it due to their poor vision or because it could not be seen from where they were sitting. Some people were asleep during the day. The registered manager told us that they felt activities had improved but more could be done by staff to support people to do things during the day. They were not able to tell us what improvements had been made and told us, "We can do more gradually". Minutes of a staff meeting stated that, 'Improvements were needed for activities'. However, action had not been taken to identify the improvements needed and how to address them.

The registered manager stated that, "One-to-one" time with staff was important to people and staff were now doing this, "More often". However, during our inspection staff were often busy completing other tasks, such as making snacks and drinks and completing paperwork. This reduced the time they had to spend with people. The provider had not invited entertainers and other people into the service to provide activities for people.

Staff told us that people did not like to leave the service, even to go into the garden, so they did not try to take people out into the community. Staff said people enjoyed a 'sing-a-long', but staff did not play music

that people could sing-a-long to. Two people often started to sing during the inspection. Staff commented, "Oh [the person] has a nice voice" and, "Oh they do like singing", but did not join in or encourage others to join in with the songs.

On occasions staff spent some time with one person at a time playing games which people appeared to enjoy. One person liked knitting and was given their knitting to do on their own on a couple occasions, which helped them to pass the time. Another person enjoyed playing cards and was given a deck of cards when they wanted them. Staff told us and activity records showed that staff did try to encourage people to take part in other activities, such as arranging quizzes and different games. However, staff did not always understand how to communicate with people living with dementia and there was a risk that people did not have the right support to take part in these activities.

The provider had a complaints procedure in place and this was on display in the entrance hallway of the service. It was not easily assessable to people using the service because it was only available in small print which people may not be able to see or understand. The registered manager told us that no complaints had been received since our last inspection. They explained to us how they would investigate any complaints received, take action to make sure they did not happen again and provide feedback to the person making the complaint. However, concerns that one person's family had raised with the person's social worker about the quality of the care the person received had not been seen as a complaint by the registered manager. They had told the person's social worker that they were 'annoyed' that the person's family were reporting their concerns to the person's care to the social worker.

Some people were not able to tell staff if they were unhappy with the care and support they received. Staff told us they knew from people's facial expressions and responses if they were unhappy. One person told us they were unhappy but was not able to tell us why. We reported this to a member of staff who said, "Oh that's unusual [the person] isn't usually unhappy. If they want attention they will call out". The staff member did not ask the person why they were unhappy at this time. They staff member later told us they had spoken to the person but, "They told me they weren't unhappy. They probably couldn't remember that they had been unhappy". There was a risk that the staff member had missed the opportunity to find out why the person was unhappy and resolve their concerns because they had not spoken to the person quickly. There was also a risk that the person would be unhappy again in the future if the situation occurred again.

Inadequate

Is the service well-led?

Our findings

A registered manager was working at the service; they were also one of the registered providers. The registered manager was not leading the staff team or managing the service on a day to day basis. They had delegated some responsibilities for the management of staff and of people's care to a manager. The registered manager was not able to provide us detailed with information about people and the care and support they received. The registered manager was not present in communal areas of the service during most of our inspection. The registered manager was completing a level 5 practical management course and the manager was completing a Level 5 Diploma in Leadership for Health and Social Care.

The registered manager said he planned to deregister as the registered manager if the manager's application to register was successful. An application to register with the commission had not been received from the manager at the time of the inspection.

The registered manager did not have oversight and scrutiny of the service. They had not taken action to monitor and challenge staff practice to make sure people received a good standard of care. Shifts were not planned to make sure that people had the support they needed when they wanted it. Staff were not held accountable for the care and support they provided, such as treating people without dignity and respect and were not challenged about poor care. The registered manager was present when a member of staff shouted at a person. When we asked the registered manager about this, they told us that they had not seen anything untoward or unusual and the member of staff, "Probably spoke loudly because people are hard of hearing".

Values, such as involvement, independence and respect were not central to everything the staff did. Staff did not always involve people in their care and did not always promote independence and treat people with the respect they deserved. The provider did not have a clear set of values for the service. Their Statement of Purpose stated that, 'The home is committed to provide a service which is, safe, caring, responsive, effective and above all well-led demonstrating a happy and homely environment' and, 'To ensure the privacy and dignity of all residents at all times'. These values were not demonstrated by staff during the inspection and there was a culture where staff made decisions without consultation with the people involved. Staff did not challenge the culture at the service or their colleagues.

People and their relatives were not involved in the day to day running of the service for example, in recruiting new staff and planning activities. A system was in place to obtain the views of people and their relatives and some annual surveys had been completed. These had not been reviewed and the registered manager was not aware that one survey stated that all areas of the service were 'poor'. Action had not been taken to find out why the person thought the service was poor. We discussed this with the registered manager and manager. The manager asked the person to fill in the survey again. On this occasion they stated that all areas of the service were 'good'. The manager stated that the person had told them they were, "Only joking" when they completed the survey before. However, the person was not given the time to consider their responses and complete the survey alone or with an advocate. They were not able to provide anonymous feedback.

Staff had not been asked for their views on how to improve the quality of the service.

Effective systems and processes were not in operation to ensure that the service was of a consistently good quality. The registered manager had not supported staff to know what good quality care looked like and how to provide it. The registered manager was not aware of most of the shortfalls in the quality of the service found at the inspection.

At the previous two inspections we found that the provider had not taken action to make sure that people received a good quality service that kept them as safe and well as possible. At this inspection we found that limited action had been taken to improve the quality of the service. The provider, who was also the registered manager, continued to provide a service that breached a number of Regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and the Care Quality Commission (Registration) Regulations 2009.

Following our last inspection the provider sent us an action plan detailing the actions they would complete in July and August 2015. We found that they had not completed all of these actions. For example, the action plan stated, 'Service users are treated with respect and dignity and this is reinforced by management'. This was not evident at our inspection. The registered manager was not able to tell us why improvements they had assured us would be made had not happened or had not been sustained.

The registered manager had completed a number of checks on the safety and care practices at the service. These were not always effective. For example, there was a daily audit for care plan documentation. This included checking that care plans and risk assessments were up to date. These checks had not identified the shortfalls in care plans that we found during the inspection including the changes in the supported offered to people to help them move safely around the service.

Health and safety checks were recorded daily. The purpose of the checks was to make sure that staff had completed all the required
tasks correctly .However, there was a risk that these checks were not effective as the registered manager did not always complete an actual check but relied on staff telling them that tasks had been completed.

Some checks had been recorded but were not relevant. For example, one check stated the 'sharps box' (which is where needles are disposed of safely) was emptied daily, however staff and people did not use sharps and there was no sharps box at the service.

Recommendations made by external contractors had not been acted on, which had the potential for staff to be using equipment which was unsafe. For example the lift engineers had recommended that the lift needed some work to be carried out, but the registered manager had not actioned this.

Systems and processes were not operated effectively to assess and monitor the service and improve the quality and safety of the service. Feedback from relevant person's had not been acted on. The provider had not evaluated and improved their practice by processing and acting on the information they gathered. This was a breach of 17(1) (2) (a)(e)(f) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last inspection we found that records in respect of each person's care, records for staff employed at the service and the management of the service were not accurate. At this inspection, some records were not in place, not available or not up to date. For example, records relating to new members of staff, including interview notes and induction records, could not be found.

Since the last inspection the registered manager had updated and implemented new policies and procedures. Some of these were not specific to the service and did not give staff the guidance they needed. For example, the training policy was a generalised policy and had not been adapted to describe the processes in operation at Parsonage Lodge EMI. Other policies and procedures had not been followed in practice. For example, staff did not follow the policy for the administration of 'when required' medicine. Policy statements such as 'focusing' on the new Care Certificate' were not accurate.

The provider did not have systems and processes in operation to maintain an accurate and complete record in respect of members of staff. This was a breach of Regulation 17 (2)(c)(d)Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last inspection we found the registered manager was not notifying CQC of reportable events. Notifications are information we receive from the service when significant events happen, like a death or a serious injury. At this inspection we found that the registered manager had not notified CQC about further notifiable events, including the outcome of applications they had made to supervisory bodies to deprive people of their liberty.

The provider had not notified the Care Quality Commission of significant events that occurred at the service. This was a breach of Regulation 18 Care Quality Commissions Act (Registration) Regulations 2009.

The provider had written a new Statement of Purpose since our last inspection. A Statement of Purpose is a document about the aims and objectives of the service, the kinds of services and the range of people's needs. When changes are made to the Statement of Purpose, the registered person must provide written details to CQC within 28 days, so we can be assured that providers have produced a clear statement about the service they are providing. The provider had failed to notify us of the changes they had made to their Statement of Purpose.

The provider had not supplied CQC with notification of the changes to their Statement of Purpose. This was a breach of Regulation 12 (3) of the Care Quality Commissions Act (Registration) Regulations 2009.

Following our last two inspections we awarded Parsonage Lodge EMI a rating which they are required by law to display 'conspicuously and legibly at each location delivering a regulated service'. The rating was not displayed at the service at the beginning of our inspection. The registered manager arranged for the inspection report with the rating to be put on display during the inspection.

Before our last inspection we asked the provider to complete a Provider Information Record (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We did not receive the information we requested from the provider.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 Registration Regulations 2009 (Schedule 3) Statement of purpose The provider had not supplied CQC with notification of the changes to their Statement of Purpose.

The enforcement action we took:

Served an NOD to stop admissions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider had not notified the Care Quality Commission of significant events that occurred at the service.

The enforcement action we took:

Served an NOD to stop new admissions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care Assessments were not carried out with the person and include their preferences for care. Care was not designed and provided to achieve peoples' preferences and ensure their needs were met consistently. Care plans were not all updated with any changes in people's needs. Care was not provided to reflect people's preferences.

The enforcement action we took:

Served an NOD to stop 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 treated with dignity and respect at all times.

The enforcement action we took:

Served an NOD to stop new admissions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had failed to comply with the Mental Capacity Act 2005 and to make sure that care was only provided with the consent of the relevant person.

The enforcement action we took:

Served an NOD to stop admissions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to make sure that people received appropriate care and treatment to meet their needs at all times. Risks to people had not been mitigated and equipment was not used in a safe way. The provider had not made arrangements for the proper and safe management of all medicines. The provider had failed to ensure that the premises were safe and risks of infection were assessed and mitigated.

The enforcement action we took:

Served an NOD to stop 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 against the risk of abuse and improper treatment. Care and treatment was not always provided in a way that was not degrading to people. The provider had not planned people's care to make conditions of some Deprivation of Liberty Safeguards authorisations were complied with.

The enforcement action we took:

Served an NOD to stop admissions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs People had not been offered suitable food and drink to meet their nutritional needs. People were not always supported to eat and drink.

The enforcement action we took:

Served an NOD to stop admissions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes were not operated effectively to assess and monitor the service and improve the quality and safety of the service. Feedback from relevant person's had not been acted on. The provider had not evaluated and improved their practice by processing and acting on the information they gathered. The provider did not have systems and processes in operation to maintain an accurate and complete record in respect of members of staff.

The enforcement action we took:

Served an NOD to stop admissions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Safe recruitment systems were not in operation to protect people from staff who were not of good character.

The enforcement action we took:

Served an NOD to stop admissions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had not ensured that consistent numbers of suitably qualified, competent, skilled and experienced staff were deployed to keep people safe at all times. Staff had not received appropriate training and development as was necessary to enable them to

carry out the duties they were employed to perform.

The enforcement action we took:

Served an NOD to stop admissions