Maria Mallaband Limited

Furze Hill Lodge

Inspection report

Furze Hill
Kingswood
Surrey
KT20 6EP

Tel: 01737362316

Date of inspection visit:
02 June 2021

Date of publication:
16 August 2021

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Furze Hill Lodge is a care home and accommodates up to 29 people in an adapted building. The service supports adults requiring care and support due to their physical health conditions, mental health needs and those living with dementia. At the time of our inspection there were 17 people living at Furze Hill Lodge.

People's experience of using this service and what we found
There was a lack of managerial oversight of the service. Quality assurance systems were not effective in ensuring continuous improvement. Relatives were not able to effectively contribute to how the service was run and records of people's care lacked person centred detail.

Risks to people's safety and wellbeing were not always monitored and reviewed to help keep them safe. Accident and incident records lacked detail and robust action to minimise risks was not consistently taken. Safeguarding concerns had not always been reported to the local authority in line with requirements.

Records of people's healthcare needs contained contradictory information. Support from healthcare professionals was not consistently tracked to ensure people received the support they required. People's care was not always personalised, and staff were not aware of people's life histories. Activities provided had improved since our inspection in August 2019 although further development was required to ensure these were personalised to people's interests.

People were not always supported to have maximum choice and control of their lives as people were not always fully involved in reviewing their care. Staff supported them in the least restrictive way and in their best interests; the policies and systems in the service supported this practice.

Individual interactions between people and staff were caring and people appeared comfortable with staff. People told us they enjoyed the food and people's dietary needs were catered for. Provision had been made to ensure people were able to maintain contact with those important to them throughout the COVID-19 pandemic. Staff were seen to be wearing the correct PPE and safe infection control practices were in place.

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

Rating at last inspection and update
The last rating for this service was requires improvement (published 23 October 2019) and there were multiple breaches of regulation. We completed a further targeted inspection on 23 July 2020 (published 26 August 2020) to look at concerns reported to us in relation to people's safe care. Targeted inspections do not change the rating from the previous inspection. This is because they do not assess all areas of a key question. We identified one breach of regulation. The provider completed an action plan following both of

these inspections to show what they would do and by when to improve. At this inspection enough improvement had not been made and the provider was still in breach of regulations.

Why we inspected
The inspection was prompted in part by notification regarding a person's unexpected death. As this incident is subject to an ongoing safeguarding investigation, this inspection did not examine the circumstances of the incident.

The information CQC received about the incident indicated concerns about the management of health concerns and the emergency protocols in place in relation to these. This inspection examined those risks. During the inspection we found concerns regarding the way in people's health care needs were monitored and how risks to their safety and well-being were managed. We have found evidence that the provider needs to make improvements.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to how risks to people's care and support were managed, the reporting of safeguarding concerns, the monitoring of people's healthcare needs, staff training, how people were involved in planning their care and the management oversight of the service.

Please see the action we have told the provider to take at the end of this report.

Follow up
We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service caring?

Requires Improvement

The service was not always caring.

Details are in our caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Details are in our responsive findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

Furze Hill Lodge

Detailed findings

Background to this inspection

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

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection team consisted of two inspectors.

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

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

During the inspection

We spoke with two people who used the service about their experience of the care provided. We spoke with three members of staff, the registered manager, regional director and one healthcare professional. We reviewed a range of records. This included six people's care records and multiple medication records. We looked at three staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We spoke with four relatives regarding their experience of the care their loved ones received. We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records.

Requires Improvement

Is the service safe?

Our findings

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

At our inspection in August 2019 this key question was rated as Requires Improvement. We completed a targeted inspection in July 2020. The rating of this key question was not changed as we only looked at areas we had specific concerns about. At this inspection this key question has remained Requires Improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management/ Learning lessons when things go wrong

At our inspection in July 2020 the provider had failed to robustly assess the risks relating to people's health, safety and welfare. Accidents and incident reports were not completed or investigated in sufficient detail, risk management plans did not contain detailed guidance for staff and records were difficult to access. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider forwarded an action plan detailing how improvements would be made through document review and staff training. Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12. We found the actions taken by the provider and registered manager had not been effective in ensuring sustained changes.

● We received mixed responses from relatives regarding how risks to their loved one's safety was managed. One relative told us, "There's little co-ordination or communication and things don't get followed up on. Staff can never tell you anything and say the manager will deal with it." Another relative said, "They've been really good at letting us know when anything has happened, and we can talk to them if we have concerns."
● Risks arising from people's healthcare needs were not consistently recorded and monitored. Guidance in relation to specific health care conditions was not always available for staff to follow. Records for one person did not include details of the signs indicating the persons health was deteriorating or when medical attention should be sought. Fluid intake was a significant indicator of concern. However, no risk assessment was completed in relation to this.
● Another person's records indicated they were prone to certain infections which increased their risk of falls. There was no guidance for staff regarding how this risk should be minimised or the person's health monitored. Records showed the person had experienced a number of falls when they had an infection which had not been identified.
● Risk management records were not always consistently recorded and followed. This meant people were at risk of avoidable harm. One person who had experienced a high number of falls had four different care plans or risk assessments. These contained contradictory advice regarding the persons needs and the support they required to maintain their safety.
● Out of hours support for staff was not reviewed in order to develop staff skills in dealing with situations in the registered manager and deputy manager's absence. The registered manager told us they provided the on-call for the service alongside the deputy manager. They told us they thought staff needed to take responsibility for decision making rather being reliant on the on-call service for advice. However, no system

had been implemented to develop staff development in this area. A recent safeguarding report had demonstrated staff lacked skills in their ability to make decisions when the registered manager was not available.
● Where people had sustained skin tears or bruises, accurate descriptions of the injuries and treatment were not always recorded. The size of injuries were not always provided and skin care plans were not implemented to inform staff of treatment and monitoring. This meant there was a risk the person would not receive the appropriate care and treatment.

The failure to manage risks in relation to people's safety and wellbeing was a continued breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● In other areas we found plans were in place to manage risks to people's safety. Risk assessments had been completed in relation to people's skin integrity and guidance was followed by staff. Relevant equipment was in place to minimise risks and people were regularly supported to reposition.
● Health and safety checks of equipment and services were completed regularly. Any actions required were completed. Fire equipment was regularly checked, and staff received training in how to respond in the event of a fire.

Systems and processes to safeguard people from the risk of abuse

At our inspection in August 2019 the provider had failed to ensure systems and processes were effective in safeguarding people from the risk of abuse. This was a breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At our inspection in July 2020 we found improvements had been made. There had been an increase in reporting to the local authority. However, reports continued to lack detail and where supplementary information was requested this was not always consistent. At this inspection we found the improvements made had not been sustained and there was a further breach of regulation 13.

● Potential safeguarding concerns were not always reviewed and reported to the local authority in line with requirements. Records showed one person had sustained bruising to their back and arms. Internal processes to share and investigate the bruising were not followed. Following the inspection, the provider informed us the they believed the bruising was caused by a recent unwitnessed fall five days prior to the bruising appearing. A second person had sustained a skin tear to their leg. It was not known how the injury had occurred although action was taken to remove potential hazards. There was no evidence to show these potentially unexplained incidents had been shared with the local authority safeguarding team for review. We spoke with the local authority who confirmed they would have anticipated these incidents being shared with them.
● One person's records described two incidents involving another person living at Furze Hill Lodge. They had not been recognised as a potential safeguarding concern and had not been reported in line with local safeguarding protocols. The local authority confirmed they would have expected to be alerted to these incidents.
● Staff we spoke with were aware of their responsibility to report safeguarding concerns. Whilst the above incidents had been reported to the management team, they had not been followed up to check the relevant safeguarding teams had been alerted. The local authority safeguarding team confirmed they would have expected to be alerted to these concerns.

The failure to ensure safeguarding concerns were consistently reported was a breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008

(Regulated Activities) Regulations 2014.

Staffing and recruitment

At our inspection in 2019 the provider had failed to ensure sufficient staff were deployed. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 18 in relation to the number of staff deployed. However, continued monitoring of weekend staff deployment was required to ensure this remained safe and appropriate to meet people's needs.

● Relatives' feedback in relation to staffing levels varied. Some relatives told us staff were always available when their loved ones required support. Other relatives said their family members had not always received the support or stimulation they required promptly due to there not being staff available.
● We observed there were sufficient staff deployed to meet people's needs and people were not seen to be waiting for support. However, staff rotas showed that weekend staffing levels were reduced due to there being no activities staff available and less housekeeping hours. During our inspection we observed the activities staff member ensured people were not left alone in communal areas. Staff told us at weekends a member of the care staff stayed with people. However, this may be more difficult to manage at the weekends with less staff available.
● Staff told us they felt staffing levels were adequate although periods at the weekend could feel stretched. They did not believe this impacted on people's care. One staff member said, "Sometimes you might be short but normally there are no issues with staff. No one is left or having to wait but weekends I know can be hard." A second staff member said, "Sunday afternoons can be difficult, but everything still runs on time."
● Staff had been recruited safely and appropriate checks completed. These included identity checks, references and a Disclosure and Barring Service (DBS) check.

Using medicines safely
● Medicines were managed safely. Staff received training in administering medicines and their competency was checked.
● Each person had a medication administration charts (MAR) in place which contained a recent photograph, personal details and information regarding any allergies. No gaps in administration records were noted and stock checks were found to be correct.
● Guidance was in place regarding medicines prescribed to be taken as and when required (PRN). Protocols outlines when people should be offered PRN medicines and how they should be administered.

Preventing and controlling infection
● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was meeting shielding and social distancing rules.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was accessing testing for people using the service and staff.
● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.
● We were assured the provider was facilitating visits for people living in the home in accordance with the current guidance.

Requires Improvement

Is the service effective?

Our findings

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

At our inspection in August 2019 this key question was rated as Requires Improvement. At this inspection this key question has remained the same. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Staff support: induction, training, skills and experience

At our inspection in August 2919 the provider had failed to ensure staff training was effective. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Not enough improvement had been made at this inspection and the provider was still in breach of regulation 18.

● Staff were not always able to demonstrate their skills in areas such as supporting people living with dementia and mental health support needs. One staff member told us they had completed dementia training online but did not complete training in supporting people with mental health needs. They told us, "The eLearning don't help us much. Especially for people who have never worked in the care service." Following the inspection, the provider shared evidence that a number of staff had attended training in the above areas. We will review the on-going impact of this training during our next inspection.
● Staff training in how to support people's health care needs had been provided to a number of staff but not consistently across the whole staff team. This included areas such as diabetes care, prevention of falls and urinary tract infections and supporting people with oral healthcare. The registered manager told us they had identified these areas of learning with the quality assurance team. They were looking to set up group learning sessions to address this.

The lack of effective training in relation to people's individual needs was a continued breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Following our inspection, the registered manager told us they had completed training in how to identify early warning signs of a person is becoming unwell. They said they intended to roll this training out to all staff in the near future.
● Staff received regular refresher training in areas including health and safety, moving and handling and infection control. They told us they found this useful and informative. One staff member told us, "It's useful to go through it all again as there's always something new or something that's changed."
● Staff told us they had regular supervisions to support them in their roles and records confirmed this. One staff member said, "We meet with (registered manager) and talk about how everything is going. She will tell me if there is anything wrong with how I do things."

Supporting people to live healthier lives, access healthcare services and support; Staff working with other

agencies to provide consistent, effective, timely care
● People's health care needs were not consistently monitored. Records of people's health appointments contained contradictory information and lacked detail about the actions required and whether they had been completed. A GP contact book was in place which gave brief bullet points regarding the reason for contact and advice given. It did not record if the GP had visited the person or if advice provided had been acted upon.
● Records of health care appointments within people's files did not always contain the same information as within the GP book. Again, these records lack detail regarding who would be responsible for following up on any actions and outcomes were not recorded. This meant there was a risk that people would not receive the care they required.
● Daily notes did not always contain information regarding people's health or concerns noted by staff. Notes detailed within the GP book regarding concerns were not always recorded in people's notes. As not all staff had access to other records there was a risk they would not be aware of any concerns previously noted.
● Oral health care plans were not always completed in line with NICE guidance. Following the inspection, the provider told us, "In line with its mission to ensure a high standard of care for residents within the Home, the Provider will be working with the home to implement the NICE recommendations."

The lack of consistent monitoring of people's healthcare needs is a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

At our inspection in August 2019 the provider was not following the principles of MCA and consent was not always obtained before care was delivered. This was a breach of regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 11.

We checked whether the service was working within the principles of the MCA
● People's mental capacity to make specific decisions had been assessed. Where people were found to be lacking capacity to make certain decisions, these had been made in their best interests and with the involvement of people who knew them well.
● Where restrictions were in place such as the locked external doors, DoLS applications had been submitted to the local authority. These documented the persons needs and reasons for the restrictions in place.
● Staff had received MCA training and were able to give examples of how they offered people choices throughout their day. One staff member told us, "I'd offer choices in a way I knew they would understand. If I didn't get a response I might try at a different time of day or get someone else to try."

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● Assessments were completed prior to people moving in. This helped the registered manager determine if

they were able to meet their needs. This covered areas including personal care needs, health information, mobility and medicines.
● Assessments were then completed again when the person moved in to check for consistency. This covered the same areas as the original assessment document. This information was used to develop people's care plans.
● Recognised assessment tools were used to monitor people's weight. Each person had a malnutrition screening tool completed to monitor their nutritional needs.

Supporting people to eat and drink enough to maintain a balanced diet
● We received mixed feedback regarding the quality of the food provided. Comments included, "It's a bit bland but it must be difficult to please everyone." And, "The food is fairly good."
● People's weight was monitored, and action taken when significant variations were noted. However, advice provided by professionals was not always consistently followed. One person's records advised they should be supported with a high calorie snack twice a day. Records did not reflect this was consistently offered. Although the person's weight loss had slowed, they continued to lose small amounts of weight. Additional measures had been implemented shortly prior to our inspection to mitigate this risk.
● People had a choice of foods although this was not always presented in a meaningful way for those living with dementia. People chose their meals in the morning rather than being given a choice at lunchtime where they could see and smell the different options.
● Where people required support to eat this was provided in a dignified way. Details of people's dietary requirements and preferences were known to staff.

Adapting service, design, decoration to meet people's needs
● We observed some areas were difficult to access for people who were not mobile as some corridors were narrow and difficult to access with a large wheelchair. One person had asked to sit outside but staff had asked them to wait for a few days until they could assess the best way for them to access the garden in their chair due to the slope from the door
● There was clear signage around the building to guide people living with dementia. Different coloured toilet seats were fitting where appropriate.
● Communal bathrooms were adapted for people with mobility needs and handrails were fitted around the service.
● A call bell system was in place. This enabled people to call for assistance from their bedrooms when required.

Requires Improvement

Is the service caring?

Our findings

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

At our inspection in August 2019 this key question was rated as Requires Improvement. At this inspection this key question has remained the same. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity; Supporting people to express their views and be involved in making decisions about their care; Respecting and promoting people's privacy, dignity and independence

● We received mixed feedback from people and relatives regarding the approach of staff. Comments included, "Staff are nice and pleasant, but it's not personalised." And, "They look after (loved one) really well. They are very loving and caring."
● Although individual interactions with people were kind and sensitive staff did not demonstrate understanding of how to fully involve people living with dementia in their care. We asked for examples of how people may be involved in their care. One staff member told us, "If they can talk sensibly, I might sit and ask them."
● Care records did not always contain evidence of how people were continually involved in reviewing the care they received. Although care plans were regularly reviewed, it was not clear how people had been fully involved in this process.
● People's relatives told us they were not always asked to contribute to their loved one's care on an on-going basis. It was clear from assessments that relatives were able to contribute to the initial development of care plans and families were informed of significant events. However, there was limited evidence of families being asked to contribute to on-going reviews of the care provided. One relative told us that although they had not initially been involved in reviews of care plans, the registered manager had been happy to share the care plan when they requested to see it.
● Care plans contained information regarding people's spiritual and religious needs. Evidence of people attending church or taking part in services over Zoom was provided. However, we found some people's plans in this area would benefit from additional detail and guidance for staff.

We recommend the provider explore ways in which people can be fully involved in contributing to reviews of their care on an on-going basis and ensure staff understand the importance of this process.

At our inspection in August 2019 the provider had failed to ensure that people's dignity and preferences were respected. This was a breach of regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 10.

● People were supported to get up at a time of their choosing. We arrived at the service at 0630 am due to

concerns identified during our last inspection. Four people were awake and receiving support. Staff told us they only supported people to get up if they said this was what they wanted. We confirmed this with people or by looking in their records.

● People were offered day to day choices in elements of their care such as what clothes they wished to wear or what they would like to drink.

● Staff approached people in a friendly way and people appeared relaxed in the presence of staff. We observed staff supporting one person to walk along the corridor. They were linking arms, singing and laughing.

● Staff respected people's and privacy. We observed staff knock on doors and announce themselves before entering people's rooms.

Requires Improvement

Is the service responsive?

Our findings

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

At our inspection in August 2019 this key question was rated as Requires Improvement. At this inspection this key question has remained the same. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

At our inspection in August 2919 the provider had failed to ensure people received person-centred care and were offered a range of activities relevant to their needs and preferences. This was a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Not enough improvement had been made at this inspection and the provider was still in breach of regulation 9.

● We received mixed responses when asking if the service was personalised to people's history and preferences. Comments included, "I don't even think they know that information and can't think how they'd have used it.", "There's just a lack of stimulation." And, "They have known (loved one) so long it feels like we all have a shared history. It's homely and welcoming."
● Staff were unable to describe people's hobbies, interests and life histories. When we asked staff about people, they told us about their care needs rather than providing personalised information. One staff member told us, "We don't tend to need to know what jobs people did."
● We asked staff and the registered manager for examples of how people's care and activities were personalised to their preferences and hobbies. With the exception of information around providing food choices they were unable to do this. Whilst detailed information was gathered regarding people's life histories and interests this was not extensively used when supporting people.
● The activities provided had improved since our last inspection although further development was required to ensure these were personalised. Activities were mainly based around games and quizzes rather than people's specific interests. One person told us they weren't joining in the activities as it did not interest them. A staff member told us it was difficult to find group activities which met the diverse needs of people living at Furze Hill Lodge.
● People did not always have the opportunity to use the garden. Two people told us they would like to go outside more often. One staff member told us, "We haven't used it as much as I'd like. That's the thing I'm working on. It would be nice to use it a bit more."

The lack of person-centred care was a continued breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● In other areas we found improvements had been made in how people were supported with activities and interactions. Relatives gave positive feedback regarding the increase in the use of sensory items for those living with dementia. One relative told us, "It's so good they're trying these things and offering something to

them."
● Relatives were grateful for the efforts made by staff to maintaining contact when the service was closed to visitors. One relative told us, "They were so good at keeping us updated and connected. As soon as visiting rules change they let us know. They've welcomed us back."

End of life care and support
● Care plans were in place regarding people's end of life wishes. This included where they wished to be cared for and who they wished to be informed.
● Some care plans included personalised details of the care they wished to receive such as the music they would prefer. The registered manager assured us this was an area being developed to include this level of detail for everyone who wished to do so.

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.
● Communication care plans varied in details and guidance. For example, some communication plans included guidance on sensory loss, and we observed people received the support they required with this. For other people additional information would have been beneficial such as exploring the use of alternative communication aids
● Where people's verbal communication was limited, guidance was available for staff regarding how they communicated through gestures, expressions and body language. For example, how people expressed pain and discomfort.
● Staff were observed to take time when communicating with people. They demonstrated understanding of the additional difficulties wearing face masks presented to people. Efforts were made to gain eye contact with people and gentle touch was used to reassure people.

Improving care quality in response to complaints or concerns
● A complaints, concerns and compliments policy and procedure was in place. This detailed how complaints could be raised, timescales for a response and how actions would be communicated.
● Records showed that where complaints had been raised these were dealt with in line with the policy. One relative had raised concerns regarding internet access to allow them to maintain contact with their family member. This had been addressed promptly to enable video calls to take place.

Inadequate

Is the service well-led?

Our findings

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

At our inspection in August 2019 this key question was rated as Requires Improvement. We completed a targeted inspection in July 2020. The rating of this key question was not changed as we only looked at areas we had specific concerns about. At this inspection this key question has deteriorated to Inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care.
At our inspection in August 2019 the provider had failed to ensure effective managerial oversight of the service. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At our inspection in July 2020 we found improvements had been made and with support of the quality assurance team system to monitor the service were being implemented. At this inspection we found the improvements made had not been sustained and there was a further breach of regulation 17.

● We received mixed comments from people and their relatives in relation to how the service was managed. Comments included, "There is a disconnect between what the manager says will happen and what the staff do.", "Things aren't followed up and you can never get a clear response." And, "Anything we need to discuss with (registered manager) we can. She will always listen and respond."
● Leadership and governance within the service were not effective in ensuring regulatory requirements were met and responsibilities understood. This was the third inspection of the service where breaches of regulations have been identified. Where improvements were found during our inspection in July 2020, these had not been sustained.
● Quality assurance systems were not robust and not embedded into practice. The last provider visit report from April 2021 stated, "(External auditor) carried out an inspection of the home on the 14th of April. The home manager received initial feedback at the end of the visit which they describe as not very positive." And, "New actions on the provider visit will be based on the conclusions and concerns raised in the (external auditors) report when it is released." When asked about quality assurance systems to support them in their role, the registered manager did not inform us of the external audit of any actions arising from this. Following our site visit, we asked to see a copy of the external auditor's report and subsequent action plan. The regional director told us the audit did not generate a report, but feedback was fed through to the central quality team. This meant they were unable to share the scope or findings of the external audit or any actions taken in response or planned with the CQC six weeks following the audit.
● The provider later submitted an action plan they told us had been developed on 23rd June 2021 in response to the external audit in April 2021. They also stated the service had received support from the internal quality team in May 2021 to implement actions from the audit. The lack of awareness of the system, audits and action plans to monitor and improve the quality of the service demonstrated quality assurance

processes were not embedded into practice. Following the inspection, the provider told us that none of the concerns identified as part of the inspection had been raised by the external auditor.

●Internal audit systems had not been effective in monitoring the service. This meant concerns were not always identified and responded to. A provider visit report from April 2021 detailed that due to support being required in another service they were only able to spend an hour at Furze Hill Lodge. No care plans or risk assessments were reviewed as part of this visit. Audit records did not reflect how people's health care was monitored, how daily records of care were maintained or how checks on staff following care plans were completed. This meant concerns found during our inspection had not been identified through the internal quality assurance processes.

● Quality assurance systems were not always effective in ensuring continuous improvements to people's care and safety. Actions from previous audits were not checked to ensure they had been comprehensively completed and staff were following up to date guidance. An action from a previous audit stated a person's care plan be updated in relation to staff support when mobilising. The audit stated this had been actioned. We found no changes to the person's records had been made in relation to this.

● The registered manager told us the quality assurance team had conducted a visit the week prior to their inspection and they were awaiting the report the findings and actions required. We asked for this report to be forwarded. Following the inspection, the regional director told us processes had changed and this had been a support visit rather than an audit visit, so no report had been produced. The registered manager had not been aware of this change to process during our inspection. This meant the registered manager was not fully aware of the quality systems in place to support them in implementing any improvements required.

● People's records were not always kept in a confidential and personal manner. A bound book was used to record all concerns to be passed on to the GP and the agreed treatment. This meant highly personal information for all those living at Furze Hill Lodge was recorded in the same place.

● Accurate, complete and contemporaneous records in respect of people's care were not maintained. As described in the key questions safe, effective and responsive, records were not comprehensively completed and lacked detail. This had led to people not always receiving personalised and holistic care.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

● Feedback on how the quality of the service provided was not regularly sought from relatives. The registered manager told us surveys had not been sent during the COVID-19 pandemic. Alternative ways of gaining the views of people's relatives had not been sought.

● Staff meetings minutes did not demonstrate how staff were able to contribute their ideas to service improvement. Meeting minutes reflected information passed to staff by the registered manager rather than an open dialogue.

● Resident meetings were held to discuss people's views on the service they received, what they enjoyed, and any improvements required. Minutes reflected that comments were largely positive, and that people were happy with the care provided.

The lack of management oversight, inclusive culture and consistent duty of candour processes was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider had not notified CQC of all significant events that had happened in the service. Services that provide health and social care to people are required to inform the CQC of important events. We identified safeguarding concerns during the inspection about which the provider had failed to notify CQC. This had an impact on our ability to effectively monitor the service provided.

Failing to submit statutory notifications in line with requirements was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

● In other areas we found management systems were in place and worked well. Audits of infection control and medicines management were effective in ensuring standards were maintained and improvements made.
● The registered manager told us that due to the COVID-19 pandemic and visiting restrictions it had been difficult to build or maintain links with other organisations. However, where training and support in relation to the pandemic had been offered this had been accepted in order to support staff.
● Staff told us they felt supported and valued by the registered manager. One staff member told us, "If I go to her she will always listen. If she can't do anything she will explain why." A second staff member told us, "Her door is always open, and she'll do what she can."

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
● At our last inspection we made a recommendation in relation to the provider consistently acting in an open and transparent way in relation to their duty of candour responsibilities. At this inspection we found improvements had been made in the way information was shared with people and their relatives. One relative told us, "(Registered manager) tells us if there's been a fall or anything. We know it's to be expected but they always ring us and tell us."

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider had failed to submit statutory notifications in line with requirements

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider had failed people received person centred care, were involved in the planning of their care and effectively meet people's healthcare needs.

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 manage risks in relation to people's safety and wellbeing

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 The provider had failed to ensure safeguarding concerns were consistently reported

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

	The provider had failed to ensure effective management oversight, inclusive culture and consistent duty of candour processes
Regulated activity	**Regulation**
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to provide effective training in relation to people's individual needs