Saxon Lodge Residential Home Limited

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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?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

We inspected the service on 28 August 2018 and 30 August 2018. The inspection was unannounced. Saxon Lodge Residential Home Limited is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. The Care Quality Commission regulates both the premises and the care provided, and both were looked at during this inspection.

Saxon Lodge Residential Home Limited is registered to provide accommodation and personal care for 23 older people and people who live with dementia. There were 17 people living in the service at the time of our inspection visit. The service was run by a company who was the registered provider. The company was owned and operated by a single director. There was a registered manager in post. 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. In this report when we speak about the director of the company we refer to them as being, 'the registered provider'. When we speak about both the director and the registered manager we refer to them as being, 'the registered persons'.

At the last comprehensive inspection on 21 June 2017 the overall rating of the service was, 'Requires Improvement'. We found that there were two breaches of regulations. This was because the registered persons had not reliably ensured that people who lived in the service consistently received safe care and treatment. In particular, people had not been fully supported to eat enough to have a balanced diet. In addition to this, we also found that the registered persons had not established and operated robust systems and processes to assess, monitor and improve the quality and safety of the service. We told the registered persons to send us an action plan stating what improvements they intended to make and by when to address our concerns and to improve the key questions of 'Safe' and 'Well led' back to at least, 'Good'. After the inspection the registered persons told us that they had made the necessary improvements.

At the present inspection we found that sufficient steps had not been taken to address either of these breaches. This was because there were serious shortfalls in the arrangements used to provide people with safe care and treatment that had significantly increased the risk of people experiencing harm. This included suitable steps not having been taken to reduce the risk of infection and to enable lessons to be learned when things had gone wrong. There were also multiple and serious shortfalls in the systems and processes used by the registered persons to assess, monitor and improve the quality and safety of the service. This had resulted in the persistence of a large number of problems in the running of the service that had reduced people's ability to receive the high-quality care they needed and had the right to expect. In addition, we found the registered persons did not fully appreciate the seriousness of the concerns we had identified and there was no realistic prospect of them quickly being put right.

There were four additional breaches of the Health and Social Care Act 2008 (Regulated Activities)

Regulations 2014. This was because robust arrangements had not been made to safeguard people from situations in which they may be at risk of experiencing abuse. Sufficient care staff had not been deployed to enable people to promptly receive all the care they needed. In addition to this, care staff had not received all the training and guidance they needed and did not have all the knowledge and skills they needed to care in the right way for the people who lived in the service. The accommodation was not designed, adapted and decorated to meet people's needs and expectations. Furthermore, people had not consistently received care that respected their privacy and promoted their dignity. In addition to these shortfalls, there was one breach of the Care Quality Commission Registration Regulations 2009. This was because the registered persons had failed to submit statutory notifications in line with our guidance.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

As a result of these continuing and new breaches of regulations the overall rating for this service is 'Inadequate' and the service is therefore in, 'special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the registered persons' registration of the service, will be inspected again within six months. The expectation is that registered persons found to have been providing inadequate care should have made significant improvements within this timeframe. If not enough improvement is made within this timeframe so that there is still a rating of 'Inadequate' for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the registered persons from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

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

We found additional shortfalls in the service in relation to which we have made recommendations. This was because appropriate arrangements had not been made to offer people the opportunity to pursue their hobbies and interests and to engage in social activities. Suitable provision had not been made to fully enable people to review decisions they had made about the care they wanted to receive.

Our other findings were as follows: Some recruitment checks had not been completed in the right way to ensure that that only trustworthy people were employed to work in the service. Although there was a registered manager they had not been given all the resources they needed to support care staff to meet regulatory requirements. Furthermore, the registered persons were not actively working in partnership with other agencies to support the development of best practice.

Medicines were managed safely. People enjoyed their meals and were offered a choice of dishes. People were protected from the risk of experiencing discrimination. Suitable arrangements were in place to obtain consent so that people only received lawful care. People received coordinated care when they moved between different services and they had been helped to obtain any healthcare they needed. People had been supported to make decisions about things that were important to them by having access to lay advocates if necessary. Arrangements had been made to promote equality and diversity. This included promoting the citizenship rights of people if they followed gay, lesbian, transgender, bisexual and intersex life-course identities. There were arrangements in place to resolve complaints.

Provision had been made to support people at the end of their life to have a comfortable, dignified and pain-free death. Care staff recognised the importance of speaking out if they had concerns about the wellbeing of a person who lived in the service. The quality rating we gave the service at our last inspection had been displayed in the service and on the registered provider's website.

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.

There were serious and persistent shortfalls in the arrangements made to ensure that people received safe care and treatment. This included suitable steps not having been taken to reduce the risk of infection and to enable lessons to be learned when things had gone wrong.

There were significant shortfalls in the provision that had been made to safeguard people from the risk of abuse.

Sufficient numbers of care staff had not always been deployed and organised in the right way.

Background checks had not been completed in the right way before new care staff were appointed.

Medicines were managed safely.

Is the service effective?

Inadequate

The service was not effective.

There were significant shortfalls in the design, adaptation and decoration of the accommodation.

Care staff had not received all the training and guidance they needed to know how to care for people in the right way.

Suitable provision had been made to ensure that people were protected from the risk of experiencing discrimination.

People enjoyed their meals and were offered a choice of dishes.

There were suitable arrangements to obtain consent to care and treatment in line with legislation.

Suitable provision had been made to enable people to receive coordinated care when they used different services.

People had been supported to receive on-going healthcare

support.

Is the service caring?

Inadequate

The service was not caring.

Care staff had not been fully supported to provide care in a way that always promoted people's privacy and dignity.

Confidential information was not kept private.

People had been supported to make decisions about their care by having access to lay advocates if necessary.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People had not been offered sufficient opportunities to pursue their hobbies and interests and to take part in a range of social activities.

Although people received the practical assistance they needed, information about their care was not always presented to them in an accessible manner.

Suitable arrangements had been made to promote equality and diversity.

There were arrangements in place to resolve complaints.

Suitable provision had been made to support people at the end of their life to have a comfortable, dignified and pain-free death.

Is the service well-led?

Inadequate

The service was not well led.

There were multiple and serious shortfalls in the systems and processes used by the registered persons to assess, monitor and improve the quality and safety of the service.

The registered persons had failed to submit statutory notifications in line with our guidance.
Although there was a registered manager they had not been given all the resources they needed to support care staff to meet regulatory requirements.

The registered persons were not working in partnership with

other agencies to promote the delivery of joined-up care.

Care staff recognised the importance of speaking out if they had concerns about the wellbeing of a person who lived in the service.

The quality rating we gave the service at our last inspection had been displayed in the service and on the registered provider's website.

Saxon Lodge Residential Home Limited

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 registered persons continued to meet 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.

We used information the registered persons sent us in the Provider Information Return. This is information we require registered persons to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We also examined other information we held about the service. This included notifications of incidents that the registered persons had sent us since our last inspection. These are events that happened in the service that the registered persons are required to tell us about.

We visited the service on 28 August 2018 and 30 August 2018 and the inspection was unannounced. The inspection team consisted of a single inspector and an expert by experience. An expert by experience is someone who has personal experience of using or caring for someone who uses this type of service.

During the inspection visit we spoke with 10 people who lived in the service and four relatives. We also spoke with eight care staff, the housekeeper and the chef. In addition to this we met with the registered provider and the registered manager. We observed care that was provided in communal areas and looked at the care records for four people who lived in the service. We also looked at records that related to how the service was managed including staffing, training and quality assurance.

In addition, we used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of two people who lived with dementia and who could not speak with us.

After the inspection we spoke by telephone with two further relatives.

Inadequate

Is the service safe?

Our findings

At our last inspection on 21 June 2017 we found that the registered persons had not established suitable arrangements to assess, manage and reduce risks to people's health and safety so that they consistently received safe care and treatment. This was because sufficient steps had not been taken to ensure that people had enough to eat to promote their health. In particular, suitable arrangements had not been made to identify occasions when people had lost weight resulting in medical advice not being promptly obtained.

At this inspection, we were concerned to find that there continued to be serious shortfalls in relation to this matter. The registered manager told us that special provision had been made to monitor one person's weight because they had lost weight and were at risk of losing more due to having a poor appetite. However, we found that in practice the person's weight was not being regularly checked. This was because care staff had not been informed about the need to complete this task. We also noted that there were significant shortfalls in the arrangements that had been made to support three people who were at risk of not drinking enough. These arrangements included care staff checking how much each person drunk each day so that medical advice could be sought if there was a risk of them becoming dehydrated. However, we found that this task was not being completed in a safe and reliable way. When we checked records that showed how much two people had drunk between 24 July 2018 and 27 July 2018 we found that on each day the people had taken less hydration than the registered manager said a healthcare professional had advised was necessary. Indeed, in the case of one person they had taken less hydration over a period of three days than the registered manager said they should have consumed on one day. In addition to this, when we asked three care staff about this matter none of them knew how much each of the people concerned should have been drinking. Furthermore, one of them was not aware that the drinks consumed by the people needed to be recorded at all. These shortfalls had significantly increased the risk that the people in question would not have enough to drink to maintain and promote their health.

We found other shortfalls in systems and processes that had seriously reduced the registered persons' ability to provide people with safe care and treatment. The registered manager told us that it was, "Essential for the fire response procedure to start off in the right way", by all staff immediately going to the fire board in the lobby on hearing the fire alarm. However, when we asked three care staff about this matter they did not know where the board was located. In addition to this, one of them said, 'If the bell rings I'd start getting the residents out straight away if need be doing it on my own." Furthermore, records also showed that the registered persons had not made suitable arrangements for care staff to attend practice fire drills. The registered manager told us that each member of staff should participate in a fire drill, 'At least once a quarter." However, we noted that the last fire drill had been held on 15 March 2018. Furthermore, the record of the drill had not been created in sufficient detail for the registered manager to assure us that all staff had actually attended the event.

These shortfalls had seriously reduced the level of fire safety protection provided in the service and had increased the likelihood of people experiencing harm in the event of a fire.

The service had an addressable call bell system that was designed to enable care staff to quickly identify

from which bedroom a person was calling for assistance. However, we noted that four of the consoles used by people to make calls were broken and had been so for some months. These consoles had been substituted with units that were registered for use in other bedrooms that were not occupied. Unfortunately, when these replacement consoles were used they misdirected care staff. This was because they showed that the call had been made from one of the vacant bedrooms. The registered manager said that in practice this arrangement did not create the risk that people would not promptly receive assistance when they used their console. This was because all care staff knew about the revised arrangements. However, when we asked four care staff about this matter only one of them knew about the issue with the consoles and even they could not remember the details of which console referred to which bedroom. This poorly operated system had increased the risk that the people concerned would not be able to quickly ask for the assistance they needed to remain safe when in their bedrooms.

There were a number of other defects in the accommodation and equipment that had increased the risk of people having accidents.In one of the hallways the plaster on the wall was badly damaged and as a result it presented a sharp edge that could have caught a person's lower leg as they were walking by. There was also a further piece of plaster in another hallway that protruded at ankle level. A further shortfall was the toilet seats fitted in three communal toilets and in one bedroom's en-suite bathroom were loose and slid to one side as soon as any pressure was placed upon them. All these defects had significantly increased the risk of people having avoidable falls and experiencing harm.

We examined records of a weekly audit that had been completed to make sure that wheelchairs remained safe to use. The most recent audit completed on 21 July 2018 stated that no repairs needed to be completed. However, when we checked four wheelchairs that were in use we found that one of them did not have any working brakes.

We raised our concerns about the management of these risks to people's health and safety with the registered persons. They were not able to give us a detailed account of the steps they would take to put things right. They were also not able to give us a clear timescale within which any changes would be completed. Therefore, we concluded that there was no realistic prospect of the shortfalls promptly being addressed to ensure people's health and safety.

There were also significant shortfalls in the arrangements made by the registered persons to ensure that lessons were learned when things had gone wrong. This is necessary so that people can be helped to avoid accidents and near misses from happening again. There was a document called a 'Falls Audit Tool' that the registered manager said was used to plan how best to support people who were at risk of falling. However, we found that in practice this system was poorly managed and was of little value. An example of this was an entry dated 19 February 2018 that referred to the need for care staff to ensure that a person's bedroom was, "Clutter free .. (with) hourly checks in place, half hourly and 15 minutes if unwell." However, the identity of the person concerned had not been recorded and the registered manager could not recall who the person had been. Furthermore, they could not confirm that any of the checks had been completed. This was also the case in relation to another entry in the tool that stated, "Resident is bed bound and believes she can walk when she cannot. Half hourly checks 15-minute checks when a urinary tract infection is present."

We reviewed other records relating to two accidents that had occurred during 2018. We were told that robust steps had been taken to keep a person safe after they had fallen when in the garden and sustained an injury. This included care staff completing frequent checks to make sure that the person was supported whenever they wanted to move about indoors and when they wanted to go in to the garden. However, we noted that this provision had not been included in the person's care plan, was not known to four care staff to whom we spoke about the matter and was not always happening in practice. There were similar shortfalls

in relation to another accident that had occurred when a person had fallen out of bed. Records showed that it had been decided that care staff should complete two hourly checks of the person when they were in bed to make sure that they were comfortable and positioned safely. However, the need to complete these checks had not been included in the person's care plan to confirm to care staff what actions they needed to take. Furthermore, when we asked two care staff about this matter neither of them were aware of how frequently the checks needed to be completed. One of them said, "We check whenever we can and we're nearby. I'm not sure it's two hourly though. It's whenever we have the time and often we're short staffed."

Failure to assess and reduce risks to the health and safety of people living in the service had seriously increased the risk that people would experience significant harm as a result of not receiving safe care and treatment. This was a continuing breach of Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

People told us that they felt safe when in the company of staff. One of them said, "I'm very settled here and the staff are lovely and kind. They're nice and kind even when they're rushed and short staffed." Another person remarked, "Staff always say hello as they pass and so I feel part of the family." Relatives were also complimentary about care staff. One of them said, "I can't praise the staff enough for all of their kindness."

However, we found that there were serious shortfalls in the steps that had been taken by the registered persons to safeguard people from the risk of abuse. Records showed that between 22 May 2018 and 23 August 2018 there had been a total of five occasions on which care staff had recorded that two people had sustained unexplained injuries. Indeed, one of the entries described the person as having sustained, "Multiple bruises." We asked the registered persons what action had been taken to notify the local safeguarding authority about these injuries. This should have been done so that the authority could decide how best to protect the people concerned from sustaining further injuries. We were very concerned to learn that neither of the registered persons were aware that the injuries had occurred and as a result they had not made any enquiries to establish what may have caused them. In addition to this, neither of them knew that referrals should have immediately been made to the local safeguarding authority. We informed the registered persons about the need to notify the authority and this was done at the end of the first day of our inspection.

Failure to operate robust systems to ensure that people were safeguarded from abuse and improper treatment was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered provider said that they had carefully calculated the minimum number of care staff who needed to be on duty to enable people to safely and promptly receive all of the care they needed. However, we were not confident about how well this exercise had been completed. This was because records relating to the calculation were not complete. We also were concerned to note that one of the measures used by the registered provider appeared to not be accurate. This was because they told us that only four people who lived in the service routinely needed two care staff to assist them, whereas care staff and care records showed that five people often required this enhanced level of assistance. Three out of the five people who lived in the service whom we asked about the deployment of staff expressed reservations. One of them summarised these criticisms saying, "On some days there just aren't enough staff on duty plain and simple." Two relatives were also concerned about the sustainability of staffing arrangements in the service. One of them said, (There is a) strong staff team but they need someone else to stop them having to rush around. Staff numbers have gone down in the past four years."

Three out of the five care staff with whom we spoke about how the service was staffed told us that they were

very concerned about care shifts not being filled. They told us that this situation had often resulted in people having to wait to receive assistance. One of them told us, "On some days we've been down to two carers and the manager in the morning when there should be four plus the manager on duty. It's not safe."

We examined the roster that described the number of care staff who had been on duty in the period from 9 July 2018 to 15 July 2018 (inclusive). The roster was difficult to interpret because some of the entries were not clear. However, the registered manager examined the entries with us and conceded that on four days sufficient care staff had not been deployed to meet the minimum level set by the registered provider.

On both days of the inspection we noted that there were enough care staff on duty to meet the minimum level that had been set. However, we found that in practice this deployment of care staff was insufficient to enable people to promptly receive all care they needed and had the right to expect. An example of this was a person dropping an item of cutlery while they were having lunch in their bedroom and having to wait 20 minutes to be provided with a replacement. Another example was a person who sat for 30 minutes in their bedroom during which time they repeatedly called out for assistance from care staff who were busy elsewhere. Eventually, we brought the matter to the attention of care staff who shortly afterwards were seen assisting the person to go the bathroom.

Failure to deploy sufficient numbers of suitably qualified, competent, skilled and experience staff was a breach of regulation 18 of the Health and Social Care Act (Regulated Activities) Regulations 2018.

We examined records of the background checks that the registered persons had completed when appointing two new care staff. We found that there were limited shortfalls in the checks that had been completed for one of them. This was because a suitably detailed statement of their employment history had not been obtained. This oversight had reduced the registered persons' ability to determine what assurances they needed to seek about the applicant's previous good conduct. However, other checks had been undertaken. These included establishing that both applicants did not have relevant criminal convictions, had not been guilty of professional misconduct and had performed well during previous periods of employment. We raised our concerns about the oversight we identified with the registered persons who assured us that the a suitably detailed employment history would immediately be obtained for the member of staff in question. They also assured us that no concerns had been raised about the conduct of the member of staff since their appointment. In addition to this they said that the service's recruitment and selection procedure would be strengthened to ensure that each future appointment was supported by the completion of suitable checks.

Suitable arrangements were in place to safely order, administer and dispose of people's medicines in line with national guidelines. There was a sufficient supply of medicines that were stored securely. Most people had asked care staff to manage their medicines on their behalf. Robust arrangements were in place to support care staff when administering medicines. There was written guidance giving care staff information about factors such as a person's allergies and any special instructions about using medicines received from doctors. Care staff had received training and had been assessed by the registered manager to be competent to safely administer medicines. We saw them administering medicines in the right way and records showed that people had been given the right medicines at the right times.

Inadequate

Is the service effective?

Our findings

The accommodation was not designed, adapted and decorated to meet people's needs and expectations. The registered provider told us that it was important to maintain good standards of hygiene in the service to reduce the risk of people acquiring avoidable infections. They said that the service was, "Very clean." Although an audit completed on 10 August 2018 by the registered manager had stated that no improvements needed to be made, we found that there were a number of shortfalls in the provision made to promote good standards of hygiene. In one of the communal bathrooms there was a large patch of plaster on the wall that could not be effectively cleaned and which was dirty. The plaster had been exposed because 13 ceramic wall tiles had fallen off and had not been replaced. Furthermore, the wash hand basin in this room was stained and dirty. In another bathroom a cracked wall tile had been crudely mended with sticky tape that itself had become discoloured with dirt. In addition to this, the carpet in one of the bedrooms was so dirty that it stuck to people's feet as they walked on it. This was also the case in one of the hallways.

We also found that three of the cushions used by people who needed help to reduce pressure on their skin were very poorly maintained. This was because their plastic covers were torn and shredded away to reveal the cushions' internal foam. This foam had become dirty and in one case had a strong stale smell.

There were also shortfalls in the arrangements that had been made to promote good standards of hygiene in the kitchen. We asked to examine a copy of the last inspection report completed by the local food standards authority and we were concerned to note that this could not be found. Furthermore, the registered persons were not able to tell us what conclusions had been reached in the report and whether they had been required to make any improvements. Although the registered manager assured us that safe food handling practices were followed in the service's kitchen this was not fully supported by records that listed the cook-through temperature achieved for hot dishes. This is an important matter as the dishes concerned needed to be cooked in the right way to reduce the risk of people developing food poisoning. However, we noted that on two days in August 2018 no record had been kept to show that two dishes served at lunchtime had been cooked through in the right way. These shortfalls had all increased the risk that people would not receive harm-free care due to there being insufficient provision in the service to prevent and control the risk of infection.

In addition to this, there were a number of defects that detracted from people's ability to live in a homely setting. An example of this was two bedrooms in which the bedside lights were positioned so they were out of reach when a person was resting in bed. In another bedroom two of the double-glazed window units had failed and were misted up. There was a further defect in another bedroom in which some wool had been used to crudely repair a broken light cord pull. Elsewhere in bedrooms we found a broken venetian blind, a stained and scuffed area of wallpaper and a heavily stained item of furniture. In three communal bathrooms there were no light shades and in the dining room an area of wall was marked. Indeed, it was so damaged that it exposed the metal strip that had originally been used to support its construction. Also in this area one of the curtains was partly hanging off its runner. Other areas of the service also looked tired. In the hallways there were a number of places where paintwork had become chipped and marked.

We noted that a length of bannister rail had been installed in the back-garden to block off an area of decking that had rotted through to the supporting structure. The bannister rail looked unsightly because it was made of untreated soft wood that had become discoloured over time.
We read a number of entries in the maintenance log that was used to record and track the resolution of defects in the accommodation. We were concerned to see an entry dated 19 July 2018 that referred to a particular bedroom and which said, "Toilet leaking again at the down-pipe at the back of the toilet." There was no date to show that the problem had been addressed and so we checked the bedroom in question. We were very concerned to find that the pipe was still leaking and indeed water had spilled out onto the floor at the front of the water closet making the floor slippery. Speaking about the accommodation a person said, "It's just run down isn't it. Things get broken or worn out and they just don't get fixed and over time things add up."

We highlighted the shortfalls we had found with the registered persons and were concerned to note that none of them had been identified by their audit process as needing attention. Although they assured us that each of the shortfalls would promptly be addressed they were not able to give us a clear timescale when the improvements would be completed.

Failure to provide premises and equipment that were suitable for the purposes for which they were being used was a breach of regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they were confident that care staff knew what they were doing and had their best interests at heart. One of them said, "The care staff here are quite good and help me a lot and know how I like things done. The problem isn't the care they give it's more that they're so busy." Relatives were also complimentary about this matter. One of them said, "I think that the staff are wonderful and helpful and they do their best within the time given to them. I've seen them give my family member lots of little kindnesses."

However, we found that care staff had not been fully supported to consistently provide care in line with national guidance. In their Provider Information Return the registered persons said that it was important for all care staff to receive thorough introductory and refresher training. We examined records of the introductory training that had been provided for two care staff. We found that the records did not show that the care staff in question had received all the training they needed. This was because some of the records had not been completed at all, some were only partly completed and some had been completed in the wrong way. In addition to this, when we asked a member of care staff to describe the introductory training they had received they were not able to give us a clear account of the steps that had been taken to ensure that they had the necessary competencies to care for people in the right way.

The registered manager told us that all care staff received refresher training to ensure that they retained the skills and knowledge they needed to provide people with safe care. They said that this training was, "Essential and compulsory." However, we found that in practice the provision of this training was poorly organised. This was because some care staff had not undertaken particular courses. Examples of this were three care staff who had not completed training on how to assist people to keep their skin healthy and how to support people who were at risk of not drinking enough. We asked the registered manager about the measures being taken to address these shortfalls and were concerned to note their reply. This was because they were not able to tell us how the shortfalls were going to be addressed. Instead, they merely said, "We've fallen behind because we're all running around just trying to cover shifts."

In their Provider Information Return the registered persons also said that it was important for care staff to regularly meet with a senior colleague on a one to one basis to review their work and to receive support and

guidance. However, we found that in practice this arrangement was not working as intended. We were concerned to hear the registered manager tell us that these supervisory meetings were, "Significantly overdue because I've fallen completely behind organising them and have no chance of catching up as I'm working on the floor all of the time." We spoke with the registered provider about this matter. They told us that they had not been aware of the shortfall and said they were, "Very surprised."

We found that these shortfalls were reflected in the competencies two care staff brought to their work. This included the care staff not knowing all of the locations on a person's body where they are most likely to develop sore skin. Also included was the care staff not knowing all the signs that can indicate when a person is becoming dehydrated. These shortfalls increased the risk that people living in the service at the time of our inspection would not promptly receive all of the care they needed. This was because there was an increased likelihood that people would not quickly receive all of the assistance they needed to prevent them developing sore skin and to reduce the chance of acquiring more serious pressure ulcers. Also, there was more chance of people becoming dehydrated and experiencing a number of potentially serious healthcare conditions that can occur when someone does not have enough to drink.

Failure to ensure that sufficient numbers of suitably qualified, competent, skilled and experienced persons were deployed was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Arrangements were in place that were designed to assess people's needs and choices to ensure that people did not experience discrimination and enjoyed the safeguards established by the Equality Act 2010. An example of this was the registered manager asking people if they had particular expectations deriving from cultural and ethnic identities about how their close personal care should be provided and who should deliver it. Another example was the registered manager checking to see if people required their meals to be prepared in a particular way. A further example was people being asked if they needed additional assistance to dress in line with special personal requirements.

People told us that they enjoyed their meals. One of them remarked, "The food here is very good most of the time." Another person said, "We always get more than enough." There was a written menu which showed that there was a choice of dish served at each meal time. The meals that we saw served at lunchtime in the dining room were attractively presented and the portions were a reasonable size. The dining tables were neatly laid, the cutlery was clean, there were condiments on the tables and meal time was a relaxed occasion. People dined at their own pace, chatted and as necessary received assistance from care staff.

National guidelines had been followed to promote positive outcomes for people by seeking consent to care and treatment in line with legislation. The Mental Capacity Act 2005 provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The law 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 make 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 in order to receive care and treatment when this is in their best interests and legally authorised under the Mental Capacity Act 2005. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the Mental Capacity Act 2005. There were suitable arrangements to obtain consent to care and treatment in line with legislation and guidance. The registered manager and care staff were supporting people to make decisions for themselves whenever possible. They had consulted with people who lived in the service, explained information to them and

sought their informed consent. Also, when people lacked mental capacity the registered manager had ensured that decisions were made in people's best interests. An example of this was the registered manager liaising with relatives and healthcare professionals when a decision needed to be made about people having rails fitted to the side of their bed. These are sometimes necessary so that a person can rest safely in bed without accidentally slipping and falling onto the floor.

The registered persons had made the necessary applications for DoLS authorisations. Furthermore, they had checked to make sure that any conditions placed on the authorisations were being met. These measures helped to ensure that people who lived in the service only received lawful care that was the least restrictive possible.

Suitable arrangements had been made to ensure that people received effective and coordinated care when they were referred to or moved between services. This included care staff preparing written information likely to be useful to hospital staff when providing medical treatment. Another example of this was the registered manager offering to arrange for people to be accompanied to hospital appointments so that important information could be passed on to healthcare professionals.

People were supported to receive on-going healthcare support. This included senior care staff referring people to see their doctor if they were not well. During our inspection we noted that a senior member of care staff telephoned a person's doctor. This was because they were concerned that the person was not responding well to the treatment prescribed for them. Records also showed that arrangements had been made for people to have consultations with professionals such as dentists, physiotherapists and opticians.

Inadequate

Is the service caring?

Our findings

All the seven people with whom we spoke were positive about the care they received. One of them said, "I do indeed find the staff to be lovely and they're good people." However, three of them were concerned that the registered persons had not consistently provided care staff with all of the resources they needed to always provide them with a caring response. Summarising this view a person told us, "The staff are good but they've only got one pair of hands and if they're rushed off their feet what can they do. They have to rush with the care they provide don't they."

We found that suitable provision had not been made to enable people to experience responsive care that promoted their dignity. We noted that the registered persons expected care staff to wear a uniform but did not actually provide the garments. Over time this had resulted in care staff buying their own uniforms that were of different designs and colours. Two people told us that this arrangement was sometimes confusing for them. One of them said, "I do occasionally get muddled up between some of the staff and one of the nurses who calls from the health centre because they wear similar tunics." Another person said, "I sometimes don't know who staff are especially if they're temporary staff because I'm not sure about the uniform they should be wearing."

We examined a sample of flannels and towels that were in the airing cupboard and ready for use. Four out of five flannels were badly frayed at the edges so that the seams were partly detached and flapping loose. Three out of four towels were thread bare. We pointed this out to the registered manager that none of these items were fit for use. They told us that they had asked the registered provider to purchase replacements that had not been delivered to the service. The registered provider contradicted this account and said that the issue had not been brought to their attention. They assured us it would be resolved straight away but did not give us a definite timescale within which the improvement would be made.

Although we found that beds were neatly made, when we checked one of the mattresses we found that it was badly worn and very lumpy. We asked the person who occupied the bedroom in question about this matter. They said, 'It makes my back ache after a while and in the past I have asked for a new one." We asked the registered manager if there were other mattresses in use in the service that were in a similar condition. They told us that were, "Numerous mattresses like it."

Bedroom doors were fitted with locks and the registered manager told us that it was important for people to be offered the opportunity to secure their personal space. However, in practice this arrangement was poorly managed. This was because the registered manager could not confirm that people had in fact been offered the use of a key with which to lock their bedroom. We asked two people about this matter. Neither of them recalled being asked if they would like to be able to lock their bedroom door. Furthermore, both of them said that they would be interested in being able to do so.

On the first day of our inspection visit we were very concerned to see that a member of care staff had left out in the dining room a document they had completed during the handover session they had just attended. The document contained confidential information about a number of the people who lived in the service.

This included elements of the personal care they needed to receive to promote their continence and to manage medical conditions.

We were also concerned to hear some care staff inadvertently disclosing confidential information when speaking with each other. An example of this occurred on the second day of the inspection when we were in the lounge. We heard two care staff organising their work. One of them pointed to a person who was sitting nearby and said, "You take her now to the toilet and I'll check on (another person) in their bedroom to see if she's wet and needs changing".

Failure to ensure that people were treated with dignity and respect was a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Most people had family, friends or solicitors who could assist them to express their preferences and to explain how they wanted their care to be provided. Records showed and relatives confirmed that the registered manager had encouraged their involvement by liaising with them on a regular basis. Relatives told us that they appreciated the way in which they were made to feel part of the service. One of them said, "When I come in I always go around and speak with all the staff. I'm always made very welcome by the manager and staff." Furthermore, the registered manager had developed links with local lay advocacy resources. Lay advocates are people who are independent of the service and who can support people to weigh up information, make decisions and communicate their wishes.

People could speak with relatives and meet with health and social care professionals in private if this was their wish. We also noted examples of care staff assisting people to keep in touch with their relatives by post and telephone.

Requires Improvement

Is the service responsive?

Our findings

People had not been offered sufficient opportunities to pursue their hobbies and interests and to engage in social activities. Although there was an activities coordinator they were only present in the service on four days a week for a total of 12 hours. The registered provider told us that on other days care staff supported people to enjoy taking part in activities. However, when we asked two care staff about this matter they told us that this was not the case. One of them said, "Definitely not, as we absolutely don't have the time. You can see how busy we all are and today because you're here the place is fully staffed."

The activities coordinator said that they offered people the opportunity to participate in a range of small group activities. They also told us that they provided people with individual support, particularly if they chose not to participate in the group activities. However, we only saw two small group events taking place and we did not see anyone receiving individual support to pursue their hobbies and interests.

The activities coordinator told us that she had not received any training or guidance to undertake her role. They said that as a result, they had to rely on using "common-sense" when deciding which activities were likely to be popular. However, they acknowledged that this arrangement had not enabled them to develop activities that successfully engaged the interests of everyone who lived in the service. We examined the record that the activity coordinator had completed for one of the people who they described as being, "Difficult to engage." We were disappointed to note that over a period of nine days it had not been possible to engage the person in any meaningful activity. The record included entries stating, "Had tea, a few throws of the dice … slept in bed all afternoon …declined activity wanted to go to bed." We asked three people to give us their views about the calendar of social activities provided in the service. Two of them replied that they would like to be offered more opportunities. One of them said, "It can be a long day when there's nothing to do and perhaps we could have the occasional trip out but the problem is that they've got no transport here."

We observed two people who we were told spent a lot of time in their bedroom. We did this over the course of half an hour because we wanted to see how they spent their time. We were concerned to note that in both cases the people concerned spent nearly all of the time on their own. They were passive and showed that they were disengaged with their surroundings. They did this by undertaking repetitive actions that filled their time without giving them any observable signs of pleasure.

We recommend that the registered persons consult national guidance about how people who live in the service can be offered a range of imaginative and innovative opportunities to pursue their hobbies and interests.

Although people told us that they received a lot of practical assistance from care staff, we found that little had been done to build upon this to ensure that people consistently received personalised care that was responsive to their needs. This was because suitable provision had not been made to enable people to make and review decisions about the care they wanted to receive. In particular, little had been done to meet the Accessible Information Standard that was introduced on 1 August 2016. This measure requires all

providers of NHS care and publicly-funded adult social care to make suitable arrangements to support people have information or communication needs relating to physical and/or sensory adaptive needs. It also includes people who live with dementia and who need to have information presented to them in an accessible manner using techniques such large print and graphics. We noted that each person had a care plan and we were told that these documents were regularly updated to ensure that they accurately described the care people needed and had agreed to receive. However, the arrangements used in the service to engage people in reviewing the decisions they had made about their care were poorly developed. This was because in practice people's care plans were kept locked away and were only available for care staff to see. In addition to this, they were written in a formal management style and often presented information using technical terms and abbreviations with which most people would not be familiar.

Furthermore, although records showed that the care plans had been regularly reviewed by the registered manager to help ensure that they were up to date, this process had not involved the people to whom the care plans related. We asked three people about their experience of contributing to decisions about the care they received. Each of them told us that they did not know that a care plan had been prepared on their behalf and was supposed to reflect the assistance they had agreed to receive. One of them remarked, "It might be nice to have a look at mine to see what it says."

We recommend that the registered persons consult national guidance about how people who live in the service can be meaningfully consulted about the care they receive.

Care staff understood the importance of promoting equality and diversity. People were offered the opportunity to meet their spiritual needs by attending a regular religious ceremony that was held in the service. Care staff also recognised the importance of appropriately supporting people if they followed gay, lesbian, bisexual, transgender or intersex life-course identities. This included being aware of how to help people to access social media sites that reflected and promoted their choices.

There were suitable arrangements to ensure that people's complaints were managed in the right way. People had been informed about their right to make a complaint and how to go about it. The registered provider told us that since our last inspection they had not received any formal complaints.

The registered persons had made appropriate provision to support people at the end of their life to have a comfortable, dignified and pain-free death. This included consulting with people and their relatives to establish how best to support a person when they approached the end of their life. A part of this involved clarifying each person's wishes about the medical care they wanted to receive and the religious observances in which they wished to participate.

Inadequate

Is the service well-led?

Our findings

At our last inspection on 21 June 2017 we found that the registered persons had not established suitable arrangements to assess, monitor and improve the quality and safety of the service. This was because the quality checks that had been completed by the registered persons had not been robust. As a result, shortfalls in the running of the service were not being identified and quickly resolved. These included the registered persons' failure to take effective steps to reduce the likelihood of people having avoidable accidents.

After the inspection the registered persons told us that new and improved quality checks had been introduced to address all our concerns. However, at the present inspection we found that there were multiple and serious shortfalls in the arrangements that had been made. As we have described in our domain 'Safe', at the present inspection we found that robust arrangements had not been made to consistently reduce the risk of people having avoidable accidents. In addition, to this shortfall we found that a number of other quality checks were incomplete, poorly administered and ineffective. This had resulted in the persistence of the other concerns we have described earlier in our inspection report. These issues included oversights in the provision of safe care and treatment, staff deployment, the completion of background checks on new care staff and the delivery of staff training and support. Also included were shortfalls in the maintenance of the accommodation, arrangements made to promote people's dignity and in the provision of opportunities for people to pursue their hobbies and interests. Furthermore, there were shortfalls in the measures taken to enable people to make and review decisions about their care.

At the present inspection we also found that people had not been fully involved in making improvements to the service. Records showed that the two most recent 'residents' meetings' had been held on 18 July 2018 and 14 August 2018. However, we noted that only a total of 12 people who lived in the service had attended one or both of these meetings. We asked the registered persons what steps had been taken to obtain feedback from people who had not wished to attend the meetings. We were concerned to be told that nothing had been done. We also noted an example of no action being taken after a person had specifically requested that an improvement be made. This involved entries that had been made in the maintenance log. We were concerned to note an entry dated 31 August 2017 to the effect that a person had requested that the broken towel rail in their bedroom be repaired. There was another entry dated 12 February 2018 stating that the person had again asked for the item to repaired. A third entry showed that the matter had only been resolved on 27 August 2018 almost a year after it had first been raised.

We spoke with the registered persons about the shortfalls we had identified in the running of the service. We were concerned to note that their response principally focused on attributing blame within the senior management team. This detracted from their ability to concentrate on giving us information about how the shortfalls were going to be addressed. As a result, they were not able to give us a clear account of the improvements they would make or of the timescale within which they would be completed. Therefore, we concluded that there was no realistic prospect of the required changes promptly being made to ensure that the service provided people with safe care.

Failure to assess, monitor and improve the quality and safety of the services in the carrying on of the regulated activity was a continuing breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Services that provide health and social care to people are required to inform the Care Quality Commission of important events that happen in the service. This is necessary so that we can check that appropriate action has been taken. However, we noted that the registered persons had not always submitted notifications to us in appropriate and timely manner in line with our guidelines. This was because they had failed to tell us about the unexplained injuries that two people had acquired about which we have spoken in our domain, 'Safe'.

Failure to submit statutory notifications was a breach of regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

Three of the people who lived the service with whom we spoke said that they considered that the service was well run. One of them said, "Yes, it's pretty good I suppose as I have what I need here and the staff are kind." However, the other people all voiced reservations that mainly referred to the way in which care staff were deployed. One of them remarked, "It's okay here but on some days the staff are very rushed indeed and then it can be a bit fraught. Really, there should always be enough staff on duty shouldn't there as we do pay for this place."

Although there was a registered manager they had not been given all the resources they needed to support care staff to meet regulatory requirements. 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 told us that staff meetings should have been held on a monthly basis because they were, "Very important in order to promote good team work." However, records showed that the most recent staff meeting had been held on 9 January 2018. We asked the registered provider about this matter and they expressed surprise as they thought the meetings were being held each month as planned. When asked by the registered provider, the registered manager replied that it had not been possible to convene the meetings because, "I've had to cover so many care shifts myself." They also added in their explanation to the registered provider, "It's not possible to do care and to run the home with things that are desirable but not essential."

Given this situation we asked five care staff to give us feedback about their experience of working in the service. We were concerned that three of them were not satisfied. One of them summed up the views of these members of staff when they said, "The morale in the staff team is desperately low largely because they're simply aren't enough care staff on duty on most days and that's the case even with the manger working flat out. Also, just look around and see how run down it is. The residents can't even have decent flannels – only rags. This could and should be a lovely home to work in, but it's not."

We asked the registered persons to tell us what steps they had taken to enable the service to work in partnership with other agencies. This is important so that services can benefit from sharing ideas with other providers about how to develop best practice in order to better provide people with safe and responsive care. However, we were disappointed to note that neither of the registered persons could give us any examples of how they had enabled the service to benefit from working in partnership with others.

Care staff told us there was an explicit 'zero-tolerance approach' to any member of staff who did not treat people in the right way. As part of this they were confident that they could speak to the registered manager if

they had any concerns about people not receiving safe care. They told us they were confident that any concerns they raised with the registered manager would be taken seriously so that action could quickly be taken to keep people safe. However, we noted that care staff had not identified as a cause for concern the examples of poor practice we had identified. This lack of insight had contributed to people not always receiving the safe and person-centred care to which they were entitled.

It is a legal requirement that a provider's latest Care Quality Commission inspection report rating is displayed at the service where a rating has been given. This is so that people, visitors and those seeking information about the service can be informed of our judgements. We found the registered persons had conspicuously displayed their rating both in the service and on their website.

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 10 HSCA RA Regulations 2014 Dignity and respect The registered persons had failed to ensure that people were treated with dignity and respect.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered persons had failed to provide people with safe care and treatment by assessing risk to peoples' health and safety and by doing all that was reasonably practicable to mitigate any such risks.

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 registered persons had failed to safeguard people from the risk of abuse and improper treatment.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The registered persons had failed to provide premises and equipment that were suitable for the purpose for which they were being used.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered persons had failed to establish and operate effective systems and processes to assess, monitor and improve the quality and safety of the service provided.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The registered persons had failed to deploy sufficient numbers of suitably qualified, competent, skilled and experienced staff.