Barchester Healthcare Homes Limited

The White Lodge

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We undertook a comprehensive inspection over two days on 20 and 21 August 2018. The first day of the inspection was unannounced. On the 01 June 2018 we received information from the local authority which related to safeguarding incidents which the Care Quality Commission (CQC) had not been notified of. We contacted the provider who identified further incidents which we should have been notified of. In response to these concerns we undertook this inspection.

The White Lodge is registered to provide accommodation for persons who require nursing or personal care for up to 80 older people, some of who may be living with dementia. At the time of our visit 63 people were using the service. The home is situated over three floors. There were communal lounges and dining areas with satellite kitchens on each floor with a central kitchen and laundry. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

There was no registered manager in post at the time of our inspection. The last registered manager left the service in December 2017. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons. Registered persons have the legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We last inspected the service in June 2017. The service was rated Good in each domain and Good overall.

At this inspection we have found the service was not always safe, responsive or well-led. Therefore, the service has been rated as Requires Improvement in these three domains. The service remained Good in effective and caring domains. As a result, The White Lodge has been rated overall as Requires Improvement.

The registered provider failed to suitably assess risks to the health and safety of people who received care and treatment. Additionally, the service did not always do all that was reasonably practical to reduce such risks. This was a breach of Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

The registered provider failed to deploy sufficient numbers of staff to make sure that people's care and treatment needs are met. This is a breach of Regulation 18 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

The registered provider failed to operate an effective and accessible system for identifying, receiving, recording, handling and responding to complaints. This was a breach of Regulation 16 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Ineffective quality assurance systems meant that the provider could not always continuously learn, improve

and innovate. Ineffective audits put people at risk of potential harm, as areas for improvement had not been addressed to mitigate risk. The provider did not always actively encourage feedback about the quality of care and overall involvement with people who use the service. This is a breach of Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

The provider had not always notified CQC of other incidents within a reasonable time frame. This meant we could not check that appropriate action had been taken to ensure people were safe. The provider is in breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

The registered provider did not always ensure that people's mental capacity assessments were in line with the Mental Capacity Act Code of Practice. We made a recommendation that the provider seeks guidance to ensure they are meeting these standards.

Staff were trained and understood their responsibilities in regard to the safeguarding of vulnerable adults and were able to identify signs of abuse to keep people safe.

Staff received training relevant to their roles and were supported with regular supervision and annual appraisals. Staff spoke positively of the training that they were offered and undertook.

The provider had an effective recruitment and selection procedure in place and carried out relevant checks when they employed staff.

People received their medicines safely and on time from staff who were trained to manage medicines safely.

People were supported to maintain a healthy balanced diet. People told us the food was good and plentiful.

People using the service and their relatives commented the service was kept clean. The building was well maintained and provided a spacious environment.

Staff had developed caring relationships with people and treated people with kindness, and compassion. People were treated with dignity and respect. They were supported to maintain their independence wherever possible.

Staff spoke positively about the teamwork on units and expressed that they want the service to improve.

We identified three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and one breach of the Care Quality Commission (Registration) Regulations 2009. You can see what action we told the provider to take at the back of the full version of the report. Full information about CQC's regulatory response to breaches in regulation 12 Safe care and treatment and regulation 17 Good governance, will be added to the report after any representations and appeals have been concluded.

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 has deteriorated to Requires Improvement.

Risks to people were not always identified and mitigated.

There were not always sufficient staff deployed to meet people's needs.

Accidents and incidents were not analysed to reduce risks and actions were not always completed or followed up.

Medicines were managed safely.

People were supported by staff who knew how to recognise and report abuse.

People were protected from the risk of infection.

Is the service effective?

Good

The service remained Good.

People were encouraged to make decisions and the processes were in line with the Mental Capacity Act 2005.

Staff were supported through supervision and were provided training to undertake their roles.

People received support to eat and drink and lead healthy lives.

The environment was spacious and bright and met people's needs.

Is the service caring?

Good

The service remained Good.

People were positive about the caring nature of staff.

People's rights to privacy, dignity and independence were promoted.

People's confidentiality was maintained.

Is the service responsive?

Requires Improvement

The service has deteriorated to Requires Improvement.

Records did not always reflect the most up to date and accurate information about people.

Systems and processes were not effective to ensure complaints were responded to appropriately and in line with the providers policy.

People had their end of life care needs and preferences discussed and recorded.

Is the service well-led?

Requires Improvement

The service has deteriorated to Requires Improvement.

The systems in place to monitor the safety and quality of the service were not fully effective in identifying all shortfalls in the service and ensuring improvements were made.

The provider failed to identify themes and trends or lesson learnt.

The provider failed to notify us of other incidents without delay.

People and relatives were not actively encouraged to give their feedback.

Staff felt positively about their team members.

The White Lodge

Detailed findings

Background to this inspection

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

This was a comprehensive inspection which took place on 20 and 21 August 2018, the first day of the inspection was unannounced. The inspection team consisted of three inspectors and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of service.

Before the inspection we reviewed the information we held about the service which included previous inspection reports and notifications. A notification is information about important events which the service is required to tell us about by law. We also contacted the local authority safeguarding team.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

During the inspection we spoke to 10 people who use the service and observed interactions between them and the care staff. We also spoke to 12 relatives of people who use the service. We spoke to 24 members of staff including nurses, care assistants, activities coordinator, chef, maintenance, housekeeping, regional head of activities coordinator, deputy manager, clinical development lead, senior regional director and a general manager from another home who was supporting the management of The White Lodge.

We looked at 12 people's care records and associated documents. We looked at 15 people's medicines records. We checked 7 staff recruitment files, including the most recently recruited staff. We also looked at staff training records, quality assurance audits, compliments, complaints and accidents and incident records.

Requires Improvement

Is the service safe?

Our findings

The service was not always safe.

People were not always protected from a risk of harm. For example, one person's care plan dated January 2018 said the person had a "history of falls" and was at a "high risk of falls". The person had suffered another fall a few days before our inspection. Their care records stated that staff had organised for a sensor mat to be ordered. The equipment was still not in place on the first day of our inspection. We spoke with management and they told us although they specifically instructed the staff to order the sensor mat the previous week, this had not been done. Management told us that this was a "lesson learnt" and that "I should have checked it". In the accidents and incidents log, we additionally identified that the same person suffered another two falls earlier this year. There was no evidence that actions identified following these incidents, such as keeping the person's falls diary updated, had been completed. Management said they would follow this up immediately.

We reviewed another person's care records and their care plan stated they were at "high risk of falls". The person's falls diary had stated they had two falls this year in their bedroom, one of which resulted in a skin tear. Their falls care plan was last reviewed on 02 August 2018 and stated that the person was unable to call for assistance using a call bell due to their diagnosis of dementia, however, that they had a sensor mat in place and "Staff to ensure sensor mat is in place when [person] is in her bed or in her chair in her room". During the inspection we went to this person's room, where the person was found sitting in their chair however there was no sensor mat in place. We spoke with a member of the management team who told us, "If it is in the care plan, it should be there" and went on to say, "it may be in someone else's room". They later confirmed that the sensor mat had been unplugged and taken to another person's room. We raised our concerns with a member of the management team regarding this practice who told us "there are not enough sensor mats". Furthermore, we reviewed the accidents and incidents log and found that this person had fallen four times in their bedroom. There was no evidence that the actions identified following these falls had been completed. The falls diary was not up to date and the sensor mat was not in place at the time of inspection despite it being recorded as being in place following an incident in January 2018. Management ensured the person's sensor mat had been put in place following these concerns being raised.

Another person was assessed in January 2018 as being at "high risk of malnutrition". Their care plan stated that any further weight loss needed to be reported to the GP and involve a dietitian if needed. The person's weight chart showed that when the person was weighed 10 days before our inspection and they had lost 1.8 kg in one month and their BMI (Body Mass Index) dropped from 15 to 13. There was no evidence of any action taken to address this. We asked the staff who told us, "We need to refer [person] to GP, [we] will put them down for Thursday for the GP's visit".

People were not always protected from a risk of harm in case of an emergency. There was a summary of people's PEEPs (Personal Emergency Evacuation Plan) stored in a portable grab bag which was kept in reception. The grab bag was to be used in case there was an emergency such as a fire. This meant this information could be used for example, by the emergency services such as a fire service. We found the list

was dated 15 August 2018 and had not been reviewed or updated in five days. As a result, the list did not accurately reflect the people living at the service. This meant people would be at risk of delayed evacuation if there was an emergency. We raised this with the management who immediately updated the list.

We asked people and their relatives if they felt the service was safe. We received mixed responses. One person who resides at the service told us, "By and large as places go you have freedom and can't be completely safe. Now and again things do go missing as people wander around". Another person told us they, "Feel safe enough nothing ever happens to make me think otherwise". Another person told us they, "Don't feel worried about safety, [I] call and staff come".

We spoke with relatives who raised concerns about people's safety. A relative told us, "[I] came in today [and] found him asleep with food in his mouth", they went on to say it's "short staffed, [I] came in the other night and there was only one member of staff on the floor. It took an hour for him to be hoisted". Another relative told us they, "Don't feel [person] is safe. The number of times [person] has been safeguarded. [I] demanded a meeting with the mental health team, social services and the management."

Systems in place to investigate and monitor accidents and incidents were not always effective. Recording of accidents and incidents was not accurate or consistent. We found that accidents and incidents were not always recorded. For example, one person had fallen the week prior to the inspection and sustained injuries however, there was no accident/incident form available for this at the time of inspection and management could not assure us this had been completed. This meant the provider failed to ensure, where things had gone wrong, that information was available so that lessons could be learnt to improve the safety of the service for people.

Accidents and incidents were not consistently reviewed to look for patterns or to check that effective measures had been put into place to reduce the chance of them happening again. Investigations into incidents lacked sufficient detail which meant that opportunities to learn from them were missed. For example, we saw that one person had had seven falls this year, one of these falls did not have an accident/incident form completed and was found by the inspector through the person's falls diary in their care records. We reviewed the actions on each accident/incident form that had been identified to prevent reoccurrence and in five of the forms it stated staff should complete the falls diary. However, when we followed this up only one of these falls had been recorded in the person's falls diary. In addition, one of the accident/incident forms did not have any recorded actions to reduce the risk of a recurrence. We discussed this with management at the time of the inspection and they were unaware of this or that these actions had not been completed. This meant that people were at risk of harm as the provider failed to ensure that measures were in place to reduce the risk of recurrence.

Failure to suitably assess risks to the health and safety of people who received care and treatment and to do all that was reasonably practical to reduce such risks is a breach of Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

The service did not always deploy the number of staff it said it needed. There was inadequate deployment and management of staff. This was supported by comments we received from people who use the service where they raised concerns about how many staff were regularly on duty. For example, one person told us, "All the [staff] who work here [are] so busy rushing around like maniacs. Always give their best". Other people who use the service told us, "…there are not enough of them – not enough staff. [There is a] long wait sometimes". Other people told us, "[I get] attention when I need it" and "[There is a] bell by my bed to raise attention during the night. Usually [they] get to me fairly quickly, although I have had waits".

During our inspection we saw staff were not always deployed effectively. For example, we observed on one floor of the service that had nineteen residents, that there was only one member of staff visible for a 10-minute period despite there being a number of residents with complex needs left unattended in communal areas.

Staff told us there were not sufficient staff to keep people safe and meet people's needs. One staff member told us, "We said we need two or three staff [on the top floor], there is one carer based on top floor [at night]. I think it's unsafe". Another staff member told us, "We have one person [on the top floor] with challenging episodes, mostly at night and I think it could be down to staffing". We received further feedback from staff such as, "We have lots of people who need hoist or assistance with eating and if they need two staff then if someone else rings the bell they need to wait", "Sometimes we are short [of staff]. One person needs four staff, we go in 3" and "They are just not getting enough care and attention".

Relatives told us that the service did not have enough staff. One relative said, "There are not enough carers here. They don't get the attention". They went on to say when their family member had a personal care need that needs attending to, "I shouldn't have to ask, if I report it they don't bother to come. That's wrong". Another relative told us, "The biggest thing is shortage of staff, very often you can't find them". They went on to say about their family member, "[name] was left wet, you have to wait. She sat through her lunch wet".

The service used a dependency tool to set staffing levels to meet people's individual needs. On the first day of inspection we requested the rota for that week to show what staff were on duty. We reviewed the rota for the staffing levels for week commencing 20 August 2018. On the 22 August 2018 there were five staff on the rota for the night time shift, this consisted of two nurses and three care staff. However, one person in the service required four people to attend to them. Should they require support during the night this would leave one staff member to cover the needs of the remaining 62 people residing at the service. One staff member told us about the floor they worked on, "[there are 26 people and four [care] staff, we tell nurse to watch the floor when four of us attend one person".

Failure to deploy sufficient numbers of staff to make sure that people's care and treatment needs are met is a breach of Regulation 18 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Staff were trained in protecting people from abuse. Staff knew how to report abuse and were knowledgeable about safeguarding and identifying the signs of abuse. One staff member told us if they had concerns, "You have to report, to nurse in charge, deputy or regional manager or social services". Another staff member told us, "You have to report any safeguarding concerns, we've got the social services on call number for the weekends". Staff were knowledgeable in the providers safeguarding and whistleblowing policies. However, staff did not feel confident to follow the whistleblowing policy if they needed. One staff member told us, "I have no one to turn to". Another staff member said, "Staff are worried about the job, nobody listens to us".

The service kept recruitment records of staff. Records showed the service sought evidence of people's conduct in previous employments in the form of employment references and carried out Disclosure and Barring Service checks. These checks identified if potential staff were of good character and were suitable for their role.

Medicines were managed safely. People told us they received their medicines safely. One person said, "[I] wait for nurse to come in and bring my tablets then I can get about. In a lot of pain so I need painkillers". Another person told us about their medication that they, "Get them when I need them". People's medicines were stored in a designated, secure room and were locked in a medicines trolley. Temperatures of the

medicines refrigerator and medicines storage room were monitored and recorded to ensure medicines were stored as per manufacturers' guidance. People's medicines administration records were accurately completed. Where people were prescribed 'as required' medicines, there were protocols in place to guide staff in when these medicines may be required. The disposal of medicines and the management of controlled drugs was safe and in line with guidance. We observed staff administering people's medicines and they followed good practice guidance, for example, staff washed their hands before administering people's eye drops or checked and recorded people's pulse before administering medicine that required this. Staff responsible for handling medicines had completed training and had been observed in practice to ensure they were competent to administer medicines.

Staff had training in infection control procedures. There was a cleaning schedule in place to ensure the service was clean and regular infection control audits were carried out to ensure correct procedures were followed. Throughout our visit the service was being cleaned and there were no unpleasant odours in the building. We observed staff followed good hygiene practice guidelines and used personal protective equipment such as disposal gloves and aprons when supporting people with personal care. People told us that they felt the service was clean. One person said, "Oh yes nice and clean. Can't fault them on that one". Another person said, "[I] like my room, [it's] cleaned very well".

Good

Is the service effective?

Our findings

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 people lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and be as least restrictive as possible. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals is called the Deprivation of Liberty Safeguards (DoLS). The provider had made DoLS referrals for people who had restrictions in place in relation to their care and support. We checked whether the home was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We saw where the applications were due to expire the staff promptly contacted the local DoLS team as per their procedures.

People were able to make their own decisions and we observed staff offering choices to people. People told us that they were able to make decisions about their care. One person told us, "I can choose when I get up and when I go to bed". Another person told us, "[Staff] ask me if it's alright to do something. [They are] all very kind". Another person told us, "If a male carer is on duty, staff will always ask me if would mind having a male carer. I don't mind".

Staff knew the principles of the MCA and understood people's right to choose and sought people's permission before supporting them. During inspection, we saw staff gave people choices and encouraged and supported them to make decisions. For example, one staff member was observed asking a person, "Can I give you your medicines?". One staff member told us, "Even if [people make] an unsafe decision, or you think it's not right – respect people's decision but make sure they are safe". Another staff member told us, "You always assume they [people] got capacity unless you carried out an assessment".

We however found people's capacity assessments were not always in line with the Code of Practice. We identified these were not always decision specific and in some cases more than one decision had been recorded. For example, one person's capacity assessment reflected the two following decisions, "control of all activities of daily living" and a "restriction of movement". A staff member told us, "We need to redo the capacity assessments so they are decision specific". The provider had already identified this as an area for improvement through their own quality assurance processes and planned to address this in due course.

We recommend that the provider refers to the Mental Capacity Act Code of Practice when formulating people's individual capacity assessments.

People's needs were assessed prior to admission to the service to ensure these needs could be met by the staff. The information gathered during the pre-admission assessment was used to formulate people's care plans. The pre-admission assessment included people's physical needs such as mobility, as well as their communication needs and cultural and spiritual needs.

People were cared for by staff who were supported through training and supervision which helped them to care for people effectively. This training included topics such as basic life support, health and safety, moving and handling, safeguarding and food safety. Nursing staff told us they had specialist training surrounding clinical procedures such as wound care and syringe driver training. Staff complimented the training and support received. Comments included, "Training is really good, [I] had wound care [and] syringe [training]", "Good training, if you did not understand something she [trainer] explained" and "We had training around dementia which included challenging behaviour". Staff told us they received supervision from a manager. One staff member told us, "We do get supervision, the deputy did mine". Another told us, "I had four supervisions with nurse in charge". Staff told us that they felt the induction was a positive learning experience to enable them to do their role. One staff member told us, "Good induction. They showed us how to treat people, including moving and handling and I did all the e-learning". Another staff member said, "When I started I did shadowing (working alongside an experienced member of staff) it was helpful".

People were supported to maintain a healthy balanced diet and their nutritional and hydration needs were assessed. The plans detailed people's food likes and dislikes, food allergies or intolerances, any special dietary requirements, equipment and support people needed to eat and drink. Staff were knowledgeable about people's dietary needs. People told us they got a choice of food and drink and that it was plentiful. One person said there is, "Plenty to eat and drink". We got mainly positive responses from people about the quality of the food. One person told us, "Course I like the food. [I] would tell them if I didn't and they would bring me something different". Another person told us, "[The] food [is] alright, not a fussy eater. Known to eat everything [and] never send anything back". Another person told us, "[The] food [is] brilliant. Putting on weight so needed new clothes".

We observed people being provided meals during lunchtime. Staff encouraged people to sit in the dining room to eat their meals. They offered verbally and visually a choice of two hot meals. Staff guided some people on how to use their cutlery until they were confidently eating independently. Some people became distracted and left the dining room before finishing their meals. We observed staff sensitively encouraging people to return and finish their meals, however some people declined. We were told their meals and desserts would be kept for later in the day and staff would try again.

People were supported to access a range of health professionals when required. People told us they were supported by appropriate health care professionals. Comments included,"[The] GP pops in and I see the mental health team…" and "[I see a] GP when I need one. My GP is the same one as for here". Staff told us they work alongside healthcare professionals. One staff member said, "[The] nutritionist came and reviews and gives us guidance, she's really good". Staff worked well between the departments within the service, for example, we saw that information was shared between the care and kitchen staff. The management told us they planned to have a nutrition meeting in the near future to look at management of people's dietary needs and weight management. The meeting would include catering and nursing and care staff.

The environment was spacious, bright and well-lit and some refurbishment and decoration had taken place in communal areas and in some bedrooms. The service consisted of three units over three floors. There was a choice of communal areas and an enclosed secure garden. The building was free of trip hazards. People could personalise their bedrooms with their own items. The provider ensured the décor was maintained and updated when needed, for example, when people moved out. People told us they were happy with the building, how it was maintained and the garden areas available. One person told us, "[I'm] lucky I have one of the bigger rooms. Very nice view. When I first came I said I would like this room so it has worked out very well". Another person told us, "[There is a] nice garden. [I] do go in it". Relatives told us they were happy with the premises and that it met people's needs. One relative told us, "It's a lovely home and lovely setting". Another relative said, "The home itself is lovely".

Good

Is the service caring?

Our findings

People benefitted from having a staff team who were kind, caring and compassionate. Some of the staff team had been working for The White Lodge for a long period of time. People told us, "Very nice carers, no worries at all, everyone is very kind". Another person said, "So far [staff have] coped very well with me. Nurse [is] brilliant and carers fabulous. Can't fault them. Very good". Relatives told us they felt the staff were kind and caring. One relative told us, "They are caring..." . Another relative said, "Some carers are outstanding…".

We observed positive interactions between staff and people. Staff listened to people and talked to them in an appropriate way so they could understand. They adjusted themselves so they were at the same level and maintained eye contact when speaking with people. Staff were purposeful and positive in their communication with people and gave people time to express their wants and needs and make decisions about their care. One staff member told us, "We should always give a choice to people, we offer choice, like clothing".

Staff respected people's wishes if they refused support and assistance but monitored people from a distance and intervened when necessary. For example, one person was offered support to get dressed which they refused. Staff ensured they remain warm and comfortable in their nightclothes and the person joined an activity. Later in the morning, staff approached the person again who willingly agreed to be helped to get dressed. People's relatives where appropriate were involved in people's care. Records reflected discussions with significant others including family and health care professionals and the outcome of the decision were detailed.

People told us they were treated with privacy, dignity and respect. One person told us, "[Staff] always make sure they knock on my door". Another person said, "Carers help me with showering, [they] always treat me with dignity and respect. [I'm] given a choice of male or female carers. [I] don't mind either". Staff were mindful of the importance of maintaining people's privacy and dignity. Staff told us, "You've got to see any person as your own grandfather, as you would want your family to be treated". Another staff member said, "I treat people like I would like my own parents to be treated". We observed staff interactions with people were respectful. Staff knocked on people's doors and asked if it was alright to enter. Staff approached people in different ways, encouraging independence and indicating that they knew how people liked to be treated.

People's confidential information and records were stored appropriately and securely in the offices within the service.

Requires Improvement

Is the service responsive?

Our findings

People's needs had been assessed and personalised care plans were in place. The plans included information on their preferences, communication needs, daily routines and their personal care needs. There were care plans surrounding people's personal hygiene, elimination and mental cognition. We reviewed people's care records and we found some care plans were not always clear. For example, one person's care plan reflected the person was assessed as at risk of choking. Their nutrition care plan stated they required drinks thickened to "stage 3". The person's risk assessment said the person needed drinks thickened to a "custard consistency". The person's medicine chart read, "add 3 scoops [of fluid thickener] to drinks", not specifying the amount of drink. We asked the staff for a copy of the assessment by the Speech and Language Therapist to clarify the directions but the staff were unable to produce it. The nurse told us they were going to refer the person for a reassessment.

Some care plans did not always reflect the level of support needed. For example, one person's care plan stated the person needed to have 1.5 litre of fluids per day and this needed to be documented on food and fluid chart. When we talked with staff they said there was no concern around the person's hydration and told us it was not the amount of the fluid but the temperature of the hot drinks served that needed monitoring due to the risk of scalding. We saw that another person's care records stated that they had a history of urinary tract infections and staff should encourage them to drink 1.5 litres of fluid a day and document this on a food and fluid chart. However, the chart was not available. We spoke with a staff member who told us that this person did not require monitoring anymore as they drank "plenty of fluids".

We asked people how they spent their days and what activities they were involved in. One person told us, "[I] like to join in with the things that are going on here. Like going outside and on trips". Another person said, "I write, read, do puzzles and I have a TV". The service had a weekly activity timetable which included a number of activities on offer to people such as garden walks, bingo and arts and crafts. However, there was not always evidence available that people were provided with meaningful activities that met their assessed needs. For example, one person's activities care plan said the person was to have "room visits many times throughout the day, come down to group activity twice per week and that the service would look at [providing] an "art book". This person's records of activities for July 2018 showed they attended four activities in one month; a chat with a volunteer, a group picnic on the lawn, fancy hats and breakfast club. Additionally, in the first three weeks of August the person attended: one singing activity, one "tea and chat" and had another" "chat".

Another person's records stated the activities they would do each week included bingo, arts and crafts, music and wiggles, entertainers, trips, coffee morning, film afternoon and garden walks. However, the person's monthly activity evaluation had last been updated in June 2018 and stated, "not managed to get [name] to activities yet". We discussed this with the senior regional director and the regional head of activities coordinator who told us that the recording of people's outcomes and involvement in activities was an area they had identified that needed improvement. The service had recently employed a new activities coordinator to help enhance people's social and recreational pursuits.

Records did not always reflect the most up to date and accurate information about people. This meant that people may not receive the care and support they need. This is a breach of Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

The provider had a complaints policy however this was not always followed. Complaints and concerns were not adequately managed and investigated by the provider. The service did not always have a record of complaints and concerns that had been raised by people or their relatives. We spoke with management who told us, "we don't have a [complaints] log". However, they confirmed that they believed they only had one open complaint currently. We requested where this was recorded and they advised "we cover complaints in our daily stand up meeting". We reviewed the minutes of these meetings and did not find evidence of this complaint being discussed. We spoke with management who said, "there should be a file [for complaints]". Following the inspection, the provider sent us two copies of complaints which evidenced they were responded to appropriately. However, they did not relate to the open complaint that we were made aware of during inspection. During the inspection a number of relatives informed us they had raised concerns or made a complaint that they had not received an adequate response for and we could not find evidence that these complaints had been documented or responded to during our inspection. Relatives told us they often never received a response following a complaint. One relative said, "I have put my concerns in writing". Another told us, "I know how to complain but not keen on the system. Not kept informed of what has been done". Another relative said, "I have made a complaint and the manager said, 'leave it with me'. Nothing has been done".

The registered person failed to operate an effective and accessible system for identifying, receiving, recording, handling and responding to complaints. This is a breach of Regulation 16 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

At the time of inspection, we were informed that no one was receiving end of life care. People's care records contained the Treatment Escalation Plan that included people's choices around their wishes in relation to resuscitation decisions. The records showed these decisions were discussed with people and, where applicable and relevant, their relatives..

Requires Improvement

Is the service well-led?

Our findings

At the time of our inspection the service did not have a registered manager in post. The last registered manager left in December 2017. The service had another manager since then who left their post before they registered with the CQC. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like the registered provider, 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 provider had put measures in place to ensure the service had adequate management support whilst they were recruiting a new manager. During the inspection there was a deputy manager, a registered manager from another service, clinical development lead, regional head of activities coordinator and a senior regional director present in the service.

The acting general manager was on leave at the time of inspection. We asked people about the manager of the service. People told us they did not know who the manager was. We received comments such as, "I know nothing about the management", "I don't know who the manager is" and "Manager…I don't know". Staff and relatives raised concerns regarding the high turnover of management in the service. One relative told us, "[I have] concerns about the changes in manager". Another relative said, "We are on our fifth manager here. [It] worries me too". Staff told us, "It's been up and down, managers come and go. We had a difficult time, different managers with different ideas", "Little bit hard not having a stable manager but we help each other" and "[There has] been so many changes with changing managers".

Systems for monitoring and improving the service were not always effective. There were a range of audits in place to monitor the quality and effectiveness of the service. These included kitchen, medication, housekeeping and infection control audits. Care plans and risk assessments were in the process of being audited to ensure that they were a complete and accurate reflection of a person's needs. The provider completed a quarterly Quality Improvement Review (QIR) which identified all areas of improvement needed within the home. Many areas for improvement had been identified on the QIR. However, areas for improvement identified were not always actioned promptly. For example, a QIR completed in March 2018 identified an action that mental capacity assessments should be decision specific. The QIR stated, "MCAs are to be decision specific…". At the time of our inspection we found capacity assessments were still not always decision specific.

The March 2018 QIR also stated that the provider was not completing annual mattress audits. At the time of inspection, we spoke to a relative of a person using the service who had made a complaint to a staff member that the person's mattress was dirty. The relative advised that this had been dealt with very recently by the service. We spoke with management and asked to see the mattress audit that should have been undertaken, however they advised this had not been completed.

We found that the most recent QIR completed in July 2018 by the provider, identified that personal emergency evacuation plan (PEEPs) "have not been updated following change to occupancy". At the time of our inspection, PEEPs were still not up to date and did not contain information for all the people residing at the home.

The service did not have sufficient oversight of accidents and incidents. Accidents and Incident forms had not always been completed and investigations and actions had not always been undertaken to prevent reoccurrence. Where actions were identified these had not always been followed up. When we raised these concerns with the management team they were unaware that these actions had not being completed. At the time of inspection, the provider was unable to assure us that they had completed audits on accidents and incidents to assess, monitor and improve the quality of the service being delivered to ensure they were keeping people safe.

The provider had failed to ensure the complaints were managed in line with their policy and to assure themselves that investigation and action was taken. The provider could not evidence that patterns and trends had been identified to understand how improvements could be made to the service, or that learning had taken place and shared with the staff group to improve performance.

Staff were not fully confident in the provider and felt their views and feedback was not always valued. Staff told us that team meetings took place but they were not always well attended and communication was not as good as it needed to be. One staff member told us, "Poorly attended team meetings, sometimes only two people attended", and went on to say, "Even if we raise concerns nothing changes". Another staff member told us, "we have unit meetings to discuss concerns and improvements. There is not enough communication across the units and with management".
We looked at whether people and their relatives were encouraged to give their views about the service they received. Resident and relative meetings took place periodically throughout the year. There was evidence that meetings with people and relatives had occurred, however further improvement was needed in the frequency of the meetings and to ensure relevant information about the home was shared appropriately with staff, people and relatives. One relative told us, "Apparently there is a relatives' meeting. I haven't been to one yet".

The provider had implemented a 'resident of the day' scheme to enable care home staff to gain a better understanding of what is important to each resident and what would make a difference to them. This could then inform staff how to improve people's experiences of care going forward. However, people told us they did not feel engaged in providing feedback about their care. People and relatives told us they were not always involved in the development of their care and their care plan. One person told us, "Care not discussed". Another person said, "Care plan, not involved with this". We asked relatives if they were involved in the development of care of their relative and we received a mixed response. Comments we received from relatives included, "To a degree. It was rushed and we had to ask for things that [person] needed", "[I'm] involved in care plan reviews" and "…[I] don't feel communication is good".

Ineffective quality assurance systems meant that the provider could not always continuously learn, improve and innovate. Ineffective audits put people at risk of potential harm, as areas for improvement had not been addressed to mitigate risk. People were not always actively encouraged to feedback about the quality of care and overall involvement with the service. This is a breach of Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Services that provide health and social care to people are required to inform the Care Quality Commission (CQC), of other incidents that happen in the service, without delay. The provider had not always notified CQC of reportable events within a reasonable time frame. This meant we could not check that appropriate action had been taken to ensure people were safe. This is a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

We saw that staff worked well as a team and spoke highly of each other. We received comments from staff

such as, "The team is good", "We [the team] support each other" and "I am very happy to work here, people here are like my family". Staff told us they wanted the service to improve. We received comments such as, "It will be good to have a stable manager and some directions", "If we can get a manager who has a vision it would be good" and "I just want the service to get well".
The team also worked in partnership with other organisations including local social and health professionals. People's care records reflected a number of professionals were actively involved in people's care and appropriate information was shared with other professionals. This included GPs, chiropodist, mental health teams and opticians.

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 Treatment of disease, disorder or injury	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The registered person failed to have effective and accessible systems in place for identifying, receiving, recording, handling and responding to complaints by service users and other persons in relation to the carrying on of the regulated activity. Regulation 16 (1)(2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The registered person failed to deploy sufficient numbers to meet people's care and treatment needs. Regulation 18 (1)

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents
Treatment of disease, disorder or injury	The registered person failed to notify the Commission without delay of other incidents. Regulation 18 (1)(2)(a)(b)(e)

The enforcement action we took:

The provider was served with a fixed penalty notice on 11 October 2018.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	The registered person failed to provide care and treatment in a safe way. Risks to service users health and safety were not always assessed and the registered person failed to do all that is reasonably practicable to mitigate any such risks. Regulation 12(1)(2)(a)(b)

The enforcement action we took:

The provider was served with a warning notice, which required compliance with Regulation 12 by the 21 December 2018.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	The registered person failed to assess, monitor and improve the quality and safety of the services provided. Risks were not always assessed and monitored to mitigate such risks to ensure the safety and welfare of service users . Service user records were not always up to date and accurate.

Audit and governance systems were not always effective.

Regulation 17(1)(2)(a)(b)(c)(e)(f)

The enforcement action we took:

The provider was served with a warning notice, which required compliance with Regulation 17 by the 21 December 2018.