Care Quality Commission

Barchester Healthcare Homes Limited

Ritson Lodge

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

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

Ritson Lodge provides care and support for up to 60 people who live with dementia and have nursing or residential care needs. At the time of the inspection, there were 49 people using the service. People were accommodated across three separate units in the home: Seabreeze (nursing care), Seashore (residential care) and Memory Lane (dementia care).

At our last inspection 31 October 2017, we identified a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014. There were concerns over staffing level arrangements and the service was not consistently well-led. We rated the service 'Requires Improvement' overall. We told the provider to submit an action plan of how they intended to address the concerns we raised. At this inspection 31 October 2018, we found the provider had not made satisfactory improvements to ensure that they were consistently delivering a quality safe service and that standards of care had deteriorated.

During September and October 2018, we received several whistleblowing concerns, safeguarding concerns and other information of concern about the service. We therefore brought this scheduled inspection forward, so that we could check that people were receiving safe care. At this inspection we found people's health, safety and well-being was being compromised in multiple areas and identified significant concerns regarding the management and leadership of the service due to ineffective governance and oversight arrangements. People were being put at risk of harm due to unsafe management of medicines, poor record keeping and ineffective risk management. We have rated this service overall inadequate.

We found the home was in breach of four regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. One of these regulations is a continued breach from the last inspection 31 October 2017. You can see what action we told the provider to take at the back of the full version of the report.

Since the last inspection there had been several changes of manager. The registered manager of Ritson Lodge was no longer employed by the provider nor was the provider's operations manager, who had been brought in as their replacement. A third manager has been appointed and they are in the process of registering with CQC. 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.

There were ineffective governance oversight arrangements in the service. The provider had not made the improvements expected since the last inspection, as a result people did not consistently receive safe care

and remained at risk of harm. Systems in place to monitor the quality and safety of the service provided were not robust enough for the service to independently identify shortfalls and mitigate risk.

Risks to people's health, safety and welfare were not managed effectively, placing them at significant risk. People's care records were not always person centred and accurate. They lacked information to guide staff in how to meet their needs safely and effectively.

Systems for the safe management of medicines and safeguarding people from abuse were not robust. The service was not consistently working within the principles of the Mental Capacity Act 2005.

Although staff were caring in their approach, people were not consistently supported in a way that upheld their dignity and respected their privacy. Activities did not always meet the individual and specialist needs of all people.

There were sufficient numbers of staff to meet people's needs who had been recruited safely. However, the deployment and organisation was not wholly effective at times. Improvements to support staff through supervision and training were ongoing.

There was a complaints procedure in place and people and relatives knew how to voice their concerns.

The environment met the needs of the people who lived there. Systems were in place to protect people from the risk infection.

The overall rating for this service is Inadequate and the service is therefore in 'special measures'.

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

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

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

Full information about CQC's regulatory response to any concerns found during inspections is added to reports 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?

Inadequate

The service was not safe.

Risks to people's health, safety and welfare were not managed effectively which placed people at risk of harm.

Systems for the safe management of medicines were not robust.

Consistently reliable systems, processes and practices needed to safeguard people from abuse were not in place.

There were sufficient numbers of staff to meet people's needs who had been recruited safely. However, the deployment and organisation was not wholly effective at times.

Systems were in place to protect people from the risk of infection.

Is the service effective?

Requires Improvement

The service was not always effective.

The service was not consistently working within the principles of the Mental Capacity Act 2005.

Risks regarding people's nutritional needs were not consistently identified, assessed, monitored and managed effectively.

People's care records contained limited or conflicting information and shortfalls were found in people's food and fluid charts.

Improvements to support staff through supervision and training were ongoing.

People had access to healthcare services and appropriate referrals were made when people's needs changed.

The environment met the needs of the people who lived there.

Is the service caring?

Requires Improvement

The service was not always caring.

Although staff were caring in their approach, people were not consistently supported in a way that upheld their dignity and respected their privacy.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's care records were not always person centred and accurate. They lacked information to guide staff in how to meet their needs safely and effectively.

Activities did not always meet the individual and specialist needs of all people.

People and relatives knew how to complain.

Is the service well-led?

Inadequate

The service was not consistently well-led.

The service had not made the improvements expected since the last inspection. People did not receive safe care and remained at risk of harm.

There were ineffective governance oversight arrangements in the service.

Care Quality Commission

Ritson 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 comprehensive inspection took place on 31 October 2018 and was unannounced. It was undertaken by three inspectors, one of whom was a pharmacist inspector from the medicines team, a specialist advisor in nursing care 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 requested that the provider complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. This was received from the provider.

We also reviewed information that we held about the service. Providers are required to notify the Care Quality Commission about events and incidents that occur including unexpected deaths, injuries to people receiving care and safeguarding matters. We received feedback from the clinical commissioning group (CCG) and the local authority quality assurance team. We were made aware that on 5 October 2018, following recent safeguarding's and concerns about the care provided, the local authority served a quality improvement notice on Ritson Lodge. The provider responded with an action plan which they shared with us as part of this inspection.

We spoke with 14 people who used the service, seven relatives and one visitor. We observed the interactions between staff and people. We spoke with the newly appointed general manager, the provider's regional director and senior regional manager, a registered manager from another of the provider's services, two activities coordinators, one maintenance person and 11 members of care and catering staff.

Following the inspection visit we spoke to one relative on the telephone and received electronic feedback from another relative. We also received feedback from four health and social care professionals.

To help us assess how people's care needs were being met, we reviewed nine people's care records including risk assessments and medicine administration records. We also looked at records relating to the management of the service, recruitment, training, medication records and systems for monitoring the quality of the service.

Inadequate

Is the service safe?

Our findings

During our last inspection on 31 October 2017, we rated this key question as requires improvement, as there were not enough staff to meet people's needs. At this inspection the staffing levels were sufficient but deployment of staff was not wholly effective. In addition, people continued to be at risk of harm as risks to their safety and wellbeing had not been adequately assessed, monitored or evaluated. In addition, the management of people's medicines was not safe. This resulted in a breach of the Health and Social Care Act 2008 (Regulated Activities) 2014. The rating for this key question has changed to inadequate at this inspection.

We were not assured that risks to the safety of people were properly assessed or their safety appropriately monitored within the service. This was because the care records we looked at either lacked clear information or contained conflicting information. They were cumbersome and disorganised. This made it difficult to access information in a timely manner.
Where risk assessments were in place, they did not clearly and concisely indicate the actions which staff needed to take to reduce those risks to people. Information in risk assessments was not always accurate or up to date and risk assessments had not been regularly reviewed.

For example, information regarding one person's skin fragility in respect of acquiring skin tears, stated that the person was at very high risk of acquiring pressure ulcers, with a Waterlow risk assessment score of 23. This assessment was dated 21 October 2018. An additional assessment that was also in the person's care plan stated that the person was only medium risk. A Waterlow risk assessment is a tool used to provide a score or scale of the estimated risk for the development of a pressure sore in a person. A score of 20+ indicates very high risk. Information in this person's care records did not assure us that the person's skin fragility had been safely assessed and effective guidance was in place for staff in the prevention and management of pressure ulcers.

This person also had diabetes. There were no risk assessment or care plan in place with regard to their diabetes. Information in this person's care records did not identify how risks associated with their diabetes were being safely assessed and managed.

For another person, we saw that their care records had been briefly updated with handwriting that was difficult to read. A few sentences, that were not prominent, stated that a speech and language assessment had been carried out on 4 October 2018. The advice following this assessment was that the person required supervision and pureed food. However, a prominent facing page in the care plan headed 'Meal Information' clearly stated that the person required a medium portion that was fork mashable. The choking risk assessment we saw for the person, updated 30 October 2018, stated that they were at low risk of choking, with a score of seven.

For a person with a diagnosis of Parkinson's' disease and also dementia, there were no specific care plans to enable staff to be guided on how to safely and effectively meet this person's needs. An elimination and continence care plan was in place which depicted the catheter changes and irrigation required, however this

was not always consistent. For example, the irrigation solution regime stated to be completed every Friday, but there were gaps in the recording. On one occasion there was a gap of 22 days. People who were catheterised were at risk of not having the best quality of care, minimising infection risk and other side effects.

For another person admitted to the service on 5 September 2018, their moving and handling risk assessment had not been completed until 25 October 2018. Their Waterlow assessment wasn't completed until 3 October 2018, almost a month after admission. This person was receiving end of life care but at the time of this inspection did not have a specific end of life care plan in place.

Information in one person's care plan regarding their pain relief was conflicting. It was recorded they had a syringe driver and then later discontinued. The person's care plan had not been updated to reflect the latest recommendation from the nurse practitioner. There was also no pain assessment in place to evidence that the person's pain levels were being monitored.

Wound management recording was not wholly effective. Documentation did not consistently match the accompanying photograph. For example, one photograph was of a deep hand wound but there was no corresponding information or care plan. Wound assessment forms were in place but these were not always completed correctly or regularly and the photographs of people's wounds were not always named or dated. Information in one person's care plan dated 29 July 2018 depicted they had three pressure ulcers. We asked the manager to clarify this and were told that the clinical lead who deals with pressure care was on annual leave. The manager tried to obtain an audit of all the current pressure areas in the service but later advised us they were unable to access this information. We were unable on the day of our inspection to determine from the information seen the number and grading of people's pressure areas and how this was being managed.

Well-being charts were located in people's rooms, For, one person it was recorded that they were to be checked hourly and re-positioned every four hours. On 27 October 2018, there was a gap between 15.40pm and 8.20pm for when they should be checked hourly and in their position chart it reflected the person had been in the same position from 7.30am and 12.30pm

Although records with information relating to people's safety were securely stored and available to relevant staff they were not all up to date or accurate. This meant that staff were unable to follow guidance to help ensure people were consistently supported safely. This is a particular risk with the current level of agency staff in place.

Systems for the safe management of medicines at the service were not robust. Records were in place for medicine administration with prescribed instructions. However, we found some gaps and discrepancies in the records indicating that some medicines may not have been given to people as prescribed. This also included records for external medicines such as creams.

We found that one person re-admitted to the home from hospital the day before the inspection, did not have all the medicines listed in hospital discharge information written on to their medicine charts and so could have missed some medicines intended by the hospital. We found that some medicines had recently not been given to people because they had not been available and obtained in time to ensure their treatments were continuous. Staff had not predicted shortfalls in these medicines and taken action to obtain them in time. Because of this, one person did not receive an important medicine for their mental health for a period of seven days. Audits of medicines were conducted at the service but we noted that the most recent audit had been carried out 3 September 2018 and they were ineffective at promptly identifying

and resolving issues that we identified.

When people were prescribed medicines for external application such as creams some body-maps indicating where on the body they were to be applied were not available. For people prescribed pain-relief medicines on a when-required basis and who were unable to tell staff about their pain there were no methods, such as pain assessment tools by which staff could consistently assess their pain-levels to know when to give them their pain-relief medicines.

Records showed when people refused their medicines or when their medicines could not be given to them because, for example, they were asleep. However, we unable to determine from the records that later attempts had been made by staff to give them their medicines or had referred this to their prescriber for review.

We noted that a person managing their own medicines had some that were not secured and that the home was unaware that they had to take in addition to those prescribed. This could have placed them and others living at the service at risk. Medicines prescribed for external application located in people's rooms were not always secured and so could also have placed people at risk of accidental harm if they accessed them. The service had not considered the risks around this.

There were gaps in the temperature records for medicines requiring refrigeration so they did not confirm that the medicines had been stored at correct temperatures and were still safe for use.
Medicines with limited lives once opened such as containers of eye drops and creams were not always handled in a way that indicated to staff when they were due to expire. We noted one container of eye drops available for use for a person that had expired and may have been no longer safe for use.

We were not assured that there were effective systems with regard to promoting and encouraging concerns to be shared appropriately. Thorough investigations were not always carried out in respect of any issues or concerns such as safeguarding, accidents and incidents.

We found that staff did not act appropriately with regard to reporting an unexplained injury that we observed on one person during this inspection. We saw this person in their room at approximately 12.15pm and noted that they had skin tears on their legs with fresh blood. We also noted some bruising around the person's knees. We saw that a member of care staff took the person some lunch in their room shortly after our initial observation.

We looked at the person's care folder but could not find any record of the person's skin fragility or of the injury we had seen. We asked the senior and one member of care staff about this but neither member of staff had any knowledge of the incident. A second member of care staff confirmed that they had supported the person with their personal care that morning. They said that they had mentioned it to the unit's Care Practitioner but they had not yet had chance to record it. This member of staff also stated that the person's legs had not been, "Like that at lunchtime."

We visited the person in their room again at 4pm and, although the incident had been brought to the attention of all four staff on Memory Lane by 2pm, we found that the person had not been helped have their skin tears cleaned and the person's legs remained stained with a mixture of dried and fresh blood. There was a lack of clarity around how and when the person's injuries had been sustained but no safeguarding referral had been made. We therefore informed the manager and regional directors and requested that a safeguarding referral was made without further delay.

Effective systems were not in place to ensure that lessons were learned and improvements made when things go wrong. Recording, reviewing and investigation of accidents and incidents was not robust. Documentation was cumbersome and disorganised and either lacked clear information or contained conflicting information. We therefore requested an audit of the accident and incidents and lessons learnt from January to October 2018 from the manager. Following the inspection visit we were provided with statistical details that identified the nature of the accident and incident but this did not include the actions taken and lessons learnt to mitigate the risk as requested. The manager informed us they were prioritising the reporting of accidents and incidents and would be leading in this area. This included ensuring staff understood the provider's processes through further training and support such as communications, team meetings and 1:1 reflective practice. They added that any accidents and incidents would be escalated to their attention as soon as they occurred.

All of the evidence above constitutes a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw that safeguarding information was available around the home for staff, visitors and people living in the home. Staff told us that they had completed training in safeguarding, understood what constituted a safeguarding concern and knew the reporting procedure. However no one had identified concerns about the person who had bruising and skin tears.

People told us they felt safe living in the service. One person said, "Well it has to be safer than living alone." Another person said, "I feel safe, I wish I could have stayed in my flat but I couldn't. Yes, I feel cared for, the staff are very good." A third person said, "I have settled in well and feel quite safe and comfortable here."

There was mixed feedback from people living in the service regarding if there was sufficient staff to meet their needs. One person said, "Plenty of staff, they come when you need them. Not a problem." Another person said, "I think there are, yes [enough staff]." A third person said, "I have never had a problem, when I pressed my buzzer they [staff] came straight away." A fourth person commented, "During the day [there is enough staff], but there is often only two or three staff on at night for the whole place. If someone needs two staff to sort them out, that leaves very little for the rest. That means the rest of us have to wait and I do wait some nights."

Feedback from relatives also varied. One relative said, "I think there are enough. I come once a week and there's always someone [staff] around." A second relative commented, "There are often only two or three staff on the floor and if someone needs two staff that leaves only one [member of staff] to deal with everyone and everything else. The home seems to be using more and more agency staff too." A third relative commented, "It's at weekends I find there are hardly any staff. I have come in and there's been no-one around. There used to be someone on reception until 2pm but that doesn't seem to be the case now."

We saw that appropriate measures to ensure there were sufficient numbers of suitable staff on duty to meet people's needs were in place. However, we observed occasions where the deployment of staff was not wholly effective.

For example, we saw that eight people living on Memory Lane had chosen to come to the dining room for their lunch. At one point we saw there were four members of staff, including the manager, overseeing people in the dining room and serving their meals. We observed that these eight people required only minimal assistance and encouragement with their food and drink. However, on walking around the unit, we saw 10 people who had remained in their rooms for their meals.

Of these, we saw that one person was being assisted by a relative to eat and drink and another person was being supported by a member of staff. We saw another member of staff taking meals in to each of the remaining people. We also saw people left alone in their bedrooms to eat their meals when they clearly needed support to do this.

We therefore concluded that staff had not been deployed appropriately to ensure that people in their rooms received sufficient support, encouragement and oversight, as required, with their meals.

The manager told us that, although the use of agency staff was still high, there had recently been a marked reduction following a successful recruitment drive. The manager told us that newly recruited staff included two nurses, two care staff and two housekeeping staff. The manager confirmed that all of these had commenced their inductions and were in the process of completing shadow shifts with more experienced members of staff.

We saw that robust recruitment procedures were followed, to ensure that only staff who were suitable to work in a care environment were employed. Staff we spoke with told us that they had not started working in the home until appropriate checks such as references and police checks had been completed. Records seen confirmed this.

Lifting equipment such as hoists and slings had been serviced in line with relevant legislation to ensure they were safe to use. There were systems in place to monitor the safety of water systems and the prevention of legionella bacteria. The fire exits were kept clear in case of the need for evacuation and staff could explain to us what action they would take to keep people safe in the event of a fire.

Most people told us they received their medicines when they needed them. One person told us, "The staff give me them on time." Another person said, "The nurse comes and gives me my tablets." A third person said, "I always get my tablets after breakfast. The staff leave them with me, they know I'll take them." However, one person told us, "I have morphine patches now but I did have a syringe driver. One night as the morphine was about to run out a nurse came in and turned the driver off, saying I'll come back soon and reset it. The driver stayed off for over two hours as it got forgotten. I tell you I reported that."

The majority of relatives said they had no concerns regarding people's medicines. One relative said, "No issues that I know of." Another relative told us, "I don't think there are any issues with [person's] medication." However, one relative commented," I cannot understand why there are antibiotic delays. In this day and age with computers there shouldn't be any delays." Another relative described there not being sufficient levels of medication following a discharge from hospital and asking staff to chase this.

We found the home to be clean and hygienic throughout. There were sufficient handwashing facilities in the service and we observed staff regularly washing their hands during the course of their duties. Staff were observed to use good practice to reduce the risk of infection. This included wearing aprons and gloves. When we spoke to the staff, they demonstrated the importance of doing this as well as washing their hands regularly, for the protection of people living in the home.

Requires Improvement

Is the service effective?

Our findings

During our last inspection on 31 October 2017, we rated this key question as good. At this inspection, we found people were at risk of harm as their risk of not eating or drinking enough was not effectively managed. This resulted in a breach of the Health and Social Care Act 2008 (Regulated Activities) 2014. We have rated this key question as requires improvement.

We found inconsistencies in the records relating to some people's nutrition and hydration. We were not assured that people using the service were consistently supported to have sufficient amounts to eat and drink enough and to maintain a healthy diet. In addition, we were not confident that risks regarding people's intake of food and drink were identified, assessed, monitored and managed effectively. Whilst input and guidance was sought from dietary and nutritional specialists, the recommendations from the professionals was not always conveyed clearly in people's records for staff to follow.

People's care records contained limited or conflicting information and there were gaps in people's food and fluid charts. Food charts did not consistently have the information completed at the top of the charts. For example, it was not always recorded if there was a choking risk or which diet a person was on. In addition, our observations of people did not consistently match the information we read in respect of the support people required.

For example, two people's care records stated that they required supervision and encouragement with their food and drinks. However, we saw that both of these people were left alone in their rooms after their lunch time meal had been taken to them. The handover cover sheets we looked at for both of them contained no information to indicate that food and fluid charts were in place, as these sections had been left blank.

For one person, we found both food and fluid charts from 27 to 31 October 2018. There were no food charts for 24 and 26 October and neither chart for 25 October 2018. This person's care records stated that the person required small portions of a high calorie, high protein and fork mashable diet. However, some charts did not specify that a 'fortified' diet was required and all the 'Daily Food Intake Charts' we looked at for this person had 'normal' circled, rather than 'fork mashable'. In addition, there was no information to guide staff on what was deemed to be a sufficient intake, nor what action to take if the intake was deemed to be insufficient.

There were also inconsistencies in this person's fluid chart dated 28 October 2018 which showed that the person had only actually drank on three occasions throughout the day. As with the person's food charts, the fluid charts did not contain any information to guide staff on what was deemed to be a sufficient intake, nor what action to take if the intake was deemed to be insufficient.

Information in two people's care records stated that they required support and encouragement with their food and drink. These two people also had food and drink charts in place. However, for both people we saw that the member of staff delivered their meal and then left the room.

On seeing another person in their room, they smiled and told us they were enjoying their lunch. However, we noted that the person looked to be at an awkward angle in their bed, had spilt food down their front and did not look very comfortable. Another person also told us that everything was fine with their meal saying, "Lovely, thank you." However, we saw that this person was only using a fork with one hand and they appeared to be struggling to cut into the pastry topping of their dinner. We saw that the person's fork kept missing the puff pastry lid, resulting in it being pushed around the dish.

This is a breach of Regulation 14 (Meeting nutritional and hydration needs) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

People can only be deprived of their liberty 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 are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met.

We were not confident that the service ensured that consent to care and treatment was always sought in line with current legislation and guidance. For some people who had capacity which fluctuated, information was not clearly recorded to explain which decisions people could make by themselves and which they need assistance with.

A senior member of staff told us that DoLS applications had been submitted for all of the people living on Memory Lane, although only two had been authorised at the time of this inspection. From what we were told and records viewed, the DoLS applications had been made predominantly based on the fact that people lived in an environment with locked exits. The DoLS applications were not wholly based on individual assessments and considerations had not consistently been made for the least restrictive options to be applied.

For example, one person's mental capacity assessment stated that the person had capacity and wanted to go home. However, an accompanying statement in the assessment read, '[Name] has been assessed as having capacity to make informed decisions about leaving Ritson Lodge independently. Therefore, we feel it is correct for [Name] to live in the Memory Lane community with its locked exits.' In another part of this person's mental capacity assessment, we saw a box had been ticked to indicate that the person lacked capacity. We were unable to establish the exact dates and timelines for the conflicting information or know which parts of the information were accurate.

In another person's care plan mental capacity assessments had been carried out but were not person-centred and there was no evidence that the person's next of kin, representative or advocate has been involved where there was no capacity to make a specific decision.

People told us the food was generally good, there was a variety and that enjoyed their meals. One person said, "The food's okay I suppose. I only like plain food so I'm not eating much, yes I suppose there's a

choice." Another person said, "Oh the food's the best in the world. Yes, we get a choice. My favourite though is jacket potatoes with beans, cheese, tuna; lovely. I don't need any help with my meals but as I'm diabetic they [staff] have given me cranberry juice and I've even had diabetic marmalade."

We saw staff demonstrated an understanding of people's nutritional needs and the meal time experience was positive. For example, staff quietly and discreetly explained to one person who was diabetic why they couldn't have orange or pineapple juice. Where support was required this was done sensitively and at an appropriate pace. This included providing support and encouragement for one person to eat their food. For another person we observed them having their lunch in line with their preferences including the specific cutlery they wanted.

Most of the people we spoke with told us they felt the staff were competent and met their needs. One person said, "Oh yes the staff are very good, I'm very happy here." Another person commented, "Well trained, oh yes." However, one person commented, "Some of them [staff] are. I'll tell them if they're not doing things how I want them done. Everyone in here is a bit different and the staff have to treat everyone differently." Another person said, "I suppose most of the staff are [well-trained]. I will report things if they're not right."

We were aware that the local authority in October 2018 had served a quality improvement notice on the service following recent safeguarding concerns and concerns about staff competence. The provider had responded with an action plan which included further training to ensure staff were competent in their role and to meet people's needs safely. Following this inspection, the manager shared with us the plans for further staff training during November and December 2018. This included, but was not limited to, infection control and safeguarding refresher training, dementia awareness, syringe driver, enteral feeding and venepuncture and catherisation training for nurses.

The manager told us that all new staff completed a comprehensive induction. In addition, staff told us that they completed essential training that was relevant to their roles, as well as training in subjects that were 'service or person specific'. Staff said that they also completed refresher courses to ensure their skills and knowledge remained up to date and relevant. We noted that a dementia training course took place in the service on the day of this inspection.

Staff we spoke with told us that supervisions and appraisals had been sporadic but that they were feeling positive that this would improve as more permanent and senior staff were being recruited. In addition, the recent changes in management and high turnover of staff had been unsettling. One member of staff explained that they felt too many staff had left and this was due to staff losing confidence in management and having a lack of support. They described a reliance on agency staff. The manager advised us they had been in post for just over two weeks and had prioritised supervisions and that active recruitment was ongoing. Records seen confirmed this.

People were supported to have access to healthcare services and we saw that referrals were made to the relevant healthcare service when people's health needs changed. Although people's care plans were difficult to follow, we could see that there was some information regarding their individual healthcare history and support needs. We also saw that healthcare professionals were involved to help support people in maintaining good health such as, district nurses, mental health nurses, GPs, dieticians and speech and language therapists. It was not clear from some of the care plans we looked at whether routine appointments were also scheduled with other professionals such as opticians, chiropodists, audiologists and dentists.

When speaking with one person they told us they had sore feet and had been asking to see the chiropodist.

We asked staff about the visiting chiropodist and were told there wasn't a list of appointments and that the chiropodist just visited the service. We were told that the chiropodist did not come when they were last due to visit as they were unwell.

Following the inspection visit, the manager updated us that the staff had filed the person's toe nails and a completed care plan in relation to foot care was in place. They advised that the person's relative had arranged for a private chiropodist to visit.

People told us that the staff gained their permission before they provided any care. One person said, "Oh yes the staff always ask me if they can do things. You know help me to wash and all that." Another person said, "The carers ask me and wait till I am ready." We saw staff helping people to make their own choices regarding their care and heard staff consistently seeking people's consent before providing them with support or assistance.

The premises were safe and accessible and people could choose whether they wished to spend their time in the communal areas, their own rooms or a quiet area alone or with visitors. Throughout the service people's bedrooms were individually furnished and decorated in accordance with their choices. There was clear signage and lots of colourful, 3D and tactile objects in Memory Lane, which helped people to find their way around. This helped reduce anxiety for people who could feel lost or confused.

Requires Improvement

Is the service caring?

Our findings

During our last inspection on 31 October 2017, we rated this key question as good. At this inspection, people's privacy, dignity and confidentiality was not consistently promoted and respected. We have rated this requires improvement.

We were not assured that people's privacy and confidentiality was consistently respected. For example, we saw that confidential information about some people who lived in the home was displayed on a white board, visible to anyone who walked past the nurses/staff office on the Seashore unit. This included details of appointments they were attending; their names and what staff were monitoring in relation to their health and well-being.

One person shared with us how having to wait for assistance by staff with their personal care had compromised their dignity. They said, "I have had to wait at night for over 15 minutes. I can't get out of bed myself. By the time they [staff] got to me and got me up I was already doing it before I got to the toilet. I didn't like that at all. I'm very proud and it was embarrassing." Another person shared with us their discomfort, "I'm a very proud person and to have a female youngster [staff] come in to undress me and so on was difficult as first. I've got used to it now but I still prefer the mature, more experienced ones [staff]."

People told us their independence was promoted. One person said, "I do as much as I can for myself then they [staff] step in." Another person said, "I am mostly independent but get them [staff] to help if I am struggling." A third person said, "The staff are very good, they help me walk which I have to do even though my leg is in a cast. The home organised me a wheelchair so I can move around the place on my own. The staff do have to help me to get into it though."

Although people told us they were supported to be independent this was not always reflected in their care records. For example, details on the level of support and assistance that was needed, what the person could do on their own and guidance for staff on when to prompt and encourage a person.

People spoken with said that the staff were caring and treated them with respect. One person told us, "The staff are good on the whole." Another person commented, "I like most of them [staff]." A third person said the approach of the staff was 'brilliant'. However, one person shared with us that the staff were not always gentle, they said, "They [staff] can be a bit rough when they get me dressed. They [staff] often pull my arm."

Feedback from relatives about the staff was positive. One relative when asked if the staff treat their family member with kindness and compassion said, "Absolutely." Another relative said, "Mostly I think they [staff] are caring. [Family member] is left to do what they want to do." A third relative added, "The staff are okay but they are now so busy." A fourth relative commented, "The staff are the one reason to keep [family member] in the home, though we are looking around at others at the moment." They added, "The home has lost continuity and I think the care is suffering."

There was a relaxed and friendly atmosphere in the home, interactions we viewed between staff and people

were caring and respectful. The staff made eye contact with people and were patient when waiting for them to reply. Staff used appropriate touch when communicating with people which responded to people's preferences and needs, for example when a person reached out for the staff member's hand, the staff held it.

We saw many positive interactions between staff and people living in the home and we heard staff speaking cheerfully and kindly to people. For example, one person had recently been admitted onto Memory Lane from another area of the home and was understandably feeling confused and anxious. We saw that staff were patient with this person and consistently provided them with reassurance. We observed and heard members of staff introducing other people to the new person, explaining how they also lived on Memory Lane and they would be the person's new neighbours.

We saw one of the maintenance staff in Memory Lane and noted that they were chatting kindly and cheerfully with people who were in the dining room. We also heard the maintenance person ask a person if they would like a drink and, when the person replied that they would like a cup of tea, the maintenance person promptly made it for them.

Another person was recovering from a cold and was still not feeling very well. We observed that staff showed concern for this person and ensured they were comfortable and warm whilst in one of the communal areas. Another person was concerned about their spouse, who was also living on Memory Lane. We heard staff regularly reassuring this person and offering to take them to their spouse's room for a visit.

Staff talked about people in a caring manner and knew people well. One staff member described how one person was not feeling well and that they were encouraging them to join the Halloween party as it might cheer them up. We saw them provide reassurance to the person when mobilising and the person was later seen at the party laughing and smiling.

Requires Improvement

Is the service responsive?

Our findings

During our last inspection on 31 October 2017, we rated this key question as requires improvement. Staff were not always responsive to people's needs due to the staffing level arrangements. At this inspection, we found significant shortfalls in people's care records. These required further development to ensure they were person-centred, accurate, met people's individual needs and reflected their preferences. This resulted in a breach of the Health and Social Care Act 2008 (Regulated Activities) 2014. The rating remains requires improvement.

We were not assured that people's health, care and support needs were regularly assessed and reviewed. Some of the updates and changes we saw had not been recorded clearly and some were inaccurate. People's care records were cumbersome, disorganised and contained conflicting information. For example, one person had a breathing care plan in place with the outcome documented to not have breathing difficulties, However, due to their diagnosis they will always have breathing difficulties as a side effect of their condition. Therefore, this person's outcomes were not realistic.

There was limited personalised information in people's care plans that consistently described the holistic care and support that each person required. Not all care records explained how people could be supported to maintain their independence or what could help ensure people consistently had a good quality of life.

We were not assured that people and where relevant, their representatives were fully involved in decisions about their care arrangements including their personal preferences. One person said, "I haven't been asked about my care. I would like to have a bath more than once a week and not at the designated time it suits the staff. I have mentioned this before but nothing's happened." Another relative when asked if they were involved in the planning and reviewing of support needs for their family member said, "Firstly, yes [on admission to the service]. [Family member] came in for respite initially and we spent time going over everything, but in recent time not much input, no."

We were not confident that people living in the home could consistently be reassured by knowing that any pain or symptoms they experienced would be regularly assessed and managed as the end of their life approached. There was limited information in one person's care plan on Memory Lane that indicated advice and input from palliative care professionals had been sought. However, it was not clear whether the person required any additional support, equipment or medicines to help ensure they remained comfortable, dignified and pain free.

The details we read in this person's care plan stated that the person was at end of life and required palliative care. Additional information stated that the person's life expectancy was between six weeks and six months. However, we could not find any find any more detailed information, such as a specific end of life care plan. Nor could we establish exactly who had determined the person's condition, nor when or why the prognosis had been made.

Another person's care records showed they were admitted to the service on 5 September 2018, with a lung

condition and were receiving end of life care. However, there was no end of life care plan in place.

Improvements were needed to ensure the activities provision met the individual and specialist needs of all people. The activities schedule that had been compiled for the week commencing Monday 28 October 2018 was the same schedule for all three areas of the home. This meant that, with the exception of one-to-one time in people's rooms, some of the activities were not always appropriate, relevant or accessible for all the people who were living in the home. For example, bingo in the blue lounge and flower arranging in the café may not be accessible to people living on the nursing unit or the dementia unit. In addition, there were no records to show what individual activities had taken place and no formal systems to identity which people were at risk of social isolation and becoming withdrawn and how the service was effectively managing this. Information to people was not always accessible and appropriate to meeting all the needs of the people that lived in the home. For example, the lunch time meal was displayed in a written menu format with no photographs or pictures that may aid understanding of the meal choices for people living with dementia.

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

People told us about the activities provided in the service which they could participate in if they wanted to. One person said, "I like bingo and when the singers come to visit us." A second person said, "Plenty goes on during the week, less so at the weekend. To be honest I prefer my own company. They [activities co-ordinators] do try to do things." Another person commented, "Yes, there's things on but they're all strangers [other residents] so I don't come up here [main reception area]. My family come every day and I watch TV in my room." A fourth person said, "I lay here [in bed] where it's most comfortable and watch TV a lot of the time or fall asleep."

Relatives feedback was mixed about the provision of activities in the service. One relative shared with us how there was 'plenty to do' and that their family member, "clearly enjoys getting involved as they're always smiling." This was echoed by another relative who said, "There is always something going on, [family member] is encouraged and supported to participate fully." However, one relative commented, "Activities? There is nothing going on. Staff leave constantly." A second relative said, "The fees don't reflect the few activities there are now. The board doesn't mean anything. There used to be a lot of activities to do at one time." Two relatives expressed concern over the impact of one of the activities co-ordinators impending planned leave. One relative said, "Not all staff get involved in the activities. It's left to two activities co-ordinators to cover the whole service and one is going on leave soon. No talk of replacing them. They work so hard but it's not fair expecting them to meet the needs of all the people here."

On the day of our inspection visit there was a lively, warm and welcoming atmosphere within the service. To celebrate Halloween some of the staff were wearing fancy dress and were later joined by some people who lived in the home wearing hats and masks during the Halloween party, where they were visited by children trick or treating and entertainers.

People told us that if they had a concern about the service they would report it and were confident they would be addressed. One person said, "I have always spoken to the nurse or manager and things have been sorted out." Another person told us, "I would speak to a carer. They always listen and try to sort things out if I am worried about something." A third person commented, "I would speak to staff."

Relatives knew how to make a complaint if they were not happy with the service provided. One relative told us, "I spoke to the nurse about the night carers not being gentle." Another relative said, "I have complained about the laundry shortfalls. Clothes lost and damaged. I have to say things are improving a bit." They

added, "I've complained about the standard of bathroom cleaning, well cleaning really."

There was a complaints procedure in place and information displayed in the service about how people could raise a complaint. Records showed that complaints were investigated, responded to and were being used to improve the service. Themes covered a range of areas, such as, fees, food and quality care concerns. Two complaints concerning nursing care and fluid intake monitoring and daily targets were currently being investigated. In response to this the manager informed us they were reviewing their systems including documentation and were introducing policy of the month; revisiting a range of areas to improve staff awareness and understanding, starting with the promotion of good nutrition and hydration strategy.

Inadequate

Is the service well-led?

Our findings

During our last inspection on 31 October 2017, we rated this key question as requires improvement and included a breach of the Health and Social Care Act 2008 (Regulated Activities) 2014. This was because staffing levels were not sufficient to meet people's needs and the provider's quality assurance systems and processes had not been wholly effective in identifying where improvement was needed.

At this inspection this key question has been rated as inadequate. We found a significant decline in the standards of care at the service. The provider's quality assurance systems were not robust. There was ineffective governance and poor oversight at manager and provider level which had failed to fully identify shortfalls in the service putting people at risk of harm. Improvements were needed to ensure the service was effectively monitored and assessed to ensure that people were consistently provided with a good service.

We found breaches of regulation in respect to safe care and treatment, need for consent, person centred care, and a continued breach of regulation in relation to good governance. During the inspection the new manager was unable to access some information we requested, such as the number of people with pressure areas. It also took time to establish exactly how many people were living in the service and in which units. In terms of an emergency this was a concern. In addition, we identified shortfalls in the accident and incident process and inconsistencies with staffing arrangements including deployment.

Records relating to the care and treatment of people were not always reliable and fit for purpose. People were placed at risk of inappropriate care as their records were not consistently person-centred, accurate and detailed. People's medicines were not always managed safely and properly, risks to people's well-being, health and safety were not always assessed and mitigated. Despite a programme of audits and checks being carried out there was not an effective quality assurance system to identify these issues and take appropriate action.

Despite the support of several health and social care professionals on issues that had been identified, including concerns from the last inspection, we found that progress had been slow. This was due to a lack of ownership and accountability in the service. Effective management and leadership to address the concerns and to take appropriate action had not happened.

Feedback from people and relatives when asked if they had seen improvements since the last inspection was not positive and was linked to lack of staff continuity and poor communication. One person said, "I think there is less temporary staff but a few good people have left." Another person commented, "Negatively there seems to be a lot of agency staff." A third person said, "There are different staff." A relative told us, "It is expensive and not well organised enough. We know it would be a big thing to move [family member] out and we're still thinking about it." Another relative commented, "No improvements as far as I am concerned. Staff changes and stretched staff is what I see." A third relative added, "I think it is much the same. A few different staff I suppose."

10 out of the 14 people we spoke with were aware of the leadership changes in the service but did not know

who the manager was. One person said, "There is a new manager so I am told." This was replicated in the feedback from five out of the seven relatives we spoke with. One relative commented, "There's a lack of continuity with management. I don't know the new manager." One relative said, "For two years things were quite constant but in the last few months there has been a lot of changes of staff." Another relative commented about the personnel changes saying staff were, "Approachable, busy and changeable."

In the month prior to our inspection there had been three managerial changes, this had impacted the service with staff describing conflicting ways of working and ineffective communication. The registered manager was no longer in post, and the provider's operations manager, brought in as an interim replacement, no longer worked for the company. At the time of our inspection the newly appointed manager had been in post just over two weeks and was being supported by a registered manager from another of the provider's services, and three regional managers including a clinical lead. A period of stability is required with regards to the leadership of the home to ensure that improvements are made and sustained.

Morale in the workplace was low. Staff described feeling unsupported and isolated and not working together as a team. We noted several permanent staff had left since our last inspection and there was a reliance on agency staff. The new manager was working to address this through active recruitment and addressing the slippage in staff supervision. However, further improvements were needed to ensure that systems in place would support new and existing staff.

On 5 October 2018, following two significant safeguarding referrals and concerns raised about staffing levels and quality of care, the local authority placed a quality improvement notice on the service. The provider responded with an action plan on how it would address the identified concerns. At this inspection we found that these improvements were a work in progress and record management and effective leadership remained an issue.

These concerns amounted to a continuing breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Staff spoke positively about the new manager who had been in place since 15 October 2018 and said they were approachable and supportive. Staff were aware of the provider's involvement in the service and changes being made.

People told us they were happy living at Ritson Lodge and would recommend the home. One person said, "I am a happy bunny and well looked after. In my view its 80% perfect here, 10% 'iffy' and the rest needs looking at." Another person said, "It's not my own home but I'm happy here."

Meetings were in place for people and their relatives to share their views and to be kept informed of events and changes taking place at the service. However, there was mixed feedback about their effectiveness and accessibility. One person said, "They have meetings regularly where relatives can come." However, another person said, "I don't go to the meetings as it's the same old things being talked about. Just get on with it." A relative commented, "The new manager was at the last meeting and introduced themselves and talked about the changes they want to make. Sounds promising but we shall see. A lot of the issues have been going on a long time." Another relative said, "They hold their meetings at 2.30pm, I work full time so I cannot get there." Another relative said, "We never get to know about staff or management changes."

Following the inspection visit, we received updates from the manager on concerns we had identified for several people and had asked them to follow up on. This included a potential safeguarding. We were

advised of the actions taken to mitigate further risk and to prevent reoccurrence.

We received information from the manager of the improvements they were planning and implementing in the service. This included becoming a visible presence within the home, through walk arounds the service three times a day. This would enable them to check on the environment, speak with people, relatives and visitors, observe staff practice and check systems in place were working effectively. In addition, active recruitment was ongoing, plans to support staff and improve morale through team meetings and specific training were scheduled in the upcoming month. To improve clinical governance and oversight the manager advised they would lead the monthly meetings to review the risk profile of the home to review trends and patterns for falls, tissue viability, weight loss/gain, incidents, safeguarding's, reviewing lessons learnt and actions required. These measures need to be fully implemented and sustained to ensure there is a positive culture within the service and people's needs are safely and effectively met.

Feedback from health and social care professionals involved with the service told us they were working closely with the manager to support them in implementing the provider's action plan in response to the quality improvement notice.

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 9 HSCA RA Regulations 2014 Person-centred care How the regulation was not being met: People's care records were not always person centred and accurate. They lacked information to guide staff in how to meet their needs safely and effectively.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment How the regulation was not being met: Risks to people were not always adequately assessed and mitigated. Medicines were not always safely managed or administered to people in the way the prescriber intended.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs How the regulation was not being met: The provider did not consistently ensure that people had enough to eat and drink to meet their nutrition and hydration needs or receive the support they needed to do so. People's nutritional needs were not reliably assessed.

Regulated activity	Regulation

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance How the regulation was not being met: The provider had failed to implement systems and processes that effectively assess, monitor and determine risks to people or maintain accurate, complete up to date records.