# Barchester Healthcare Homes Limited

# Sherwood Lodge

## Inspection report

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## Ratings

| | |
|---|---|
| Overall rating for this service | Inadequate |

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

# Summary of findings

## Overall summary

We previously undertook a comprehensive inspection on 20 and 25 April 2018 because of concerning information we had received from the Local Authority in relation to the safe care and treatment of some people who lived at the service. These included, staffing levels, personal care, lack of monitoring, incidents and accidents as well as the leadership and management of the home.

Due to unforeseen circumstances we were unable to produce a report of our findings. Therefore, we undertook this unannounced comprehensive inspection on 18 and 22 June 2018. This meant the home did not know we were going to inspect. This inspection took account of the risks identified during the April inspection. We last inspected the home and provided a rating on 6 and 9 March 2015 where it was rated as good overall.

During this inspection we identified a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to safeguarding people from abuse, safe care and treatment, meeting people's nutrition and hydration needs, medicines management, staffing, management of risks, accidents and incidents, person centred care, infection prevention and control, Mental Capacity Act and Deprivation of Liberty Safeguards, records and good governance. Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

We also identified breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to dignity and respect and consent. You can see what action we have taken at the bottom of the full version of this report. We made recommendations in relation to checks, audits and monitoring takes place on the environment an equipment actions are taken to rectify any findings to ensure it is safe for people to live, visitors to access and staff to work in.

Sherwood lodge is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection.

Sherwood lodge is registered to provide accommodation and personal care for up to 49 older people in one purpose built building over two floors. People who used the service had access to lounge and dining facilities as well as a conservatory and secure outside gardens to the rear. All bedrooms were of single occupancy a number of which had ensuite facilities. At the time of our inspection 36 people were in receipt of care at the home.

The service did not have a registered manager in post at the time of our inspection. A new general manager had been recruited to the home and was in the process of her registered managers application with the CQC. This process has been completed since our inspection. 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 was run.

Whilst some areas of the home were clean and tidy we noted a number of people's bedding was dirty. The general manager told us they had introduced a daily walk around to check all areas of the home. We saw staff wearing appropriate personal protective equipment during personal care and household duties.

Accidents and incidents were not consistently recorded; we saw gaps in their completion. Not all people who used the service told us they felt safe. Where risks were evident or had changed, we noted not all people's risks assessments were updated to reflect their current needs.

Whilst there was evidence of the procedure followed for staff recruitment we noted risks assessments had not been completed to satisfy the company, staff were safe to work in the home. There was very little evidence of consistent supervision taking place for all the staff team. Whilst there was some evidence of staff training taking place not all staff had up to date training to support the delivery of care to people. We saw little evidence to confirm that inductions had been completed for new staff on commencement of their role.

We received inconsistent feedback about the staffing levels in the home. Dependency assessment tools were completed that identified what staffing levels were required to meet people's needs. However, we saw these were not always achieved.

We saw servicing and checks of equipment had been completed along with fire safety checks. However, we noted some areas of the environment required attention to ensure people lived in a safe and monitored environment.

We observed the lunchtime experience for people who used the service, whilst we saw kind interactions taking place, the service provided to people was disorganised. People were seen waiting for long periods of time for their meals. Records relating to one person's dietary needs was out of date on the first day of our inspection we saw these had been updated on our second day. Food and fluid charts had gaps in their recordings.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible; the policies and systems in the service did not support this practice.

We saw little evidence of completed capacity assessments or best interest's decisions in people's records. Where deprivation of liberty applications had been completed we noted the content to be basic. Records completed by staff had not always been completed or signed. Written consent had not been recorded in people's care files however we observed staff asking permission before undertaking people's care or activity.

People told us they had access to health professional reviews when they required it. We saw evidence in people's files of visiting professionals to the home.

Feedback about the care people received was mixed. Not all people were happy with their care. We identified several concerns relating to the personal care people received. Records identified people were not being supported to have baths or showers regularly. Where people were supported with their mobility, equipment to support safe moving and transferring was not always used.

Staff were seen speaking nicely to people but this was not always the case. We also observed public areas of the home were left unsupervised for long periods of time.

We received mixed feedback about whether people were involved in choices about their care. People consistently told us they were supported to maintain their privacy and dignity. We observed staff discussing people's care needs discreetly. Records contained information about people's likes, dislikes, choices and preferences.

We looked at care files and daily records for people living in the home. We identified a number of concerns relating to the guidance in them about how to support people in that they did not reflect people's current and individual needs. The home had recently recruited a new activities co-ordinator. We observed activities taking place during our inspection.

The home had guidance and information about how to complain. Records were completed about the complaints received and the actions taken. Feedback from people was that they felt able to raise any concerns with the management and had confidence in the new general manager to deal with complaints appropriately.

Whilst evidence of audits were seen, actions to address any shortfalls were not always recorded. The inspection identified a number of failings in the home that impacted on the care people received and placed them at risk of harm.

We received positive feedback about the new management team and the confidence for improvements in the home.

Throughout the inspection the management team were open and transparent and supported the inspection process. We discussed the concerns identified at the inspection with the senior management of the company who gave their commitment to making the required improvements in the home.

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.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

**Inadequate**

The service was not safe.

There was evidence that some incident and accident reports had been completed however not all recommendations to prevent any future risk had been followed. Where risks had been identified these had not been updated to ensure people received safe care in some of the care files we looked at. We received mixed feedback from people about them feeling safe in the home.

We identified a number of concerns relating to the cleanliness in a number of people's bedrooms. We were told daily walkarounds of the home were being completed to identify areas that required action. However, the records we looked at demonstrated these had not been done every day.

During our observations we noted long periods of time where public areas of the home were left unsupervised. A dependency assessment tool was completed by the home however we saw that the required numbers of staff were not always achieved. People who used the service and relatives were mixed about the staffing numbers in place.

We saw servicing and checks of equipment had been completed along with fire safety checks. However, we noted some areas of the environment required attention to ensure people lived in a safe and monitored environment.

### Is the service effective?

**Inadequate**

The service was not effective.

Records we looked at confirmed staff training needed updating to ensure all staff had the knowledge and skills to deliver effective care. Induction records were absent from the staff files we reviewed other than three members of the catering staff and these had not been completed in full. Staff supervision was not consistently being undertaken.

We observed the lunchtime experience for people who used the service, whilst we saw kind interactions taking place, the service

to people was disorganised and people were seen waiting for long periods of time for their meals. Records relating to one person's dietary needs was out of date on the first day of our inspection. Food and fluid charts had gaps in their recording.

Where Deprivation of liberty applications had been completed these had not been signed and the content recorded in them was basic. Written consent had not been records in people's care files.

The care files we looked at had evidence of the involvement of relevant professionals in reviews of people's care. We saw visiting professionals on the day of our inspection.

## Is the service caring?

**Inadequate**

The service was not caring.

We identified a number of concerns about the care and support people received to maintain appropriate, timely, regular bathing and personal care needs.

The public areas of the home were left unsupervised for long periods of time. Little interactions were noted taking place between staff and people who lived in the home.

We received mixed feedback about whether people were involved in choices about their care.

Care files we looked at had information in them about how to support people's individual communication needs. However, feedback we received was that not all people were supported to access aids to help their communication.

## Is the service responsive?

**Requires Improvement**

The service was not always responsive.

Care files we examined did not always have the relevant and up to date information in them about how to support people's individual needs. Daily records had been not completed in full to reflect what care had been delivered to people. Do Not Attempt Cardio Pulmonary Resuscitation records (DNACPRs) had not been reviewed to ensure they reflected people's up to date needs.

The complaints procedure was on display in the entrance to the hall. Policies were in place to guide and support people about how to deal with complaints. People told us they were confident

in raising concerns with the management.

The home had recently recruited a new activities co-ordinator. We observed activities taking place during our inspection.

## Is the service well-led?

Inadequate

The service was not well led.

The inspection identified a number of failings in the home that impacted on the care people received and placed them at risk of harm. We discussed our concerns with the senior management team who committed to ensuring improvements were made in the home.

Audits had been completed and the senior management team were reviewing systems and audits. However, we saw any actions required as a result of these were not always completed.

We received positive feedback about the new management team and the confidence for improvements in the home.

# Sherwood 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.

An inspection was undertaken on 20 and 25 April 2018 because of concerning information we had received from the Local Authority in relation to the safe care and treatment of some people who lived at the service. These included, staffing levels, personal care, lack of monitoring, incidents and accidents as well as the leadership and management of the home. Due to unforeseen circumstances we were unable to produce a report of our findings. This inspection took account of the risks identified during the April inspection.

This inspection took place on 18 and 22 June 2018. Both days were unannounced. This meant that they did not know we were coming. Day one of the inspection was undertaken by four adult social care inspectors and a pharmacist inspector. We also had one expert-by-experience of residential adult social care residential services and people living with a dementia. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. Day two of the inspection was undertaken by two adult social care inspectors.

Prior to the inspection we looked at all of the information we held about the service. This included statutory notifications the provider is required to send to us by law. We checked any incidents, accidents and investigations into abuse allegations. Due to technical problems, the provider was not able to complete a Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We also asked for feedback from visiting professionals to the home. We used a planning tool to collate all this evidence and information prior to visiting the home.

To understand people's experiences, we spoke with nine people who used the service, three visiting relatives and received feedback from two professionals who had visited the home. We also spoke with 14 staff members, the newly appointed deputy manager, regional director and the general manager. We

undertook a tour of all of the public areas of the home, communal bathrooms, communal toilets and people's bedrooms.

We looked at the care files and related documentation for 16 people currently in receipt of care as well as seven medications administration records. We also checked the files of five currently recruited staff members. We also looked at documentation relating to staff training, supervision, duty rotas and records relating to the operation and oversight of the home. These included audits, monitoring, feedback and minutes from meetings.

Inadequate

# Is the service safe?

## Our findings

Not all people who used the service told us they felt safe in the home. We received mixed feedback. Comments included, "It is locked at night, and there's people around, it's improved. Everybody's nice and pleasant", "I just do [feel safe], nothing can happen", "The carers [staff] are here, there's always someone to hand" and "Yes, now that these [new managers] have taken over." However, other comments included, "They are short of staff and they have in my opinion, people who wouldn't know what to do in the event of a fire. I don't feel safe in the night. There were only three [staff] last night", "Not always, the change of managers is unsettling" and "I am frightened, I don't know what to do, let me out, I want to go away from here." A visiting professional to the home told us, "I think that people are not as safe as they should be and hopefully the new management will address this."

We asked staff about their understanding of abuse and what actions they would take to protect people from harm They told us, "I would report it to a senior [staff member] and ask them to report to a manager. If they did nothing I would report my concerns to the Local Authority or CQC. I have heard of whistleblowing [reporting bad practice]." Other staff members we spoke with understood the procedure to take to report any concerns to investigating authorities. Whilst staff could demonstrate what actions they would take if abuse was suspected the training matrix we looked at noted that not all staff members were up to date with safeguarding training. The provider did not have assurance and could not be confident staff had the skills and knowledge to safely deal with situations of potential abuse.

We looked at how the home recorded, investigated and acted on any allegations of abuse. Whilst some records had been completed we identified a number of concerns. For example, we saw records in relation to one person who had displayed aggressive behaviours during personal care. Staff were directed to monitor for any physical changes and report the incident as a safeguarding concern. This was in line with the companies' policy. We saw no evidence that this incident had been reported to enable an investigation into these concerns. Other records we looked at identified a number of concerns in relation to incidents and accidents with people who used the service. These would require a referral to the Local Authority safeguarding team and a notification to be submitted to the CQC. We saw no record to confirm that a notification to the CQC had been completed. During our inspection we were made aware of a person leaving the home unaccompanied where supervision would be required. We discussed this with the general manager who had not been made aware of this incident. The general manager undertook an investigation where it was confirmed by staff that the incident had occurred. The general manager could not clarify the reasons the incident had not been brought to her attention. People were placed at risk of harm because staff failed to ensure information about incidents and accidents were notified to the management team.

We spoke with professionals from the Local Authority safeguarding team who confirmed they had received a number of safeguarding alerts from the home in relation to incidents and accidents. Where investigation had been completed, recommendations had been made to the home to ensure any future risks were reduced and people were protected from unnecessary harm. However, we noted not all people's care plans had been updated to reflect the findings and the recommendations made, following an investigation into allegations of abuse.

The provider failed to ensure people who used the service were protected from abuse and improper treatment. This was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safeguarding service users from abuse and improper treatment.

The home had a safeguarding file in place that contained information and guidance for staff to follow about how to act if abuse was suspected. We saw the home highlighted policies each month and in March 2018 the policy of the month was safeguarding. This provided staff an opportunity to ensure they were updated on how to act and investigate abuse.

During our inspection we identified a number of significant concerns in relation to how the home ensured people received appropriate and timely care from staff. We were told that one person was supported during an acute episode of illness by an inexperienced staff member and a more experienced staff member failed to respond in a timely manner to their requests for help. This placed people at risk of harm or potential harm.

We looked at how the service managed people's individual risks. We saw some evidence of risk assessments in place in people's care files. Topics covered included, pressure care monitoring, protecting skin integrity, continence needs, moving and handling and falls. Whilst we saw some reviews had been undertaken others had not been updated for several months. We were told by the management that they had identified some of these and had begun to implement measures to address these. However, we identified further concerns in relation to individual risk assessments for some people who used the service. One person's records we looked at had risk management plan for a behaviour that required close monitoring by staff to protect the person from harm. Another care file identified an injury that had occurred because of ineffective continence management. A relative we spoke with told us concerns had been raised in relation to stoma management. A stoma is where an opening is made on your abdomen which allows waste to pass out of the body. We checked this person's care file and could find no evidence that an up to date risk management plan had been developed to guide staff on how to manage their individual needs safely. This placed people at risk of harm or potential harm. A risk assessment for another person provided guidance for staff in relation to protecting them from skin injuries. However, this person had sustained several ongoing injuries to their skin that required treatment from the wider professional team. The records could not be relied upon to provide up to date and accurate information to support the safe delivery of care to people who used the service.

One person was visually impaired, we noted records which stated an over the counter cream had been left in their bathroom. We were told by the management that this had not been purchased by the home. Their record confirmed this person had accidentally used this cream instead of toothpaste that had resulted in an admission to hospital which confirmed no injury had occurred. The general manager told us that the staff had immediately responded when this came to their attention and lessons learnt were highlighted and discussed as part of staff meetings. We saw that appropriate signage had been displayed in their room following this incident to remind all staff about the safe storage of creams. We noted people were supported by staff during moving and handling procedures asking them to hold a table in the dining area. There was no evidence of staff using any equipment to support this person's moving and handling needs safely. Another person who was unable to stand independently was lowered to the floor safely by staff. Even though the procedure to support this person back into a chair was completed effectively we saw no evidence of any moving and equipment used at the commencement of the procedure to ensure they were protected from any risk or injury.

We looked at the systems in place to record any incidents and accidents in the home. The home had completed a memo to staff which had been signed by them about the procedure to follow for reporting accidents and incidents. However, it was clear from the records that this guidance was not always followed.

Whilst we saw accident and incidents records, not all of these had been completed in full. We saw gaps in the records on guiding staff on any recommendations and the actions taken or any lessons learned as a result of the accident. There were also gaps in the details of the circumstances surrounding incidents. We also noted that where incidents had occurred in the home, incident reports had not always been completed to reflect these. It was clear for the accident reports that a number of skin tear injuries had occurred in the home. However, the care plans and risk assessments for these people had no clear guidance for staff to follow to reduce any future risks to people.

The provider failed to ensure people who used the service were protected from unsafe care and treatment. Appropriate risk assessments were not in place and measures to reduce any future risk had not been implemented. Actions to act on and investigate incidents and accidents to minimise any future risks had not been taken. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safe care and treatment.

As a result of our findings we asked the general manager to undertake a number of urgent investigations in relation to three people in receipt of care at the time of our inspection. We received a prompt response for this which demonstrated the positive steps taken by the management team. This would ensure any concerns were investigated as a matter of priority to keep people who used the service safe. As part of her initial review of systems the general manager undertook to identify where statutory notifications in relation to allegations of abuse had occurred these were reported to the CQC as required by law.

The majority of people said they received their medicines on time. However, others told us, "It varies but they [staff] don't discuss them", "It varies, if they're short staffed instead of getting them at ten pm it will be eleven p.m. When asked if staff told them what medicines they were taking we received mixed feedback. Comments included, "They do tell me what they are for if I ask, but most times I just take them", "I want them to be reviewed by the doctor. Staff don't discuss them and I don't know what most of them are for" and "Recently I cleaned my teeth with [medicated over the counter cream] because I couldn't see, they have taken the [medicated over the counter cream] away." One person told us they had been waiting for a week for some cream for their legs.

We checked the medicines and records for seven people. We found that six of the seven people had photographs and seven had allergies recorded on their Medicine Administration Records (MARs) reducing the risk of a medicine being given incorrectly.

One person was prescribed a pain relief patch, which provided a seven-day pain relief for the person and was to be changed every seven days. The patch had been applied late on three occasions since April 2018, which may have increased the risk of the person's pain not being adequately controlled. A second person was prescribed a medicine for their skin to reduce inflammation. The cream was not in the home for it to be applied to the person, which may have increased the person's symptoms.

A third and fourth person had difficulty swallowing liquids and were having their fluids thickened to reduce the risk of choking. We asked two carers on how the third and fourth person's fluids should be thickened and they were unsure. Not having fluids thickened to the correct consistency may increase the risk of the person choking. Tins of thickener powder were on the dining room trolley and were not stored away when not in use, which may increase the risk of other people choking if ingested by accident. The general manager told us specialised training was planned to ensure staff had the required knowledge to safely manage thickened fluids for people who used the service.

We found other medicines were not stored safely in the treatment room and in peoples' bedrooms. An

incident had occurred, prior to our inspection, where a person with visual impairment had used a topical heat cream as toothpaste in error, as it had been left in the bathroom by carers by mistake. We also noted topical creams both prescribed and over the counter medicines were stored in a number of people's bedrooms. When we checked the date of opening for these we could not see all had been recorded when they were opened. This would prevent accurate disposal of creams as well as ensuring they were safe to continue to use. We discussed this with the management who told us some of these creams were supplied and applied by visiting professionals to the home. However we saw that some of these creams had been provided by the pharmacy. On the second day of our inspection the management team confirmed and we saw that appropriate locks had been fitted to the cupboards to ensure medicines stored in the treatment room was done so safely.

We looked at the fridge temperature records in the medicine room and found that there were no records for April or May, which is not in accordance with national guidance. We also looked at how controlled drugs were managed in the home. A controlled drug is a medication controlled under the controlled drug legislation. Weekly audits were not always completed following the homes medicines policy and records for when a controlled drug had been returned to the pharmacy, for destruction, had not been completed.

The MAR records for two medicines did not match the quantity remaining, which means we could not be sure these medicines had been given correctly. We found staff did not record the time people were given pain relief, which meant they could not ensure a safe time interval between doses. Homely remedies were not being used at the time of the inspection as there was no paperwork to support this, which is not in accordance to current guidance.

We identified the home had Ineffective systems to ensure the proper and safe administration of medicines. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safe care and treatment.

The MAR records contained a list of each person's regular medicines and how they had been prescribed. This helps staff to check deliveries each month to ensure no medicines are missing. We saw that staff had written the date of opening on medicines in use in the trolley where appropriate. We looked at the records and spoke with a person who looked after their own medicines in the home. Records showed that risk assessments were regularly done to check the medicines were taken properly. The medicines were stored securely and the person told us they felt it gave them some independence.

We watched some people being given their lunch and teatime medicines. Staff gave medicines in a kind and patient way and signed the records after the person had taken their medicine. Medicines that should be given at specific times to be effective were given at the right times. Staff records demonstrated that eight staff had had been assessed and knew how to handle medicines safely. Regular competency assessments were done in line with national guidance. There was evidence of additional training available for staff that focussed on aspects of care, for example, dysphasia and thickened fluid training.

All the people we spoke with told us they thought the home was clean and tidy. However, some of the people told us their beds hadn't been made. We undertook a tour of all areas. Whilst some areas were clean and tidy this was not consistent across the entire home. For example, 16 of the bedrooms we checked had concerns in relation to their cleanliness. These included stained bedding, mattress, pillows and duvets which also had debris and crumbs on them. We also saw some carpets were stained and one person's ensuite toilet was noted to be dirty. We also saw one person had no access to liquid soap or paper towels in their bedroom. The home had introduced new boxes to store any dressings required by district nurses safely in people's bedrooms however we saw in one bedroom the dressings had been left in a bag on the floor of

their ensuite. These concerns put people at increased risk of infection due to ineffective measures in place to protect them. We discussed our concerns with the general manager who commenced daily checks of the home to monitor and act on any infection control risk.

The general manager told us the infection control team from the Local Authority had visited the home to deliver training to all the staff team. We saw infection control audits had been completed recently with some results of findings recorded. However, where actions were required these were not consistently recorded to confirm what actions would be taken going forward to reduce any risks. For example, we saw records relating to an outbreak that had occurred in the home. We could not see any reference that a risk assessment had been completed and there were no details of an action plan that would guide staff to prevent any future risk. The record identified that no actions had been taken to address areas where suitable hand washing facilities were not available and a lack of liquid soap and paper towels in place. A further audit undertaken noted that wheelchairs were dirty and that a night time cleaning schedule was to be commenced. We asked the management for a copy of this but this was not provided during the inspection.

The provider failed to ensure people were protected from the risk associated with infection. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safe care and treatment.

During our observations in the home we saw staff wearing appropriate personal protective equipment whilst undertaking a variety of tasks such as personal care, household tasks, meals and kitchen duties. Where cleaning was being undertaken by housekeeping staff we noted that they had access to a variety of cleaning products and material to undertake their duties appropriately. Communal bathrooms and public areas were noted to be clean and tidy and free from unpleasant odours.

We asked people who used the service and visitors about the staffing numbers in the home. The feedback was generally consistent that not enough staff were in place. Comments included, "There is not enough staff in the dining room at lunchtime and teatime, we have to wait between courses", "At the moment there are temporary staff", "Not at the moment, two thirds of very good staff have left. There's lots of agency staff, last night there were only three [staff] on" and "I never see a carer [staff member]. I get myself up and washed and dressed. I get my own towel, I take my own laundry down, they don't even make my bed. They think I'm as good as I was five and a half years ago, but I'm not. They clean my room and bring my laundry back. I struggle to make my bed." Others said, "Most of the time [there is enough staff], sometimes they are a bit short. It could be anytime, they use quite a few agency [staff], they are very nice", "They've kept saying they're understaffed and overworked" and "There is plenty to come and see me."

Relatives told us they didn't feel there was enough staff they said, "If [person] has an accident, I need to know if they change [person] or make them wait. If they're short staffed I help" and "Sometimes you can't find the staff there doesn't seem to be many staff about. It is hard to find staff in the afternoon. Things have improved with the new manager but they are still short staffed. A lot of staff have left." Professionals we spoke with told us, "When I initially started visiting Sherwood Lodge I did not feel that the home was staffed with the numbers required to meet resident's [people who used the service] needs, and staff were hard to locate. Staffing has recently been increased." Another professional said, "Many staff since my involvement [in the home] have left."

The feedback from staff about the numbers in the home to undertake their duties was, "With regard to staffing, permanent staff are being offered incentives to cover shortages. People have left because they were unhappy. Staff are not being replaced we work with a lot of agency staff", "No definitely not [enough staff]"

and "We need new carers [staff] that know what they are doing. There are not enough staff even with less service users [people who used the service]. They are trying to recruit." A visiting professional told us, on occasions I can only describe the home as, "chaotic" staff running around; no-one knows what has been done for a specific person."

Whilst staff were seen in the home during both days of our inspection we noted public areas were left unsupervised for long periods of time. We also saw a number of people were not getting out of bed until lunchtime. We received feedback from staff that at times staffing numbers were lower and this impacted on the consistency of timely, effective care provided to people. This placed people at risk of harm as public areas of the home were not supervised appropriately and people did not receive timely support with their needs. We spoke with the general manager about this who told us all shifts were covered with either the permanent staff team or by regular agency staff.

We looked at some of the duty rotas that identified the staffing list and the shifts allocated to them over a 24-hour period. The provider completed dependency assessments for all people in the home to calculate the amount of staff required to deliver care. However, we noted the staffing numbers on duty did not always reflect the dependency assessment. For example, on the first day of our inspection we were told the numbers of staff in place to cover the shift reflected the dependency assessment. However, one of the staff members included in the numbers was new to the service and undertaking their induction to the home. This meant that levels of staff did not reflect those needed to meet people's assessed needs, placing them at risk.

The provider failed to ensure sufficient staff were available in the home. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Staffing.

We undertook a walk around of the home. This included all of the public areas, communal bathrooms and toilets, the kitchen, laundry and sluice room as well as all of the bedrooms. Whilst areas of the home were tidy, safe and suitable for people to live not all area were safe. For example, on the first day of our inspection we saw one person's bedroom had a radiator cover that was damaged with holes in it and another bedroom had a hole in the wall where the door handle had banged against it and damaged it. In two ensuites we saw the toilet raisers were loose and posed a risk of injury to people. We reported these concerns to the general manager who confirmed on the second day of the inspection the immediate actions to resolve some of the issues identified. They told us the health and safety director of the company had undertaken a full audit of the home to enable monitoring of the environment and any actions required could by implemented.

Personal Emergency Evacuation Plans (PEEP's) had been developed that provided guidance about how to support each person in the event of an emergency requiring an evacuation of the building. We saw a flow chart with a summary of all people's needs in the event of an emergency but this had not been completed in full, the general manager and regional director gave assurances that this would be completed as a priority. This would ensure relevant professionals had up to date information to assist in the safe evacuation of the home. Appropriate checks on fire equipment had been completed on smoke detectors, emergency lighting, fire doors, extinguishers and escape routes. Records included relevant guidance on the operation of the fire equipment in the home. We saw evidence of a fire risk assessment in place as well as information about fire drills completed in the home. Whilst we saw names of attendees and the dates for the fire drills there was no record of the findings from the drill or any actions or lessons learned going forward.

Environmental risk assessments had been completed and reviewed that would provide staff with the guidance about how to keep people safe in the home. Topics covered included, gardening, control of hazardous substances, bath hoists, bed rails, waste management, entertainment and activities. Whilst

records we looked at were in place these had not been completed in full and they had not been signed to confirm all control measures were in place.

We recommend the provider ensures where checks, audits and monitoring takes place on the environment an equipment actions are taken to rectify any findings to ensure it is safe for people to live, visitors to access and staff to work in.

Systems to ensure appropriate and timely checks on equipment were seen. Certificates and records confirmed appropriate servicing and professional testing had been completed had been completed. These included gas safety, electrical safety, portable appliance testing, nurse call buzzer checks, water safety, weighing scales calibration, fire detection, radiators, heating and lighting and asbestos management. This demonstrated that the home was monitored and safe for people to live in.

We looked at the recruitment system in place. We saw that satisfactory and safe recruitment procedures were followed. Evidence of completed application forms along with references to confirm the person's suitability for the post along with proof of identity and completed Disclosure and Barring Service Checks (DBS) were seen. The DBS helps employers make safer recruitment decisions and helps to prevent unsuitable people from working with people who use care and support services.

Where risks had been identified in staff files there was some evidence of risk assessments in place to keep them safe. Examples seen were pregnancy risk assessments. However, this was not consistent. We saw one staff members file where a risk assessment would be required to ensure the provider was happy they had the skills required to work in the home.

It was clear from the records that significant numbers of disciplinary investigations had been undertaken by the management of the home. The records suggested a number of these followed similar themes. We discussed these with the general manager who confirmed they would undertake a review of all disciplinary investigations to enable an analysis of themes or trends and facilitate any appropriate actions as a result of the findings.

Inadequate

# Is the service effective?

## Our findings

We spoke with people who used the service and visiting relatives about the knowledge and skills of the staff team. Whilst some people told us they felt the staff were competent in delivering their care other feedback was mixed. Comments included, "Some are", "The regular staff are great, but you've all these others coming in at the moment" and "Some are excellent, some need more training. The agency staff definitely want more training." One relative said, "The agency staff are good, some [regular staff] are not, they need more training" and "Get the staff retrained. There's too much bickering between the staff." Visiting professionals told us, "I believe that training was not up to date. I don't feel that staff have had the skills and knowledge, but training is being provided" and "On speaking with staff some are very good."

The staff we spoke with told us they had undertaken training whilst employed by the service. One person said, "The training is better, [we] get everything we need." However, others said the training was, "Not sufficient. We could do with extra training" and "Some staff are competent." Others told us that the morale in the home was, "Rock bottom. Some staff were terrible to work with but now they have gone. It makes a big difference."

The training matrix we examined had evidence of the training completed by staff on a number of topics. These included, MCA, Deprivation of Liberty Safeguards (DoLS), safeguarding, dysphagia and choking, fire drills, fire evacuation, food safety, moving and handling, health and safety and infection prevention and control. However, we saw a number of training dates were overdue. The general manager we spoke with told us action to address these shortfalls in staff training had been commenced. We saw records that confirmed senior management had issued timelines for training to be completed in the home. This would ensure staff had the knowledge and skills to deliver effective care to people.

We identified people required specific support for their individual care needs. We checked staff training records and there was no evidence that staff had completed training on stoma care and catheter care that would ensure they had the knowledge and skills to deliver care to people effectively. We discussed these needs with the general manager who told us staff had undertaken catheter training with an external company however they could not provide any written evidence of this. We did however note in one staff members file a certificate in relation to catheter, urology and sheath products from an external supplier. The general manager confirmed they were sourcing the training to ensure people's individual and specific needs could be met as a priority.

Training records and staff files we looked at identified some evidence of training completed by the staff team. Topics covered included; do not attempt resuscitation, fire training, basic life support and cardio pulmonary resuscitation. One of the staff files we looked had evidence of training log books for Mental Capacity Act (MCA) distance learning, pressure ulcers, tissue viability and risks of falls. Whilst this would provide good evidence that staff were up to date and skilled in these topics none of them had been dated to confirm when they had been completed.

The general manager told us they recognised that all new staff required an induction to their role and that a

robust programme of induction was provided by the company. The general manager confirmed all new staff were provided with an induction booklet and were expected to undertake a detailed induction to the home. However, none of the staff files we looked at had evidence that staff had completed an induction programme when they commenced their role other than some members of catering staff. However, these had not been completed in full and were not signed by the manager. The training matrix we looked at had no dates recorded that confirmed an induction had taken place.

We asked about staff supervision and appraisals to ensure staff were supported and monitored in their role and were offered the opportunity to discuss any areas for personal development. One staff member we spoke with told us they, "Used to have supervision." None of the staff files we examined provided evidence that staff had undertaken supervision. There was a list of staff supervisions but this identified only 17 of the 34 staff had supervision recently. All but two of the supervisions records that we saw were reflective supervisions that had been completed as a response to our inspection in April 2018, and we could not see which staff members had taken part in the supervisions. Topics covered included medicines management, completion of charts, creams administration and food and fluids. There was no record of discussion around staff practice, areas for development or any concerns with staff practice. Two staff we spoke with told us they had received supervision on the first day of our inspection. Records we looked at confirmed this.

The provider failed to ensure staff had the knowledge and skills to enable them to meet the needs of people who used the service. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Staffing.

The general manager told us they planned to introduce a comprehensive supervision programme for all members of the staff team. Following our inspection, the provider told us their computerised system recorded the commencement the staff programme of supervision with a number of the existing staff team. All staff were provided with an employee handbook which provided guidance about the company and relevant polices to support the delivery of care to people who used the service.

We asked people who used the service their views on the food provided to them. We received mixed feedback. They told us, "Breakfast I can manage and tea. Lunch I don't like, I wish they would take the batter off [the fish], it would help me", "It depends on the chef, the way it is cooked. The meat is undercooked, it is tough", "I don't want their food so I buy my own", and "Recently it's not been too good. It is not unusual to wait a long time between courses." However, others told us, "It used to be awful; they haven't got a regular chef. There are two choices for the main meal, if I didn't like either they'll make you something else. There's plenty to drink, I'll ask a carer and they get it straight away", "It is alright, I eat everything I get" and "It is a bit mixed."

We observed the meal time experience in the home and sampled the menu on offer to people. The food was nicely presented, looked appetising, fresh and tasty. The dining room was light and airy and tables were set with table cloths, crockery and cutlery. Staff told us people were offered a variety of breakfast options each morning and we saw people eating breakfast during our inspection. However, we saw that two people were offered porridge at 11:30am which had been made early morning with no evidence of temperature checks that would ensure it was the correct temperature for them to eat. We checked the food temperature records for all meals and could see no evidence that the temperatures of the food provided to people had been checked for four days. We discussed our findings with the general manager who gave us reassurance that temperature checks would be completed and recorded for each food provided to people who used the service. On our second day of inspection we noted these had commenced.

Whilst there was staff available during the lunch time service and staff were heard speaking nicely to people

the conversation was limited to the tasks at hand. We noted people were sat for very long periods of time waiting for their meal and the service of people's meals was disorganised. Two people were told their meal choice had run out and they had to wait for an hour from service commencing for their food to be cooked and provided. We also saw staff failed to respond in a timely manner to support people with their meals. For example, we saw one person had no plate guard who was struggling to pick up their food with their cutlery. We noted this person gave up and ate their meal with their fingers. It took several minutes for staff to attend to this person's needs and offer them support to eat.

Menu choices were on display in the entrance to the home which included light bites and alternative options available to people when the menu of the day wasn't to their liking. A variety of drinks were on offer during meals and drinks and water dispensers were seen in the public areas of the home for people to access at their choosing. However, where people were in their bedrooms we saw no drinks left for them to access. Where people required a specialist diet this was provided to them. However, one person was noted to be eating a normal diet but their care record directed staff to a specialised diet. We spoke with the general manager about this who told us a review of this person's needs had taken place and the care plan required updating to reflect their current needs. Staff did not have access to up to date information to support this person safely. On the second day of our inspection we saw this record had been updated. We noted one person's dietary needs had changed recently their care plan had not been amended to reflect their current needs. Where malnutrition assessments had been completed these were required to be reviewed monthly however we noted these had not been done. We discussed this with the general manager who ensured this person's care file was reviewed and updated by the second day of our inspection. Where one person had a choking risk identified we saw the care plan had not been reviewed since March 2018 to confirm it was current. A further care file noted a risk assessment had been completed in relation to choking but there was no choking risk identified for them. It was not clear why this documentation had been completed.

We saw several concerns in relation to the completion of food and fluid charts. Where one person's care plan directed staff to cut up food we saw the food charts advised staff of a pureed diet. This meant the record could not be relied upon to ensure this person received the consistency of the food they required to keep them safe. We also saw fluid charts were not completed in full in two people's records we looked at and the record confirmed their fluid intake targets had not been achieved for several days. This placed people at risk of a deterioration in their condition as they did not receive adequate nutrition and hydration.

We looked in the kitchen and saw plenty of supplies of foods available for the meals served to people. We saw food being prepared freshly each day. The general manager told us they were recruiting for a chef and kitchen staff and at present they were using temporary staff for some of the shifts. During our checks of the kitchen we noted cleaning schedules were not always completed in a timely manner. For example, the deep fat fryer was dirty and held old oil and one of the fridges was full of ice. Records we looked at could not confirm when these had last been cleaned. We also saw a cup and a mobile phone was placed in an area designated for raw meat preparation.

We noted significant gaps in the recording of meal temperatures, kitchen checks and the records relating to people's specialised diet were out of date. This meant the records could not be, relied upon to ensure food was safely stored, prepared and served. People were also at an increased risk of harm because kitchen staff did not have up to date information about their individual needs. We discussed these concerns with the general manager who took action by the second day of our inspection to ensure the kitchen appliances and areas were clean and appropriate records were in place that confirmed food, preparation, service and storage records were in place to guide staff.

The home had developed a weights file. Whilst there was some evidence of weights being completed since

May 2018 where weekly weights had been directed for people we saw gaps in recording from March to June 2018. We also noted in one person's care file that they had lost weight and had been recorded as high risk. However, we noted no weights had been recorded for them since May 2018 and there was no information that a further review had taken place. People were not adequately monitored to ensure any weight loss or gains was reviewed and acted upon accordingly.

The provider failed to ensure the nutritional needs of people who used the service were met. This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Meeting nutritional and hydration needs.

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 and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

During this inspection 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.

The care files we checked lacked consistency to confirm that appropriate mental capacity assessments and best interest's decisions had been completed. This would confirm all relevant people had been involved in the assessment and planning for people's care where they were required. People living in the home were not protected from unlawful restrictions.

The home had a file which contained information about DoLS applications submitted to the assessing authority. We saw completed application forms that contained information about the reasons for the application. However, we saw some records where the content was basic and not all had information relating to any discussions with relatives appointed to act on people's behalf. We also saw that not all the DoLS had been signed so were incomplete. One Mental Capacity assessment we saw clearly demonstrated that the person had the capacity to make the decision for themselves therefore it was not clear why a DoLS application had been made. We discussed our concerns with the general manager who told us they were aware relevant assessments and applications were required to ensure people living in the home were protected from unlawful restrictions.

The provider failed to ensure service users were not deprived of their liberty unlawfully. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff we spoke with understood the principles of the MCA and how to protect people from unlawful restrictions. Comments included, "Assume always someone has capacity. We would do a best interest [assessment] the DoLS."

The staff and the home had access to up to date policies and procedures to guide them about how to ensure lawful consent was obtained from people or their representative. However, the care files we looked at demonstrated these were not being followed. We saw that the capacity assessments to determine if people had the capacity to give consent to care and treatment were not completed. Consent was not

acquired from either those with capacity or from appointed representatives for those without. The provider failed to ensure consent was documented to confirm that people or their representatives had been involved in discussion and agreed to their care. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Need for consent.

We observed staff asking permission from people who lived in the home before undertaking a care task or activity. Staff spoken with told us they asked for people's consent prior to any intervention taking place. Comments included, "We ask for consent before care is done, we asked what people want to do." All staff knocked on people's bedroom doors and waited for permission to enter if people were present.

All the people who used the service we spoke with told us, they had access to a doctor if they were unwell and we saw information that confirmed regular visits took place from health professionals. These included the GP, speech and language therapy, nurse specialists and chiropodist. During our inspection we saw district nurses visited the home and completed reviews of people. The regional director and general manager told us they had developed improving links with the district nursing service that would ensure all people living in the home had access to their expertise if it was required.

There was some good evidence of care plans being developed using guidance from nationally recognised sources. This would ensure information recorded reflected up to date best practice guidance.

People we spoke with told us they could mobilise around all areas of the home with ease using the aids they required. We undertook a tour of the building, in all public areas as well as the bedrooms people resided in. The home was purpose built over two levels with large corridor access to both communal rooms, bathrooms and bedrooms. Bathrooms were equipped to support people to access bathing facilities where their mobility was restricted. There was a large light conservatory for people to access however one lounge was noted to be dark and confined. The general manager told us of their plan to extend and 'open up' this room to include a staff room to allow light and an open plan feel to the area. There was also an ongoing refurbishment plan to include new bathrooms and redecoration of all areas. This would support a positive, accessible environment for people to live in.

Inadequate

# Is the service caring?

## Our findings

We asked people who used the service and relatives about the care they received in the home. They told us, "Sometimes you ask for help and they [staff] go past", "Alright, but I never see anybody. If any of them were off ill, I'd never miss any of them" and "They could do everything better. I have to make my own bed and empty my own catheter bag". Others told us the care was, "Alright", "Marvellously well, I've made some good friends" and "Very well. They get the odd one [staff] from across the road."

A relative told us of the care that, "[Person] have to wait. My concerns are at night time", "Alright" and "They are just not getting on top of the basic care. Some [staff] good, some bad." All the people we spoke with told us they were able to follow their own routines. A comment from one person was, "You can [follow your own routine] if you're capable, I go to bed when everyone else goes, I'm alright with that."

Feedback from professionals was mixed but they felt improvements would be made with the new management in the home. They told us, "Lots of residents [people who used the service] are sat around in wheelchairs for long periods despite being reminded [that it was] not appropriate" and "Basic care needs have not been being met for example, hearing aids not being put in during personal care interventions in the morning. Baths were not being carried out/recorded. The care that the residents receive has improved, but could be a lot better, I feel this will improve with the new general manager] now being in place."

We asked staff about the importance of the care they provided to people. They told us, "People are cared for. We rewrite the care plans every month. But this is not being done at the minute. We want public areas of the home to be supervised but we can't always do it", "People are starting to feel happier. Care plans tell us what people want to do" and "I hope people feel cared for."

During our inspection records we looked at identified significant concerns about the personal care and bathing people received. This was also confirmed in feedback from people who used the service, relatives and staff. They told us, "You don't get bathed very easily it's only about once a week and I'd like at least two. When I asked there's always a reason why I can't", "I go to my [relatives] for a bath", "I've been here all this time (six months) and I have had two baths. I've no idea why I've not had more." We discussed these concerns with the general manager who was unable to provide bathing records to confirm which people had received bathing but provided bath temperate records. We cross referenced these with daily record which confirmed significant gaps in the baths people received. For example, one person had three baths in nine weeks, and two others only one bath over the same time frame. The care people received did not support their individual needs and placed people at risk. The general manager told us as a result of our findings the monitoring of bathing provided to people was included in the daily handover record to ensure people were offered and provided baths regularly.

Staff and a relative told us of a concern that was raised about the lack of care for one person who had faeces on their body with a clean continence product on them. This suggested that the product was changed without personal care being provided. The relative also told us about an injury that had occurred to them. They said, "I know the ups and downs of care but this is becoming detrimental. I feel frustrated I put [name]

in here, I now feel I am putting them in harm's way." We spoke with the general manager about this person's care who told us they had been reassessed and they were in the process of looking for an alternative placement to enable their needs to be met.

During our observations we noted some people to be nicely presented in clean clothing and their hair nicely done. However, this was not consistently the case. One person who used the service told us, "I'd like my nails cutting." We noted this person's nails were long and dirty. A staff member told us they were instructed to clean a person's nails due to brown matter under them. However, they were unable to clean them properly and the person ate their meal with the brown matter still in place. The care provided to people did not meet their needs, likes and choices. Care was not delivered to people in a timely manner.

We undertook observations of the public areas of the home, whilst people sat in the area of their choosing it was clear very little interactions were taking place between people and staff. Of the interactions we observed staff spoke kindly to people. However, we observed one interaction where a staff member spoke in an inappropriate way to one person. We discussed these concerns with the general manager who gave assurances that an investigation would be conducted to ensure all staff understood the importance of speaking to people appropriately. Another person who used the service told us, staff 'Ignored' them.

Since commencing their role, the general manager told us they wanted greater oversight of the home and had introduced three times daily walkarounds of the service looking in detail at the environment, records, observation or care and interactions taking place among others. We looked at a sample of these records and saw they examined the care people received and people's wellbeing. However, there were some gaps in the dates these had been completed. Records could not be relied upon to confirm appropriate checks and monitoring was taking place.

During our observations we saw public areas of the home were left for long periods of time unsupervised. This could increase risk to people as public areas of the home were not sufficiently monitored by staff. Where people were supported into the dining area for breakfast we saw two people who arrived late morning remained in the dining room and continued onto the lunch service. One person we spoke with told us they wanted to move but none of the staff had asked them about this. We received mixed feedback about the timeliness of staff responding to buzzers. Some people said that staff responded to buzzers promptly. However, others told us, "It varies, if there's nobody free you wait. It could be anything up to 20 minutes", "One time my buzzer was going off and they kept walking past. I don't think I'd like to be here if I can't do for myself" and, "I did ring for a towel and I got told off. [Staff member] said 'I have more people to look after'." A staff member told us, "People get told not to press buzzers." Where two people were noted to have no access to a buzzer the general manager told us risk assessments had been completed for this and regular checks were undertaken to monitor their needs.

Care delivered to people failed to meet their individual needs, choice or was appropriate. This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Person-centre care.

Most people we spoke with told us they had been included in decisions about the care they received. Other comments included, "I don't need much care, I'm very determined" and "Sometimes they ask". None of the people who used the service told us they had discussed their care file with staff. Only one relative confirmed their family members care file was discussed with them. Records could not be relied upon to reflect accurately people's likes, needs and choices and confirm people had been involved in them.
When asked whether people were supported to be independent not all confirmed this was the case. People told us, "I am as independent as I can be." However, one person told us, "I want to be independent, but

some wheel me about, but I'd rather try and walk." Another said, "It's not a case of doing what you like, but they [staff] listen to you."

We asked about whether people could choose who delivered their care to them. We received mixed feedback. Comments included, "No. There's one who wouldn't listen to me. She wouldn't use my soap or cream", "No, I have a couple of carers [staff] I would prefer" and "I just have whoever's available" others told us, "It depends" and "I've never thought about that." However, staff we spoke with told us people had a choice as to who delivered their care. One staff member said, "People are always given a choice of gender of staff."

Care files we looked contained information in them about people's life history and preferences that would guide staff about how to support their wishes, likes, dislikes, choices and diverse needs. This provided staff with information about how to support peoples individual and diverse needs. However, we observed staff offering choices to people during the inspection. For example, drinks, meals choices, support with eating meals and inclusion in activities. However, were people were given their meal we saw one person who informed staff this was not their meal choice. The staff member replaced the meal with their preferred choice.

People living in the home were not always treated with dignity and respect. This was a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Dignity and respect.

We noted that personal care was delivered by staff in the privacy of their bedrooms or bathrooms. Staff we spoke with told us they always knocked before entering people's bedrooms and that doors and curtains were closed during personal care. Professionals confirmed that they were offered private space when interacting with people who used the service.

Conversations about personal care were observed to be conducted quietly with between staff and people. It was clear staff knew people living in the home and were familiar with them. This supported the confidentiality about people's individual needs. Where one person's required support with their personal appearance we saw staff responded immediately to this need and supported them back to their bedroom to protect the dignity of this person. Staff had access to relevant policies and procedures that supported maintaining people's privacy, dignity and respect.

We saw that where people required aids to support their communication needs these were provided for example glasses and hearing. We saw information in care files that demonstrated eye checks had been completed to ensure people had access to glasses if they were required. However, we observed staff struggling to insert a hearing aid for one person. Feedback from a professional raised a concern relating to one person who was not consistently supported to wear their hearing aid. We saw one person had a significant visual impairment who was supported to access talking books that would enable them to engage in an activity of their choice when they wanted to.

The home ensured people had access to information about advocacy services. Information leaflets were on display in the entrance to the home that provided information and guidance about how to support vulnerable people with decisions. Advocacy seeks to ensure that people are able to have their voice heard on issues that are important to them. Staff had access to policies on advocacy. These provided guideance to staff about ensuring people were represented in decisions about their care.

Requires Improvement

# Is the service responsive?

## Our findings

Feedback we received from professionals raised some concerns about the content of care plans. They told us, "Care plans are poor, recording is poor." They told us of an episode where a GP reviewed one person but the care record had no documentation to confirm that the visit had taken place. Staff told us, "Care plans tell you everything about people [who used the service] if you read the right note."

We looked at the care records that guided staff on how to deliver individualised care to them. Whilst care plans were in place we identified a number of concerns relating to their content. Records were very brief and lacked sufficient information about how to deliver people's care. For example, where One person's record advised staff that there was no falls risk however we noted accident reports had been completed recently in relation to falls. Another record had a care plan in relation the persons continence needs however there was no record to guide staff about how to manage their catheter safely. Where one person required specialised and specific continence support we saw no care plan to guide staff about how to manage this safely. Records could not be relied upon to reflect people's individual and current needs to ensure they received timely and accurate care from staff.

We checked a number daily records. We saw some evidence to demonstrate the care that people had received. However, we also identified some concerns in relation to the actions taken by staff supporting people's personal care. Examples were, records that identified the need for bathing for one person on a number of occasions to ensure they were protected from any infection risk and protected their dignity. However, there was very little information recorded that confirmed personal bathing had been completed. Another person's care file recorded hourly checks were required as they were unable to use their call buzzer to request help. However, the daily record had no evidence to confirm hourly checks had been completed.

People were at risk of harm because the provider failed to ensure records were complete, up to date and reflected people's individual needs. This was a breach of Regulation17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Good governance.

Preadmission assessments were seen which had information in them about people's medical history and the support required to meet their individual needs. Other care plans covered a variety of topics. For example, medical conditions, tissue viability, personal hygiene, continence, falls management, pain, choking and cultural and spiritual needs. Risk assessments had been completed for a number of areas. These included, pressure care, protect skin integrity, no longer able to use the call bell system and urinary infections.

Care plans contained personal information in them which included, medical conditions, any allergies, the person's, GP or relevant professionals, date of birth and family members. We saw evidence of professionals involved in health reviews for people and we saw visiting professionals in the home during our inspection. People told us the home ensured they were reviewed if they were unwell. However, feedback form one relative was that they were not always updated when their family member was unwell.

The general manager told us they had introduced a detailed handover book to be used to improve communication between the staff at shift change over thus improving the care people received. We looked at a sample of these and saw a wide variety of topics were recorded these included, names of each person living in the home, their individual medical needs, meal requirements, and concerns with tissue viability, any observational records and weekly weights.

A daily allocation sheet had also been developed that identified the tasks allocated to each staff member. This would provide an audit trail of who was responsible for each task and enable effective monitoring of the care delivered to people.

We looked at the support provided to people as they neared the end of their life. We saw a number of records contained Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) forms in them which had been signed. However, there was limited evidence that reviews of the decisions had been completed to ensure the information was still relevant. We saw one record that guided staff on the use of end of life medicines however, there was no end of life care plan in place to support the delivery of their care.

Records designed to provided staff with guidance about how to meet their individual needs in relation to supporting their end of life care was ineffective. This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Person-centre care.

People we spoke with told us they knew how to complain and would be confident raising any concerns with the management. They told us, "I would now they've got a new manager and deputy manager", "I would see someone and tell them", "I think so. I have complained and it was sorted" and "Alright, I've got no complaints." There were details about how to complain on display in the entrance to the home.

The home had complaints and compliments file in place that contained information to guide staff on the procedure to follow to deal with complaints. Records about individual complaints had been recorded in relation to the type of complaint and who had raised the concern. We saw that where complaints had been raised action had been taken to address the concerns. For example, where one person had raised concerns about a bedroom the home had undertaken a refurbishment. Records indicated that people were happy with the outcome of the investigation by the manager. However, feedback from a professional stated that previous complaints had not been dealt with appropriately. This was being acted upon by the new general manager.

We asked people how they spent their day and if an activities programme was provided in the home. They told us, "I do the word search and I read quite a bit as well", "I've started a Rummy club [card game] and we play dominoes. I paint modern art and birds" and "I just sit here and if there's anything exciting [activities] I want to do I'll do it." Others told us, "That's another thing, I like quizzes and music. I like musicals, they [staff] don't ask the residents, they either change the music or turn it off", "Not a lot, there's not much to do. I occasionally get bored. The staff usually ask what we want to watch on the television". The feedback about whether people went out of the home consisted mainly about family supporting them to go out however, one person told us, "I've been on a couple of trips."

We were told by the general manager that a new activities coordinator had been recruited to the home which is hoped will bring about improvements in the activities provided to people supporting a more enriched life. We spoke with the activities coordinator who told us all people were involved in making decisions about the activities they would like to take part. They said they had plans to develop the activities programme in the home to include trips out with people if they so wished. We observed some activities taking place with small groups of people. These included, carpet skittles. There was a notice board on

display detailing what activities were available to people. Records we looked at confirmed what activities had been provided to people and who had taken part. These included, skittles, ball games, pub game and trivia quiz. Evaluations of the activity had been completed that would ensure people with happy with what was being offered to them.

Systems in the home demonstrated the use of technology to support the delivery of care and monitoring in the home. These included electronic computer systems and wireless internet in the home. The home had an electronic call bell system for people to use and sensor mats in place where required to monitor people at risk in their bedrooms.

Inadequate

# Is the service well-led?

## Our findings

We asked for feedback from people who used the service and relatives about the management in the home. We received positive comments that they had met the general manager and that she was approachable. Examples were, "Yes, she's a very nice person, very hard working. I wish her every success", "Yes, she's approachable", "Since the new manager has come into post it has improved" and "Yes, but I've not seen much of her. I see the deputy manager." However, others told us, "I've no idea; I don't think I've met her", "We have not seen her much" and "[General manager] is a good manager but there is too much to deal with. [General manager] and [deputy manager] wasn't introduced to them." A professional we spoke with told us, "Unfortunately for the care staff they have had several managers in place since the [previous] general manager went off. The managers have not been consistent with the way they wanted things to be done, so staff have understandably been very confused. It appears that there has not been strong leadership in the past, however, the new manager and deputy manager are now in post, so hopefully this will provide staff with good leadership." During our inspection we observed the general manager and deputy manager visible in all areas of the home. They were seen engaging with people who used the service, visitors and staff.

Staff we spoke with told us of the high turnover of the management in the home and the impact this had on staff morale, operation and oversight of the home. They said, "It is getting better with the new management. A lot of us are happier", "It was rock bottom. It was [morale] brushed under the carpet but now alright. I have seen a difference since the new management has arrived. [Deputy manager] is nice and polite and [general manager] is always helpful she will come and help. I feel more settled", "Staff morale is very low everyone feels under pressure. [General manager] is lovely. I hope she is going to stay, she has got the right attitude" and "The staff morale has got a lot better with [deputy and general manager]. The managers are good."

The regional director told us copies of audits and checks were uploaded to the system that would enable the monitoring of the home by senior members of the team. Topics covered included tissue viability, hospital admissions, safeguarding, and nutrition. However, we noted findings from previous audits were not carried forward to ensure actions had been taken. An example of this was documentation audits. We saw that gaps and inconsistencies had been identified in their content however there was no record to confirm the actions required had been completed. We saw a further record of actions to address the concerns with care plans dated May and June 2018. Whilst there was some evidence of staff signing that action had been taken to address the gaps in the care files, not all records had been signed as updated and reviewed. It was clear from our findings that audits lacked the evidence we had identified during our inspection in relation to gaps and inconsistencies in them.

Records seen confirmed audits and monitoring of the home's equipment and environment was taking place. These covered water checks, heating, hoist and slings and window restrictors. We saw some evidence of the actions taken where actions were required. However not all checks had been completed in full and where actions were required these had not always been recorded as complete.

During our inspection we identified a number of significant failings that impacted on the care people received in the home and placed them at harm or risk of potential harm. The provider failed to ensure

people who used the service were protected from abuse and improper treatment. Systems and processes failed to ensure people were not deprived of their liberty unlawfully. Improvements were required to ensure people were encouraged to be involved in decisions about their care.

Care files lacked documentation for consent to confirm that people or their representatives had been involved in discussion and agreed to their care. The provider failed to ensure people who used the service were protected from unsafe care and treatment. Ineffective systems to ensure the proper and safe administration of medicines was identified. Risk assessments were incomplete and did not reflect measures implemented to reduce any future risk. The provider failed to ensure appropriate actions were taken to act on and investigate accidents and incidents to minimise any future risk. Care delivered to people failed to meet their individual needs, choice or was appropriate. Records designed to provide staff with guideance about how to meet their individual needs in relation to supporting their end of life care was ineffective. People living in the home were not always treated with dignity and respect.

People were not protected from the risk associated with infection. The provider failed to ensure the nutritional needs of people who used the service were met.

The provider failed to ensure that robust recruitment procedures were established and operated effectively. There was a lack of sufficiently suitably qualified staff available in the home. Staff did not have the knowledge and skills to support the delivery of care to people. Systems and processes to ensure the environment was monitored and safe for people to live in and audits and monitoring of the home was incomplete and lacked evidence of actions from the findings.

Since our inspection the new manager had been registered with the CQC and took overall responsibility for the operation and management of the service. It was clear the number of changes of leadership in the service had impacted on the oversight and delivery of care in the service. During our inspection all members of the team were supportive of the inspection process and were open and transparent about the task ahead and the failings in the home. We discussed with the general manager some people living at the home had very complex needs who needed assessments undertaken to ensure their individual needs could be met in the home. The general manager confirmed this process had commenced and where people's needs had changed action was being taken to provide alternative accommodation to ensure their needs were met appropriately.

Systems and processes were not operated effectively to protect people from harm or risk of harm. This was a breach of Regulation17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Good governance.

We saw the home was committed to empowering the staff to feel included and recognised for the work they did by having a photograph of the employee of the month on display in the entrance to the home. However, during our discussions with staff, they told us of concerns relating to letters they had received in relation to 'enforced annual leave'. They told us, "We got a letter with our dates [for annual leave]" and "We used to have a form for our leave. They would check the diary, if no one was off it would be approved. It has just changed and we have been given weeks by the company." We saw copies of these letters to confirm this. We discussed this with the general manager and regional director who told us not all staff had been issued with these letters and that staff were given the opportunity to book their annual leave prior. They said they had taken this action to ensure staffing levels remained consentient in the home and in line with the contractual rights of employees. The regional director confirmed they would undertake a review of this practice and ensure staff were provided with the opportunity to choose which holidays they liked, taking into account the needs of the company.

We looked at the electronic system in place to record and monitor regional and external audits in the home. Records we looked at included information about the areas reviewed and the timelines for any actions taken as a result of the findings. Areas covered included daily meetings, housekeeping and maintenance, activities, new staff, any new admissions, stand up meetings and feedback about the service.

The regional manager told us, records on the electronic system and emails we looked at confirmed regional support visits were undertaken regularly in the home. As a response to these visits and the last inspection an action plan had been developed and reviews had taken place. This identified the findings of the reviews along with what actions were required going forward and who was responsible for this.

Due to the number of concerns raised at the service the home had been working closely with the Local Authority safeguarding team, commissioners of the service and health professionals as part of a quality improvement programme. The general manager and regional director told us they were working hard and were committed to making the improvements required in the home. We saw evidence that improving relationships with professionals were developing and regular 'rounds' with district nurses were being undertaken with staff. Following our inspection and feedback of our findings, we met with senior members of the company including the nominated individual to discuss our concerns. As a result of this the home developed a further detailed action plan that identified the improvements they planned to make in the home.

We asked people whether residents meetings took place. Whilst people said meetings took place not all said changes were made as a result of these. Comments included, "They have not been very successful, they don't know how to run a meeting, it's turned into a private conversation. The others don't know what's being said, they need a microphone", "We get to discuss things like the food. I suppose one or two things have changed. But they're not that frequent", "I went to the last one and they had eight pages of complaints. In some ways they change things". "they're about once a month, it depends if things change" and "Yes they have them but I've not noticed a change after them." We saw records that confirmed a variety of meetings had taken place for people who used the service and staff. Records included details of the attendees, dates of the meetings along with the topics discussed. These included, the kitchen, attitudes, conduct, consistency, mentoring, communication rotas and housekeeping. The home also undertook daily stand up meetings however, we saw these had not been completed daily.

We asked about how the home obtained the thoughts and views of people living in the home and relatives visiting the home. We were told the provider regularly asked for people's views in the form of surveys. Records of the findings we looked at confirmed this. The findings from the surveys indicated that people were happy with the care in the home however, some of the findings from these were lower than in the previous year and less than the average noted. Topics covered a wide range of areas. These included, overall happy living here, satisfied with overall standards of the care home, access to doctors, nurses and dentists, staff available when needed, good quality of food, safe and secure place to live. However, a professional told us that communication was poor with family members. They said, a relative had not been made aware of a hospital admission for their family and that they were informed when they were contacted to do a questionnaire regarding the experience during their stay.

Certificates confirming the homes registration were on display in the home along with a copy of the ratings from the last inspection in the home. We also saw evidence of an award in relation to health care service for 2017. All staff had access to online policies and procedures that would guide them on all aspects of care and management for the home.

The provider had developed a notification file that contained information about the last inspection and the

actions to be completed in the home. Prior to our inspection we were aware that a number of statutory notifications had not been submitted to the CQC as required by law. We discussed these with the general manager who undertook to ensure all relevant notifications were submitted to the CQC. We recommend that the provider ensures all staff are provided with training and guidance about the responsibilities to report statutory notifications as required by law.

This section is primarily information for the provider

# Action we have told the provider to take

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

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 10 HSCA RA Regulations 2014 Dignity and respect<br><br>People living in the home were not always treated with dignity and respect.<br><br>Regulation 10. - (1) (2) (b) |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 11 HSCA RA Regulations 2014 Need for consent<br><br>The provider failed to ensure consent was obtained and documented to confirm people had been involved in discussion and agreed to their care.<br><br>Regulation 11. – (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 9 HSCA RA Regulations 2014 Person-centred care<br><br>Care delivered to people failed to meet their individual needs, choice or was appropriate.<br><br>Records designed to provide staff with guidance about how to meet their individual needs in relation to supporting their end of life care was ineffective.<br><br>Regulation 9. - (1) (a) (b) (c) (3) (d) |

**The enforcement action we took:**

proposed enforcement withdrawn following a review of representations.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>Ineffective system to ensure the proper and safe administration of medicines was identified.<br><br>The provider failed to ensure appropriate risk assessments had been completed and measure implemented to reduce any future risk.<br><br>The provider failed to ensure people were protected from the risk associated with infection.<br><br>Regulation 12 (1) (2) (a) (b) (g) (h) |

**The enforcement action we took:**

proposed enforcement withdrawn following a review of representations.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment<br><br>The provider failed to ensure service users were |

not deprived of their liberty unlawfully.

The provider failed to ensure people who used the service were protected from abuse and improper treatment.

Regulation 13. - (1) (2) (3) (5) (6) (d)

**The enforcement action we took:**

proposed enforcement withdrawn following a review of representations.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs<br><br>The provider failed to ensure the nutritional needs of people who used the service were met.<br><br>Regulation 14.- (1) (2) (a) (b) |

**The enforcement action we took:**

proposed enforcement withdrawn following a review of representations.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>People were at risk of harm because the provider failed to ensure records were complete, up to date and reflected people's individual needs.<br><br>Systems and processes were not operated effectively to protect people from harm or risk of harm.<br><br>Regulation 17. - (1) (2) (b) (c) |

**The enforcement action we took:**

proposed enforcement withdrawn following a review of representations.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 18 HSCA RA Regulations 2014 Staffing<br><br>The provider failed to ensure sufficiently suitably qualified staff were available in the home.<br><br>Regulation 18. - (1) (2) (a) (b) |

**The enforcement action we took:**

proposed enforcement withdrawn following a review of representations.