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Orchard Lodge Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

Orchard Lodge provides nursing care and accommodation for older people many of whom are living with life limiting conditions and some who are living with various forms of dementia. The premises is an older style, purpose built building with two floors. The service is registered to provide care for up to 28 adults. At the time of the inspection 23 people were living there.

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

We carried out this unannounced comprehensive inspection of Orchard Lodge Care Home on 17 and 19 December 2018. During our last comprehensive inspection in June 2016 we rated the service as 'Good' with a rating of requires improvement in responsive. This was because care plans were not kept up to date and showed little evidence of people or their families being involved in the process. During this inspection the rating changed to 'Inadequate'. This is because we identified that previous concerns had not been adequately addressed and we found additional serious concerns about some aspects of the service. This was in relation to how the service kept people safe, considered their social needs and how the service was led.

We found the provider was in multiple breach of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

There was a registered manager in place who was also a registered nurse. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Care records, including preadmission assessments, care plans and risk assessments were insufficiently detailed to ensure people received safe, person centred care that met their individual needs.

Some people did not have a fully functioning supply of heating and hot water in their bedrooms. This was a

long - term issue and, although the provider had made attempts to address it, an effective solution had not been carried out. Poor maintenance of the premises placed people at risks of harm, by infection, inhalation of mould spores from damp, and exposure to cold or wet weather.

Staff were not deployed effectively to support people safely and people were left at risk of falling.

Although staff were kind when they spoke with people, interaction was very limited and many people were at risk of social isolation and lack of stimulation. An activities coordinator was in post and had good ideas of how to improve engagement with people. However, these ideas were not acted on when the activities coordinator was not working.

Staff did not always promote people's dignity and respect. and inappropriate language was sometimes used to describe people. Confidential information was not always stored securely.

People's social needs were not being meaningfully explored with them. Lifelong interests were not being promoted by the service. Staff were not chatting and engaging with people.

Quality monitoring checks by the provider had not identified many of these issues and therefore action was not taken to address them. Where action was taken it had not been fully effective and people were left in unsafe conditions until the Commission took action to address the issues with the provider.

The culture of the service was task based, and the registered manager did not have a strong understanding of how to promote person centred care.

Although the registered manager responded to relative's complaints, the way in which this was done was dismissive and complaints were not used to make improvements to the service.

The staff received training and regular supervision to support them to carry out their duties.

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.

The heating and hot water supply to some people's rooms was not working effectively. Temporary action was taken to address this following action by the Care Quality Commission.

Risks were not assessed properly and guidance to staff was insufficient to keep people safe.

People were at risk of harm because staff were not deployed effectively enough to keep them safe.

Staff had lack of awareness about the impact of poor care and isolation.

There was a recruitment process in place to check that only suitable staff were employed by the service.

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Is the service effective?

Requires Improvement

The service was not always effective.

People's needs assessments were not detailed enough to ensure good person-centred care was planned.

Staff and management knowledge and understanding of mental capacity was limited.

Health professionals' advice they gave about people's care was not used to update care plans.

Food and drinks offered to people was of a good standard. However, we found many people left with no support at lunch time.

Staff received training to support them in their role.

Is the service caring?

Inadequate

The service was not caring.

Staff were kind but their interactions with people were very limited and task orientated.

Staff congregated away from people and did not spend enough time with them to reduce social isolation.

Staff, including the registered manager and the deputy manager used language to describe people that was disrespectful and undignified.

Is the service responsive?

Inadequate

The service was not responsive.

People did not receive person centred care that was responsive to their individual needs.

People's social needs, interests, and achievements were not identified effectively or treated with importance.

The service did not use complaints received to make improvements to the service and responses to concerns raised were sometimes dismissive.

Plans to support people at the end of their life were not in place.

Is the service well-led?

Inadequate

The service was not well led.

We found multiple breaches of regulations because quality monitoring was not effective..

Issues relating to the culture of the service had not been recognised.

People and their relatives' views were not taken seriously and acted on.

The poor quality of records relating to people's care had not been recognised.

The provider and the registered manager were aware of the ongoing issues relating to the maintenance of the building, but had not effectively addressed these until prompted by the Care Quality Commission.

The provider had not notified the Care Quality Commission of reportable events as required by law.□	

Orchard Lodge Care Home

Detailed findings

Background to this inspection

We carried out this comprehensive inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked 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.

The inspection site visit took place on 17 and 19 December 2018 and was unannounced. The inspection team consisted of two inspectors and an assistant inspector.

This inspection was prompted by concerning information about the service being shared with us by members of the public. These concerns included allegations of neglect and omission, poor quality care, lack of staff, and a lack of stimulation for people living at the service. We considered these issues during the inspection.

Before the inspection we contacted the local authority's contracts team and safeguarding team. We asked them for their views on the service. We looked at the notifications that the registered manager had sent us over the last year. Notifications are about important events that the provider must send us by law.

We used information the provider sent us in the 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.

During our inspection we spoke with seven members of staff including the registered manager, the deputy manager and care staff. We spoke with 10 people who were using the service and five visitors. We observed the care provided to people who were unable to speak with us. We spoke with the local authority about their views of the service. We reviewed the care records and risk assessments of six people who used the service, checked medicines administration records, clinical records and reviewed how complaints were managed. We also looked at three staff records and the training for all the staff employed by the service. We reviewed

information on how the quality of the service was monitored and managed.

Inadequate

Our findings

During this inspection we found there were significant failures of the heating and hot water system at the service. Towards the end of the first day of inspection, we found one person had no heating or hot water in their room. This person was not independently mobile and was nursed in their bedroom. They were also recovering from a recent chest infection. Their bedroom door was opposite a double fire door which was in a state of disrepair, letting draft and rain into the building. This had the effect of making the person's bedroom colder still. Although the registered manager had provided the person with a portable heater, this had been turned off when we saw them.

On the second day of the inspection we checked the heating and hot water facilities for each person's bedroom and all bathrooms. We found that 13 bedrooms (some vacant) and two bathrooms had problems with either hot water, heating or both. Five people had been provided with portable heaters to reduce the risk of them being cold, although when we arrived for the second visit, these were not all on.

Some people we spoke with told us that the problems with the heating and hot water system had been going on for a long time. One person said, "It's been a long time, but it comes and goes. Sometimes there is hot water and other times there is not." One relative said, "It's been like it for months." People told us that staff did not always have a supply of hot water to use when providing personal care. They explained that staff dealt with this by bringing containers of hot water from other parts of the building where the supply was available. However, two people told us that there had been occasions when staff had used cold water to provide their personal care. One person said, "They have had to use cold water on occasion. It's not their fault though. It's not good enough really, it needs to be fixed properly."

We spoke with the registered manager, who acknowledged there had been problems with the heating and hot water system. They said the provider had recently had a lot of work done to the system to address the problems. We saw evidence that this was the case. However, the system was still not working effectively and no further work had been planned to address the ongoing issues. This put people at risk of harm from being exposed to cold temperatures.

The lack of hot water supply to some areas of the home also raised the risk of the spread of infection, particularly the risk of legionella. We looked at the last legionella inspection report from March 2018. It too had identified concerns with the supply of hot water, including the supply to high risk areas, such as the kitchen and the sluice room. Although at our inspection the supplies to these rooms were hot enough, it indicated that the issues with the hot water system had been ongoing for many months.

Records relating to the care planned and provided to people, such as risk assessments and care plans were not sufficient to ensure people received safe care. Where risks were identified the information was very limited and was not individualised to make clear the specific areas of risk for the individual person. Many risk assessments were generic in nature and repeated from one person's care records to another's. Although there was basic information about what staff were to do to reduce risk of harm, there was a lack of guidance to staff on how this was to be achieved. In all but a small number of examples, risk assessments and care plans were hand written and often were not legible, making them impossible to follow.

Clinical records, such as repositioning charts, fluid and food intake and output charts, and body maps (a chart for noting any marks, bruises, wounds or pressure areas) were not meaningfully completed. For example, fluid intake charts were not fully completed to show how much a person had to drink. Where they were completed, in some instances the record stated 'All' rather than providing a clear amount of fluid taken. An indication of the required amount of fluid for each day was not stated, so staff were not clearly instructed about how much fluid to offer.

One person who was living with significant skin damage had not had a body map completed since 2016, despite current open wounds to their body. Another person who was in hospital at the time of the inspection had a wound on their foot. The cause of this and the location where it was sustained was not confirmed. However, when we discussed this with the registered manager, they confirmed the person had a healing scab on their foot when at the service. However, a body map completed immediately before the hospital admission did not identify this.

Medicines were not always managed safely. Although most prescribed medicines were supplied by the pharmacy in monitored dose blister packs, some medicines were in loose packets. For those supplied in loose packets, we found there were no accurate stock records kept to make sure the correct amount of medicines were accounted for. This made it impossible for the provider to carry out an effective audit of medicines or to identify administration errors if they took place.

One person's medicines were not stored safely. We were unable to locate medicines for one person in the medicines room. The deputy manager told us the person's medicines were kept in their room to save time if they required the medicine urgently. This would usually be an appropriate arrangement as long as there was a suitable way to store the medicine securely. However, we found the person's medicines stored haphazardly on an open bedside table, leaving them accessible to anyone who entered the room. This put the person at risk of their medicine going missing and other people at risk of being exposed to medicines that might cause them harm.

Although accidents and incidents were recorded, we noted that this was done sometimes several days after the incident took place. Some of the information was not relevant to the incident and was more an account of how the member of staff writing had been affected by the events that took place. Although there was a system in place to log and analyse incidents, this had not been completed since July 2018. Due to these issues we were not confident that incidents were being appropriately managed to ensure people were safe following an incident. The service was therefore unable to demonstrate that they took appropriate action to learn from when mistakes took place.

All of these issues were a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Before this inspection, concerns were shared with us about staffing levels and the way in which they were deployed at the service. These issues were raised with us by more than one source. There was concern that

people were isolated and not provided with sufficient stimulation or assistance, particularly at meal times. The concerns also made reference to staff sitting, chatting to each other, away from people in a dining room.

During the inspection we found evidence to support these allegations. Throughout both days of the inspection, we found people in communal areas were not supported by staff, and people in their rooms were also left for long periods without contact with staff. Several times we had to locate staff on behalf of people who were distressed or required assistance, and each time this happened, we found staff congregated in the dining room away from people who used the service. Furthermore, we identified that the failure to deploy staff effectively throughout the occupied parts of the building put people at risk of harm. For example, one person sitting in a reclined chair was attempting to stand up, by pushing themselves down the chair towards the raised footrest panel. As they did this, the chair began to tip. No staff were present when this was taking place and an inspector had to alert staff to the incident that was about to occur. Had they not done this, the person would have fallen from the chair and could have ended up with the heavy chair falling on top of them.

This was a breach of Regulation 18 of the Health and Social Care Act 2008(Regulated Activities) Regulation 2014.

Staff had received training about safeguarding people from harm and understood their responsibilities to report concerns they had. They had sufficient theoretical understanding of the types of harm people may be at risk of, and the signs to look out for to indicate there may be cause for concern. However, we found people were not sufficiently protected from the risk of harm through neglect. This was because people were left alone for much of the time, whether they remained in bed or occupied communal areas during the day. Many people living at the service were not able to alert staff if they required assistance, but we found little evidence to show they were checked regularly enough to ensure they were safe and comfortable. During the two days of inspection, we saw several people who were in a state of distress and had to intervene to find them assistance. This did not protect people from potential harm.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had an up to date safeguarding policy that gave guidance to the staff on how to identify and report concerns they might have had about people's safety. Information about safeguarding was on display throughout the home and it included contact details for the relevant agencies for staff to refer to when needed.

There was a recruitment process used by the service that included all necessary pre-employment checks such as references from the previous employer and Disclosure and Barring Scheme (DBS) checks. DBS checks show if the applicant has any criminal convictions. These were completed in all staff records we looked at prior to the member of staff starting work. This helped the provider to make sure only suitable staff were employed at the service. We noted that some DBS checks had been carried out many years ago because some staff members had worked at the service for a long time. It is good practice for employers to periodically repeat DBS checks to ensure the information they hold about staff is up to date.

Staff followed current guidance on good practice in relation to infection prevention and control. We saw there were plenty of gloves and aprons and staff were seen to use these appropriately to minimise the risk of cross contamination.

During the second day of our inspection a temporary measure was put in place to ensure hot water and heating was available throughout the imminent Christmas period. Action to address the damaged fire door was also arranged. After our inspection, the provider sent confirmation that the heating and hot water was working, and that a longer term solution was planned for later in the year. This was because the heating would need to be turned off for several days to make the necessary improvements. For this reason, this work was planned to take place in the warmer months of the year.

Requires Improvement

Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When 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.

Although capacity assessments had been completed in some instances, there was little documentation to show how specific decisions about people's care had been made in their best interests. One person was in the communal lounge sitting in a chair that was in a reclining position. They made repeated attempts to stand up from the chair and it was obvious that they wanted to move. Staff repeatedly told the person to sit down, and although this was said kindly, they made no attempt to find out what the person wanted and help them to move out of the chair safely. The member of staff then left the room, without attending to this person's needs. This was restrictive and there was no evidence in records to show this practice had been agreed in the person's best interests. On the first day of the inspection there was an incident where this person nearly fell from the chair.

On the second day of the inspection the registered manager told us they had decided that the person would be nursed in bed in future to keep them safe. We challenged this decision and the process used to make it. We were concerned this solution may not be in the person's best interest or the least restrictive way to support them safely. The registered manager then made an urgent referral to an external professional who attended that day to support the service to identify less restrictive ways to support the person to remain safe. However, had we not intervened, the decision to restrict the person to their bed may have remained in place. This would not have been in the person's best interests and would have put them at risk of other harm, such as pressure ulcers, and social isolation.

People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). We saw from records that DoLS authorisations had been applied for when it was considered appropriate. However, some documents were poorly worded and demonstrated a lack of understanding of this legislation. We spoke with the registered manager about this. They told us that a different form was now used, but the original form was found in use in records we looked at.

Records of consent to various aspects of care were held within people's records. Some of these records were

signed by relatives on behalf of people, although there was no record to indicate that the relative had legal powers, such as the power of attorney for health and welfare, which allowed them to give this consent. We noted in some people's records that information about consent was confusing. For example, one person's relative had signed to withhold their consent to bedrails. Other documentation indicated that the person had bedrails in place, but then elsewhere stated that the person got out of bed independently. This would not have been possible if bedrails were in place. This could have led to unsafe care or overly restrictive care because guidance to staff was inconsistent.

These issues were a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Although the provider had a pre-admission assessment process in place that was in line with legislation and up to date guidance, these were not completed thoroughly to ensure people's needs and preferences could be understood before planning care. The assessment format covered people's needs in relation to issues such as eating and drinking, mobility, skincare, emotional wellbeing, personal care, and specific health conditions. It also invited the assessor to explore meaningful relationships, life events, interests and aspects of life that were important to the person. Although partially completed to establish the person's basic needs and clinical needs in relation to any medical condition, information about the person as an individual was insufficient to ensure personalised care was planned. This was also reflected in the care plans developed from this process.

Orchard lodge is an older style, purpose built, property on two floors. People's bedrooms were of an acceptable size and many had en-suite facilities. However, the décor of some rooms and corridors was tired and would have benefitted from redecoration. We found that two bedrooms had been affected by damp. The maintenance staff told us there had been a leak that had caused damage to one of these rooms and a dehumidifier had been placed in the room to dry it out. The person had not vacated the room during this process. The second room showed damage to the paintwork and walls as a result of damp or leakage. There was a distinct smell of stale water in the room which suggested this issue had been ongoing for some time. The person was still occupying the room and may have been at risk of harm from mould spores in the air.

There were two large communal areas throughout the premises, although only one of these was used by people living at the service during the inspection. We found that the environment required improvement to support the needs of people living with dementia, with regard to signage, décor supporting them to find their way around the building, and to identify where various rooms were located.

Where people required specialist care from healthcare professionals, such as neurology nurses or tissue viability nurses, we found that the nursing staff had not always recognised when referrals may have been appropriate. For example, one person who had on going and serious skin damage had not been referred back to the Tissue Viability Nurse following discharge in May 2017. This put people at risk of receiving inappropriate or unsafe care.

The service worked with other healthcare providers to meet the health-related needs of people who used the service. We saw from records that people had support to access health care from community health professionals such as opticians, GPs and chiropodist. However, although advice from professionals was recorded in documents under visit records, this information was not always used to update care plans. This meant staff had to search for up to date information on how to support people's healthcare needs.

People told us they had enough to eat and drink and that the quality of the food was usually good. One person said, "The food is really good here." Another person said, "I always get my special scrambled eggs." A

member of the kitchen staff told us they ensured there was always a choice for people and we saw them going around during the day to check what people wanted for lunch.

At lunchtime we saw that the meals provided were served warm and looked appetising. People confirmed the food was nice. The registered manager had introduced a 'protected hour' to ensure that staff could prioritise assisting people to eat and drink at mealtimes. However, we noted at lunchtime that engagement with people in the communal areas at lunchtime was minimal and for most of the mealtime staff were not present. This meant that, if anyone in the communal areas required assistance, there were no staff available to attend to their needs. This put people at potential risk of harm, such as choking.

Feedback from people and their relatives about the skills and knowledge of the staff team was mostly positive. One person said," The carer's are good." A relative said, "Most of the staff are good." However another person told us , "Some staff are good, but other's don't know what they're doing, especially night staff." Staff told us they received training that supported them to do their job and that they received one to one supervisions and an annual appraisal.

Training records showed that staff undertook training related to the specific needs of people using the service such as dementia awareness. This was in addition to training such as safeguarding people from abuse, moving and handling people, first aid, food hygiene, fire safety and health and safety. We saw that the registered manager carried out competency checks to ensure staff had put their training into practice.

Inadequate

Our findings

Although work had been carried out to attempt a repair to the heating and water system, it had not been successful, or followed up to address the situation fully. The extent of the damage to the fire door and to other parts of the premises through damp and water leaks, as well as a lack of lighting to one corridor were extensive and appeared to have been there for some time without action being taken to address the issues properly. This did not demonstrate that the provider was caring.

People told us that staff were kind, although there was mixed feedback about whether staff spent time talking with them. One person said, "Staff don't regularly talk to me." Another person said, "Sometimes they will have a chat with me, but they don't have the time."

Although we saw staff were kind when they provided care to people, engagement between them was very limited and was mostly restricted to exchanges about a task being carried out. We saw few meaningful conversations between staff and people beyond this. As a result, people were at risk of isolation, particularly those people who were cared for in bed at all times. Some people spoke about this, and told us that they were not confined to their room by choice and would like the opportunity to leave their bedroom more often. One person said, "I would like to see other people more. I don't like to be a bother though, so I don't ask and they never ask me, so I stay here." Another person said, "I would just like to go to the lounge to see the Christmas tree, but they haven't taken me." The registered manager refuted this and said that all the people who were able to get up were asked if they wished to come into the lounge every day.

There were long periods of time when staff were not visible in communal areas of the service occupied by people. We also found a lack of staff providing support to people who were nursed in their rooms. On several occasions we had to intervene to find a member of staff to support people who were in need of assistance. On the second day of the inspection, we found one person in their room was very distressed and appeared to be in pain. They were unable to verbalise this and were not able to use a call bell to alert staff. They had not been presenting in this way on the first day of the inspection and had been able to make themselves understood to the inspector. When we located a member of staff they said, "Yes, [name] is always like that." They went on to explain it was due to the person's condition, which could be painful and also affected their mood. Although this is likely to be true, this did not mean that the person did not require assistance, and we asked the member of staff to attend to the person, which they then did.

Another person nursed in their bedroom was showing distress by banging their wrist against their mouth. Their mouth was very dry and congealed food was seen to be stuck around their teeth. They were also

unable to alert staff when they required assistance, yet at 11.42 am, from records it did not appear they had been offered a drink for several hours and had not been assisted with oral care. We could not find staff on the floor to assist the person, so went to the ground floor where three staff were located in a dining room that was not being used by people living at the service. We alerted them to the person's need for assistance and a member of staff went to see them.

There were occasions during the inspection when staff, including the registered manager and the deputy used language to describe people that was not respectful and did not uphold their dignity. For example, they referred to the process of assisting people to eat as, "Feeding the feeders" and to people who were living with dementia as, "Demented." Although these comments were not made in front of people, this language is out dated and institutionalised. It showed an underlying lack of valuing people and revealed a culture within the service that did not put people at the heart of the care provided.

Documents relating to people's care were not always stored securely. We found clinical notes, referring to repositioning, personal care and continence support left outside their rooms in the corridor. This did not prevent records from being looked at by anyone else who entered the room. This did not uphold their privacy.
Several rooms had frosted glass windows which faced out into the corridor. With lights on it was easy to see directly in to these rooms. Although blinds had been provided to protect people's privacy when they were occupying their room, we noted these were not always used.

These issues were a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some people told us they did not feel able to make decisions about their care. One person said, "No, I don't make any decisions." Another person said, "They are alright as long as you do as you are told." However, other people told us they did make day to day decisions about their care such as when to get up and go to bed, or whether to join in any activities on offer.

People told us that staff maintained their privacy when delivering personal care, keeping them covered as much as possible. They also told us that staff knocked on their doors before entering their bedrooms.

Inadequate

Our findings

Although care plans were developed following an assessment of people's needs, these were task based and not sufficiently detailed to ensure people received personalised care. Care Plans contained only very basic information about what care people required, and gave little to no information about how staff were to provide care to ensure people's individual needs and preferences were met. Some of the care plans were generic and copied from one person's records to another. The information was brief; just one sentence in some instances. Many care plans were hand written and not legible, making them impossible to follow. Although reviewed regularly, the reviews were not carried out effectively and often were just a repeat of the comment made the previous month.

The service took a medical approach to care planning which, in a clinical setting, may be sufficient because people do not live there. However, within a residential setting, where people lived there, the needs of the person in relation to all aspects of their whole life and wellbeing needed to be considered as equally important. This approach was also reflected in our observations of the care provided during the two days of the inspection. Staff engaged with people to carry out tasks such as bringing them a meal and collecting the plate again 20 minutes later, or supporting them with personal care, or to take medicine. However, in between this support there was little to no interaction between people and staff.

Many people were nursed in bed and went for long periods, sometimes several hours without contact with another person. Those people who were sitting in the lounge also had minimal contact with staff. Although the television was on, no one checked whether it was showing a programme that people wished to watch. Other than this, there was no means of stimulation provided for people, and we found several people were isolated and distressed.

The provider employed an activities co-ordinator who was responsible for organising activities for some part of each week day. We saw photographs displayed of activities provided and some people told us of events they had enjoyed, such as a church service, bingo, and children visiting to sing. However, on the first day of our inspection no activities took place at all. The registered manager told us this was because the activities coordinator was absent from work on that day. They explained that the service would have been very different if we had visited when the activities worker was on duty as they worked hard to engage with people. We saw evidence that the activities coordinator had spent time getting to know people. However, this information was kept separate from people's other care information, which meant that other staff would not access this knowledge of people's lives and interests. This was unfortunate because it was a missed opportunity for staff to get to know people better and have things to talk about that may have been

of interest to people.

Although the activities coordinator kept a record of what activities had been offered to people, there was little evidence to show that people's lifelong interests had been used to inform the planned events on offer. Where information was known about people's interests, we did not see evidence that this had been used effectively. For example, one person was known to have an interest in dance and in painting, yet there was no evidence to indicate staff had been encouraged to provide activities or to have conversations with the person about these pastimes.

The activities coordinator had come up with a number of ideas about how to improve stimulation and reduce isolation, and how to promote an environment that was more appropriate for people living with dementia. However, many of these ideas had not yet been put into place.

There was a limit to what one member of staff could achieve in terms of reducing isolation for people, particularly in a service where so many people were nursed in their rooms. Although it was positive to see the impact that they had on the people using the service, it was a concern that all their positive input was not in evidence on the first day of the inspection, and that the responsibility to provide an enjoyable atmosphere for people in the home was left to them. This showed that, when the activities coordinator was absent, other staff did not see it as part of their role to engage with people or provide opportunities for stimulation.

On the second day of the inspection we saw the activities coordinator in the communal lounge singing Christmas Carols with no musical accompaniment. We could see they were trying to engage with people, but there was no input from other staff, who were congregated in a different part of the building away from people.

Many of the people living at the service were living with life limiting conditions and some people came to the service specifically to receive end of life care. The provider had a policy which set out how the service would approach planning personalised end of life care, but this was not followed in practice. In the policy it stated that people's end of life support needs would be documented in the person's care plan. It stated, "The needs and wishes of the service user are paramount at this time and these must be recorded clearly in the care plan and reviewed and updated regularly to ensure they are met." However, there were no end of life care plans in any of the care documents we looked at. The registered manager spoke with compassion about supporting people to have a comfortable end to their life, and that adequate pain relief was a priority. Whilst we saw from these discussions that the registered manager was committed to providing this, there was no evidence that people's wishes were taken into account in relation to the end of their life.

These issues were a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was a complaints policy in place and information on display encouraging people to raise any concerns they had with the registered manager. However, we received mixed feedback from people about how concerns they had raised were responded to. One person told us that "[Registered Manager] thinks [they are] always right about everything." Another person said, "[Registered Manager] thinks I am a trouble maker. I am surprised [they] let you talk to me, because [they] don't like me speaking up." A relative who contacted us after the inspection told us they felt the registered manager had not taken their concerns seriously.

We looked at how complaints had been managed in the last year. Although complaints were responded to,

the wording of written responses was sometimes dismissive, explaining to the complainant why they were wrong, rather than addressing the complaint and explaining what action would be taken. We asked the registered manager how they analysed complaints and used them to learn from and make improvements to the service. They did not have a formal log to monitor complaints but showed us a memorandum informing staff they had carried out an analysis. This document stated they had considered the reasons for why family members made complaints, and concluded that they complained because they felt guilty and therefore, staff would never be able to do anything right in relative's eyes. Staff were then instructed to direct families to the management team. This interpretation of complaints demonstrated a disregard for the views and experiences of people and their relatives, and showed that the service was unable to use criticism constructively to learn and make improvements to the care provided to people.

This was a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Inadequate

Our findings

There was a registered manager in post who was a registered nurse. They were supported by a deputy manager who was also a nurse, and one of the provider's directors was based in the service for much of the time, although, they were on leave from work during our inspection.

During this inspection we identified multiple breaches of the Health and Social Care Act (Regulated Activities) Regulations 2014. We identified issues related to the maintenance of the building, the culture of the service, staffing, consent to care, record keeping, care assessment and planning, and management oversight including the management of complaints.

Systems in place to monitor the quality of the service were not used effectively to ensure people received good care and issues we identified had not been picked up through audits or through the registered manager's day to day oversight of the service.

The issues relating to the poor maintenance of the building had not been effectively addressed until prompted by this inspection. The provider had made some attempts to repair the heating and hot water supply to people's rooms, but this had not been successful. The registered manager was aware of this but had not taken further action. The registered manager did not bring this to our attention at the inspection and only took action when we found out about it during our first day. Other maintenance issues, such as a fire door which let in draft and rain due to damage had not been addressed until prompted by the inspection. Damage from damp identified by inspectors had not been addressed and people were still occupying the rooms affected.

Records such as care plans and risk assessments were of poor quality and in many cases illegible. Clinical records were incomplete and sometimes incorrectly completed which meant an accurate record of the care provided was not available.

The registered manager spoke passionately about their commitment to providing good care, and told us that they aimed to promote a person-centred culture within the service. However, we found their understanding of what this entailed was not strong, and this resulted in people not receiving a service based on their individual needs. While people's basic physical needs and medical needs were identified, the approach to meeting their needs was task led and not based on individual preferences. People's needs in relation to their preferred lifestyle, interests, likes and dislikes were not given equal importance. The use of out--dated language by the management team promoted an institutionalised culture rather than a person

centred one.

Most people and relatives we spoke with knew who the registered manager was, although one person said, "I don't know who they are. Is it one of the ones in dark blue?" People and their relatives gave us mixed feedback about how approachable the registered manager was. One person said, "The manager is alright once you get to know [them]. [They] are quite abrupt." Another person said, "I don't feel like management listen to me." A third person said, "I'm a trouble maker in their eyes, because I can speak up for myself, and I say if I don't like something." However, another person said, "[Registered Manager] sometimes comes to chat to me. Yes, I can talk to [them]."

We found the manager did not promote a culture that was open and transparent, although, on the surface this appeared to be the case. For example, notices on display invited relatives to speak to the manager if they had any concerns, and the registered manager confirmed that she believed she encouraged this. However, people we spoke with who had raised concerns with the registered manager had not felt that she responded positively to them, and records also showed that responses to concerns were sometimes dismissive. One person told us they felt the registered manager was laughing at them when they discussed their concerns. The way in which the registered manager responded to issues we raised during the inspection came across as if she was not taking our concerns seriously on some occasions. We do not believe this was because they were laughing at what we said, but was possibly a way of coping with information they found uncomfortable to hear. Therefore, we think it was unlikely that she was laughing at relative's concerns, but never the less it showed a lack of awareness that people or relatives may experience it this way.

We found a number of records which appeared to promote a negative attitude towards relatives who raised concerns. The wording of a memorandum from the registered manager about complaints encouraged staff to dismiss the concerns of family members. Recent minutes from a staff meeting stated, "Families can be quite difficult at times and it is not your responsibility to deal with them." A question asked at the recent interviews for nursing staff asked candidates, "How would you deal with a problematic family in a nursing home?" A recent satisfaction survey had been completed, but again, negative comments were responded to dismissively. This approach discouraged staff from reflecting on their practice and enabled a division between staff and people's families. It put people at risk of poor care because the registered manager did not use challenges made to reflect on and improve the care the service provided.

Staff were very positive about the support they received from the provider and the registered manager. They all felt the registered manager was approachable, and that they could share any concerns they had with them. One member of staff said, "It's like a family here." Another member of staff said, "The manager is good, and we are a good team here." It was clear from our observations that the relationship between the management and staff was good. However, the concerns identified at this inspection led us to conclude that the registered manager did not strike a balance between supporting staff well and challenging practice where necessary. This did not ensure the needs of people using the service were prioritised. This was particularly noticeable in relation to the deployment of staff, where it was noted that, on several occasions, the registered manager was seen to be sitting with a group of staff while people went without support.

All of these issues were a breach of Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

The provider had failed to send us notifications of Deprivation of Liberty authorisations and of the heating and hot water issues as required by legislation.

This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

The provider had failed to display the rating from their last inspection at the premises. This is required by legislation.

This was a breach of Regulation 20a of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider worked with other key agencies, such as the local authority and the clinical commissioning group to ensure they were working towards making improvements to the service provided. Prompts to make improvements from these agencies have been responded to proactively by 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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 Registration Regulations 2009 Notifications of other incidents Notifications were not sent to the commission as required

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care People were not receiving personalised care. There was a lack of information within care plans detailing people's individual needs and preferences. A lack of engagement and stimulation put people at risk of social isolation.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect Care to people was task led, engagement was limited. The use of institutionalised language did not show respect for people. Peoples' privacy was not protected.

Regulated activity	Regulation
Accommodation for persons who require nursing or	Regulation 11 HSCA RA Regulations 2014 Need

personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	for consent There was limited evidence to show how decisions were made in peoples best interest when they lacked capacity. Consistent information about consent was not in place . Reasons for restrictive practices were not redorded.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Staff did not recognise the signs that people were at risk of social isolation and neglect , and did not take action to reduce this risk.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints Complaints were not managed appropriately.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 20A HSCA RA Regulations 2014 Requirement as to display of performance assessments The rating was not displayed at the premises

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment There maintenance of the building was poor and put people at risk, including a lack of heating and hot water to some areas of the home, risk assessments and care plans were insufficient to meet people's needs safely, effective records were not kept, medicines were not managed safely, people were not protected from the risk of infection.

The enforcement action we took:

We imposed an urgent condition on the provider's registration to take immediate action to address our concerns and to restrict admissions to the service without our written agreement.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Management oversight of the service was poor. Issues we identified at the inspection had not been picked up or adequately addressed, there was an institutionalised culture at the service, records were poor, and people's views were not used to make improvements to the service.

The enforcement action we took:

We imposed an urgent condition on the provider's registration to take immediate action to address our concerns and to restrict admissions to the service without our written agreement.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff were not deployed effectively to ensure

Diagnostic and screening procedures Treatment of disease, disorder or injury	people were cared for safely.

The enforcement action we took:

We imposed an urgent condition on the provider's registration to take immediate action to address our concerns and to restrict admissions to the service without our written agreement.