More-Care (Home Counties) Limited

Chadwick Lodge Residential Home

Inspection report

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Essex
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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

Overall summary

This inspection was unannounced and took place on 26 and 27 May 2015 and 2 June 2015. Chadwick Lodge Residential Home can accommodate up to fifteen older people who require personal care and support and who may have care needs associated with dementia.

The overall rating for this provider is 'Inadequate'. This means that it has been placed into 'Special measures' by CQC. The purpose of special measures is to:

- Ensure that providers found to be providing inadequate care significantly improve.
- Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.

Summary of findings

- Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.

Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains 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 the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will be kept under review and if needed could be escalated to urgent enforcement action.

The service had a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. At Chadwick Lodge Residential Home the Registered Manager is also the owner/provider of the service run as a Limited Company.

This inspection found that although people and their relatives told us they were happy with the service, there were significant concerns about how the service was being run and managed. Improvements were needed in many areas where the provider was not meeting the requirements of Regulations.

Management and staff in the service had been unable to recognise poor practices and had not made referrals to the appropriate agencies, such as the local authority safeguarding teams, when this was needed. This had left people at risk and had not protected them from harm.

The local authority was investigating multiple concerns that had been raised in relation to the service. These related to issues such as staff and management behaviours, institutionalised practices and poor or neglectful care. Many of these had been substantiated.

Information from other agencies and our inspection found that people using the service had been left at risk in a number of ways.

There were no evident audit and monitoring processes in place to ensure that the service recognised and took action when improvements were needed.

Practices in the service were institutional and not person centred or person led. This meant that people were not always given meaningful choices in relation to their daily routines.

There were shortfalls in recruitment procedures that should protect people from receiving care from people not suitable to undertake a caring role. Staff were not fully trained to ensure that they understood and could meet people's needs effectively. People's levels of dependency were not assessed to establish if the staffing levels provided were suitable to meet their needs.

The environment had not been maintained to a high standard, health and safety risks were not adequately assessed and account had not been fully taken of how the environment should meet the needs of people living with dementia.

People's rights were not being protected through management and staff having a good knowledge of the Mental Capacity Act 2005 and the Deprivation of Liberty safeguards.

You can see what action we told the provider to take at the back of the full version of the report.

People were supported to eat well and enjoyed the food provided. There were opportunities for people to engage with activities. People's medicines were being managed adequately and only minor practice issues were highlighted to improve the systems in place.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was not safe.

People were not protected through risks being assessed and staff recognising and taking action against poor practices.

Staff recruitment was not robust and staffing levels were not assessed to ensure that they were suitable to meet people's needs.

Inadequate

Is the service effective?
The service was not effective.

People were not supported by staff who were well inducted or trained. People's health and welfare needs were not therefore supported through an adequate understanding or their needs or an adequate maintenance of records.

People's rights were not being protected through the application of the Mental Capacity Act 2005 or the Deprivation of Liberty Safeguards.

Inadequate

Is the service caring?
The service was not caring.

Staff were friendly and supportive towards people however, this was against a background institutionalised practices being allowed to continue which did not support people's choices or dignity.

People were able to keep in contact with their families and friends through unrestricted visiting.

Inadequate

Is the service responsive?
The service was not consistently responsive.

People's care plans did not consistently reflect a comprehensive, complete or person centred approach to assessing and meeting people's care needs.

People had some opportunities for engagement and were able to voice any concerns they had about the service.

Requires improvement

Is the service well-led?
The service was not well led.

The registered manager was not managing the service effectively. The service had not been monitored to ensure quality and safety.

The provider had failed to notify us of events happening in the service.

Improvements made had been instigated by other agencies and not recognised as needed by the provider.

Inadequate

Chadwick Lodge Residential Home

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 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.

This inspection took place on 26 and 27 May 2015 and 2 June 2015 and was unannounced.

This inspection was undertaken by four inspectors.

Before our inspection we reviewed information that we hold about the service such as safeguarding information and notifications. Notifications are the events happening in the service that the provider is required to tell us about. We used this information to plan what areas we were going to focus on during our inspection.

We also used information gathered from liaising with other stakeholders such as the local authority and the Police. We had been working with these agencies due to the high level of safeguarding concerns being raised about the service.

During the inspection we spoke and interacted with all 11 people using the service during our visits. We spoke with four relatives, two visiting entertainers, a visiting professional, the registered manager, four members of care staff, two agency staff and two volunteers.

Not everyone who used the service was able to communicate verbally with us so we used observations, spoke with staff, reviewed care records and other information to help us assess how their care needs were being met.

As part of this inspection we reviewed seven people's care records. This included their care plans and risk assessments. We looked at the support records for six members of staff. We reviewed other records such as complaints and compliments information, quality monitoring and accident records.

Inadequate

Is the service safe?

Our findings

Although people and their relatives told us that they felt safe, one person saying, "I feel safe, the carers are very good" and a relative saying, "Since [name of relative] has lived here it is as though a great pressure has been lifted", we found the systems in place and actions of the service did not ensure this was the case and they were not always protected. There had been several safeguarding allegations made which were being investigated by the local authority. Although the registered manager was aware that safeguarding matters were being investigated, they had not notified the Commission of this as required.

During our inspection we identified two incidents where people had sustained unexplained injuries. These had not been identified or reported under safeguarding arrangements to the local authority or the Commission. Staff had a lack of understanding that the incidents were cause for concern and therefore had not taken appropriate actions to protect people from further risk of injury. We asked a senior member of staff to report the concerns to the local authority which they did.

Although staff told us that they had received training in safeguarding and that they would report any concerns to senior staff or a relevant agency, training records did not confirm this for 7 of 10 staff. Staff were unable to recognise or challenge poor practice or respond appropriately when people were at risk. There were also poor practices which some staff did not recognise or challenge, such as getting people up very early without their consent and not responding appropriately to people's care or behavioural needs.

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

Some risk assessments were not adequate. For example, one person's risk assessment for the use of bedrails stated 'Ensure bed rails comply with bed rails risk assessment tool,' but this could not be seen. When we queried this with the registered manager they were able to find a blank template of the tool but the process had not always been completed. This left people at potential risk of bedrails being used inappropriately.

Risks within the service were not well identified or managed. For example, the registered manager told us they had instructed staff to keep the laundry door locked at all times, yet on each of our visits we found this to be open and the area easily accessible. One person using the service has been known to enter this area where potentially hazardous items which posed them a risk, were readily available.

There were no regular audits of the premises to identify potential risks to people's health and welfare. During our visits we identified issues such as hanging/exposed wires, frayed carpets and extension lead sockets placed under sinks. The provider had not identified any of these issues independently and had only take action on other matters when the local authority had pointed them out. This included there being no effective window restrictors in place to ensure people's safety and dangerous chemicals being stored in the open access office.

There were also risks for people outside the premises. A pond in the garden with scaffolding type poles over it which jutted out over the path. The potential risks for people linked to tripping or falling in the pond had not been recognised.

The premises had not been adapted or maintained in a way that ensured people's safety and wellbeing. The registered manager was unable to provide any action plans or documentation to show that they were addressing these concerns.

Most of the people at the service were living with early onset to the advanced stages of dementia. There was limited signage or adaptations to the environment to support people living with dementia. People's rooms were not identifiable to them through names or pictures. Bathrooms and toilet areas were not warm or homely places. The clock in one person's room gave the wrong time so that it would not assist with their orientation. A 'day board' showing the date, weather and other information was not always updated to show people the correct information. The environment and signage did not support their care needs including supporting them to be as independent as possible.

Staff were not using equipment safely and as directed to ensure people's health and wellbeing. The risk of people developing pressure sores was assessed as part of the care planning system. Where risks had been identified we saw that preventative measures such as pressure relieving mattresses or cushions had been put in place. This was positive; however, we had concerns about how the

Is the service safe?

identified risk was consistently monitored to ensure ongoing preventative care. Some care records had not identified that a mattress was in use. One person's care plan had not identified or given any instruction to staff regarding the safe settings the mattress should be set at relevant to the person's weight. We found some mattresses that were at the incorrect settings for the people using them. For example, one person's care plan did identify what setting their mattress should be on to keep them safe, it should have been at a firmness of two and was set at eight, another person's set at six should have been set at four according to their records. Staff being unable to maintain the correct settings on air mattresses as agreed by professionals supporting people could result in further injuries or skin deterioration.

This is a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us that they were happy with the levels of staff provided during the day and that help was available to them when they needed it. One person told us, "There is always staff around to assist me if I need it, for example to use the phone or for personal care." Another person said, "I have a call bell when in my room, but in the lounge there is always someone around." However, it was not clear how care was provided at night for people who needed two members of staff to support them.

The registered manager told us that four or five people needed the help of two staff to assist with their moving and handling or care needs. They confirmed that there was no formal process for assessing people's care needs on an on-going basis. The lack of staff continuity and the safe deployment of staff in sufficient amounts at night had placed people's safety and welfare at risk. This was because one night staff member on duty had not had the time to care for people safely. People had experienced poor care outcomes, injury and neglectful practice as a result. The provider's inability to recognise the need for such revised deployment based on people's needs meant that they were unable to consistently deliver safe levels of care to people.

At the time of our inspection the service was using a high level of agency staff. These staff members were not inducted or supervised effectively. This resulted in a poor standard of care to people, for example, we saw that one agency staff member did not engage with people except for delivering personal care and then sat impassive and dozing in the lounge during the afternoon shift. They were also seen to support a person to eat in a very inappropriate way by standing behind the person holding them up whilst assisting them to eat. This was corrected by the acting manager, but showed a basic lack of understanding of good practice and indicated that they had not been instructed on how to properly support the person before starting the task.

The registered manager was unavailable at the service and the cover arrangements were not suitable due to the acting manager's a lack of confidence and experience. The local authority was so concerned about the standard of care being delivered that they organised additional staff from an agency to support people. They also increased monitoring visits as they were so concerned that the needs of people were not being met.

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

People told us that they liked the staff working in the service. Staff told us that their recruitment had been done properly with checks being undertaken. One said, "I came down and brought all my certificates and CRB, (Criminal Records Bureau,) check and had an interview. I then did a trial shift but had to wait for two weeks for my DBS, (Disclosure and Barring Service,) check to come through."

However, a robust recruitment procedure had not been maintained. Records available were patchy and not consistent, for example, one person had declared in their application form that they had a criminal conviction, but no completed DBS check was available and neither was any note or risk assessment in place relating to the declared offence and how the provider had determined that this person was safe to work with people using the service. On another staff member's file, notes had been made about offences declared and identified on a DBS check but the notes did not show how the provider had determined that the person was safe to work with people using the service. One of the staff members for whom we could not locate a DBS check or risk assessment for their declared criminal record was a staff member suspended whilst allegations against them were being investigated by the local authority.

The application form in use by the service only asked for the previous 10 years of employment history, rather than

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Is the service safe?

the full employment history required by Regulation. Records were inconsistent with some gaps in employment history having been explored and notes made and others not.

The provider did not have established recruitment procedures in place that they operated effectively to ensure that persons employed were of good character and had the competence, skills and experience which are necessary for the work to be performed by them. This placed people's safety and wellbeing at risk.

This is a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People received their medication as prescribed. Staff administered medicines to people in a way that showed respect for people's individual needs. They explained what was happening, and stayed with them while they took their medicines to ensure that all was well.

People received their medicines safely and systems were in place for the ordering, booking in, storing and disposing of medicines. Staff had received training in administering medicines. Staff confirmed however that there was no system in place for regular audits to be undertaken. The service relied on periodic audits undertaken by the providing pharmacy company. Other practice issues were also highlighted. There were no protocols in place for medicines to be used on an as and when required basis. This is important to ensure that such medicines are used consistently for people. There was not a fully completed list of staff signatures and sample initials in place, (as to be used on the medication administration records.) This is important so that if any errors or issues occur the person responsible can be identified.

Inadequate

Is the service effective?

Our findings

Relatives told us that they were pleased with the care and support provided. One said "I would give them ten out of ten for everything." Although people and their relatives were happy and felt that their needs were met, we had concerns over the level of skills in the staff team. People were not being supported by staff who received an effective induction and maintained good levels of training in order that they could properly support the diverse needs of people using the service.

One member of staff told us that they started they had worked for a week shadowing other staff including a senior. They were to be enrolled to undertake a National Vocational Qualification, (NVQ) at level two or three. However, there was no structured or recorded approach to ensuring that staff were orientated to the service, understood health and safety, safe manual handling procedures, safeguarding and other essential issues. A staff file contained a 'Skills for Care' Induction package. This was a detailed document for ensuring that new staff learnt about the service and good care practices, but this had not been completed. There was no information available to confirm that new staff had been exposed to ideas about best practice, they had only been reliant on the ideas and practices of existing staff. Safeguarding investigations and our inspection findings have shown practices in the service to be poor so new staff were potentially learning and repeating these poor practices.

Most people using the service were living with some level of dementia. Six of the ten members of staff had received training in this area. However, this training was ineffective as staff had a lack of understanding of how to care for people in a kind and appropriate way. We saw that one member of staff provided inappropriate support to a person and complaining loudly that a person who used the service had hurt them through the way that had behaved or mobilised. This was poor practice and did not show an understanding or empathy towards the person's dementia related or other care needs. One person's care plan included inappropriate actions to support the person without any rationale or consideration of whether or not this was the best approach for this person. This could have caused the person further distress. When we spoke to a senior member of staff about this they did not show a knowledge or understanding of current best practice relating to dementia care and why the instructed actions could be distressing for the person.

Although a number of people using the service needed support with moving and handling, three staff had not undertaken this training. Other professionals shared that they had witnessed poor moving and handling practices by Chadwick Lodge staff. We saw a member of staff who had received recent moving and handling training assisted a person out of their chair. The person had not been encouraged to get into a good position first or push up. This placed the person at potential risk of injury and showed us the training staff had undertaken was either incorrect or had not been effective.

Few staff had completed training in health and safety, fire safety, infection control or food hygiene. A volunteer worked in the kitchen to heat and serve the ready prepared meals used by the service. They confirmed to us that they had not received training in food hygiene or infection control procedures. A further volunteer who did the cleaning at the service had also not had any health and safety, infection control or other training. This put people at risk as staff did not know how to ensure that their roles were carried out safely.

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

Only one member of staff was identified as having undertaken training in the Mental Capacity Act 2005 (MCA) or Deprivation of Liberty Safeguards (DoLS). The services' MCA and DoLS procedure identified that, 'All employees involved in our residents care should be trained in the working of and the codes of practice in respect of the MCA and DoLS'. The service was not therefore complying with their own procedures. In addition the MCA and DoLS Codes of Practice were not available in the service for reference. The registered manager told us that they would use on line versions when needed. The registered manager told us that they hoped to address the issue of staff training in this area by October 2015.

Some people's care files included information about their capacity and identified what help would be needed with day to day decisions. Staff spoken with said that people

should be offered choices in their daily lives. However, practices in the service such as rising and retiring routines did not support that people were given meaningful choices in their daily lives and routines.

An on-going safeguarding investigation found that people were being supported to get up in the mornings from as early as 04.30. At this inspection we found that although people were not being got up and taken downstairs in the early hours of the morning any longer, the practice of washing and dressing people from as early as 05.00 was still taking place. People were then placed back in bed to be supported to get up later by day staff. This was recorded by staff and the practice was confirmed by a senior member of staff. Staff failed to understand why this was not an appropriate way to support people. People had not consented to this approach to supporting them with their personal care. There was no reasonable rationale as to why this was appropriate for people. The arrangements supported a task based approach by staff rather than care that was determined by people's individual choice and preference.

The registered manager had to be guided by the local authority as to how to submit the appropriate applications to ensure people had their rights protected. In addition some staff had used unlawful methods to restrain people such as pushing people up to a table in an attempt to restrict their movements and the inappropriate use of bedrails to restrict movement. The local authority had identified eight people who needed to be referred to have further assessments completed to ensure appropriate actions were being taken, and that their rights were protected.

People were not receiving care and treatment with their consent or with that of the relevant person. Some people were unable to give such consent because they lacked capacity to do so and the provider had not acted in accordance with the MCA.

Although staff supervision had taken place, this had been ineffective in recognising poor practice and staff development needs. Staff told us that they were well supported and were able to attend regular supervision sessions. However, one newer member of staff who had worked at the service for two months told us that they had not received supervision as yet. Records showed that staff had had the opportunity for regular one to one supervision. One to one supervisions included observations of their practice.

This is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Records of people's meals and what they had eaten were well maintained. But we did have some concerns as to the accuracy of the fluid records. Although no one had been identified as being at risk of dehydration, the records relating to people's fluid intake was not always accurate which could mean they were not receiving sufficient fluids. The local authority had raised concerns that people might not receive adequate fluids as some people on occasion had strong or odorous urine which is an indicator for lack of drinking. The registered manager told us that fluid records were completed, "A couple of times a day," and that staff kept notes during the shift of what people had drunk and completed the records at the end of their shift. When we asked staff about this they told us that they did not keep notes but "Just remembered." We saw one person's records at 1.45pm had had no entry made since 8.20pm the previous day. Another person's records had no entries for four days during May 2015.

People saw relevant healthcare professionals when they needed to such as their general practitioner or district nurse. Care plans and records however did not support a consistent or comprehensive approach to ensuring that people's healthcare needs were fully identified, met and recorded. We saw records of people who had specific conditions, for example, diabetes. A care plan in relation to diabetes was in place but this provided limited information to guide staff practice and support. Arrangements for monitoring the condition had not been identified. The person's 'dietary' care plan did not identify the fact that they had diabetes. Another person's care records contained only a passing reference to the fact that they had a significant health condition that would affect many aspects of their care needs.

'Records of professional visits' were inconsistently maintained, for example one person's record recorded on 10 January 2015 that a nurse had been in to dress the person's leg and would be back on the Monday of the

Inadequate

Is the service effective?

following week. Nothing further was recorded until 27 January 2015. There was no information in the person's care plan (dating from 2012) regarding district nursing input or a wound to their leg.

The lack of effective records meant that we could not be assured that people's care and treatment was always appropriate to meet their needs consistently and safely.

People told us that they liked the food at the service and were given choices about what they ate. One person told us, "The food here is very good, I am on a diet to help me lose weight." On each day of our inspection we saw that people were offered a choice of menu for lunch and asked what they would like for tea. People's individual preferences were respected such as a person who preferred a vegetarian diet. One person told us, "At suppertime we have something light like cheese on toast or scrambled egg," a relative added, "Everyone seems to have something different so I know they have a choice." The 'cook' clearly knew all the individual residents well, had a good knowledge of people's likes and dislikes and showed empathy and understanding towards people.

People were generally well supported and encouraged at mealtimes. Aids such as plate guards were used to support people's independence. People were given a choice about where they ate and the meals were not rushed.

Inadequate

Is the service caring?

Our findings

Some practices were not caring in the service and did not support an ethos of dignity and respect for people. Neither did they demonstrate individual choice or person centred care. Safeguarding investigations had identified a lack of choice in people's lives and how they led them in a meaningful way that supported their wellbeing. We saw records that identified practices such as, '05:00 washed and dressed and changed,' '06.03 Still asleep, was washed and dressed and put back to bed,' '05.00 Washed, dressed and drink given.' A senior member of staff spoken with confirmed that people were washed and dressed and then left in bed ready for the morning staff. They felt that this meant that people received less handling and so were less agitated. They did not recognise this as poor and institutionalised practice. Staff had no understanding that the service routines were institutionalised and not person centred. The service's 'Philosophy of Care' statement said, 'Residents have the right to expect staff to treat them with respect, and ensure promotion and maintenance of the resident's dignity and self-worth while performing their duties.' The practices in the service did not support this philosophy. We were so concerned that we spoke with the registered manager who told us they were unaware of the practice.

Staff were friendly with people and took an interest in them, for example, asking one person if they were feeling better and encouraging another person to look at a book which they liked. But most of the staff engagement was task led, and staff did not always make the best of opportunities to engage with people or develop their relationships. Often staff would sit and observe without engaging. Staff spent a lot of time together at a dining table writing up notes. Senior staff were careful to ensure that the lounge was monitored by staff at all times but because of the lack of interaction people were often left to their own devices and spent time dozing or staring into space.

People did not receive care and treatment that was appropriate to meet their needs and reflected their preferences. Care was not designed with a view to achieving people's preferences and ensuring their needs were met.

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

Despite our concerns people told us that they felt cared for and comfortable with the staff. A relative and a visiting professional felt that staff were approachable, friendly and helpful. A relative told us, "It's the little things they do like organising a birthday party for (relative). It was nice."

Visitors said that they were able to come and go at any time and were always made welcome. One person told us, "The carers are all lovely when you visit. They always offer a chair and a drink, it feels like a family."

Requires improvement

Is the service responsive?

Our findings

Relatives spoken with felt that the service was responsive to their loved ones needs and that staff at the service kept them informed of events.

The service undertook a six monthly review when they sought the views of people, their families or others involved such as a solicitor, and feedback was positive. However, the reviews did not effectively explore people's experience of using the service to help improve their wellbeing to ensure they lived in their preferred way. For example, there was no prompting to find out if people's bedtime or morning routines suited their preferences and choices, or how they preferred their personal care to be provided, or how they could be supported to be more independent. People who were more able told us that staff did consult with them, gave them choices and enabled them to follow their own routines. However, many of the people who had more complex needs, were deemed unable to be meaningfully involved in planning their own care and support and staff made the decisions for them, without necessarily exploring other approaches with family, friends or advocates.

People's care records lacked detail and, because care plans were often out of date, they did not always reflect people's current needs. Information was contradictory, for example, one person had been admitted to hospital with renal failure, on their return a doctor had visited and said that the person was dehydrated and should drink at least one litre of fluid a day. The person's 'dietary' care plan did not reflect this information and staff could not demonstrate that care was being provided to reflect this change. Another person's 'oral' care plan stated that there was no risk as [name of person] has no teeth and does not wear dentures. There was no recognition that oral health might relate to more than teeth and there was nothing in the person's dietary care plan to reflect the impact of no teeth might have on their ability to eat and the type of foods that might be appropriate. Through the interventions and suggestions of the local authority the service were changing their care plans to a more person centred and detailed format.

Staff were able to tell us about individuals' histories and backgrounds, although this was not reflected in their care records. Only one care record contained any personal history information. The care plan format in place allowed for people's 'strengths' to be identified under different categories. Often this simply said 'none' This indicated that staff found it difficult to recognise people as individuals and acknowledge their past lives, skills and experiences. The registered manager told us that they were just looking at introducing a comprehensive 'life story' document which would provide information about people's backgrounds, interests and preferences. A copy of this was sent to us following the inspection. A lack of this information could mean that staff might not be able to engage with people on an individual and personal level which could result in poor outcomes for people.

A person was employed to support activities during weekday mornings. We saw that they had a good rapport with people and were able to engage them in activities such as reminiscence and crafts. They ensured that everyone was included, even those who were unable to contribute verbally. The service had plenty of equipment to be able to facilitate a range of activities to suit individual's needs. Some people's care records identified their individual interests such as music and certain television programmes. Where possible people were supported by their families to keep up with previous activities and interests, and maintain their circle of friends.

We met entertainers who came and performed for people on a fortnightly basis. They told us that they felt the service cared for people very well and were responsive to people's diverse needs.

People told us that they were happy with the service, had no complaints or concerns. They said that the management was very approachable and that they would feel comfortable in speaking with them if they had any concerns. However, we had concerns about the process for people or their relatives to complain as several relatives and people came forward as part of a recent safeguarding investigation by the local authority to express their concerns about the care being delivered at the service. This meant that people either had not had the opportunity to raise their concerns, their concerns had not been recorded and listened to or they had not felt confident enough in the management of the service to do so.

There was a complaints procedure accessible to people in the hallway of the service. A pictorial version was also available to assist people's understanding. The procedure informed people of where they could go for support should they not be happy with the homes response to their concerns. The service had a 'Complaints Register' available. We saw that nothing had been recorded in this since 2006.

Inadequate

Is the service well-led?

Our findings

The service had a registered manager in post who was also the nominated individual for the provider. All of our findings at this inspection, and the findings of local authority investigations, showed that the service had not benefited from good leadership and a strong and principled approach to providing quality care and support to people.

The provider was unable to demonstrate that audits were undertaken to show how the quality and safety of the service was kept under review and improved where needed. A senior member of staff told us, "That's all down to the manager." Staff confirmed that medication audits were not undertaken. No audits were made available to us relating to health and safety, infection control, the environment, care plans and records or other safety monitoring systems.

Lack of effective governance meant the service had failed to independently recognise and remedy problems at the service identified by the inspection and other agencies and professionals. This included the impact of a lack of staff training, poor maintenance of records, health and safety issues and a failure to provide properly for people's health, welfare and safety. The registered manager showed a lack of awareness of the issues raised and displayed a lack of knowledge relating to standards of best practice expected. These included, the need to continuously monitor staffing levels, delivering appropriate training to staff and monitoring the safety and quality of the service on an on-going basis to ensure continual improvement of care and support for people.

The management was reactive rather than being proactive to ensure the quality of the service. For example, on 26 May 2015 the registered manager told us that some agency staff were working in the service before profiles to demonstrate their training and competences had been received from the providing agency. Following the inspection it was confirmed and evidenced to us that all profiles were in place. Similarly our inspection of 26 May found that agency staff were not receiving any formal induction into the service. When we returned on 2 June 2015 we found that inductions for agency staff had been completed, the majority back dated 30 and 31 May 2015.This improvement was not identified independently by the provider. This meant that the provider could not be assured that people were suitable to be working at Chadwick Lodge and had the skills and knowledge required prior to us raising it as a concern.

Policies and procedures were in place to guide practice. However, these were basic, based on previous requirements, outcomes and prompts, not dated and without a timescale set for review. The registered manager told us that they were negotiating with another agency who would be reviewing and renewing all the service's policies and procedures.

Some improvements to the service had been made such as the fitting of window restrictors, the provision of dining tables, the clearing of communal areas, the reduction of health and safety hazards, some redecoration, and starting to review the effectiveness of care planning. But, these had all been achieved through the instigation of the local authority staff, and not through the recognition of the service's manager and staff.

The supervision and support of staff was inadequate as the management team had not identified poor practice on-going in the service and had not addressed the shortfalls in staff training and development. This was evidenced throughout our inspection in terms of staff and management's lack of understanding when we identified poor care that did not meet people's needs in a person centred way.

Although staff told us that they had regular team meetings, a record could only be provided of a recent meeting in May 2015 and one from January 2013. The process of staff meetings had not been effective as a platform for staff to discuss openly their concerns, or, used as a lever to improve care for people. Staff members expressed their concerns to professionals visiting the service about people's care delivery which they felt unable to raise with the management team of the service directly. There was a culture of feeling unable to challenge poor practice or suggest ways of improving the care provided. Staff felt unable to positively influence care outcomes and discouraged from aiming for good quality person centred care.

Effective processes were not in place to monitor the quality of care being delivered, reduce the risks to people's safety, maintain accurate records and improve the service for the people who lived there.

Inadequate

Is the service well-led?

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We discussed the issue of notifications with the registered manager. We were aware that safeguarding incidents and incidents involving the police had occurred that had not been reported to us as required. The manager recognised that this should have been done but admitted that they had not done so.

People told us that they were generally happy with the service being provided at Chadwick Lodge Residential Home. Relatives told us that they found the staff and management supportive and approachable. One person said, "[The manager] is very approachable and we have a good rapport."

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

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 People who use services were not protected from abuse through systems and practices in the service. **Regulation 13. 1, 2, 3, 4 (d), 6 (d)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment The registered person had not ensured people's safety as the premises was not suitable for the purpose for which it was being used. **Regulation 15 (b) (c) and (e)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment The registered provider did not have suitable systems in place to ensure that sufficient staffing was provided to meet people's needs. **Regulation 18 1 and 2 (a)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed The registered had not ensured the protection of people from unsafe or unsuitable care through robust recruitment procedures being in place. **Regulation 19 1 (a), (b), 2 (a) and 3 (a), (b),**

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent People's rights were not protected through the robust application of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. **Regulation 11 (1) (2) (3) (4)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care People's care was not focused on their individual needs and institutionalised practices detracted from maintaining people's dignity. **Regulation 9 (1)(a)(b) (2) (3)(a)(b)(c)(I)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider had not established systems to monitor the quality and effectiveness of the service. **Regulation 17 (1) (2)(a)(b)(c)**