CareQuality Commission

Mr. Liakatali Hasham

Crest Lodge

Inspection report

Churt Road
Hindhead
Surrey
GU26 6PS

Tel: 01428605577
Website: www.chdliving.co.uk

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This unannounced inspection was carried out on 2 June 2016. Crest Lodge is a care home and provides accommodation for people who require residential or nursing care. Many people have a mental health diagnosis and health conditions, some require nursing in their beds. The service is registered to accommodate up to 52 people. The accommodation is a large house arranged over three floors, there is one small bungalow within the grounds and a small cottage 10 minutes' drive from the service. On the day of our inspection 49 people lived at the house and bungalows and three people lived in the cottage.

There was a registered manager in place however they were on leave on the day of the inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. We were assisted during the inspection by the clinical lead, the operations director and a member of staff from the quality assurance team.

The last inspection of this service was on the 15 April 2015 where we found breaches around inadequate cleaning and infection control, lack of detailed and personalised care plans, staff training and supervisions, mental capacity assessments for people and the lack of robust quality assurances. We found on this inspection that whilst some improvements had been made there were still concerns.

The environment had not always been well maintained at Crest Lodge however the Cottage environment was clean and tidy.

People's safety could not be assured because risk assessment guidance for people was not always followed by staff. There was a risk that staff did not have most up to date and appropriate guidance around the risks to people. Staff were not always following infection control guidance.

People were not always having the health monitored whilst on medicines that required particular checks. Medicines were safely stored and people received their medicines when they needed them. Not all Medicines Administration Records (MARs) for people were signed appropriately. All medicines were disposed of safely by staff.

Staff did not always have a good knowledge of safeguarding adults procedures. Although there were clear policies in place staff were did not always record incidents of abuse appropriately.

People's rights were not always met under the Mental Capacity Act 2005 (MCA), and the Deprivation of Liberty Safeguards (DoLS). These safeguards protect the rights of people by ensuring if there are any restrictions to their freedom and liberty, these need to be authorised by the local authority as being required to protect them from harm. Assessments had not always been completed specific to the decision that needed to be made around people's capacity. DoLS applications had been submitted to the local

authority but were not always supported by the appropriate mental capacity assessments.

People were not always receiving care from staff who had received appropriate training around the specific needs of people. Other aspects of service mandatory training and clinical training were up to date. One to one supervisions with staff were up to date.

The environment did not always meet the needs of the people, particularly those who had a mental health diagnosis.

There were mixed opinions from people about the food at the service and people did not always have a choice around meals. However people at risk of dehydration and malnutrition had their needs met. People were supported to remain healthy.

People were not always supported to be independent and were not always involved in the planning of their care. At times people were not treated with dignity and respect and staff were not always caring. We also saw some caring interactions with people and staff and it was clear that staff knew people well
People did not always have access to meaningful and person centred activities.

Staff did not always have the appropriate information about people before they moved into the service and care plans did not always provide guidance around the most appropriate care for people.

There was a complaints procedure but complaints were not always recorded appropriately and there wasn't always evidence of how complaints were responded to.

There were not effective systems in place to assess and monitor the quality of the service. Audits and surveys had been undertaken with people but had not always been used to improve the quality of care for people. Records were not always kept securely and people's care was not always discussed discreetly.

Incidents and accidents were recorded however there was not always evidence of any learning from that had occurred to reduce the risk of falls and incidents in the service.

Services that provide health and social care to people are required to inform the Care Quality Commission (CQC) of important events that happen in the service. The registered manager had not informed the CQC of all significant events.

There were enough staff to support people with acitivites. However other aspects of people's cares needs were being met in relation to staff levels. Appropriate checks were undertaken on staff before they started work.

People and staff said they knew the manager and that they felt supported.

The overall rating for this service was rated as 'Inadequate'. We found on this inspection that sufficient improvements had not been made and the service therefore will be placed into '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 time frame. 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

During the inspection we found several breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

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.

People were not always safe because risks of harm had not always been managed. The environment had not always been maintained to a safe standard.

People told us they didn't always feel safe and staff did not understand their responsibilities in relation to abuse and reporting this to the safeguarding authority.

There was a risk that people were not receiving their medicines in a safe way. However medicines were stored safely.

There were enough staff deployed at the service to meet people's needs.

Safe recruitment practice were followed

Is the service effective?

Requires Improvement

The service was not always effective.

People's human rights were at risk because the provider had not followed the requirements of the Mental Capacity Act 2005 and people's capacity assessments were not always completed appropriately.

Staff did not always have the most appropriate training to be able to meet people's needs. Staff's competencies were assessed.

The environment did not always meet the individual needs of people living at the service particularly those with a mental health diagnosis.

People did not always have a choice of meal however people were provided with nutritious food and drink and people's weight and nutrition was always monitored.

People were able access to healthcare services to maintain good health.

Is the service caring?

Requires Improvement

The service was not always caring.

People were not supported to lead independent lives.

People's dignity was not always respected. We did see occasions where staff were kind and considerate to people.

People and relatives were not always consulted around preferences of care and some people's rooms were not personalised to them.

Is the service responsive?

Requires Improvement

The service was not responsive to people's needs.

There was not always the most up to date information available to staff about people's care needs.

There were not enough activities that suited everybody's individual needs. People said that there wasn't always a lot to do.

Complaints were not always recorded and there was not always evidence that complaints had been responded to.

Is the service well-led?

Inadequate

The service was not well-led.

There were not appropriate systems in place to monitor the safety
and quality of the service. Records were not always kept securely and people's care was openly discussed by staff.

Where people's views were gained these were not used to improve the quality of the service.

Notifications of significant events in the service had not been made appropriately to CQC.

People and staff said they felt supported by the manager.

Care Quality Commission

Crest Lodge

Detailed findings

Background to this inspection

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

This was an unannounced inspection which took place on the 2 June 2016.

Prior to the inspection we reviewed the information we had about the service. This included information sent to us by the provider, about the staff and the people who used the service and a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make

We looked through notifications that had been sent to us by the provider. A notification is information about important events which the provider is required to tell us about by law. This included safeguarding concerns, accidents and incidents and notifications about important events that had occurred.

The inspection team consisted of three inspectors, one specialist in mental health care and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

During our inspection we spoke with the clinical lead, the operations director, a quality assurance manager, 12 people that used the service, one relative and 13 members of staff.

We looked at 12 care plans, three recruitment files for staff, medicine administration records, supervision records for staff, mental capacity assessments and deprivation of liberty applications for people who used the service. We looked at records that related to the management of the service. This included minutes of resident and staff meetings and audits of the service. We observed care being provided throughout the day both at the cottage and at the main house including during a meal time.

Inadequate

Is the service safe?

Our findings

On the previous inspection in April 2015 there was not enough information to guide staff on what steps to take to reduce the risks to people. We found that improvements were still needed.

People's safety could not be assured because not all identified risks of harm were appropriately managed. One person's care plan contained guidance regarding smoking, it stated that the person used creams that were 'easily ignited by a naked flame'. The guidelines to minimise this risk were that the person needed to be observed by staff when smoking and that they needed to be encouraged to wear a safety apron. On the day of the inspection we observed the person smoking in their room without a safety apron on or a member of staff present. The person told us "I have been smoking (in my room) but I know I am not supposed to." One member of staff told us that they advised the person not to smoke but they can't stop them. The policy around smoking at the service states 'Service users are able to smoke only in the designated areas in and outside the home'. Despite this the person was known by staff to smoke regularly and unsupervised in their room which was a risk to their own and others safety and the assessment of the risks was not being used in practice.

There were other examples where risks were not always appropriately managed. One person had a history of behaviours which may put other people at risk. Their care plan stated that they should not be permitted to be left alone with a member of the opposite sex. However on the day of the inspection we saw occasions where this happened. On one occasion the person was seen leaving another persons room where they had been without staff supervision. The person whose room they were in was (according to their care plan) was vulnerable and at risk from other people's behaviours. We asked staff about this whose response was that they had not been any 'issues' with the person. One member of staff told us that people can look "awful" on paper "but when they arrive turn out to be fine." There was no recognition from staff that despite the absence of any incidents from known risks there was still the potential of incidents occurring. There were other incidents of identified risks to people where there was no detailed guidance for staff on how to manage the risks particularly around people's behaviours.

There was a risk that staff did not have the most up to date and appropriate information on how to evacuate people in the event of a fire. There were individual personal emergency evacuation plans (PEEPs) in people's care plans however the copy held in reception had not been reviewed since December 2015. There were people on the list that were no longer at the service and not all of the new people living at the service were on the list. After the inspection the registered manager provided evidence that the PEEPs were now up to date in relation to all of the people who lived at the service.

There was risk that staff would not know how to support people in the event of an emergency. At the cottage staff could not recall when they last had a fire drill or where the records were kept in relation to this.

There were aspects to the building that were not safe. One cupboard was used to store Christmas decorations and other items which were stacked in boxes above head level and looked unsafe. The door was left unlocked and people were able to access it.

At the previous inspection in April 2015 there were concerns that related to the cleanliness and infection control at the service. There had been some improvements around this but there were still some concerns identified.

People were at risk of cross contamination. The laundry room was now set up to ensure that there was a designated area for the clean and dirty laundry to be handled. However a member of staff showed us that they would empty the people's soiled washing into a large black bin. There were several bins in use but it was not identified which was for soiled or unsoiled laundry. This meant that the same bin could be used for soiled and unsoiled laundry which presented a risk of cross contamination. On another occasion we observed a member of staff dispose of a bag with soiled items; they removed their gloves but failed to wash their hands before they left the room. Another member of staff was seen to carry a bag of soiled waste without wearing gloves. On the laundry cupboard upstairs we saw a sign asking people to share the same blankets that they covered their legs with and to return the used blanket to the cupboard unless the person thought it was dirty. Staff had received training around infection control but were not always putting this into practice.

At the previous inspection in April 2015 we found risks around whether people received medicines when they needed them and a lack of guidance for staff around PRN (as and when) medicines. There was now guidance for staff around PRN medicines however other improvements were required.

At this inspection people told us that they understood the medicines that they were taking. Despite this there was a risk that the medicines that people received were not being monitored in a safe way. One person had recently been prescribed medicines with known associated side effects which were potentially harmful to the person if they were not being monitored in the correct way. There was no evidence that daily observations were taking place including blood pressure and blood taking where there should have been. In other areas we saw from people's medicines charts that one members of staff's signature resembled the same as the symbol for someone who refused their medicine. Staff told us that they had come to recognise the signature however this was not safe practice and there was a risk that other staff (including agency) may believe that a person had not received their medicines. Particularly as people on occasions were known to refuse their medicines which had an impact on their behaviour.

People were not always protected from the risk of harm in relation to people's behaviours, fire, medicine management and infection control. These are a continued breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were other aspects to people's medicine management that were safe. People told us staff helped them to take their medicines at the right time and that they could have pain relief if they needed it. Each person had an individual medicines profile that contained a photograph and information about the medicines they took, including any medicines to which they were allergic. Medicines were stored securely and in an appropriate environment. Staff told us they had completed training in the safe management of medicines and had undertaken a competency assessment where their knowledge was checked and we confirmed this with the records. Medicines records were audited regularly and had achieved a high level of compliance (98%) at the most recent audit in May 2016.

The environment in the main house had not always been well maintained. In one person's bedroom there was a hole in the wall caused by the handle of the bedroom door when opened. In the back garden which people accessed there was a large wooden desk leaning against the wall and an old fridge that had been disposed of. Down the side of the building there was a large skip filled with furniture, black bags, clothes and other items along with three small fridges left on the floor by the skip. Throughout the service the paintwork

was scuffed, the main lounge carpet was dirty and stained as were some of the lounge chairs. The stairs leading from reception to the first floor were sticky and dirty and remained this way throughout the inspection. The tiles in one of the bathrooms in one person's room were coming away from the wall under the sink and looked unsightly. However, the environment at the cottage was well maintained and clean. Staff cleaned the property each day and people told us that they were happy with the cleanliness there.

The environment had not been well maintained. This is a breach of regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes were not always put in place to protect people from the risk of abuse. At times people did not always feel safe. One person told us "I don't feel safe here as the other residents are intimidating." Another person told us that they felt at times unsafe due to other people's behaviours. Despite safeguarding training being provided not all members of staff were able to describe how they would identity abuse or neglect. Two members of staff told us that safeguarding people was about best interest meetings and the use of bed rails and people 'absconding' from the service. During the inspection one person became abusive to another person. Although staff intervened and encouraged the person being abusive into another room no support was given to the person who received the abuse. The person had started to cry and left the room with no support from the member of staff. This was not recorded as a safeguarding incident.

Other similar incidents like this occurred and from what we observed staff did not acknowledge this type of behaviour as potential abuse. There were other staff that were able to describe how to safeguard from the risk of abuse. However none of the staff knew who the lead safeguarding agency was. They all told us they would refer any concerns to the registered manager. This is the correct first step, but staff should be aware, through training that the local authrotiy has primary responsibility for safeguarding. Staff should know how to contact them or where relevant contact details can be found.

People were not always protected from the risk of abuse. This is a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were other people at the service who said that they felt safe. Comments included, "I feel safe because there are lots of staff around" and "I feels safe and empowered to speak to staff if I felt unsafe."

People told that there were enough staff at the service. One person said "Staff are always visible" whilst another told us that they see staff respond to people quickly. Another person said "Staff are always available and respond quickly when I use the call bell." Despite these comments there were times where there were not enough staff at the service to meet people's needs. There was only one activities coordinator for Crest Lodge and the cottage. We were told by the activities coordinator that they did not go to the cottage as they did not have the time. Staff told us that a new activities coordinator was being recruited.

We recommend that enough staff are provded to meet the needs of people particularly around people's social needs and activities.

We observed staff pre-empted support for people and supported them with personal care when needed. We reviewed the staff rota and saw that there were always the correct numbers of staff on duty at the main house and in the cottage. The registered manager ensured that on days that people required hospital treatment additional staff were brought in to support that. Staff confirmed with us that there were enough staff to support people.

Appropriate checks had been undertaken on staff before they started work that reduced risks to people.

Applicants had submitted an application form, attended a face-to-face interview and had provided proof of identity and details of two referees. The provider had obtained written references and had undertaken a previous convictions check for each member of staff. There was up to date registration information for all permanent nurses.

Requires Improvement

Is the service effective?

Our findings

At our inspection in April 2015 we found that there were a lack mental capacity assessments and staff did not have an understanding of the Mental Capacity Act 2005 (MCA) regulations. At this inspection we found that improvements were still needed.

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

People were at risk of having decisions made for them without their consent, as appropriate assessments of their mental capacity were not fully completed. The assessments were brief, lacked detail and were not specific to the particular decision that needed to be made. There were standards sentences used to describe people's capacity for example 'X can make decisions around ADL (all aspects of daily living) but has no mental capacity' and '(no capacity) any health and welfare.' Due to the mental health diagnosis of some of the people that used the service their capacity to make decisions may fluctuate. There was no evidence that this had been considered and that additional assessments were taking place. There were people who received their medicines covertly (the term used when medicines are administered in a disguised format, for example in food or in a drink, without the knowledge or consent of the person receiving them) however there were no MCA assessments specific to this decision.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met . Three of the applications we looked at lacked evidence that the person was unable to consent to the restriction as no MCA assessment had been completed. The DoLS application stated 'service user refuses treatment and lacks capacity' which was a stock phrase used in most of the assessments we looked at.

The lack of MCA assessments and lack of understanding of DoLS is a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

On our inspection in April 2015 we found that the staff had not had appropriate training, support or supervisions in relation to the needs of people. There had been some improvements around this but there were still further imporvements needed.

People did not always receive care from staff that had the training and experience to meet their needs. One of the main purposes of the service was to provide care and support to people who had a mental health diagnosis. However other than the registered manager and Registered Mental Nurses (RMNs) no other staff had been provided with training in mental health. The registered manager told us after the inspection "We

had failed to carry over some essential training on mental health awareness." There was a lack of understanding from staff about how people with mental health diagnosis could fulfil their lives and what could be offered to people to encourage independence to move on from the service. There was no evidence that staff had received appropriate training around behaviours that challenged people. Staff told us that they relied upon the guidance and support from their colleagues in relation to caring for people with a mental health diagnosis. One member of staff said that they felt they needed more training around the needs of people who lived there.

One person told us that they felt staff needed to have more training around the "behaviours" of people. One member of staff told us that they did not like the behaviours of one person and asked not to support them. Another member of staff said, "They make sure we are up to date with our training but it's mostly online, I don't think its ideal." The registered manager told us that they had cascaded training to staff in behaviours that challenge however we were not able to provide any evidence of this. A report from the local authority quality assurance team in December 2015 recommended that staff may want to understand more the conditions that people were living with however there was no evidence to show that this had been done.

Staff were not always suitably competent and skilled in their role. This is a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff were competency assessed in relation to the work that they carried out. Although, these assessments had not identified that staff were not always competently meeting people's needs in relation to supporting them with behaviours that challenged. There were clinical supervisions with nursing staff to assess their competencies including wound care and catheter care. All care staff received supervisions with their manager on a regular basis and discussions included any additional support they may need or additional training. All other mandatory and clinical training had been completed by staff.

The environment did not always meet the individual needs of people living at the service. The building was based around a circular corridor system which was not easy to navigate. Due to the similarity of decoration of the different areas of the home it could be confusing for individuals to find their way to the dining room, or main entrance. This could present a particular challenge to any people with confusion or disorientation. There was no variation to the decoration in the different areas, or the use of signage to guide people to the lounges, dining area, or main reception. This was also raised in the report to the registered manager from the quality assurance team at Surrey County Council. The report stated 'The main building is large and confusing.' We found it difficult to navigate the building on the day of the inspection.

There were mixed responses from people about the food at Crest Lodge. Comments included, "Didn't like the lunch, there was too much gristle", "There is a good choice of food and there is enough", "We have good food", "The food is ok, but there is not enough for supper" and "The food is just ok."

We were told by the chef that choices of meals were not available to people who were on a soft or pureed diet however other people were offered choices. There were no snacks such as fruit or biscuits left around for people to help themselves to. The chef also told us that people could ask for food if they wanted but we did not see staff being proactive and reminding people of this option.
We recommend that people are offered choices of meals and that people are able to access food throughout the day without having to seek permission from staff to do so.

People at risk of dehydration or malnutrition had effective systems in place to support them. Where people needed to have their food and fluid recorded this was being done appropriately by staff. Intake and output of food and fluid was recorded on forms that were kept in people's rooms so that staff could easily keep an

accurate record of what people had eaten and what they had had to drink. We saw that drinks were within reach for people that were in being cared for in bed. People were weighed regularly, in most cases monthly. If there was a change in someone's weight then this routine would be changed to weekly. If staff had concerns they would raise this with the appropriate health care professional.

The chef had records of some of the people's individuals requirements in relation to their allergies, likes and dislikes and if people required softer food that was easier to swallow. For those people that needed it equipment was provided to help them eat and drink independently, such as plate guards and adapted drinking cups. Nutritional assessments were carried out as part of the initial assessments when people moved into the home. These identified if people had any specialist dietary needs.

People were supported to remain healthy. People told us that they were able to access health care professionals when they wanted and we saw that this was the case. People had access to a range of health care professionals including mental health professionals, GP and dietician. The GP visited regularly and people were referred when there were concerns with their health. We saw that where necessary multi-disciplinary teams of health care professionals supported people with their needs.

Requires Improvement

Is the service caring?

Our findings

On our inspection in April 2015 we found that care and treatment was not designed with the input of people who used the service. People were not encouraged to live independently. On this inspection whilst some improvements had been made we still had concerns.

People were still not always involved in their care planning. One person told us, "Staff have never explained my care plan to me." Whilst another person told us that staff did discuss their care with them and their family. Another person said, "Staff could definitely do more to inform me of my care." The care plans we looked at lacked personalisation and there was no evidence that people or their representatives were asked what they wanted. Some were half written in a person centred way and then changed half way through to the person being referred to. People did not always have an opportunity to comment on their care planning or whether their needs were accurately reflected.

People were not always supported to be independent. The service websites states that 'We offer residential, nursing care for those who need 24-hour care, respite and day-care to support families and carers and supported living in one of our well-appointed apartments at Crest Cottage. These apartments are specially designed for those individuals who prefer independent living combined with as much or as little care as needed. This step-down, supported living service enables residents to build confidence and aids them in a speedy return into the community.' However we found that people at the Cottages were not being offered this type of support. One member of staff said, "(We) would like to encourage people to be independent." They went on to say that they didn't see how this could be achieved. People at the cottage said that their meals were supplied from the providers neighbouring service which was in the same grounds as the cottage. However the potential for independent living had not been realised. It had not been considered how people living at the cottage could be encouraged to develop their living skills such as cooking their own meals.

The provider had not ensured that care and treatment was provided that met people's individual and most current needs. This is a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not consistently treated with dignity and respect. On the day of the inspection there was a large notice on the wall directed at people which was not written in a dignified way. In addition there were notices in the bathrooms directing staff how to separate washing covered in 'faeces' and 'vomit' which was not dignified for people who lived there. There was a strong smell of smoke from one person's room which could be detected from other people's rooms and the corridor which others used. No consideration had been given to people having to smell this. One person told us that they were not happy about people smoking in their rooms and did not like the smell. Other incidents around lack of dignity included 14 people on the first floor had to share one shower room as the bathroom was not being used. A member of staff told us that the bathroom was kept locked for storage. They said that people could use the downstairs bathroom if they wanted.

There were occasions during the inspection where staff were not as caring as they could have been. One

person politely asked a member of staff if they were able to purchase something for them. The member of staff responded without looking at the person, "Not today no." No explanation was given to the person who accepted this and walked away. A member of staff took a call from a relative who wanted to speak to someone about their family member's welfare. The relative was told that the member of staff they needed wasn't available (despite the staff member taking the call not checking if this was the case as they confirmed that with us). They did not offer to take the relatives contact details or suggest that the member of staff they needed could call them back despite the service policy stating that this should be done. We saw one member of staff in the lounge that did not chat to people but stood leaning against the wall just observing. We found that the chairs in one of the dining rooms did not have rubber stoppers on the feet. Every time one person pushed her chair out they were asked to be quiet. The chairs were very noisy and we could see that people were agitated with the noise.

One member of staff told us that they held a Church of England church service at Crest Lodge once a week. We asked whether other services of other denominations were held and they told us they were not but people (with different faiths) liked attending this one. However one person told us that wanted to access their faith more as once a week was not enough for them and they were unable to do so without staff support. People told us they were offered day to day choices and freedom. One person said, "I feel to make my own choices about what I do with my time." We did see staff offer people's choices around where they wanted to sit at lunch and about day to day care.

As people were not always treated with dignity and respect and staff were not always caring this is a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were times during the inspection where people were treated with dignity and respect. We saw staff knocked on people's doors before entering and were asked if they wanted to wear clothing protectors at lunch. When staff talked with people in their rooms they closed the door behind them so that the conversation was in private and all personal care was provided behind closed doors.

People told us staff were caring towards them. Comments included, "I like the staff, they are good, friendly", "I get on well with them (staff), we're all friends", "Staff treat me with compassion, they help me with my self-esteem", "Staff always have time for me." One relative said, "Staff are very visible and caring to (their family member.)"

There were other times where interactions between people and staff on the day showed staff to be caring and compassionate. Staff anticipated people's needs and went to them to offer support. One person asked a member of staff if they could buy them some sweets when they went out. The staff responded, "Of course, I will write that down on my list." On another occasion one person was upset and a member of staff knelt beside them and offered reassurance and comfort. We saw staff chat to people and it was clear from their interactions that staff knew people well. One member of staff asked a person if they wanted to wear a cardigan before they went out as it was cold.

There were some people at the service who had access to an independent advocate to assist them to make decisions about their care. Although there was information around advocacy for people displayed in certain parts of the service it was not visible in places that was easy for people to see. There was no discussion at the residents meetings around how people could access this service. We recommend that the provider ensures that people have knowledge of and are able to access the advocacy services to obtain independent support if needed.

Requires Improvement

Is the service responsive?

Our findings

At the previous inspection in April 2015 care plans were not detailed and people did not always have access to activities. At this inspection we found insufficient improvements had been made.

People did not always receive care and support that met their needs. The provider's website states 'At Crest Lodge 'Residents can part-take in activities, watch television and entertain guests……allowing our residents to pursue gardening and outdoor activities to fulfil a socially active independent lifestyle.' We saw no evidence of this taking place on the day of inspection. Those that were able could go out when they wanted. However, those that were dependent upon staff support to go out did not get as much opportunity. One member of staff said, "Everyone wants to go out and that's the main problem here." They told us that another activities coordinator was being recruited part time. On the day of the inspection one person was asked about whether they wanted to go to the cinema and was excited about this. This was not able to happen due to a hospital appointment taking place for another person in the morning and another person being taken out on their own in the afternoon. One member of staff told us that they were only able to take one person out at a time if they were wheelchair dependant as only one of the two vehicles they had was adapted to take wheelchairs. They told us that the drivers of the vehicles finished work at 16.00 which meant people could not go out after this (unless they did this independently).

One person told us that they felt the same people got the opportunities for activities. One member of staff told us that there were not enough activities for people; they told us that (due to time constraints) they were unable to visit people at the Cottage which left them socially isolated. The member of staff said that there was a "Tight budget" for activities and most of this was spent on music entertainers that came to the service twice a month. One member of staff said, "I think people need more to do, we would like to do more activities but we don't have time." We saw from the residents meeting in December 2015 that people said there was a lack of activities and that one person wanted to go fishing. We saw no evidence that this had been addressed. People were not doing much on the day of the inspection and there was no evidence of any activities taking place within the service.

We did see that people were able to walk around the grounds of the service and had access to a computer in the lounge if they wanted to use it. Those that were able could go out independantly.

Pre-assessments of people needs were undertaken before they moved in however, these were not always used effectively in determining whether their needs could be met. One person had been at the service a short time and a decision had been made that staff were unable to meet their needs. One member of staff told us that they did not have all the information they needed about the person before they moved in. It was unclear why the decision was made to accept the person into the service without knowing what all of their needs were. We looked at the pre-assessments for two other people. There was evidence that there was a risk that both of the people displayed particular behaviours that would put other people at risk. There was no care plan around these particular behaviours. One person had since left the service due to a particular incident around their behaviour that was detailed on the pre-assessment.

There was a risk that staff were not providing the most appropriate care to people. Where a particular behaviour had been identified there was not always guidance for staff on how best to support the person. One person had displayed aggression at times, there were no behaviour plans in place or information on what interventions had been tried to support the person. There were people who had epilepsy however, there were no care plans on how to best support the person with this. Although on the day staff were providing the most appropriate care there was not enough detailed guidance for new members of staff. There were contradictions in another person's care plan. It had been identified before they moved in that they required particular care as a result of their past history and that they were required to be on a one to one with a member of staff at all times however later on in the care plan it stated that the person could go out independently.

Care and treatment was not always provided that met people's individual and most current needs. This is a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

There were aspects to the care plans that were more detailed. People's care had a description of their medical history, moving and handling, skin care and sleep routine and how people needed and wanted to be supported. There were examples where the person's needs had been identified and care was provided that met their needs.

There was a complaints procedure in place which was displayed in reception. People did tell us that they would make a complaint if they needed to. Not all of the complaints made were recorded in the complaints folder and there was not always a recorded response on how the complaint was dealt with. On one person's care plan we saw that a relative had written in to complain about their family member's care. There was no recorded response to this and a copy was not placed on the complaint file. There was only one recorded complaint in the folder which did not detail what action had been taken or how it was responded to. This lack of recording of complaints had also been identified by the service's quality assurance team.

Inadequate

Is the service well-led?

Our findings

On the previous inspection in April 2015 we found that the service provided did not reflect what was advertised on the service website. The quality assurances processes were not robust and were not used to make improvements to the service. There had been some improvements but there were still areas that require further improvement and the breach of regulation 17 continued.

Effective management systems were not in place to assess, monitor and improve the quality of service people received. An internal audit conducted by the provider took place in March 2016. It had been identified that there were not enough activities for people, that some areas of the service required updating, that people were subjected to the smell of smoke in the building, poor hand hygiene in areas, poor cleanliness in some areas of the flooring and there was a lack of detailed guidance around risks in people's care plans. There was a service improvement plan as a result of the audit but the necessary improvements had not been made. The audits had not identified the shortfalls around specific training in mental health, the lack of MCA assessments and other areas indentified in this report. Clinical audits were undertaken by the registered manager which were then reviewed by the quality team. However we looked at the April 2016 clinical audit which had not been fully completed, people's weights had not been filled in since January 2016 (although people were being weighed). Accidents and incidents were recorded but with no information on any further action required or how they had been analysed to try to prevent future accidents.

Although people's views had been sought these had not always been used to improve the quality of care. We were told that monthly resident surveys were taking place for six people at a time. We looked at the surveys from March and May 2016. In March 2016 one person said the service did not support them to access activities and follow their interests. Another person said they would like to be more involved in their care and support. A relative said the service could be improved by developing links between the home and local groups so that people had opportunities to meet others from the local community. The relative also suggested the service could make use of volunteers to increase opportunities for people to go out. We found that steps had not been taken to address this feedback.

In May 2016 one person was told they could help themselves to food in the fridge (because they did not feel the evening meal was sufficient) however on the day of the inspection we were told that people were not allowed into the kitchen. Another person was told that the calls bells would be monitored however we were not provided with any evidence of this happening. One person told us, "When we ask for a change the response isn't usually very good."

The Provider Information Review (PIR) that was completed by the provider did not reflect what we found at the inspection. The PIR stated that there were sufficient activities, detailed risk assessments and care plans, people were encouraged to lead independent lives and improvements from quality assurance audits were undertaken however we found that this was not the case.

Records for people were not always stored securely or updated appropriately and staff openly discussed people's personal details. There was large desk at the reception of the building. Staff regularly congregated

there to use the service computer or to take calls. We found that people's turning charts and topical cream charts were left there for people to access. One member of staff told us that the desk was never left unattended however on two separate occasions there was no staff at the desk and the member of staff's computer had been left unlocked. On two separate occasions staff were heard discussing people whilst on the phone but this was within earshot of people who were either sitting near the reception or walking past. The registered manager informed us of significant changes to a person's care however there was no record of their rationale for this change or a record of involvement with other health care professionals. The registered manager told us that they had not recorded these changes in the appropriate way.

Appropriate systems were not in place to assess, monitor and improve the quality of the service, and the records were not always complete and accurate. This is a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Since the inspection the registered manager has provided an action plan to address some concerns that were raised. The action plan details timescales to make improvements. We will assess whether thes improvements have been made at the next inspection.

We could not effectively monitor what was happening in the service as the provider had failed to provide information to the Commission in line with their legal obligations. Services that provide health and social care to people are required to inform the Care Quality Commission (CQC) of important events that happen in the service. The provider had not informed the CQC of significant events particularly around safeguarding people from abuse.On the day of the inspection an incident of abuse took place that was not recorded by staff. This is a breach of regulation 18 of the Health and Social Care Act 2008 (Registration) Regulations 2009.

Some areas had been improved as a result of quality assurance checks. Since the internal audit in March 2016 the registered manager had ensured that registered mental health nurses and general nurses were on duty at the same time to provide support to people and that clinical rooms doors always remained closed which they were during the inspection. Steps had also been taken to order additional furniture, curtains and lampshades for people. There was positive feedback provided on the survey by people who lived at the home. People said the staff that supported them were kind and caring. Relatives said their family members were cared for in a safe and caring environment and that staff were friendly.

People told us that they knew who the registered manager was that they were approachable. One person said "I know who the manager is and I get on with her." Staff told us that they were supported at the service. Comments included, "(The management) are very good, they try their best to get everything done but there Is never enough time", "There is good team work here, I would say morale is pretty good", "We have a good team, we help each other" and "We work well together."

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Accommodation for persons who require treatment for substance misuse Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect **The provider had not ensured that people were always treated with dignity and respect and that people always treated people in a caring way.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Accommodation for persons who require treatment for substance misuse Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent **The provider had not ensured that people's consent had been gained and their capacity had been assessed.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Accommodation for persons who require treatment for substance misuse Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment **The provider had not ensured that people were protected from the risk of abuse.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Accommodation for persons who require treatment for substance misuse	Regulation 15 HSCA RA Regulations 2014 Premises and equipment **The provider had not ensured that the environment was suitable for people living at the service.**

Diagnostic and screening procedures

Treatment of disease, disorder or injury

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Accommodation for persons who require treatment for substance misuse Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider had not ensured that care and treatment was provided that met people's individual and most current needs.

The enforcement action we took:

.As this is a breach we issued a warning notice to the registered provider on the X relation to Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Accommodation for persons who require treatment for substance misuse Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not ensured that people were protected from the risk of harm.

The enforcement action we took:

As this is a breach we issued a warning notice to the registered provider on the X relation to Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Accommodation for persons who require treatment for substance misuse Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not ensured that there were effective systems to assess and quality assure the service

The enforcement action we took:

As this is a breach we issued a warning notice to the registered provider on the X relation to Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.