Platinum Care Homes Limited

Church View Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

Church View provides accommodation with nursing for up to 78 older people, some of whom were living with dementia. The home is purpose built and set over three floors with six units each containing their own communal lounge and dining areas. At the time of our inspection 72 people were living in the home.

There was 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 and associated Regulations about how the service is run.

At our inspection on 30 September 2015 we found breaches of two of the regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We asked the provider to take action in relation to risk assessment and poor moving and handling techniques and assessing and monitoring the quality of the service provided. We last inspected Church View on 17 and 18 October 2016. Continued breaches of legal requirements were found and we took enforcement action against the provider and registered manager. We issued a warning notice in relation to the governance of the service. In addition we found breaches of the regulations in relation to unsafe care, staff training and supervision, staff not following the principals of the Mental Capacity Act, a lack of safe person-centre care and a lack of respect and dignity shown towards people. Following the inspection the provider submitted an action plan to us to tell us how they planned to address these concerns. We carried out this inspection to see if the provider had taken action in line with the warning notice and their action plan. Although we found that improvements had been made in some areas they had not taken sufficient action to meet the warning notice. We identified continued breaches of the regulations in relation to safe care and treatment, person centred care, protecting people's legal rights, staff deployment, the support of staff and good governance.

Since 2015 there has been a lack of managerial and provider oversight of the service to make the improvements required and to recognise and take action when concerns remain. Audits and quality assurance processes were not systematic and not effective in identifying shortfalls in the care provided. There was a lack of leadership and learning from the registered manager and provider. The effect is that people continue to experience times when staff are not always caring, respectful or responsive towards them.

People were not always treated with care and compassion. Staff were observed to treat people without kindness and people's dignity was not always respected. There was a lack of empathy and understanding shown by some staff. We did see some examples of positive and caring interactions between people and the staff supporting them.

Risks to people's safety were not always effectively assessed and there was insufficient guidance provided to staff to enable them to provide people's care safely. There was no clear guidance to staff on how to support people to manage their anxiety and behaviours. The advice of professionals involved in people's care was

not always consistently followed. In other areas we found improvements in the way risks were managed, including pressure care and routine moving and handling.

Sufficient staff were not always deployed to meet people's needs. Staffing levels determined by the provider were consistently met although we found in one unit there were insufficient staff to support people during the lunchtime period. Staff received supervision and appraisal although staff concerns were not always appropriatley addressed. Staff received training to support them in their role. However, we found that this was not always effective in ensuring people received person centred care.

People's legal rights were not always protected as staff did not have a good understanding of their responsibilities in relation to the Mental Capacity Act 2005. Although there had been some improvements in this area people's capacity was still not routinely assessed regarding specific decisions and best interest decisions were not always recorded.

The care planning system had been reviewed although the contents of care plans was not always person centred and information regarding people's needs was not always accurate. There was a range of activities provided for people in communal areas although people who needed to spend the majority of their time in their rooms did not have access to activities. We have made a recommendation in relation to this.

Recruitment checks were completed prior to staff starting work to ensure they were suitable to work at the service. Staff understood their responsibilities in relation to safeguarding people from potential abuse and had attended training in this area. People lived in a safe and clean environment and regular checks of equipment were completed. There was a contingency plan in place to ensure that people would continue to receive a safe service in the event that the building could not be used.

People's medicines were managed safely and in line with people's prescriptions. There was a wide range of healthcare professional involved in people's care although visits were not always recorded to show the outcome of appointments. We have made a recommendation regarding this. People told us they enjoyed the food provided and were able to make choices regarding what they had to eat and drink.

There was a complaints policy in place which was displayed within the service. People and their relatives told us they would feel comfortable in speaking to the management of the home if they had any concerns.

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

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

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

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

During the inspection we found eight 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?

Requires Improvement

The service was not consistently safe.

Risks to people's safety were not always identified and staff did not always follow the advice from professionals.

Sufficient staff were not consistently deployed to meet people's needs.

Medicines were managed and stored safely.

Recruitment process were in place to ensure that staff were safe to work in the service.

There was a contingency plan in place to ensure people would continue to receive care in an emergency.

Is the service effective?

Requires Improvement

The service was not always effective.

People's legal rights were not always protected as the principles of the MCA were not consistently followed.

Staff did not receive effective supervision and the effectiveness of the training staff received was not monitored.

People received support with their healthcare needs although outcomes of appointments were not always recorded.

People told us they enjoyed the food and choice was provided.

Is the service caring?

Inadequate

The service was not caring.

We observed some staff did not always treat people with kindness and did not always respect people's dignity.

People were supported to maintain their independence.

People's individual communication needs were understood by

staff.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans were not always completed in a timely manner and information was not always accurate.

People did not always receive responsive care in line with their needs.

People had access to activities in communal areas although there was little provision for people who needed to spend the majority of their time in their room.

There was a complaints policy in place and people and relatives told us they would feel comfortable in raising concerns.

Is the service well-led?

Inadequate

The service was not well-led.

There was a lack of managerial oversight of the service.

Quality assurance systems were not organised or systematic and did not lead to continuous improvement.

There was a lack of effective leadership and learning to embed systems into practice.

The registered manager did not receive effective support from the provider.

People, relatives and staff were not involved in the running of the service in a meaningful way.

The registered manager was aware of their responsibility to report significant events to the Care Quality Commission.

Church View Care 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 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 7 and 9 February 2017. The inspection team consisted of three inspectors and a member of CQC's strategy and development team who acted as our expert by experience. Their role was to speak with people and visitors as well as carry out observations.

Prior to the inspection we reviewed the information we had about the service, such as notifications, safeguarding's and other information they had submitted to us. A notification is information about important events which the service is required to send us by law.

During our inspection we observed the care and support being provided and talked to relatives and other people involved in people's care. We spoke with 3 people, 5 relatives, 6 staff, the registered manager, the provider and the general manager. We looked at a range of records about people's care and how the home was managed. For example, we looked at 14 care plans, medication administration records, risk assessments, accident and incident records, complaints records and quality assurance audits that had been completed. We also reviewed six staff recruitment files.

We last inspected Church View in October 2016 where we identified seven breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service safe?

Our findings

We asked people if they felt safe living at Church View. One person told us, "The staff cannot be faulted." They said the moving and handling equipment used to move them made them feel safe. Another person said they liked the environment and, "There's always somebody here if I need help, they usually come straight away." A relative told us, "Here is as safe as anywhere. She's better off than I am in a way because she doesn't have a worry in the world." A visiting healthcare professional told us, "I don't walk away from the service feeling people are unsafe." However we found that further improvements were needed to ensure people consistently received safe care.

During our inspections in September 2015 and October 2016 we found that risks to people had not always been managed appropriately. At this inspection we found that although improvements had been made in some areas, staff were not always identifying and addressing risks in a consistent manner.

Where people required support to manage their anxiety during personal care there was insufficient guidance for staff on how to support people safely. Where people's care plans stated that due to their anxiety and behaviour they required two staff to restrain their hands whilst a third staff member provided their care. There was no detailed guidance to staff on how this should be managed safely and staff had not received training in this area. This meant that people were put at risk of harm from staff using inappropriate restraint techniques. There was no guidance to staff on how to create a relaxed environment for the people concerned or what different methods of reassurance they may respond to.

People were at risk of harm as guidance from professionals regarding the consistency of people's food and drinks was not always followed. On the first day of the inspection we observed two people who required their drinks to be thickened to prevent choking were given drinks without the thickener. We spoke to the registered manager about this and observed that on the second day of the inspection people's drinks were prepared appropriately. The same people's care files stated they required their food to be pureed to prevent the risk of choking. We observed both people were given pastry tarts with their tea in the afternoon and one person was given sandwiches at supper time. There was no risk assessment or guidance available to state that either of the people's needs had changed. On the second day of the inspection the registered manager told us that staff had previously spoken to the Speech and Language Therapy Team regarding one of people involved and agreed it was safe for them to eat some solid foods. However, this conversation had not been recorded and there was no guidance to staff on the types of food that were safe for the person to eat.

Risks to people's safety were not always assessed in a timely manner. During the first day of the inspection we observed one person start to slip from their wheelchair almost to the floor. Rather than guide the person to the floor where they could then be supported safely, two staff members lifted the person under their arms whilst a third staff member lifted their legs. This procedure is known as a drag lift and puts the person and staff at risk of harm. The person had recently moved into Church View and had no care plan or guidance in place for staff to follow. We brought this to the registered manager's attention who told us that a care plan should be in place with two days of someone moving in. On the second day of the inspection we found the person had a care plan in place which stated that when not in bed the person should be seated in a reclining

chair which would prevent them from slipping forwards.

The failure to appropriately mitigate risks to people's safety was a continued breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

In other areas we found the risk of harm to people was reduced because risks had been identified and guidance was in place for staff to help reduce the risk. One person was unsteady on their feet and their care plan recorded, 'ensure close monitoring'. We observed staff do this throughout the inspection and offered support to the person when they mobilised. At our last inspection we observed one person was wearing inappropriate footwear which put them at increased risk of falls. At this inspection we found that this had been addressed and the person was now wearing suitable footwear. People at risk of pressure sores had repositioning charts and daily fluid charts in place which were both completed so that staff could monitor their fluid intake and the condition of their skin and take appropriate action to keep them safe. Daily checks were completed to help ensure people's pressure mattresses were set at the correct setting. These measures are important to maintain people's skin integrity. Where people were routinely supported with moving and handling we observed this was done in a safe manner using equipment appropriate to people's needs. There was a designated smoking area in place and smoking aprons were available to people to protect them from the risk of fire.

We asked people if they felt there was enough staff on duty to meet their needs. One person told us they rarely used the call button but when they did the response had been quick. However, they added, "They could do with a few more member of staff. It doesn't affect me, but it's hard on them. They work very hard." A relative told us the staff could not be faulted and there was always someone to attend (to their mother).

Sufficient staff were not consistently deployed to ensure people's needs were met in a consistent manner. The registered manager told us that there should be one nurse and six carers on each of the three floors during the day. Rotas' showed these levels were consistently met and the majority of people did not need to wait for care. However, we found that in one unit there were not always sufficient staff to respond to people's needs, particularly during the lunchtime period. We observed that there was one staff member in the dining room area for the majority of the time lunch was being served. Two people required support to eat their meal and the staff member was moving between them whilst also supporting a person who kept getting up from their seat. This meant the people who required assistance to eat were left for long periods of time waiting for their next mouthful of food and eating cold food. Although during the second day of the inspection staff were more organised we still found there were insufficient staff deployed in this unit at lunchtime to ensure people received support in a consistent and timely manner.

We observed instances where staff were interacting with people in communal areas and needed to interrupt this and leave to offer support to others. There was little social interaction provided by staff for people who needed to spend the majority of time in their room.

The lack of sufficiently deployed staff was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's medicines were stored and administered safely. One person told us, "I did know what medication I took but it has changed." They said if they thought it was greatly different they would ask. Another person said they knew their medication and it was explained to them or they would ask. A relative said, "Medication has been discussed quite a lot lately. They (staff) are always trying to improve."

We looked at the Medicines Administration Records (MAR) for 25 people. All MAR charts contained an up to

date photograph of the person, their GP details and any known allergies. Where specific information was required regarding how medicines should be administered this was recorded. This included where medicines were prescribed on a PRN (as and when required) basis. Clinical staff were knowledgeable about the medicines they were handling and followed recommended guidance when administering medicines. Medicines trolleys were locked between use and staff did not sign to say people's medicines had been administered until they had seen the person take their medicines. Regular stock checks were completed and any unused medicines were returned to the pharmacy.

People were safeguarded from the risk of abuse as staff understood their responsibilities to report any concerns they had. Staff had access to safeguarding and whistleblowing information should they suspect any abuse taking place. One staff member told us, "I have never seen anything like that go on here. If I did, I would go to the nurse or the manager." Records confirmed that staff had received safeguarding training.

In the event of an emergency, there was a contingency plan in place to ensure that people would continue to receive care. This provided information on evacuation in the event of a fire and how people's care would continue with the least disruption possible. This included moving people to units in the home that may be unaffected or liaising with the local authority to find suitable, alternative accommodation. A relative told us, "They (staff) take all precautions, there is a fire practice every week."

People lived in a safe and clean environment. Maintenance staff were responsible for monitoring the safety of the environment and records showed that regular checks were completed. Equipment was regularly serviced and maintained and any faults were reported and actioned promptly. The general manager took responsibility for auditing checks on the home and records were stored in an organised manner.

The provider followed safe recruitment processes to help ensure that only suitable staff were employed to work in the home. This included obtaining references, a full employment history, evidence of identification and a right to work in the UK and a disclosure and barring check for a criminal record. A DBS check allows employers to see if an applicant has a police record for any convictions that may prevent them from working with people who use this type of service.

Requires Improvement

Is the service effective?

Our findings

At our inspection in October 2016, we found that staff were not meeting the requirements of the Mental Capacity Act 2005 (MCA) and lacked knowledge regarding their responsibilities. At this inspection we found some improvement had been made, however further work was required to ensure that people's rights were being protected.

The 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 make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty 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).

One person told us that staff spent time talking and listening to them and asking how they would like things done. They told us they felt encouraged to make their own decisions. A relative said they were involved in decisions about their family member's care. They told us, "The staff are all doing their best. I am always able to discuss things with them."

Despite these comments we found that staff were not aware of their responsibilities with regards to the MCA and DoLS. The registered manager told us that following the last inspection all clinical staff had completed training with regards to the MCA and DoLS. The clinical staff we spoke with could not tell us the implications of Deprivation of Liberty Safeguards (DoLS) for the people they were supporting or anything relevant about the Mental Capacity Act. Care staff had also completed MCA training as part of their induction. However, staff were unable to describe to us the principles around MCA. One staff member said, "Is it something to do with dementia?" Two further staff members were unable to tell us anything about the MCA.

People's legal rights were not always protected. Capacity assessments and best interest decisions had been completed for people where staff were using physical interventions when supporting people with their personal care. However, the best interest decision did not refer to any less restrictive options which had been explored or what methods of interaction people may respond positively to. DoLS applications had been completed for the majority of people who had bedrails in place. However, their capacity had not been assessed in relation to this decision and there was no evidence of discussion to decide if this was in people's best interests and the least restrictive way in which to keep individuals safe. We spoke to the registered manager about this. They told us they were not aware that they needed to do this. We looked at the records of four people who had moved into the service in the past six weeks. We found that although all four people were living in units where doors were locked and they were under constant supervision there were no capacity assessments, best interest decisions or DoLS applications recorded. The registered manager told us they believed that DoLS applications had been submitted but was unable to produce evidence this was the case.

People's human rights were not protected because the requirements of the MCA were not always followed. This is a continued breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We observed that in some areas staff had acted in accordance with the MCA when providing people's care. Where people's relatives felt it was not in the best interests of their family member to be admitted to hospital, a mental capacity assessment had been completed and where appropriate medical professionals consulted to agree the decision was in the person's best interests. Three people received medicines covertly, (without their knowledge or permission). Records confirmed that mental capacity assessments and best interests meetings had been held for each person with the involvement of their GP and pharmacist. One person had refused the use of pressure relieving equipment which had been recommended by professionals involved in their care. Staff had explained and recorded the risks of not using the equipment to the person and had explored alternatives. The person had signed a statement confirming that they understood the risks and reserved the right to make this decision. This showed that staff understood the person's right to take risks and had respected their decision.

At our inspection in October 2016 we found that staff did not always receive regular supervision or appraisals and that staff did not always receive the training they required to support people with specific health conditions such as epilepsy. At this inspection we found that staff were now receiving more regular supervisions and that training had been provided with regards to supporting people with epilepsy and those living with dementia. However, staff supervisions and appraisals did not demonstrate that concerns expressed by staff were dealt with appropriately. Staff training was not always effective in ensuring people received person centred care.

A supervision matrix was in place to enable the registered manager to track when staff had received supervision. The matrix showed that staff were now receiving supervision in line with the providers policy. However, where staff had expressed concerns these were not always responded to in a manner which supported them in their role and some contained derogatory comments. One staff member had expressed concerns that some staff did not work as a team and were unwilling to help them. The registered manager had recorded that if the staff member worked hard their colleagues would be willing to support them. Despite this, the staff we spoke to told us they felt supported in their roles and could approach the registered manager or nursing staff with any concerns.

Staff were provided with training to support them in their role although staff knowledge was not assessed. People told us they felt staff had the training they required to support them safely. One person said the staff were skilled and experienced and said they were, "Always very willing and attentive." A training matrix was in place which showed that staff received training in areas including moving and handling, safeguarding, health and safety, MCA, dementia and fire safety. However, from our observations of people's care it was not clear how effective the training had been in ensuring staff had the skills they required to carry out their role. As reported staff did not always work within the principles of the MCA. We observed that some staff lacked understanding of how to support people to eat in a safe and dignified manner and did not demonstrate a skilled approach to supporting people with sensory impairments.

Health professionals working with the service told us they were in the process of developing training programmes for clinical staff to ensure the nursing care provided is effective and clinical practice is up to date.

The failure to provide effective supervision and assess staff skills is a repeated breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

New staff received an induction into the service. Staff told us they had an induction and shadowed more experienced staff before they started working on their own. One staff member told us, "I did induction training which included moving and handling and then I learnt all about the units."

People were supported to access the support of health care professionals should they require it. One person told us staff were very quick, responsive and reassuring when they had suffered a bleed from their nose. They said staff checked with the doctor at the time and arranged for them to go to the hospital for tests. We found where people's health needs changed staff had referred them to relevant health professionals. We read people were referred to the GP, dietician, Speech and Language Therapy team, optician and dentist. However, we found that people's records had not always been updated with the outcome of visits with professionals.

Some people had percutaneous endoscopic gastrostomies (PEG) in place. PEGs involve placement of a tube through the abdominal wall and into the stomach through which nutritional liquids and medicines can be infused, when taking in food and drink orally is no longer possible. Staff were knowledgeable about the management of these and all nursing staff had been trained in this area. People's care in this area had been regularly reviewed by a dietician and a speech and language therapist and staff followed the guidance provided.

People had a choice of foods and were supported to eat their preferred foods. Each table had a menu displayed for people and we saw staff reading choices out to people and observed some staff gave people visual choices. During lunch we heard chatter and banter in some of the dining areas and people seemed to be enjoying the food which led to people experiencing their meal times in a sociable way. One person told us they were happy with the food that was served. They said they chose to eat their meals in their room. A second person said, "The food is edible – not like home, but always hot and a choice of menu and I can ask for more." People were being weighed regularly and in the event someone lost weight staff took appropriate action. One person was at risk of malnutrition and staff had instigated fortifying their foods with high calorie options whilst waiting for an assessment from the dietician. A relative told us, "Mum tends to like soft things. They (staff) know her preferences."

Inadequate

Is the service caring?

Our findings

At our inspection in October 2016 we found inconsistencies in the care that people received. At this inspection, some improvement was seen however we continued to see poor practices by some individual staff.

People and relatives were happy with the care that was provided at Church View. One person told us the staff could not be faulted. One relative told us they felt the home was, "Just right" for their family member. Another said, "Generally the care is of a responsible standard." A third told us, "I can talk to staff if I want to. They are caring and interested in (family member). When I come in, she is always comfortable and warm and very clean." They added that staff were, "Attentive and always popping in." A further relative said, "Staff are okay. I can't see how anybody could do better."

Despite these comments we found people were not always given the time they should have expected to eat their meals in an unhurried way. We observed one staff member putting large spoonful's of food into a person's mouth and before they had a chance to finished giving them juice. This person was visually impaired and the staff member did not warn them before they put the spoon or juice to their mouth and as a result the person jumped each time this happened. On another occasion this same member of staff was seen giving people juice without letting people swallow properly before the next mouthful. One person was drinking unsupported and yet the staff member took the cup from their hands and started to feed them their juice. They were interrupted by another staff member who told them to let the person drink on their own. We regularly heard this staff member say to people, "Drink, drink."

People did not always receive undivided attention from staff and staff did not always respond to people's requests. One staff member sat beside one person and opened up a crossword book, suggesting they do a crossword together. However, before they had a chance to start the staff member left them without explanation to respond to another person. Before they came back a second staff member had removed the crossword book informing people they were going to play a game of bingo. One person asked for a second piece of cake with their tea during the afternoon. We heard the staff member say, "When the trolley comes back I'll get some for you." However, the staff member did not do this when the trolley returned and they then went on their break, which meant this person's request had not been met. One person said to staff, "I want to go to my room." However, we heard staff say to them, "Please sit down and finish your food first." Staff did not respect this person's request to return to their room and we saw staff push the person closer to the table to try to avoid them getting up again.

On a separate occasion the same member of staff was heard saying to one person, "On Wednesday your sister comes. Remind me of her name." The person could not remember and the staff member said, "You forgot? Okay, I'll go and have a look and let you know." Despite people's care plans sitting beside the member of staff, they did not look in this person's records to tell them their sister's name. As a staff member passed one person who was visually impaired they stroked their hair. The person said, "Oh, that's nice. I'm having my hair done." However the staff member had already walked away and did not respond.

People were not always treated with dignity and respect by staff. On the second day of our inspection we observed one staff member sitting between two people at lunch time. We saw the staff member support the two people at the same time by giving them alternate mouthfuls. We read notices that had been attached to some people's ensuite doors. The wording on these notices was not respectful. For example we read, 'aggressive, try to hit the residents and staff', '(name) don't let them eat in your hands. He sit on the commode and transfer to the toilet facilities'. One person was taken into their ensuite by staff. The staff member then responded to someone's call bell, they did not take the time to close the person's ensuite and bedroom door to ensure their dignity. On another occasion we asked a staff member a question. They went to speak to a colleague who was supporting someone in the toilet. The staff member knocked on the toilet door and opened it without waiting for a response. They began to have a conversation with the second staff member about another person's care. During this time we observed the door was open into the corridor whilst the person was using the toilet. We intervened and asked the staff member to close the door. Whilst the majority of staff knocked on people's doors before entering and waited for a response, we observed two occasions when staff walked into people's rooms without knocking.

People did not always receive empathetic care. One person was heard saying to a staff member, "I don't feel well, I feel sick." The staff member (who was writing care notes at the time) responded, "Mmm" and carried on writing notes. Later whilst a game of bingo was taking place this person started to moan. A staff member said to them, "What do you want mm?" "You don't know?" The staff member moved away and did not give the person time to answer.

We spoke with the registered manager about our concerns. They told us, "Staff should know this is not correct." They did not state how they were going to address these issues with staff to prevent these examples happening again.

The lack of respect and dignity shown to people was a continued breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We did see some examples of kind caring interaction from staff. We heard a staff member say to one person, "I have a lovely cup of tea for you" when they handed over their drink. We saw and heard staff show attention and care to people when supporting them to transfer between chairs and wheelchairs or when they used a hoist to transfer people. We heard a staff member encourage one person to put their feet onto the foot rests of their wheelchair before moving them. One person did not wish either of the choices of the main meal for lunch and we heard a staff member take time with the person suggesting different foods they may prefer instead, until the person settled on a pudding which they received. On the second day of inspection a staff member sat beside one person to help them eat and we heard them chatting to the person about the food. One person told us, "I have not seen one member of staff not be respectful or lose their patience."

We observed occasions where people's individual ways of communicating were recognised by staff. One person was unable to verbally communicate and their care plan recorded, 'use the pictures or ask them to write things down'. We noted a selection of pictures in their room depicting simple requests. We also saw a note pad in which they had written requests to members of staff. A staff member told us, "I am always smiling with people and communicate with them to make them feel they're in their own home." The majority of staff knelt or sat beside people when they were talking to them to gain eye contact.

People were encouraged to be independent with the exception of the example where a member of staff took a drink cup from someone to help them despite them managing this on their own. We saw throughout our inspection that people were able to move around their individual unit without restriction. We observed

people walking together down corridors or choosing to sit in areas of the unit, other than the communal lounge. A staff member told us, "If someone doesn't want to eat or walk, I try to encourage them so they do it themselves." We observed one staff member encouraged someone to start eating by supporting them with the spoon. They gradually withdrew their support when the person understood what was happening and left them to eat independently.

We found that concerns regarding the environment identified during our last inspection had been addressed. All units were now decorated to a good standard with pictures and comfortable furnishings. People's rooms were personalised with pictures and objects which were important to them. Each person had a name plate on their door which contained a recent photograph to help people identify their room.

Requires Improvement

Is the service responsive?

Our findings

At our inspection in October 2016 we found that care was not always based on individual needs, care plans were hand written and inconsistent in their approach and care plans in relation to specific medical conditions were not in place. At this inspection the general manager informed us that all care plans were in the process of being renewed and a new format was being used. We were told approximately 50 of the 72 care plans had been updated. They said they planned to continue to develop the care planning process with the assistance of healthcare professionals. We found that improvements had been made although some people's care plans still lacked detail and staff did not always follow the guidance in place.

Care plans contained information on a person's mobility, communication, nutrition, skin integrity, life history, oral health needs and continence. Newly updated care plans were more detailed and contained additional information and guidance for staff. However, we observed a number of gaps in people's care plans which may put people at risk of not receiving the care they required. On the first day of our inspection we found one person who had recently moved into the home did not have a care plan in place and another person who had been in the home for three weeks had a large amount of their care plan not filled in. We spoke with the general and registered manager about this and noted on the second day of our inspection these people's care plans had been completed.

Although the majority of staff were aware of people's needs, we found that care plans did not always contain sufficient and accurate information. One person had a catheter fitted, however the continence assessment in their care plan was blank and there was no guidance for staff on how the person should be supported with this. Later in the care plan staff had written, 'silicone catheter'. Another person was visually impaired, however their care plan did not make mention of this in relation to their mobility or how staff should approach them. A third person had recorded in their care plan that they were continent, however this was not correct. Another person who was fully mobile had written in their care plan, 'encourage mobility and repositioning twice hourly during the day and four hourly at night'. This meant staff may not know the most up to date information about these people. The writing in some care plans was very difficult to read which would make it hard for staff, particularly new or agency staff, to understand a person's requirements.

People did not always receive responsive care. One person looked very uncomfortable as they were leaning over to one side in their chair. They kept calling out, wincing and putting their hand over their ear in pain. A staff member asked them what was wrong but did not take time to adjust the person's seating. We asked the person if they were uncomfortable and they told us they were. They said that their neck hurt and that was why they were putting their hand over their ear. We asked the staff member if they could support the person to adjust their position which they did. The person said to the staff member, "That feels good." Another person required, 'prompting/close supervision' when eating. However at lunch time we observed staff sit with their back to this person which meant they were not aware of what they were eating. A relative told us, "Some of the staff are brilliant, but new staff sometimes are not aware of (their family member's) needs or how she takes her drinks." They added that when new staff did not know their family member's routine they became agitated and vocal.

Records of people's care were not person centred. We reviewed the records maintained by staff of the care they had provided to people. We found that notes were task orientated and did not contain details of how the person had spent their day, when they had received visitors, their mood or how they had responded to interactions. This meant staff did not have a holistic understanding of people's care in order to monitor their well-being. The general manager told us they were looking to access training for staff on report writing in order to develop their skills

The failure to ensure people's care was planned and delivered in a person centred manner in line with their needs was a continued breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's care plans contained information regarding the people's past history and preferences. The general manager told us that staff had worked with people and their families to gain information about their working life, family, significant events, hobbies and interests. The information was presented in a clear format using person centred language. We read in one person's file that the person loved to watch football. We observed staff talking to the person about which team they supported and their memories of different matches. Another staff member talked to a person about their family members and the careers they had chosen.

People told us they were happy with how they spent their time. One person told us they spent time reading, watching television and enjoying the view from their window. Staff told us they felt things had improved in relation to activities for people and that there was more going on. They said that although there was a co-ordinator it was up to care staff to do things with people as well. One staff member said, "Carers do activities now too."

People had access to a range of activities in communal areas although people spending time in their rooms were not always catered for. During the inspection staff did not engage in activities with people who needed to spend the majority of their time in their rooms which put them at risk of isolation. One person's care plan stated, 'Unable to assess' in relation to activities and, 'Unable to take part in any activities'. There was no record that staff spent time with the person unless they were supporting them with their care. A relative told us they felt there was a lack of stimulation for their family member and staff did not take time to take their family member into the lounge area.

The failure to ensure people were provided with activities in line with their individual needs was a continued breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were activities taking place in individual units. This included staff playing cards with people, playing ball games or hosting a game of bingo. During the morning in one unit we saw a bingo game taking place and five people were engaged in participating. In another unit a staff member played a ball game with three people. There was a lot of laughter and people were clearly enjoying it. One person sat in the same room doing a jigsaw and a further person said they wished to watch the television. Other people sat reading the newspaper or looking at books. One person told us they had played skittles and giant dominoes and took part in the weekly knitting club. They said they had also tried painting by numbers and enjoyed when the dog came to visit. Activity staff were supporting people to decorate photos for their rooms. When they left the area to get snacks one person was heard to say, "She's so good, absolutely lovely."

Complaint information was made available to people. This was displayed in the lobby of the home and provided information to people on what they could expect in response to a complaint. It also provided details of people they could go to if they were unhappy with the response they received. We checked the

complaints folder and saw that no written complaints had been received by the registered manager since our inspection in 2016. One person said they had not had cause to complain but, "If something is not right I can speak to the staff or manager and make a complaint. If I don't like one of the staff member's attitude I would say so." A relative told us, "Staff do come and go but generally I have no complaints."

Inadequate

Is the service well-led?

Our findings

At our inspections in September 2015 and October 2016 we found a failure to maintain accurate, contemporaneous care records and a failure to carry out quality audits in order to improve the service people received. At this inspection we found that although some improvements had been made there was a general lack of management oversight and a failure to act in a timely way to improve the service for people or to meet regulations . There was an ongoing failure by the registered manager or the provider to implement an effective system to recognise continued failures or to put these right.

We found there was a lack of effective leadership in the service which meant that the improvements required to ensure people received safe, caring and responsive care had not been fully met. The supervision of staff was not effective in identifying concerns regarding the care people received. The registered manager and senior staff conducted periodic observations of staff although these were not recorded in detail and there was no system in place to monitor which staff had been observed. Clinical staff were responsible for the supervision of staff but there was no evidence they received guidance or training from the registered manager or the provider on how this should be done to ensure all staff were monitored in their performance. . The registered manager and general manager told us that clinical staff continued to struggle with their understanding of record keeping and care planning. They were unable to tell us how they were supporting staff to improve their skills.

Following our inspection in October 2016 the general manager had asked for support from the Surrey Quality Assurance Team. As a result the registered manager had been receiving support from a team of healthcare professionals for eight weeks to review the care people received. We asked the registered manager what they had learnt from this process and what skills they would be able to take forward. The registered manager was unable to answer our question in detail. They told us they had learnt that staff competency needed to be assessed to ensure they were doing what they should be doing and processes should be embedded. However, there was no evidence to show how the registered manager had acted upon this learning.

There was no audit procedure or schedule in place to ensure the quality of the service was systematically reviewed. The manager provided us with a paper file which contained various audit and review notes. The majority of these were written on blank paper with no format in place to show what should be checked and when. This meant that although the registered manager and provider had implemented new systems they were not checking that these were effective in providing staff with guidance regarding people's care. For example, despite our concerns at the last inspection regarding the information contained in people's care plans, only four people's care plans had been audited. Three of these audits were handwritten lists of the different sections of the care plan which were ticked to say if information had been completed. However, the quality of the information was not assessed and the concerns we found had not been identified. There was no evidence that the provider had conducted any audits of the service since our last inspection.

Accidents and incidents were not reviewed on a regular basis to ensure that measures were implemented to prevent reoccurrence and to identify trends. On the first day of the inspection the registered manager told us

that periodic reviews of accidents and incidents were conducted. Records showed that no reviews had taken place since the last inspection. On the second day of our inspection the registered manager had collated all the incident and accident forms between October 2016 and February 2017. However, the review was written on forms designed for another purpose and did not give a comprehensive overview of the action taken to mitigate risks to people's safety.

The provider did not provide effective support to the registered manager and had failed to implemented systems to ensure people received a safe, effective, caring, responsive and well-led service. There was no evidence that the provider had taken action in response to the concerns identified in previous reports or in response to the warning notice issued. The provider had not conducted any quality audits or on-going monitoring of the service since our last inspection. The registered manager told us that they felt supported by the provider although they did not receive any formal supervision. They told us that working for a small organisation presented them with challenges. They said, "It can be difficult being just the one service in the area with no head office to refer to for help." The provider told us they had spoken to the registered manager regarding their workload and the general manager had taken on tasks to support them. However, they had not taken steps to monitor the registered managers performance and ensure they had the skills and resources they required within their role.

Staff meetings were held regularly although these were not recorded effectively. One staff member told us there was a weekly staff meeting so the registered manager could update them with any new information. This took place with the weekly fire drill. The notes were kept in a folder, together with relative's meeting notes but they were not filed in date order and did not follow any set agenda. Minutes were not clear and lacked detail, making it difficult to determine what had been discussed. In addition there was no information on which staff were present at these meetings which meant the registered manager could not satisfy themselves that all staff received any new information.

People and relatives were not supported to be involved in the running of the service on a regular basis or in a meaningful way. We were told that meetings were held annually and the last meeting, held in August 2016, focussed mainly on food tasting. The registered manager and general manager told us meetings were held annually as it was difficult to engage people and their relatives. There was no evidence to show that different methods had been tried to increase attendance or ask people and their relatives how they would like to be involved. However, relatives did tell us that managers were available to discuss any concerns. One relative told us, "(The registered manager) is always around and the general manager is always available and supportive." Another relative said, "(The registered manager) is very accessible."

Records relating to the care people received were not always comprehensive or detailed. As reported daily records of people's care were not person centred and people's care plans were not always completed in a detailed, accurate and timely manner. People's healthcare records were not always updated with the outcomes of visits by professionals. The registered manager told us that one person had seen their GP and community psychiatric nurse following an incident. Although the measures recommended by the professionals had been implemented there was no record of their visits. This meant that people were at risk of not receiving the care that they required and that their health and well being could not be accurately monitored and adjusted. When we spoke to the registered manager about this they told us that healthcare professionals had been asked to update people's records. This showed a lack of awareness that it is the responsibility of the service to ensure that records were accurately maintained.

The training completed by clinical staff was not accurately recorded. The training matrix did not include training specifically for clinical staff. The general manager informed us that regular training was provided to nurses to keep their knowledge updated in areas including pressure care, phlebotomy (the taking of blood)

and epilepsy. They provided evidence that the courses had been held although there were no records to show which clinical staff had attended. The general manager told us that they would ensure that clinical training would be added to the training matrix.

The failure to assess, monitor and improve the quality and safety of the service and to maintain complete and contemporaneous records was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our inspection in October 2016 we found a failure of the registered manager to notify the commission without delay of incidents/accidents as per the requirements of their registration. At this inspection we found that improvements had been made in this area and the registered manager had notified the CQC of all significant events that had occurred in the service in a timely way. This meant we were able to check that appropriate action had been taken when necessary.

Relatives and other stakeholders were asked to give their feedback about the service on an annual basis. The service completed an annual survey to gain stakeholders views on the service. The last survey highlighted concerns regarding the food provided. The service offered a taster session to relatives and reviewed the menu's offered. This had led to an increase in people's satisfaction regarding the food available.

We asked staff if they felt supported by the registered manager. One staff member told us, "I feel supported. I can talk to him and he listens." Another said, "I feel valued because of the way he talks to me. I go straight to him if I have any concerns and he listens."