Mr & Mrs J Dudhee

Cheam Cottage Nursing Home

Inspection report

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Ratings

Overall rating for this service	Inadequate
Is the service safe?	Inadequate
Is the service effective?	Requires improvement
Is the service caring?	Requires improvement
Is the service responsive?	Requires improvement
Is the service well-led?	Inadequate

Overall summary

This inspection took place on 9 and 10 December 2015 and was unannounced. At our last inspection on 25 November 2014 we found the provider was meeting the legal requirements we checked.

Cheam Cottage Nursing Home provides accommodation with personal and nursing care for up to 19 older people many of whom were living with dementia. During our inspection there were 19 people using the service.

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 2008 and associated Regulations about how the service is run.

The provider did not have effective arrangements to manage risks to people and others. People were at risk

Summary of findings

from scalding, falling from height and entrapment in bed rails from inadequate risk management processes. In addition other risks to people such as moving and handling and choking risks were not always adequately assessed and managed.

Medicines were not always managed safely and our checks indicated people did not always receive their medicines as prescribed. Auditing systems to pick up errors and ensure people received the necessary support with their medicines were not effective.

People were at risk from poor infection control procedures such as using one electric shaver to support several men to shave and sharing slings between different people. There was also a lack of cleanliness in some areas.

The provider did not operate robust recruitment systems to make sure people were only cared for by suitable staff who have been fully vetted. They did not always check and retain documentation in relation to proof of identity, address and any health conditions which may require reasonable adjustments to be made. However, other checks of staff were carried out such as of criminal records and employment history.

People using the service and their relatives felt it was safe. However, staff had a limited understanding of how to keep people safe, particularly suitable reporting procedures of allegations of abuse or neglect.

Care staff also had a limited understanding of their responsibilities under the Mental Capacity Act 2005. Although the provider had applied for and been authorised to deprive some people of their liberty as part of keeping them safe, we found one person who might have been deprived of their liberty because there were a number of restrictions on them. The provider and staff had not recognised this and had taken no action in regards to this.

Staff did not always receive the necessary support from the provider to carry out their roles. Records relating to training were incomplete and so we were unable to confirm staff had received recent training in topics relevant to their role. In addition records showed staff did not receive regular and frequent supervision and had not received appraisal in the last year.

People were not always supported appropriately in relation to their risk of malnutrition and with eating and drinking. The provider did not always incorporate professional advice into people's care plans. However, people received appropriate support in relation to their day to day health needs.

The provider did not always treat people with dignity or respect and we found several examples of poor practice relating to this.

The premises were not appropriately adapted for people living with dementia. We have made a recommendation for the provider to review the premises to make sure these were suitable to meet the needs of people with dementia.

Staff seldom interacted with people in a meaningful way and our observations showed they interacted with people mostly in a task-based way. People were at risk of social isolation, particularly those who spent the majority of time in their rooms. They were not supported to meet their religious and spiritual needs. There was little stimulation for people and few activities tailored to meet people's needs. We have made a recommendation for the provider to review the provision of suitable activities for people with dementia.

A suitable complaints procedure was in place and people and their relatives told us they were aware of it and would complain if they had reason to.

The service was not well-led. Leadership across the home was lacking and the registered manager did not identify and address opportunities to improve care practices. Shifts were poorly planned and several required tasks were not always delegated or carried out. Audits for the provider to assess, monitor and improve the service were inadequate or lacking altogether for some aspects of service provision. The audits were also ineffective in that they had not identified the various areas for improvements we found during our inspection, some of which were putting people at risk of harm.

The provider had made some arrangements to support people with their end of life care needs. People and their relatives were encouraged to make plans for their end of life care and the provider liaised with the local hospice for support with this.

Summary of findings

We found a number of breaches of regulations during this inspection relating to safe care and treatment, person-centred care, meeting nutritional and hydration needs, dignity and respect, safeguarding and good governance. You can see the action we told the provider to take at the back of the full version of this report in relation to safeguarding, dignity and respect, meeting nutritional and hydration needs and person-centred care. Because of our serious concerns in relation to the breach of regulations about the safe care and treatment of people and good governance we took enforcement action which you can also read about at the back of the full version of the report.

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.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe. People were at risk from scalding, falling from height, entrapment in bed rails and other risks due to inadequate risk assessment processes.

People were also at risks from poor medicines management and infection control practices.

The provider did not carry out all the necessary employment checks on staff before they started work.

The provider did not have robust arrangements to ensure people were protected from the risk of abuse. Staff had a limited understanding of how to keep people safe from abuse and neglect, particularly reporting procedures.

Is the service effective?

Requires improvement

The service was not always effective. The provider did not always support people at risk of malnutrition appropriately. Staff did not receive the necessary support from the provider to carry out their role through supervision, training and appraisal.

Staff had a limited understanding of their role in relation to the Mental Capacity Act 2005. Although the provider had applied for authorisation to deprive many people of their liberty lawfully, they still might have been depriving one person of their liberty unlawfully because the provider and staff had not recognised that the person was being subjected to a number of restrictions which could have amounted to a deprivation of liberty.

The premises were not well adapted to support people living with dementia.

People were supported appropriately with their day to day health needs.

Is the service caring?

Requires improvement

The service was not caring. On some occasions staff did not treat people with dignity and respect or did not take action where necessary to maintain their comfort.

People were not always treated with dignity and staff interacted with people mainly to carry out tasks instead of interacting with them in a meaningful way.

Is the service responsive?

Requires improvement

The service was not always responsive. There were few activities and little stimulation provided for people. There was no focus on tailoring activities to suit the needs of people living with dementia. People were not supported adequately to have their religious and spiritual needs met.

People were not always involved in assessing and planning their care.

Summary of findings

A suitable complaints system was in place and people and their relatives told us they knew how to and would complain if necessary.

Is the service well-led?

Inadequate 

The service was not well-led. There was a lack of leadership in the home and the registered manager did not always recognise poor practice and did not take action to address this.

The provider did not have robust audits and the issues we found, some of which put people at risk of harm, had not been identified by the provider through their auditing system.

The provider did not have effective systems to gather feedback from relevant people so this can be used to improve the service.

Cheam Cottage Nursing 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 inspection took place on 9 and 10 December 2015 and was unannounced. It was undertaken by an inspector, an expert by experience and a specialist (a registered nurse). An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service.

Before our inspection we asked the provider to complete a Provider Information Return (PIR). The PIR is a form we asked the provider to complete prior to our visit which gives us some key information about the service, including what the service does well, what they could do better and improvements they plan to make. We reviewed this, as well as other information we held about the service and the provider. We also contacted a local authority contracts and quality assurance officer and a district nurse who told us their views of the service provided to people.

During the inspection we observed how staff interacted with the people who used the service. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We spoke with six people who used the service, one relative, the registered manager, the two nurses, the chef, the domestic assistant and two care workers. We looked at five people's care records, five staff recruitment files, medicines records and records relating to the management of the service.

Inadequate

Is the service safe?

Our findings

The provider did not have suitable arrangements to help ensure the health and safety of people who used the service and others. People were at risk of scalding from hot water. This was because the service had not identified, assessed and managed risks relating to people's health and safety satisfactorily. We tested hot water temperatures in three people's bedroom sinks and a communal bath and sink and found them all to be above 50°C. This is above the temperature recommended by the Health and Safety Executive "Managing the risks from hot water and surfaces in health and social care". If people are exposed to hot water above 44 °C for either washing, showering or bathing, they are at increased risk of serious injury or fatality.

Records showed the provider tested hot water temperatures weekly but we found these records were unreliable. During our inspection we observed a nurse recording hot water temperatures from memory for the day before our inspection. When we compared our tests' findings with these records we found they were greatly different. The provider's records showed hot water temperatures were safe when they were actually dangerously hot. The provider was unable to explain this. During our inspection we asked the provider to rectify this issue urgently to keep people safe.

The provider was not able to provide suitable equipment to test the hot water appropriately with only room thermometers with a maximum temperature of 50°C. This meant the provider was unable to accurately test the temperature of the hot water.

People were at risk of falling from height through windows. We saw that the provider had not carried out an adequate risk assessment and had not identified suitable control measures to minimise the risk of people falling from windows. The provider had installed window restrictors on some windows, but not all, to reduce the risks of people falling from height. We also found that the restrictors in place could be overridden by unscrewing them by hand, which meant that the windows could be fully opened. The Health and Safety Executive in its Guidance 'Falls from windows and balconies in health and social care' on pg. 2 states 'Window restrictors should ….be robustly secured using tamper-proof fittings so they cannot be removed or disengaged using readily accessible implements (such as cutlery) and require a special tool or key.' We informed the provider of our serious concerns and they told us they would address these.

A person was at risk of becoming trapped or injured in their bed. This was because the provider had inadequate processes to assess and manage risks arising from bed rails. We found one person's mattresses did not fit their bed frame correctly and the resulting gaps between the mattress and bed rails were large enough for them to become trapped and as a result of which they could sustain injuries. The provider showed us a monthly risk assessment they carried out relating to bed rails. However, this was inadequate as it had not identified the risks we found relating to this person's bed and how these were to be managed.

People's choking risk assessments and management plans lacked clear guidelines for staff to follow to reduce choking risk, including guidance on diets such as soft or pureed. One person's care documentation guided staff to provide soft or pureed food. However, these are two very different consistencies provided for different needs. In addition, this person was seen by the speech and language (SLT) team regarding swallowing difficulties yet their care documentation had not been updated to include the professional advice provided.

Several doors preventing people accessing various hazards were left unlocked during our inspection, despite us informing the provider of our concerns verbally during our inspection. These included doors to the hazardous chemicals cupboard, all machinery in the laundry, contaminated waste in the sluice and a ground floor fire door with access to the road. The fire doors had a suitable locking mechanism linked to the fire alarm which was disabled in the event of a fire to keep people safe. However, during our inspection we observed a ground floor fire door leading to the road was repeatedly left unlocked. This meant the provider was not keeping people safe by managing these risks adequately.

Risks to people of being exposed to cold had not been considered and adequately assessed and managed. During the first day of our inspection outside temperatures were around 11°C. While communal lounges were warm we found people's bedrooms and hallways around the home were cold as many windows had been left open. Four people were in bed for most of our inspection and so were

exposed to these cold temperatures. We raised our concerns with the provider and when we returned the following day we found temperatures across the home were suitable.

The provider had not suitably assessed some risks to individuals and had not put suitable management plans in place for staff to follow in reducing risks such as those relating to moving and handling, choking and incontinence.

Risk assessments and risk management plans for moving and handling people were incomplete as they did not detail the type of equipment required to move people where they could not mobilise and these did not guide staff on the steps to take to move people safely.

In addition there was a lack of choking risk assessments and management plans for people. We did not see any choking risk assessments in any people's documentation we looked at, even though a few had been identified as at choking risk by speech and language therapists.

People and their relatives made positive comments about medicines management. One person told us, "Yes, I get my tablets when I should." Notwithstanding what people and their relatives told us, we found that the provider did not manage medicines safely. Our stock checks showed that the quantity of medicines expected to be in stock did not match the actual quantity in stock. This could suggest that some people had not received their medicines as prescribed even though staff had signed for these, and one person had received too much of a medicine, because there was less in stock than what should be expected.

We also found some medicines received by the home were not recorded to provide a clear audit trail about the way the medicines were managed. The provider carried out some audits to monitor the management of medicines but these could not have been effective if the quantity of medicines received were not recorded.

We found one tablet out of its foil wrapper during our checks. This medicine requires packaging in foil and we could not be sure how long it had been stored outside of the foil wrapper, and whether it was still effective and safe to take. When we raised our concerns with the nurse picked it up by hand and returned it to its box, instead of removing it and seeking advice from the chemist whether it was safe to take that medicine.

Where people were prescribed 'as required' medicines, the provider lacked individual protocols for staff to refer to, to guide them when to administer these medicines. For example, a person's paracetamol had no information about the maximum dose, specific indications and reasons for administering the medicine or when this should be reviewed.

The medicines policy for staff to refer to within the medicines file was out of date and contained some information relevant only to a previous supplying pharmacist. In addition the service's copy of the BNF, a reference book used by g staff to check information on medicines was from 2009. This meant staff did not have an accurate and up to date reference manual to guide them when necessary.

Although staff received some medicines training, the provider did not carry out competency assessments to check staff were safe to administer medicines to people. However, NCIE guidelines 'Managing medicines in care homes' 2014 states staff should only administer medicines when they have been assessed as competent by the care home provider.

People and their relatives were satisfied with the standards of cleanliness in the home. One person told us, "The Home is clean, it's very nice". However, we found people were not always protected by safe infection control procedures and good cleanliness standards. We observed a staff member shaving a group of men. They told us they were using the service's electric shaver for all the men and this was usual practice. However, the risks of the spread of infection from this had not been considered. In addition, slings for hoisting people were also communal which meant people were at risk from the spread of infections carried via the slings. Although staff told us the home was cleaned daily by a domestic assistant, and we observed cleaning in process, this cleaning was not always effective. We observed black mould had accumulated in a large soap receptacle in the bath and on the items within it and this had not been noted. We notified the provider about this.

These issues were breaches of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

One relative told us, "I think there are enough staff." However, our observations were not always in line with this. For example in one person's care plan we saw staff

Inadequate

Is the service safe?

were guided to observe them due to risks related to them being unsupervised yet there were several periods when they were left unsupervised. The provider informed us they would review this.

Staff recruitment was not always robust. The provider did not always check staff identification, proof of address and did not consider the applicant's health conditions to make sure they were suitable to fulfil their roles. . The provider told us they would get the necessary documentation in place for all staff. There was evidence that the provider carried out other recruitment checks including criminal records through a DBS check as well as employment history with references and evidence of the right to work in the UK.

People told us they felt safe at the home with typical comments including, "Yes, I do feel safe." However, staff we spoke with had a limited understanding of how to keep people safe from abuse and appropriate reporting procedures. For example a nurse did not indicate, even with prompting, that they would report suspected abuse. Staff had not all received recent training in safeguarding people from abuse to ensure their knowledge on this was current and they were able to safeguarding people in the right ways.

Besides the inadequate premises and equipment checks referred to above, other checks of the safety of the premises and equipment were carried out appropriately. External contractors tested lifting equipment such as the lift, hoists and slings. They also tested the fire system. Portable electrical appliances and electrical installation had been tested, as had gas safety. The provider carried out internal checks of the fire system to make sure these were in working order.

Requires improvement

Is the service effective?

Our findings

People told us they enjoyed their meals and the portion sizes were good. One person told us, "The food is alright." However, we found a few instances where people were not appropriately supported with eating and drinking according to their preferences and choices. Although there were set times for hot beverages people were usually left without access to fluids in between these times. One relative told us, "I bring in juice and give it to [my relative] when I am here." The provider had also not ensured people were assessed in regards to equipment they might need when eating. We saw that there were no plate guards or adapted cutlery for some people who might have benefited from these to help them maintain their independence while eating.

Some of the arrangements in place to ascertain people's needs and choices in relation to their meals were not effective. The chef was unable to communicate in English and so was unable to answer any questions to show they understood different types of diets. In addition, our discussions with other staff showed they lacked understanding of different diets and consistencies. One nurse incorrectly told us a soft diet was, "Almost watery". When we asked a care worker what food was provided for people who were diabetic they were unable to answer properly and asked that we ask the registered manager instead.

The provider did not always take appropriate action when people were losing weight. Records showed a person's weight was 11.2kg below their target weight, as determined by a dietician, at the time of our inspection. The provider had supported the person to see a dietitian in August 2014. However, the person's weight had continued to drop each month and they had lost 8.1kg over 14 months since they saw the dietitian. The provider had taken no further action to support them to manage the weight lost and to reduce the risk of malnutrition. The person's monthly care plan reviews stated the person was eating and drinking well with no acknowledgement of their continued weight loss. The provider told us they were not concerned about their weight loss as they had recently been placed on end of life care. However, this did not account for their lack of action to help maintain the person's weight and nutritional state. In addition the provider had not followed the Mental Capacity Act 2005 in determining that this was in the person's best interests.

Records showed another person had lost 9.5kg in the nine months prior to our inspection. Their monthly care plan reviews also stated they were eating and drinking well with no acknowledgement of their weight loss or any action taken regarding this. However, their care plan also stated they required encouragement from staff while eating. We observed a mealtime and saw the person appeared confused about how to eat and drink, trying to drink from an empty cup they held upside down and using their eating utensils incorrectly. We observed staff did not provide any encouragement to them while they were attempting to eat and they did not complete their meal. We queried this with the provider who told us the person preferred to be left to manage independently when eating, contrary to their care plan. The provider also told us they were not concerned about this person's weight loss as their BMI was 21.6, above the level of 18 which would trigger them to refer him for further support. However, the person had unintentionally lost 16% of their body weight in this nine months and so were classed as being in a malnourished state according to National Institute for Health and Clinical Excellence (NICE) 'Nutritional support in adults' NICE, 2006. This guidance states unintentionally losing more than 10% of a person's body weight in three to six months means they are malnourished and so require support.

These issues were in breach of regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Our discussions with staff showed their knowledge and understanding of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) was limited. Although staff told us they had received training in these topics records of training did not support this. 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 take particular decisions, any made on their behalf must be

Requires improvement

Is the service effective?

in their best interests and as least restrictive as possible. We observed staff did not always inform people and obtain their consent for tasks such as covering their clothes with clothes protectors before eating and drinking.

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). The provider had applied for, and been granted, authorisations to deprive several people of their liberty under DoLS. The provider had submitted notifications to CQC in relation to DoLS as required by law. However, we identified one person who may have been subjected to a number of restrictions which could have amounted to them having their liberty deprived unlawfully. The person's movement in the home was restricted as they were unable to operate the stair gate and lift outside their bedroom. When we raised our concerns with the provider they told us they would apply for authorisation as soon as possible.

These issues were in breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Although staff told us they received supervision regularly with the manager and a range of regular training this was not supported by records. Records showed a lack of regular and frequent supervision for most staff, with no records of supervision in the last 12 months for some night staff. There was no evidence of any staff receiving appraisals in the last year.

Some staff told us they had attended a range of training in the past year including moving and handling, dementia awareness, infection control and male catheterisation. The provider told us records of staff training were not up to date as many certificates for different courses had not yet been received. After the inspection they e-mailed us a document indicating all staff received training in ten key topics within the last year. However, we were unable to confirm this from the lack of certificates.

The home was not well adapted for people with dementia. There was a lack of directional signposting to help people navigate around the home and the service had not utilised colour effectively to help orientate people, for example corridors and doors were painted similar colours so people did not have a point of reference to orientate themselves. While some people's bedroom doors had signs on them to indicate they were bedrooms, the provider had not written names on the majority of these doors to help people identify their rooms. The provider had decorated the home to reflect it was Christmas time to help people appreciate the particular time of year.

Besides the concerns detailed above, people were supported to maintain their day to day health. One person told us, "If I needed the doctor, they would call him". Records showed people were supported to access health services such as the GP, optician and chiropodist.

We recommend that the service seek advice and guidance from a reputable source, based on current best practice, in relation to environmental adaptations for people living with dementia.

Requires improvement

Is the service caring?

Our findings

People and their relatives made positive comments about the staff. One person told us, "The people who work here are kind." A relative said, "The staff are very good, kind and respectful." However, we found that, while staff meant well, people were not always treated with privacy, dignity and respect.

The provider did not always treat people in a 'person-centred' way which focused on them as an individual. During our inspection we observed a staff member shaving men in the communal lounge with an electric shaver. The registered manager was aware of this and the staff member told us this was the usual location men in the home were shaved. Carrying out a personal care task in a communal area showed that staff and the provider had not considered how this could be a lack of respect for people's privacy and dignity.

We observed the provider used one person's bedroom for storage of various items which also showed a lack of dignity and respect. At the time of the inspection there were two zimmer frames and four wheelchairs stored in there. When a person returned from a trip out with their relatives we observed staff returned their wheelchair to this person's bedroom bringing the total number of wheelchairs stored in there to five. When we raised this with the registered manager they told us they were aware they should not do this and would remove the items.

Most staff had worked at the home for many years and knew people's preferences and people who were important to them, but had little knowledge of their life histories. Staff did not use their knowledge of people to engage with them in conversations or to use reminiscence aids they would be interested in, such as old photos and music. Throughout our inspection we observed staff engaged with people in a way that was usually task-driven, for example supporting them to the toilet and assisting them to eat. We monitored two people who spent all of their time in bed during out inspection and saw they had no engagement with staff except for personal care tasks, eating and drinking. A staff member told us, "We try to check on those residents in their beds." In addition there was no other stimulation provided in their bedrooms. When we queried this with the provider they told us one of these people liked to listen to music and they usually had music on. However, there was no music on in their room during our inspection.

The provider treated people with a general lack of care towards their comfort and personal appearance. We observed six men in one communal lounge for most of the day wore socks with no shoes or slippers. We queried this with staff who told us these men all took their shoes off and so it was their choice to wear only socks. However, we checked their care plans and saw this was not an identified behaviour or choice. Although people's clothes appeared clean and ironed we observed one person had a large hole in their jumper. We asked staff about this and they were unable to explain why they had not been supported to wear something more appropriate.

Four people were in bed for the whole of our inspections and we observed they were dressed in their day clothes. We queried this with staff who told us these people had all been supported to be washed and dressed at the start of the day and some of them had been sat in the lounge earlier in the morning. However, we observed these people were in their day clothes for seven hours, mainly sleeping, on the first day of our inspection. Staff could not explain why they had not helped those people to wear their bed clothes.

The above shows that people were not being treated with dignity and respect. These issues were in breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service received support from the local hospice in helping people plan their end of life care. The hospice representatives visited regularly providing staff training and supporting people and their relatives to complete 'looking ahead' plans, which were plans about how they wanted their end of life care to be carried out. The provider was working with outside professionals so that several people had their end of life care plans recorded as part of the 'coordinate my care' (CMC) project. This meant that healthcare organisations involved in their care, such as the GP, ambulance service and hospice could access information they needed at any time as part of coordinating their end of life care.

Requires improvement

Is the service responsive?

Our findings

People's care plans contained information about their individual preferences and interests but not their personal histories, aspirations, views on their strengths, levels of independence and what their quality of life should be. As a result, people's care plans did not fully reflect how they would like to receive their care, treatment and support and so this was not taken into consideration as part of planning their care. There was little evidence people, or those acting on their behalf, contributed to the assessment and planning of their care.

People's care plans for diabetes were insufficient in guiding staff to support them safely. They did not provide staff with clear guidance on the acceptable ranges of blood sugar for people, nor what the signs of low and high blood sugar were or what a suitable diet for them would consist of.

Some people's needs were not assessed appropriately, recorded and reviewed. For example, continence care plans were not always sufficient in supporting people appropriately as they did not detail the types and sizes of incontinence wear to be applied and how often they should be changed. Some people's continence management plans aims to promote continence were unachievable due to their level of dementia and associated incontinence which meant people were not always supported in the best possible ways. People's care plans in respect of specific mental health needs and behaviour which challenged the service included insufficient instructions for staff to follow in supporting people appropriately.

The provider carried out monthly care plan reviews for people. However these did not always refer to the progress being made in meeting the outcomes and goals of the plans of care. Staff often did not fully consider what had happened in the month during which the care plans were being reviewed, such as changes in people's weight and so the reviews were often ineffective.

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

People and their relatives told us there was not much to do in the way of activities. Typical comments included, "There's not much to do here" and, "There's not much going on." The provider did not have adequate arrangements in place to meet people's social and recreational needs with few activities or forms of stimulation suitable for people with dementia. The provider told us a musician visited twice a week and people sang songs with them, and staff engaged people in board games and dominos. Although there was an activities programme in place this was not followed during our inspection and we observed a lack of activities provided. In the afternoon people were encouraged to colour drawings and cut up magazines. Besides this TVs were left on to entertain people although we observed few people appeared interested in the TV. People did not have individual planned programmes of activities and were not supported to pursue their own hobbies and interests. There were also limited opportunities for outings. The registered manager told us they did not usually provide any day trips although in the summer staff supported some people to visit a local park.

People were not always supported to have their religious and spiritual needs met. The provider told us two people were usually supported to go to church by their families once a week. However, the provider had made no arrangements to support some people with their religious needs since a Catholic minister had stopped visiting some time ago.

One person was in bed throughout both days of our inspection. Their care planning documentation did not clarify why they stayed in bed for so long. Although there was a generic care plan regarding social isolation for this person, this was not individualised enough to show what was in place to prevent the risk of social isolation for that person. The registered manager told us the person was unable to sit in a chair due to their behaviour which challenged as they would 'jump out of the chair'. However, their care documentation referred to their immobility so we asked the provider to clarify this information. The provider then said that the person would slide out of the chair so it was safer for them to be in bed, although sometimes they were supported to come out for meals. There were no records to show that attempts had been made to assess the person for seating equipment to prevent them from sliding when seated. These issues meant this person's needs in relation to their social and recreational needs had not been fully assessed and planned for to ensure these were being met.

Requires improvement

Is the service responsive?

We observed the provider did not use mealtimes as an opportunity for social interaction. People were served at staggered intervals, usually remaining in their usual seats in the two lounges. However, two people were asked to come to the dining area after most of the other people had eaten. We observed they were both seated on tables by themselves facing the wall. We sat with them and noted they both immediately engaged with us, smiling as if appreciating the company. However, staff did not engage with them through their meal.

People and their relatives told us they had no complaints but knew how to complain if necessary. Typical comments included, "I've never needed to complain at all" and "I would speak up about something if needed". The provider had not received any complaints in the past year but a suitable complaints procedure was in place which was accessible to people.

We recommend that the service seek advice and guidance from a reputable source about activities and stimulation for people living with dementia.

Inadequate

Is the service well-led?

Our findings

People were not protected against the risks of poor care and treatment because the provider had inadequate processes to assess, monitor and improve the quality of the service for people. The provider had some audits or reviews in place for aspects of the service such as health and safety, care plans and risk assessments and medicines management. However these were not comprehensive and had not identified the issues we found, some of which put people at serious risk of harm. A comprehensive health and safety audit was last carried out in December 2014 and this had not been carried out when it was due in June 2015. The health and safety checks had not included window restrictors and bed rails safety. In addition, our findings indicated records of hot water checks may not have been recorded correctly. Systems in place had not identified the service was putting people at serious risk of scalding. There were no recent audits in place which could have identified the issues we found relating to issues such as staffing, recruitment, DoLS, supervision, training and appraisal, how suitable the premises were for people with dementia, how caring the service was and how responsive it was to people's needs. This lack of auditing meant the provider was unable to identify and manage the failings of the service.

The provider did not always seek and act on feedback from people using the service, their relatives, staff and professionals involved in the service. Records showed residents meetings were held occasionally and at the last meeting in September 2015 people's views on how they should celebrate Christmas were gathered. Relatives told us they were not aware of any relatives meetings held at the home to gather their views. Questionnaires gathering feedback from residents and relatives had last been carried out in early 2014 and of professionals in 2012. The brief results of a questionnaire sent to staff in 2015 were available and this stated the only action required was relating to training and that this would be actioned 'ongoing'. The provider had compiled an annual development plan for 2015 which identified activities as an area for improvement. The provider had also identified transport for activities to be in place by June 2015 although this had not been acted on. It was not clear how the provider had identified these areas for improvement as it did not appear to be from feedback from relevant persons.

A relative told us, "The manager is OK and all the staff are approachable." The registered manager was also a director of the service and had managed the home for over a decade as a registered nurse. However, our findings indicated the registered manager was not fully aware of their responsibilities in ensuring they provided a high quality and safe service to people.

The registered manager was supported by a team of senior staff who were nurses as well as care assistants, a maintenance person, domestics and chefs. Our findings indicated that staff were also not aware of their responsibilities in meeting people's needs in a safe, effective, caring and responsive way.

During our inspection we observed the registered manager to be frequently carrying out caring duties in the service. While they were visible in this way, leadership in the home was not visible. We observed several occasions when the registered manager observed poor practice and ignored it. When we observed and challenged a nurse recording hot water temperatures taken the previous day from memory the registered manager supported them, telling us their findings were likely to be accurate as they had worked at the home for many years. In addition, when we observed staff shaving a group of men in the communal lounge the registered manager also saw this and ignored it which indicated it was usual practice. When we raised concerns with the provider such as people being in bed all day in their day clothes and people being in bed without a valid reason for long period their comments indicated they found these issues to be acceptable. Although a senior member of staff was delegated as shift leader for each shift we found shifts lacked clear plans with effective delegation and oversight. We found tasks were not all clearly assigned and carried out as necessary, such as spending time interacting with people across the home, including those in their rooms.

These issues were a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **The registered person did not ensure that the care and treatment of people was appropriate, met their needs and reflected their preferences. They did not design care or treatment with a view to achieving people's preferences and ensuring their needs were met.** **Regulation 9(1)(a)(b)(c)(2)(3)(a)(b)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect **The registered person did not ensure people were treated with dignity and respect.** **Regulation 10(1)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **The provider did not ensure that all people were protected from the risks of being deprived of their liberty for the purpose of receiving care or treatment without lawful authority.** **Regulation 13(5)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs

This section is primarily information for the provider

Action we have told the provider to take

The registered person did not ensure the nutritional and hydration needs of people were met as part of their care by supporting people to eat and drink and determining the best interests of people as part of this.

Regulation 14(1)(2)(a)(i)(b)(4)(d)(5)

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Care and treatment was not always provided in a safe way for people through assessing the risks to the health and safety of people of receiving the care or treatment; doing all that is reasonably practicable to mitigate any such risks; ensuring that the premises and equipment are safe and used safely; the proper and safe management of medicines and assessing the risk of, and preventing the spread of, infections. Regulation 12(1)(2)(a)(b)(d)(e)(g)(h)

The enforcement action we took:

We used our enforcement powers to request the provider to send us reports of audits of the following by **Friday 14 January 2016, 5pm:**

(a) a health and safety risk assessment of the premises to ensure the premises are safe to use for their intended purpose and are used in a safe way for providing care or treatment, including an assessment of hot water temperatures in all outlets to which service users have access, all window restrictors, room temperatures and areas to which service users may have access which may present risks.

(b) health and safety risk assessments of the use bed rails.

(c) all service users' risk assessments and risk management plans, including moving and handling, choking risks and diabetes.

(d) medicines

In addition we imposed the following condition on the provider's registration:

The registered provider must undertake monthly audits which must include audits of the following:

(a) health and safety risk assessments of the premises to ensure the premises are safe to use for their intended purpose and are used in a safe way for providing care or treatment, including assessments of hot water temperatures in all outlets to which service users have access, all window restrictors, room temperatures and areas to which service users may have access which may present risks.

(b) health and safety risk assessments of equipment used for providing care and treatment to service users, including the use of slings and bed rails.

(c) all service users' risk assessments and risk management plans, including moving and handling, choking risks and diabetes.

(d) medicines

The registered provider must send to the Care Quality Commission ("the Commission") a report which states the action taken or to be taken as a result of these audits which report is to be sent to the Commission every month , the first report to be sent 28 days after the date on which this condition takes effect . This condition will remain in place for six months from the date this condition takes effect. This condition takes effect from 10/03/2016.

Regulated activity	Regulation

This section is primarily information for the provider

Enforcement actions

Accommodation for persons who require nursing or personal care

Treatment of disease, disorder or injury

Regulation 17 HSCA (RA) Regulations 2014 Good governance

The registered person did not have effective systems and processes to assess, monitor and improve the quality and safety of the services and to assess, monitor and mitigate risks relating to the health, safety and welfare of people. The registered person did not always seek and act on feedback from relevant persons and other persons on the service provided for the purposes of continually evaluating and improving the service.

Regulation 17(1)(2)(a)(b)(e)

The enforcement action we took:

We used our enforcement powers to request the provider to send us reports of audits of the following by **Friday 14 January 2016, 5pm:**

(a) a health and safety risk assessment of the premises to ensure the premises are safe to use for their intended purpose and are used in a safe way for providing care or treatment, including an assessment of hot water temperatures in all outlets to which service users have access, all window restrictors, room temperatures and areas to which service users may have access which may present risks.

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