Mr & Mrs J Dudhee

Cheam Cottage Nursing Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 16 and 21 June 2016 and was unannounced. The last Care Quality Commission (CQC) comprehensive inspection of the home was carried out on 9 December 2015 when we found that the provider was in breach of six regulations. These related to person-centred care, dignity and respect, safe care and treatment, safeguarding people from abuse, meeting nutritional and hydration needs and good governance.

We rated the service as 'Inadequate' and placed it in special measures. The special measures framework is designed to ensure a timely and coordinated response where we judged the standard of care to be inadequate. The purpose is to use our enforcement powers and work with or signpost to other organisations within the care system to make sure providers significantly improve the quality of service they provide within a determined timeframe.

We had serious concerns regarding the provider's failure to meet legal requirements in relation to good governance and the safe care and treatment of people and in response to this we imposed two conditions on the provider's registration that they were legally required to take into account when providing a service. The first condition requires the provider to carry out comprehensive audits of health and safety aspects within the home and the second condition requires the provider to send to the CQC reports of the audits undertaken and any action the provider was taking as a result of the findings of the audits. The provider also sent an action plan telling us they would address all of the shortfalls we identified.

As part of this inspection we checked the improvements the provider said they would make in meeting legal requirements and collected evidence to provide a rating for the service. We found that the provider has made enough improvements for none of the key questions to be rated inadequate. The service will therefore come out of special measures, however it is also rated 'Requires Improvement' in all key questions and overall.

Cheam Cottage Nursing Home provides residential and nursing care for up to 19 people who may be living with dementia. At the time of our visit there were 13 people using the service, 12 of whom had been diagnosed with dementia.

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

The provider had taken action to address many of the shortfalls we found at our previous inspection in relation to the assessment and the management of risks, but we found that people were still at risk because the provider was still not carrying out comprehensive risk assessments and did not have suitable risk management processes. Some risk assessments were not sufficiently detailed or personalised to keep

people safe. We also found safety hazards in the home that the provider had not identified. We found a picture frame with broken glass in one person's bedroom that had not been noted by staff and addressed. Clinical waste was not appropriately stored prior to removal from the premises.

Although the premises were visibly clean and cleanliness checks were in place, we noted an odour throughout the ground floor of the home which made the environment where people lived unpleasant. People did not always have the support they needed to eat and drink because the provider had not arranged for people to be assessed for the use of appropriate aids. Records were not maintained accurately to identify and address the risk of people becoming malnourished. People were supported to choose from a variety of nutritious food and were offered adequate fluids.

People got on well with staff and the provider promoted positive caring relationships with the use of key workers and gathering information about people's preferences and life histories. However, this information was not always used to engage people in conversations or activities that reflected their interests and life histories. Staff did not have an adequate awareness of people's diverse needs and these were not reflected in people's care plans or activities. There was not sufficient support for people to meet their needs in terms of religion. Staff usually spoke to people in a respectful manner, but at times we observed interactions where they used inappropriate language. Staff offered people support and reassurance most of the time when they needed it, but did not do this consistently.

Staff were aware of the need to support people during personal care tasks in a way that promoted their privacy and dignity. However, staff did not always ensure that people's privacy and dignity were respected. Confidential records were left in communal areas. People did not always receive the support they needed to wear clean and well maintained clothing and that was their own.

People's care plans were personalised in places with information about what they enjoyed doing and what their interests were. There were systems in place to protect people from the risk of social isolation if they remained in their bedrooms during the day. Although the service provided regular group activities, we found that people were not offered activities that reflected their individual needs in terms of interests, life histories and hobbies.

The provider had improved the quality of their systems for auditing and monitoring the quality of the service. There were audits in place to check several aspects of the service on a regular basis. However, although the audits had been improved since our last inspection they were still not effective as they had not identified the issues we found during this inspection. Some records were incorrect, incomplete or insufficiently detailed for the provider to assure themselves that people were receiving good quality care.

We found that the provider had made progress and was regularly checking hot water temperatures so these fell within acceptable ranges. They had also taken appropriate action to help address the risk of people falling from a height by making sure windows had appropriate restrictors and from becoming trapped in bed rails by reviewing the beds and bed rails in use. Health and safety audits were in place to monitor these. They had also improved staffing levels to ensure there were sufficient numbers of suitable staff to keep people safe and their arrangements for the management of medicines.

The provider had taken steps to ensure that they were meeting the requirements of the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards (DoLS). This included carrying out sufficiently robust assessments of people's mental capacity in relation to making specific decisions about their care and consulting appropriate people, such as social workers and people's relatives, in making those decisions. We have made a recommendation for the provider to look for ways to better support people with dementia in

making decisions about their care.

People felt that staff were sufficiently knowledgeable and skilled to do their jobs. Staff received regular supervision, appraisal and training from the provider and were able to attend meetings to discuss their work and best practice.

People and their relatives were happy with the provider's response to any concerns they raised. There was a complaints policy in place and this was displayed for people and their relatives to see. There was evidence that people received support to access healthcare services when they needed to. The provider had begun work on adapting the environment to meet the needs of people living with dementia, such as orientation aids and memory boxes.

People, their relatives and staff had opportunities to give feedback and be involved in the development of the service. They felt that the provider listened to their opinions. The provider had systems in place to systematically gather feedback and use it to improve the service. They had a plan for improving and developing the service. However, we found that the provider did not always promote a culture that was empowering for people who used the service.

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, and good governance. In regards to safe care and treatment and good governance, we are continuing with our action in relation to the conditions of registration imposed on the provider that require them to carry out monthly audits and to send relevant reports to the CQC. We have taken further action against the provider for a failure to meet legal requirements in relation to person-centred care, meeting nutritional and hydration needs and dignity and respect. You can read about the action we have told the provider to take at the back 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

Some aspects of the service were not safe.

Although the provider had made improvements to address previous concerns, there were still shortfalls around assessing and managing people's individual risks because information was incomplete, unclear or insufficiently detailed. Clinical waste was not appropriately managed to reduce the risk of infection spreading and we found broken glass in one person's bedroom which could posed a risk to them.

There were processes in place to ensure medicines were managed safely and that the environment was kept clean.

The provider ensured there were adequate numbers of suitable staff to keep people safe.

Is the service effective?

Requires Improvement

Some aspects of the service were not effective.

The provider had not taken all reasonable steps to ensure people were protected from the risk of malnutrition. Some people did not receive adequate support to eat.

The provider had made improvements to address previous concerns around the requirements of the Mental Capacity Act (2005). Where people did not have the capacity to make decisions about their care, processes were in place to ensure that these were made in people's best interests.

Staff received supervision, training and other appropriate support to carry out their roles effectively.

People received the support they needed to access healthcare services.

Is the service caring?

Requires Improvement

Some aspects of the service were not caring.

People's privacy and dignity were not always respected. People were not always supported to wear clothing that was their own, clean and in good condition. Staff sometimes spoke to people in an inappropriate manner. However, people and their relatives were happy with the care they received.

Information gathered about people's individual interests and life histories was not always used effectively to promote positive caring relationships with people.

Is the service responsive?

Requires Improvement

Some aspects of the service were not responsive.

The provider did not always respond to people's needs in terms of their diverse backgrounds and religious beliefs. Activities were not tailored to people's individual interests although the provider did offer daily group activities. There were systems in place to protect people from the risks of social isolation.

The provider responded appropriately to concerns raised by people and their relatives and had a complaints procedure in place.

Is the service well-led?

Requires Improvement

Some aspects of the service were not well-led.

The provider had made improvements to address the issues we found previously and had introduced audits and checks to cover several aspects of the service. These were not sufficiently robust to identify further issues found at this inspection.

There were systems in place to gather and analyse the feedback of people, their relatives and staff. These were used to inform the development of 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 16 June 2016 and was unannounced. It was carried out by one inspector.

Before the inspection, we looked at the information we had about the service. This included previous inspection reports, notifications the provider is required by law to send to us about events that happen at the service and reports we asked the provider to send to us about how they were meeting legal requirements following our last inspection. The provider also completed a provider information return (PIR). This is a form that asks the provider to give some key information about
the service, what the service does well and improvements they plan to make.

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 also spoke with two people who used the service, two relatives of people who used the service, the registered manager, three members of staff and a contracts and quality assurance officer from the local authority. We looked at six people's care plans, three staff files, eight people's medicines records and records relating to the management of the service, including audits and staff rotas.

Requires Improvement

Is the service safe?

Our findings

People's relatives told us they felt people were safe at the home and were adequately protected from harm and abuse. One relative said, "I have no fear of that here at all." Another said, "[My relative] is safe here. I'm sure of it."

At our previous inspection in December 2015, we found that 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. They sent us an action plan and told us they would make the necessary improvements.

At this inspection, we found that while the provider had taken some action to address the above issues and had put in place risk management plans for these, risk assessments still did not contain all of the information staff needed to keep people safe. Each person had an individual risk assessment and a risk summary so staff could quickly familiarise themselves with people's main risks. We looked at four of these and found that the assessments covered potential triggers for risky situations and what action staff should take to avoid or reduce these risks.

However, some information in the risk assessments was contradictory, unclear or incomplete. Falls risk assessments were not personalised. One person's falls risk assessment contained contradictory information about whether they were able to perform a specific task. One question on the assessment was worded in such a way that the "yes" or "no" tick box would not provide a clear answer about whether there was a risk and how this may affect the risk of the person falling. Each person had a risk summary sheet, but this was not designed in such a way that the risks most relevant to each person were easily visible. There was a chart showing staff what action to take in response to any of these risks being flagged up, but this was not personalised and was the same in all of the risk assessments we looked at. It was not clear from the information given how staff should support individual people, as opposed to using general safety measures, in order to reduce the risk of them falling. We found similar issues with other assessed risks, such as skin integrity and malnutrition.

At our last inspection, we identified a number of issues around cleanliness and infection control including visibly dirty areas, shared razors and staff using the same slings to support different people to mobilise, which were not good practice in relation to the prevention and control of infection. At this inspection, staff told us they now had a sling for each person who needed one and these were marked with people's initials.

We saw the home was visibly clean. Staff told us the standards of cleanliness at the home had improved within the last six months. We saw evidence that domestic staff used a cleaning schedule to ensure that all parts of the home were cleaned at appropriately regular intervals. They completed records to show that this was done.

On arrival to the home, however, we noticed an odour in the hallway and front lounge of the home. The registered manager told us this was because most people used the toilet in the morning soon before we

arrived. Staff later used cleaning products to make the home smell more pleasant but the urine odour was still present. On the second day of our inspection, we arrived in the afternoon and noticed the odour again. The provider was therefore not ensuring that the premises were adequately cleaned and maintained to prevent unpleasant odours.

There were bins in bathrooms for used incontinence pads and other clinical waste. These were appropriately lined and covered to help prevent the spread of infection. However, the lids were hand-operated, which meant the provider had not followed Department of Health guidance for infection control in nursing homes. This states that areas where clinical/hazardous waste is produced should have foot-operated bins. We also noticed on our second visit to the home that the clinical waste bin outside the home was open, which meant there was a risk of infection spreading via animals or unauthorised persons entering the bin. We alerted the provider, who asked a member of staff to secure the bin, but it was still open when we left the premises two hours later.

We noted that there were some discarded pieces of wood and other debris in the garden, which could present a risk to people as there were some edges with splinters. We also saw that one person had a framed photograph in their bedroom with cracked glass. One edge was sticking out and presented a risk that the person, their visitors or anyone else entering their bedroom could sustain an injury. We told the registered manager, who said they would remove this. However, when we returned to the home five days later, the debris had been removed from the garden but the broken glass was still in the person's bedroom. We pointed this to the manager who then removed this immediately.

Whilst the provider had taken action to address many of the concerns raised at our previous inspection in December 2015, the above shows that they continued to be in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our previous inspection we found that the provider did not have suitable arrangements to protect people from the risks of scalding from hot water, falling from height, becoming trapped in bed rails, choking, accessing hazards via unlocked doors and exposure to cold weather. At this inspection, the registered manager told us thermostatic valves had been installed on every water outlet to ensure the water temperatures remained within acceptable ranges. We toured the premises and saw that there was a suitable water thermometer in each bathroom. We tested the water from the hot taps of two sinks and two baths and found it to be between 35-37 degrees Celsius. These agreed with the data recorded in the daily temperature log books.

Although we could not verify whether the provider had taken appropriate steps to ensure people were protected from cold weather because this inspection took place in the summer, we checked the air temperature in three parts of the house and found it fell within an acceptable range.

We looked at bed rails in three people's bedrooms, which the provider had replaced after we identified safety concerns at our last inspection where there was a risk that people may become trapped in gaps between their beds and the rails. The new bed rails we saw did not have any gaps large enough for people to become trapped. People who used these had bed rail risk assessments on file. These covered the condition of equipment and assessments of the size of any gap.

Since our last inspection, the provider had introduced monthly and two monthly health and safety audits. These covered items such as water temperature checks, boiler maintenance and checks that any maintenance and servicing of lifting equipment was completed when due. We saw that fire extinguishers had been checked and serviced within the last six months. Staff we spoke with knew how to support people

in the event of a fire or other emergency requiring evacuation of the premises. A relative gave us an example of a risky behaviour their family member habitually engaged in and told us how staff had put in place measures that significantly reduced this risk without restricting the person's freedom.

The registered manager demonstrated that all external fire doors were alarmed. This meant staff would be alerted if people attempted to leave the building without support. Doors leading to rooms where potentially dangerous equipment or chemicals were stored were locked during our visit. The provider had installed window restrictors to address the risk of people leaving the service via windows or falling from height. We tested several of these and found they could not be disabled easily. However, we noted that the staffroom door was unlocked and the window in this room did not have a restrictor in place. This meant that people were potentially able to access at least one unrestricted first floor window. We alerted the registered manager, who immediately locked the door and told us they would remind staff not to leave it unlocked.

We inspected two refrigerators, a freezer and a cupboard in the kitchen and found that they were clean and tidy with food covered and stored in an appropriately hygienic manner with use-by dates marked. There was evidence that the service had been inspected under the Food Hygiene Rating Scheme and had been awarded the maximum score of 5. Staff, including kitchen staff, had up-to-date training in food hygiene. This helped to protect people from the risk of infection as a result of poor food hygiene.

Where people had been assessed as being at risk of sustaining pressure sores, there was information about how staff should manage this risk, for example by using pressure relieving equipment and turning people regularly when they were in bed. We saw that people were sitting on pressure relieving cushions where these were required and records showed that people were being turned in line with their care plans. A relative told us about the care staff gave them to protect them from the risk of pressure sores and we found that this was the same as the information given in their care plan.

Relatives told us staff handled people correctly where they needed support to mobilise. We saw that people who required such support had care plans showing staff what equipment to use and how to support the person. These were reviewed monthly.

We asked staff about their knowledge of safeguarding people from abuse. While some staff were able to list the types of abuse and the signs that people were being abused, others did not show a good knowledge of this and were unsure how to recognise non-physical abuse. When we asked what staff should do in response to suspected or alleged abuse, a nurse told us they would carry out an investigation by asking the person and staff about what had happened. This was not in accordance with the service's safeguarding procedures and could put people at further risk by compromising any formal investigations by the statutory agencies. There was a risk that staff were not sufficiently knowledgeable of the relevant procedures to protect people from abuse. However, other staff we spoke to were aware of the correct reporting procedures and we saw evidence that the provider was in the process of training all staff in this area. When we discussed this with the provider they said they would reinforce the correct process of reporting safeguarding concerns with the member of staff.

We saw that staff had signed the service's whistleblowing policy to show they had read it. This meant staff had access to the knowledge they needed to be able to report harm and abuse of people using the service in the event that the provider did not respond appropriately.

At our last inspection, we found that there were not always sufficient numbers of staff to keep people safe because some people whose care plans stated they needed constant supervision were left without staff support for significant periods. At this inspection, people's relatives and staff said they felt the home had

sufficient staff to keep people safe. One relative said, "My [family member] needs two members of staff to attend to them and there are enough staff to provide that." The registered manager told us they had regular meetings with senior staff to discuss people's needs and any adjustments needed to staffing levels. Although they did not document the process used to determine this, senior staff confirmed that they were consulted. We checked rotas for the last four weeks and found that all shifts were filled to the manager's prescribed level of staff including senior and domestic staff.

At our last inspection we found that the provider did not have robust recruitment processes that included checking the identity and fitness to work of staff they employed. At this inspection, people told us "staff are very good" and "I have no problems with the staff." The registered manager told us about the recruitment process they used to help ensure they were recruiting suitable staff to care for people. We looked at three staff files, including records for a member of staff who had been recruited since our last inspection. There was evidence that they had completed a questionnaire demonstrating they were fit to work with people. The provider had asked for and received copies of identity documents and proof of right to work in the UK, documents showing staff were appropriately qualified to carry out their role and criminal record checks.

At our last inspection, we identified a number of shortcomings around medicines management, including a lack of accurate recording of medicine stock, checks that staff who administered medicines were competent to do so and guidelines around medicines to be administered as required. At this inspection we found that qualified staff received medicines training and that the provider was carrying out regular competency assessments for staff who administered medicines to people. Since our last inspection the provider had introduced a weekly medicines audit to ensure that medicines were given to people as instructed and that correct records were maintained to reduce the risk of people receiving medicines inappropriately or unsafely. We looked at the last four weeks of the medicines audit and saw that no concerns had been identified in this time.

We checked the medicines administration records (MARs) of seven people and found no gaps or discrepancies in these records for the last three weeks. Each person who used "as required" medicines had a cover sheet with appropriate guidelines for administration and dosage. This information helped to ensure that people received their medicines correctly. We saw evidence that the provider had carried out individual risk assessments of people's ability to manage their own medication so their independence was promoted. Medicines stock records that we saw were complete and accurate when we checked these against people's medicines records.

Requires Improvement

Is the service effective?

Our findings

At our previous inspection we noted a number of deficiencies with regard to adequate nutrition and hydration. People only received drinks at set times, the provider had not ensured people were assessed with regard to equipment they might need to support them to eat, staff did not show adequate understanding of different types of diet and the provider did not adequately monitor people for the risk of malnutrition. They sent us an action plan and told us they would make all the necessary improvements.

At this inspection one person told us, "The food is all right. I get my favourite foods, more or less." Another person said the food at the home was "fine." Staff we spoke with were able to give examples of people's differing needs around food and nutrition. Relatives told us people's needs were met in terms of the variety and consistency of food that they received. One relative told us, "The food is very edible. [My relative] has it pureed, but it smells very nice." Care plans included relevant information for those who needed their food served at specific consistencies. However, we did not see information about people's food preferences. This meant there was a risk that people did not receive choices of foods that they enjoyed.

We found that people had malnutrition risk assessments with monthly updates where this need was identified. We looked at the records for one person whose records showed they had a history of malnutrition. These had been updated monthly but their risk score was incorrectly calculated meaning a risk that should have been highlighted was not. Although this person was receiving regular support from relevant health professionals, this demonstrated that people's records were not always accurate and staff therefore might not notice the risk to people of malnutrition was increasing.

We did not find evidence that people had been assessed for the use of eating and drinking aids as a way of promoting their independence during meal times. Furthermore, we observed staff supporting people at lunchtime and found that people still did not have access to specialised crockery or cutlery. One person, whose care plan stated that they did not need assistance to eat their meals, appeared to have difficulty holding and manipulating their cutlery. The person appeared disorientated at times, attempting to use a fork to take their drink, but did not receive staff support for most of the meal and had had their lunch in front of them for five minutes before a member of staff assisted them to cut up their food. This person and two other people we observed also spilled significant quantities of food onto themselves and the floor, which could have been avoided with the use of plate guards. We spoke to the registered manager about this and they told us they had attempted to use a plate guard for one of the people we saw but the person had thrown it on the floor. They confirmed that they had not tried any other methods to support the person such as deeper or high-sided plates and did not explain why the other two people we saw did not have access to plate guards.

We found that the provider was still in breach of regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Relatives told us people were offered plenty to drink. We visited people in lounge areas at various times throughout the day and saw that drinks were available for people. Staff we spoke with understood the

importance of adequate hydration. In two people's care plans we saw that they were to be offered hourly drinks of at least 200ml, but there was no evidence such as an assessment to show where this figure came from.

We saw a board displayed in the dining room showing pictures of the planned menu for that day. During the morning, the chef took the pictures to each person and asked them to choose which dish they would like. This helped to ensure that people understood what their choices were, particularly those who were less able to express their preferences verbally.

Staff told us they received supervision at least every two months and records confirmed that this had been the case in the last six months. Staff told us they found supervision useful and were able to discuss the best ways of supporting people. The registered manager told us they were in the process of carrying out appraisals with all staff and we saw evidence that junior and unqualified staff had received these. The registered manager told us they had prioritised these staff because qualified nurses also received support through their professional body. This helped to ensure that staff had the knowledge they needed to carry out their roles and responsibilities.

We spoke with staff about the training they received. They told us they had training in supporting people living with dementia and that this was useful in supporting the people using the service. Staff we spoke with were able to describe some of the key principles in good practice when supporting people living with dementia. We looked at the provider's training matrix and saw that their planned programme of staff training was in progress although it was not yet complete. Staff had received a variety of training in the last year, including specialist training in areas such as catheter care and diabetes management. Some staff had not yet received training in safeguarding people from abuse. However, we looked at minutes from staff meetings and saw that staff had the opportunity to discuss the training they had and how to put it into practice. They also discussed relevant legislation, policies and procedures including safeguarding. This helped to ensure that staff had the knowledge and skills to carry out their roles and knew how to apply this to their work.

At our last inspection we found the provider did not always ensure people's rights were protected by appropriate application of legislation such as the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). 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 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). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met.

Since our last inspection, the provider had sought guidance from the local authority on following this legislation and carrying out assessments of people's mental capacity. There was evidence that they had followed guidance set out in the MCA Code of Practice, for example by returning to people at different times of day and using pictorial information to see if people had the capacity to consent to decisions about their care under different circumstances. People's care plans contained information about whom to contact to assist with making decisions about their care, where people did not have the capacity to make these

decisions themselves. This was usually a close relative and was intended to ensure that where decisions were made on people's behalf these reflected what the person would have chosen if they had the capacity to do so. Documentation demonstrated that social workers had also been involved in these processes.

We saw that where people were deprived of their liberty, the appropriate paperwork was in place showing people had been assessed by the local authority and the decision to deprive them of their liberty had been made within legal requirements. People's care plans contained information about why they were deprived of their liberty and what staff needed to do to support them, for example using rails on their beds to keep them safe.

We saw evidence that people were supported to access health professionals when needed. Records showed that people had seen opticians, dietitians and speech and language therapists (SLT) when this need was identified. Relatives told us people had access to the health services they needed.

We saw that the provider had started making changes to the environment to suit the needs of people living with dementia. There were signs and photographs of people on their bedroom doors to help people identify their rooms. The provider had introduced memory boxes for each person's bedroom. Memory boxes are small displays of items and pictures that are meaningful to an individual person. For people with dementia, these can provide comfort and reassurance as well as aiding in orientation and reminiscence work.

Requires Improvement

Is the service caring?

Our findings

At our last inspection we found that people were not always treated with dignity and respect. At this inspection, although relatives told us people were treated with dignity and respect, we found these issues were not fully resolved. One relative said, "Staff dress [my relative], comb her hair and she always looks nice. Their attitude is really good and they are compassionate."

One person's care plan stated that looking smart and tidy was very important to them. We observed this person as they ate their main meal. The person was not offered any way of protecting their clothing such as a napkin, although other people were given clothing protectors. We saw that the person did not receive support to eat and struggled with their cutlery, spilling food on their clothes. The person had prominent food stains on their clothes when they got up to leave the table. Although we saw the person had changed into clean clothes when we saw them two hours later, we noticed on our second visit to the home that the person was wearing a stained shirt with a button missing. The registered manager told us this was because the person chose their own clothes but did not explain why they had not arranged for the person's clothes to be properly cleaned or repaired. Furthermore, a relative told us staff did not always ensure that people were dressed in their own clothes. They said, "They share each other's clothes. There seems to be a central supply of clothes." Although this relative stated that they did not mind their family member sharing clothes, this showed that the provider had failed to consider people's individuality and to ensure that people's dignity was upheld.

Staff told us how they maintained people's privacy and dignity when supporting them with personal care, for example by ensuring they were covered with dressing gowns when moving from bedrooms to bathrooms. We asked about one person whose care plan said they did not require support to wash and dress. Staff told us they maintained this person's privacy and dignity by looking away once they had supported the person to choose their clothes, but were not able to fully explain why they needed to remain in the person's bedroom while they dressed as this was not outlined in the care plan.

We saw that staff gathered information about people's preferred names and communication styles during their initial assessment. During the inspection, we observed staff referring to people using the preferred names recorded in their care plans most of the time although for one person we observed two different members of staff using their full first name when their care plan specified that they preferred a shorter nickname. We also observed that conversations between staff and people using the service were focused on the tasks they were completing with them and we did not observe staff speaking to people about their interests, families or other subjects that were meaningful to them as individuals.

Care plans we looked at contained information for staff about how to reassure each person if they were upset or anxious and this was personalised. However, staff did not always implement the care plans and did not offer people support and reassurance when they needed it. For example, we observed one person saying to staff, "I don't know what's happened" and appearing distressed and disorientated, but staff did not respond. At other times we observed staff offering reassurance, such as when a member of staff told a person who had spilled some food not to worry and assured them that they would clean up the spillage.

Although the majority of interactions we observed showed that staff usually spoke to people in a polite and respectful manner, we occasionally observed staff using inappropriate or disrespectful language such as "don't do that" and "good boy."

Although some information in care plans was written in the first person, this did not always appear to reflect people's own points of view. For example, we saw statements such as, "I can sometimes be a bit difficult," which contained judgements about people's behaviour rather than explanations of what they did that could make it difficult for staff to support them or what might help the person in these situations.

We found that the service had a culture which was, in some aspects, not empowering to people. For example, we found that some care plans contained phrases such as "[person] is unable to communicate in any form" and this was reflected in the language staff used when talking about people. We met one of these people and saw they used non-verbal forms of communication such as facial expressions and eye movements. Other information in the care plans and in what staff told us contradicted their statements that people were unable to communicate, for example saying that the person smiled when they wanted something and describing the body language the person used when they were anxious. This meant there was a risk that non-verbal communication methods would not be considered as important as speech and that people who did not communicate verbally would not be empowered to have their say in how their care was delivered.

The provider was still in breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

One relative told us their family member got on well with staff and where they had preferences for which member of staff supported them, these were respected. Another relative said that although their family member had lost most of their ability to communicate, they still responded well to staff and they felt this demonstrated that staff had developed a good relationship with the person.

People were allocated key workers to help them develop positive caring relationships with staff. Each person had a key worker agreement that set out in writing how their key workers would support them and there was a copy of this, with photographs of key workers, in each person's bedroom. There was also a board displayed in a communal part of the home with photographs of care and management staff. This was to help people access the information they needed about who could help them if they needed advice or support.

We saw that issues such as DoLS had been discussed at relatives' meetings. The registered manager told us they did this on discovering that people's relatives were not familiar with the legislation and what it meant for their loved ones. They told us they had added the items to the agenda so relatives were better able to be kept informed and actively involved in decision making around people's care.

Staff told us how they supported people to make decisions about their day-to-day care, such as by offering a choice of clothing for people in the morning. They told us the new style of care plans that the provider had introduced since our last inspection enabled to involve people more in decisions about their care, because there was more information about people's preferences and histories.

The registered manager told us most people who used the service were not able to make decisions about their care and so their relatives were involved. They told us they spoke to people's relatives as part of planning how to redecorate the home. Relatives told us and we saw evidence that they were involved in making decisions about people's care. We looked at the care plan of a person staff had told us was capable

of making some decisions for themselves. We found evidence that this person had been involved in planning their care and that their views and experiences were taken into account. For example, the care plan stated that the person sometimes found being supported with personal care embarrassing and that staff should respond in a friendly and reassuring manner. However, we did not see evidence that the provider had attempted to engage any other people in planning their care to the best of their abilities. In one person's care plan we saw a document stating that they had been involved in planning their care, but this had been signed by staff and not the person which meant that the extent of their involvement in making decisions about their care was not clear.

Staff told us they tried to maintain people's independence as far as possible by allowing them to perform tasks for themselves and carefully observing to see if they were able to do so without assistance.

We recommend that the provider seek advice and guidance from a reputable source, based on current best practice, in relation to involving people with dementia in care planning and decision making.

Requires Improvement

Is the service responsive?

Our findings

At our last inspection, we found that people's care plans contained little information about their life histories, aspirations or how they would like to receive their care and we found that care plans for incontinence and diabetes were not appropriately tailored to people's needs. We also found that the service was not adequately meeting people's needs around religion. The provider wrote to us and told us they would make the necessary improvements.

At this inspection, people and their relatives told us staff responded to people's individual needs. One relative said, "Some people need more help than others. Staff respond to their individual needs." Another relative told us, "My [relative] has been here for several years and I would not keep them here if I did not feel their needs were being met." A third relative said their family member was "looked after very well and all their needs are catered for."

Since our last visit, the provider had made improvements and had worked to make care plans more personalised and responsive to people's individual needs. Each person had a list of "important things to help me have a good day," which showed the things that were most important to that person. For example, one person's list included being able to listen to music on their radio, while another person particularly liked to be encouraged to wash and dress independently. There was personalised information about each person's preferred morning and bedtime routines. Care plans included detailed information about people's hobbies and interests, life histories, previous employment and significant life events. People's care plans also contained personalised information about what signs might indicate that they were unwell, such as symptoms of constipation and urinary tract infections, and what action staff should take. This meant staff had access to the information they needed to carry out their roles effectively with regard to people's needs.

However, we did not find evidence that the provider was actively using the information about people's needs, including their life histories and interests in the delivery of care that was individualised and meaningful to them. For example, one item in people's personal information in care plans asked them what they liked to drink when they went to the pub, but we found no evidence that people had been offered their favourite drinks or trips to the pub within the last six months. One person's care plan indicated that they were very interested in football and that watching football on television was both important and enjoyable to them. On the day of our inspection, the football team representing that person's home country was playing a match of significance and this was televised. We observed staff supporting that person around the time this match began, but they did not offer the person the option of watching the football and instead engaged them in another activity. We spoke with this person when we returned five days later and they told us they would have liked to see the match and that they would like staff to inform them when football matches were on TV.

Staff did not always have an adequate awareness of people's diverse needs. When we asked one member of staff about how the diversity of the people living at the home affected how their care was delivered, they told us, "We don't have that problem here. They're all the same." This was despite the service supporting people from a variety of backgrounds, religious groups and ethnic origins at the time of our visit. Another member

of staff also described one person's family expecting the service to meet their diverse needs as "a problem." This contradicted the service's own diversity policy, which stated that they would consider and attempt to meet the diverse needs of people using the service in all aspects of their work.

Care plans indicated people's religions or religious beliefs where relevant. However, although the provider showed us evidence that one person received visits from friends at their church, they were unable to demonstrate that they had done any proactive work in supporting other people to attend services or otherwise have their religious needs met.

At our last inspection, we found that care plans for people with diabetes 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. At this inspection, we looked at the care plan of a person with diabetes and found there had been some improvement. For example, nurses were monitoring the person blood sugar levels as per the care plan and there were now details of a diet appropriate for them in their care plan. There was however, still no information about the acceptable blood sugar ranges or the signs for staff to observe if the person's blood sugar level was outside the safe range of blood sugar levels so anyone caring for the person could note these signs and report them to the person in charge.

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

People's care plans set out what support they needed around personal hygiene, continence and communication. This included details of how many staff they needed to support them to use the toilet, what type of continence wear they used and how often it should be changed. One person, who was unable to express themselves in words, had a care plan with details of how to tell if they were anxious and what staff should do to help them relax. There was a separate care plan for the specialist dental equipment they used.

There was a system in place to ensure that people who spent the majority of time in their rooms were able to spend time with staff during the day. We visited one person in their bedroom and saw a member of staff was present with them. The person's care records demonstrated that staff visited them hourly each day, either to perform routine personal care tasks or to engage them in activities such as chatting and listening to music.

During our visit, we saw some activities taking place. Music was playing and some people were smiling and nodding their heads, appearing to enjoy the music. We observed a member of staff engaging two people in a game of dominoes, one of whom later told us they particularly enjoyed playing dominoes. We saw a member of staff going to another person's bedroom for a chat. We saw an activities timetable displayed in communal areas in the home, although staff did not always complied with it, which could have been disorientating to people. For example this stated that there would be a music activity in the afternoon. We observed this activity taking place in the morning rather than the afternoon.

Relatives told us the provider was responsive if they raised issues or concerns. One relative told us, "If I notice anything concerning [my relative], they act on it straight away." They gave us examples of times when staff had made changes to the person's care as a result of their relative's feedback. One relative said, "They listen to me. If something needs doing, I make sure it's done and they've always followed it up." We saw evidence that where relatives had suggested improvements, the provider had acted on these. For example, one relative asked that the garden be improved and the provider had added this to their action plan and had begun work on this when we visited.

We observed that a copy of the complaints policy was displayed where people and visitors could see it. This included information about how people could escalate their concerns externally if they were not satisfied with the manager's response. However, the relatives we spoke with told us they had never had the need to make a complaint although they would know what to do if they did. Records showed that the service had not recorded any complaints since our last inspection.

Requires Improvement

Is the service well-led?

Our findings

At our last inspection, we found the provider did not have adequate systems in place to assess, monitor and improve the quality of the service. Audits were not comprehensive and some were overdue. The provider did not always seek and act on feedback from people using the service, their relatives, staff and professionals involved in the service. They did not always act on issues identified by their own audits.

During this inspection, we noticed that the provider was not displaying their CQC rating so that people who used the service, their relatives and visitors were able to see it. This is a legal requirement. We informed the registered manager and they printed and put up a poster showing the required information.

The provider had introduced or improved a number of audits since our last inspection. These included a variety of health and safety audits. There was a maintenance checklist that the provider had used to monitor any outstanding jobs that needed to be done and we saw the tasks on the list were all complete. A complaints audit was in place so that the provider could analyse and learn from any complaints they received, but they had not received any complaints since putting this in place six months before our inspection. Similarly, we saw a system was in place to analyse data from falls, pressure sores, safeguarding alerts and other incidents, but only one incident had been recorded in the last six months so we were unable to confirm at the time of the inspection whether this system was effective.

However, we found that the provider's health and safety audit dated May 2016 had not identified any of the safety issues we found at our inspection. We also found that the provider did not appear to understand some aspects of their responsibilities with regard to safety. For instance, they told us that removing a photograph frame with broken glass from a person's bedroom was the responsibility of that person's relatives. This demonstrated that the provider still did not have an effective system for assessing, monitoring and improving the quality of the service. We found that although the provider often acted quickly to address problems we told them about, they did not work in a proactive way to identify and address problems themselves. This meant there was a risk that problems with the safety or quality of the service would not be identified and addressed in a timely manner.

The provider carried out spot checks at random times to ensure the home was clean and that the home was safe. This was designed to ensure a safe environment for people, although the issues we found demonstrated that these were not effective in identifying a number of safety issues.

Some of the records kept at the home were not sufficiently detailed for the provider to be assured of the quality of some aspects of the service. For example, daily records of people's care contained information about their mood, whether they had eaten well and whether staff had supported them with personal care. However, with the exception of people who remained in their bedrooms during the day, the records did not show how people had spent their time or what support staff had given them other than personal care. The home's records about the activities that took place in the mornings and afternoons did not also show which people had taken part in the activities to determine if their individual needs in this respect were being met. This meant the provider could not be sure that each person under their care was receiving appropriate

support to ensure their social and psychological wellbeing and their quality of life were being promoted.

We noticed that some people's confidential records, including medicines records, were left unattended in an open dining room and not stored securely. This meant that people's privacy around their medical information could be compromised. We drew the registered manager's attention to this and they moved the records into the office. However, this room also remained unlocked and was often unattended throughout the day. There was therefore a risk that other people might have access to these records if these are not stored securely.

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

The registered manager showed us their plan for developing the service. They had improved this since our last inspection and had completion dates for the actions they planned to take. The registered manager was able to use the plan to demonstrate progress against their goals and to show us a number of improvements they planned to make this year. One of these, to improve the garden so people could enjoy use of outside space, was due but had not been completed as we saw the garden was overgrown and there was rubbish on the ground. The registered manager explained they had to delay their plans because of bad weather and when we returned for the second day of our inspection, the grass had been cut short and the rubbish removed.

Relatives told us the home had an open, welcoming culture and that they were kept informed about their relative's care. One relative told us, "They keep in touch. The manager is very approachable and keeps me informed. I always know what's going on with [my relative]." Another relative said, "They always talk to me. They ring me all the time." We saw evidence that the provider had invited relatives to meetings to discuss their views about the quality of the service and to gather their feedback on how the service could be improved. Relatives told us they had recently been invited to one of these meetings and that they had also been invited to complete a questionnaire about what they thought of the service. We saw copies of these and saw that relatives had been asked for their opinions on cleanliness, friendliness and attitudes of staff, safety, the complaints procedure, the food provided and whether the service was caring. We saw questionnaires completed by four relatives, all of whom gave positive feedback.

We also saw copies of questionnaires for people who used the service. These appeared to have been filled in by staff and the registered manager confirmed that staff sat with people and helped them fill in the questionnaire. This showed that people had the opportunity to discuss their care with staff and express their views, as many people would not be able to fill in questionnaires without assistance. However, the fact that staff from the home were supporting people to do this meant that the provider could not be sure the questionnaires were free from bias. For example, people may have felt unable to speak freely if they had negative comments about the staff who supported them. We also noticed, and the registered manager confirmed, that comments written by staff did not always accurately reflect people's responses. For example, when people's responses had been non-verbal, staff had written comments in the first person such as "I am happy" rather than "[person] smiled and nodded their head." This approach was also subject to bias, as in many cases staff were interpreting people's gestures and facial expressions and this method may not always have provided accurate representations of people's opinions. Because the records did not reflect this, there was a risk that the provider would assume there were no problems and not listen to people's true opinions.

We spoke with staff and people's relatives about the changes the provider had made to the service since the last CQC inspection. All the staff and relatives we spoke with told us they felt the provider had made a lot of

positive changes. Staff told us morale was good, the manager was approachable and the provider gave them the support they needed to work well as a team. They told us they were able to support one another with difficult aspects of their work. Staff we spoke with felt that the safety of the service had improved in the last six months as a result of the provider's work. We spoke with a representative of the local authority commissioning team, who told us they felt the service had done a lot of work to make improvements since our last inspection.

Staff told us they were able to attend regular meetings and that they felt comfortable voicing their opinions. They said the service had an open and fair culture, where everybody was entitled to have their say. We looked at minutes from the most recent monthly staff meetings and saw that staff had been invited to express their opinions and discuss their work. The provider had asked both staff employed by the home and visiting professionals such as social workers to complete questionnaires about their opinions of the quality of the service. At the time of our visit the provider had only recorded positive feedback so did not have any outstanding actions arising from these.

The registered manager told us they had appointed champions for important issues such as Mental Capacity Act compliance, and caring for people living with dementia. There were senior members of staff responsible for medicines management and keeping care plans up to date, key workers allocated to each person using the service and an appointed deputy to take over the running of the service if the registered manager was sick or on leave. We saw an organisational chart with lines of accountability shown clearly.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care
Treatment of disease, disorder or injury	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)

The enforcement action we took:

We have served a Warning Notice on the provider for this breach of Regulation. We have asked the provider to make the necessary improvements to meet the relevant legal requirements by 31 August 2016.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect
Treatment of disease, disorder or injury	The registered person did not ensure that people were treated with dignity and respect. They did not ensure people's privacy. Regulation 10 (1)(2)(a)

The enforcement action we took:

We have served a Warning Notice on the provider for this breach of Regulation. We have asked the provider to make the necessary improvements to meet the relevant legal requirements by 31 August 2016.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	Safe care and treatment. The provider did not do all that was reasonably practicable to assess and mitigate risks to the health and safety of people. They did not ensure the premises were safe, and adequately maintained to prevent and control the spread of

	infections. Regulation 12 (1)(2)(a)(b)(d)(h)

The enforcement action we took:

We are continuing with our action where we have imposed a condition on the provider to carry out monthly audits of health and safety within the service and to send the CQC a monthly report.

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 Meeting nutritional and hydration needs The registered person did not ensure the nutritional and hydration needs of people were fully met as part of their care by appropriately supporting people to eat and drink. Regulation 14(1)(2)(a)(i)(b)(4)(d)

The enforcement action we took:

We have served a Warning Notice on the provider for this breach of Regulation. We have asked the provider to make the necessary improvements to meet the relevant legal requirements by 31 August 2016.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Good governance. The provider did not effectively operate systems and processes to assess, monitor and mitigate the risks relating to the health, safety and welfare of people. They did not maintain a secure, accurate and complete record of the care and treatment provided to each person. Regulation 17(1)(2)(a)(b)(c).

The enforcement action we took:

We are continuing with our action where we have imposed a condition on the provider to carry out monthly audits of health and safety within the service and to send the CQC a monthly report.