Asprey Healthcare Limited

Smallbrook Care Home

Inspection report

Suffolk Close
Horley
Surrey
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Tel: 01293772576

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on 13 September 2017 and was unannounced.

Smallbrook Care Home is a care home providing support to up to 41 people who are living with dementia. The home specialises in supporting people living with dementia and there is a unit for people living with early onset dementia. This unit supports people who are under 65 and have been diagnosed with dementia. At the time of our inspection the home was providing support to 35 people.

There was a registered manager in post but they were on planned leave at the time of inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Our last inspection was in April 2017 where we identified one breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, we found that the provider had not taken enough action to resolve this breach of regulation. We also identified a further nine breaches of regulation. We found that the provider was in breach of regulations 9, 10, 11, 12, 17, 18, 19 and 20 and 20A of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We also identified a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

We will be requesting information from the provider about specific incidents involving people to ensure that there had been no instances of avoidable harm.

People did not receive safe care. Responses to incidents were not robust which meant that where people had suffered falls, the underlying risks were not managed causing incidents to occur again. The provider was not always proactive in identifying risks and staff were not clear on how to manage individual risks to people. We also identified that important information was missing from medicines records and safe medicines management practices were not always followed.

There were not enough staff at the home to safely meet people's needs. After the inspection, the provider increased staffing levels in response to our findings. However, the provider will need to ensure they are able to calculate staffing numbers based on people's needs. There was information missing from one staff file which showed that recruitment checks were not always robust enough to ensure that people were supported by safe staff. The provider took action following our inspection and assessed the risks relating to the missing information from this staff file, however this had not been done proactively.

At our inspection in April 2017, staff were not always raising safeguarding incidents with management. At this inspection we found that incidents were being reported to management and to the local safeguarding team. However, staff were not clear on where they could raise safeguarding concerns outside of the

organisation so the requirements of this regulation had not been met.

Staff lacked the training to meet the complex needs of the people that they supported. As a specialist care home for people living with dementia, people's needs often required specialist interventions from staff. We found evidence that staff lacked this specialist training and did not respond appropriately to people's behavioural needs.

People's legal rights were not protected because staff did not follow the guidance of the Mental Capacity Act (2005). Where restrictions were placed upon people, the correct legal process was not followed. Staff and management lacked an understanding of how to apply restrictions in line with the Mental Capacity Act (2005).

Care lacked personalisation and was not always provided in a way that reflected people's needs and preferences. We saw instances where staff failed to promote people's dignity when providing care. People's dietary needs were met but we noted this was not always done in line with people's routines and preferences. There was a lack of choice on offer for people.

There was a lack of leadership and governance at the home. The registered manager was on planned leave at the time of inspection. The arrangements for management cover had not worked and an assistant manager had left. There was a lack of support and coaching for staff and this was reflected in the care that they provided. Auditing systems were not robust enough to identify the concerns that we found on the day of inspection. Where improvements had been identified through audits, these had not always been actioned. The provider had also failed to notify CQC of important incidents and events.

People had access to a range of activities and we observed people and staff interaction positively. Staff respected people's privacy when providing support. Relatives knew how to complain and the provider kept a record of complaints but did not identify patterns and themes. We recommended that the provider reviews their systems for analysing complaints.

You can see what action we told the provider to take 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.

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.

Identified risks were not managed appropriately and where incidents occurred the provider's response was not robust enough to keep people safe.

There was a lack of safe medicine management processes in place. Important information about people's medicines was missing.

There were not enough staff to safely meet the needs of people. Important information was missing from recruitment checks.

Staff were raising safeguarding concerns with management but were not clear on how to raise safeguarding concerns with outside agencies.

Is the service effective?

Inadequate

The service was not effective.

Staff lacked the specialist training required to meet the complex needs of the people that they supported.

People's legal rights were not protected as staff did not follow the guidance of the Mental Capacity Act (2005).

People's dietary needs were known and people's food preferences were recorded.

People were seen regularly by healthcare professionals.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People's dignity was not always promoted by staff.

Feedback on the caring nature of staff was positive and we observed practice that was caring.

Staff respected people's privacy when providing support.

Relatives were encouraged to visit and people's religious and cultural needs were taken seriously.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Care was not always delivered in a personalised way.

People had access to a range of activities.

Complaints were recorded and responded to. We recommended that the provider reviews their systems for analysing complaints to identify patterns and trends.

Is the service well-led?

Inadequate

The service was not well-led.

There was a lack of leadership and governance at the home. The provider had failed to provide appropriate oversight during the registered manager's absence.

The provider's audits were not robust enough to identify the concerns found at this inspection.

The provider did not always submit notifications to CQC when they were required to do so.

Systems were in place to involve staff and relatives in the running of the home.

Smallbrook Care Home

Detailed findings

Background to this inspection

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

The inspection was prompted by concerns raised as part of a safeguarding investigation about a high number of incidents at the home. The information shared with CQC about the incidents indicated potential concerns about the management of risk of falls and people leaving the service unaccompanied. This inspection examined those risks.

This inspection took place on 13 September 2017 and was unannounced.

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

Before the inspection we gathered information about the service by contacting the local and placing authorities. In addition, we reviewed records held by CQC which included notifications, complaints and any safeguarding concerns. A notification is information about important events which the service is required to send us by law. This enabled us to ensure we were addressing potential areas of concern at the inspection.

Before the inspection, the provider did not complete 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. As this inspection was brought forward due to concerns, a PIR was not sent to the provider.

As part of our inspection we spoke to two people and five relatives . Most people were not able to provide informed feedback as they were living with dementia so we observed the care that they received. We spoke to four care staff ,the assistant manager, the director and the nominated individual. We read care plans for seven people, medicines records and the records of accidents and incidents. We looked at mental capacity assessments and applications made to deprive people of their liberty.

We looked at two staff recruitment files and records of staff training and supervision. We saw records of quality assurance audits. We also looked at records of food choices, activities and minutes of meetings of staff and residents.

Inadequate

Is the service safe?

Our findings

Relatives told us that they felt people were safe. One relative told us, "I chose the home for (person) because I thought it had a nice atmosphere and I really do feel she is safe here." Another relative said, "We are happy that (person) is well cared for and safe."

However, despite these comments we found people were not being protected against risks and action had not been taken to reduce the potential of harm. This inspection was prompted by concerns raised about the numbers of incidents at the home and we identified concerns in this area.

People were not supported safely after incidents occurred. Records of accidents and incidents showed similar types of incidents happening, without robust plans being implemented to manage risk. Where people had suffered recurrent falls, their risk assessments had not always been updated.

There were three recent incidents where people had fallen and required hospital treatment for their injuries. In each case, the person had fallen previously and staff had not reviewed their risk assessment. For example, one person had a risk assessment in place that stated that they were at 'medium risk' of falls. It recorded that the person needed a walking frame and support from one staff member when moving. The person had suffered two falls in five days, in each case staff were not present. This showed that the existing plan was not being followed and needed reviewing. The risk assessment had not been updated after either fall and no additional measures were introduced to keep the person safe. The person then fell again and suffered a serious injury and was admitted to hospital. The incident form recorded that, 'a call pendant would be vital to wear'. However, this equipment had not been considered proactively in response to the previous incidents.

After the inspection, the provider was able to evidence that people had been referred to healthcare professionals in response to some of the incidents. However, they accepted that the responses to incidents had not been robust enough. They told us that they would monitor incidents more closely and ensure regular reviews of risk assessments took place.

Risks to people were not appropriately managed. The provider had a tool to assess personal risks and they recorded plans on how to keep people safe. However, the plans to manage risk were not clear and records of incidents showed that they were not always followed. For example, one person had a risk assessment for if they left the building unaccompanied. It stated that staff should talk to the person and encourage them to return or call the police. However, when the person had recently left the building, a staff member had gone to find them in their car before calling the police. This lack of clarity on how to manage the risk meant that a staff member was taken from the home to find the person, which impacted on staffing numbers. Staff told us that they did not feel confident supporting this person safely, due to a lack of clarity in the risk management plan.

There were also other people who regularly attempted to leave the building unaccompanied and staff told us that they were unclear on how these risks were being managed. On the day of inspection we observed

people congregated near to the main doors. Each unit had its own locked door but these were not being used, which caused people to wait in the reception area for an opportunity to leave. During the inspection, maintenance work was being carried out on the doors. One person had a history of attempting to leave and we observed that they were left unaccompanied next to the doors for eight minutes. This further demonstrated a lack of awareness of risk.

As a specialist home that supports people living with dementia, some people had specific risks relating to their behaviour. In some cases, risk assessments for this were not in place. For example, one person who was living with dementia sometimes became agitated and aggressive. There was no risk assessment for this and no guidelines for staff on how to manage this behaviour. We observed staff supporting the person on the day of inspection. The person started to become agitated and staff were not able to calm or divert the person.

People's medicines were not managed and administered safely. Medicines administration records (MARs) contained gaps and did not always state the reasons why medicines were not administered. Where PRN (as required) medicines were given, staff did not always record the reason why. Some PRN medicines did not have any protocols in place to inform staff of when to administer them. This meant that there was no guidance for staff on how to use PRN medicines as prescribed by healthcare professionals. These were particularly important as most people were unable to tell staff verbally when they required PRN medicines. Medicines were regularly audited and the provider's last audit had identified gaps on MARs. However, the information was still missing from records on the day of inspection, despite the provider meeting with staff to discuss medicines. Staff had received training in medicines and their competency was assessed. However, records did not show evidence of staff training being revisited in response to medicines errors. This meant that the provider could not ensure that staff that administered medicines remained competent to do so.

The lack of management of individual risks and the unsafe management of medicines was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities 2014).

There were not sufficient numbers of staff present to safely meet people's needs. One relative told us, "Sometimes there's not enough staff. Numbers have ebbed and flowed and there's been a mix of abilities in terms of care." Another relative said, "My personal view is that they are stretched staff wise but they are good with [person]." The provider had a tool in place to calculate staffing numbers based on people's needs. Whilst the staffing levels maintained were accurate to the provider's calculations, we observed that staff were not able to respond to people's needs safely.

Staff told us that they could not safely meet people's needs as there were not enough of them. They told us that they did not get enough time to spend with people. Despite cleaning staff being employed, we observed care staff supporting with cleaning tasks as well as providing care throughout the day. In one unit for people with early onset dementia, staff told us they regularly supported with cleaning tasks. This meant people who required ongoing supervision on this unit did not have their safety assured by staff supervision. At times, we observed one staff member supervising six people on this unit. Records showed that there were regular incidents, many of which had escalated before staff had been able to intervene. This showed that staff were not able to provide the level of supervision required to keep people safe.

We spoke to the provider on the day of the inspection about this and they increased staffing levels with immediate effect. Whilst this demonstrated a robust response, we will require further actions to be taken to ensure that the provider is able to calculate and deploy staff safely on an ongoing basis.

The lack of sufficient numbers of suitably trained staff to keep people safe was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities 2014).

The service did not always follow safe recruitment practices. The provider carried out checks on new staff to ensure that they were of good character, but records showed information was missing from one staff file. The staff files contained evidence of one reference and a Disclosure and Barring Service (DBS) check. These checks are in place to make sure people are suitable to work with vulnerable adults. However, one staff member did not have a reference from their last employer and their work history was incomplete.

The lack of safe recruitment practices was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities 2014).

At our inspection in April 2017, staff had not always taken action to safeguard people from abuse. An incident had occurred that staff had not raised with management that meant safeguarding procedures were not followed in a timely manner. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities 2014).

At this inspection we noted that staff were raising concerns with management when they had them. Although we identified a lack of management of risks, we saw evidence that safeguarding concerns were being raised with the local authority appropriately. We did note that CQC were not always notified of incidents, we have reported on this further in the Well-Led domain. Staff that we spoke to were able to tell us who they would report safeguarding to within the organisation, but they were not aware of which agencies to call. Staff had received safeguarding training but did not demonstrate a full understanding of how to escalate concerns.

The lack of staff knowledge in how to escalate safeguarding concerns outside of the organisation was a continue breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities 2014).

Inadequate

Is the service effective?

Our findings

People's legal rights were not protected because staff did not work in line with the Mental Capacity Act 2005 (MCA). 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 people 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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

After our inspection in September 2016, we recommended that the provider reviewed their practices to ensure that staff worked in line with the MCA. This was because there was a lack of MCA assessments carried out before restrictions were placed upon people.

At this inspection, there was still a lack of MCA assessments in place. The assistant manager told us that they had recently submitted DoLS applications for every person living at the home. However, they told us that they had not completed MCA assessments for all of these people. When we reviewed records, we found MCA assessments in place. However, these had all been completed on the same date and did not state what the decision was that the assessment related to. All assessments had the same wording, stating 'due to a decline in [person]'s dementia, [person] cannot make life changing decisions'. This demonstrated a lack of understanding of the MCA as assessments must be decision specific. This blanket approach to MCA assessments showed people's legal rights were not upheld.

We also saw situations where the MCA had not been applied correctly. Two people who were living with dementia had developed a relationship. The provider had not carried out an MCA regarding their capacity to consent to this. The local safeguarding team had recently identified this as a concern. In another instance, restrictions had been placed upon a person to keep them safe. There had been a lot of resistance from the person as they were able to make decisions in other areas of their life. There had been a number of incidents involving this person in response to these restrictions. Best interest decisions did not contain evidence of the person being involved in the decision. There was also no evidence of how staff had established that this was the least restrictive way to keep them safe. This showed a lack of understanding of the principles and the code of practice of the MCA.
Staff were unable to tell us about the MCA and how it applied to the people that they supported. The impact of this was significant because as a specialist home for dementia care, staff supported a number of people with complex needs relating to their dementia who would be subject to a number of restrictions to keep them safe. We did observe instances where staff asked people's consent before providing care. This showed consideration to people's right to consent to day to day decisions. However, the provider did not have effective systems in place to ensure people's legal rights were maintained.

The lack of MCA assessments and not adhering to the principals and code of practice of the MCA was a

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

Staff lacked the training required to meet the needs of the people that they supported. The home had a specialist unit for people living with early onset dementia. On this unit, people were of a younger age and had more complex behavioural needs. These needs required specialist intervention from staff. The training offered to staff on this unit did not include any specialist training in early onset dementia. Staff had attended a dementia awareness course and some had attended an advanced dementia course. However, these did not equip staff to meet the needs of people with early onset dementia. Staff told us that they did not feel the training given to them was sufficient to enable them to support people confidently

Due to the types of dementia some people were living with, they were more likely to display behaviour that required a response from staff. Some staff had attended 'Challenging behaviour and breakaway' training. However, not all staff who supported people with these needs had attended training. Actions taken in response to incidents showed a lack of staff understanding of how to respond to people's needs. For example, one person had become agitated and hit a staff member. The staff member recorded that they had, 'asked her not to do that and told her it's not very nice to hit people'. This response demonstrated a lack of understanding of dementia and how to support people positively following incidents. A staff member told us, "Staff here are not trained properly. As a result they don't treat people with dignity or equal opportunities." Our observations were that staff skills were not consistent. Whilst we observed some practice that was considerate of people's needs, we observed times where staff appeared to lack knowledge of dementia. We observed one person being supported to carry out an activity. Staff took time with them and explained things patiently, using touch to engage the person which achieved a positive outcome. However, we also observed staff attempting to encourage one person, who was living with dementia, to eat. They all took the same approach of telling the person their meal was ready. They did not deploy any alternative techniques to support the person.

We spoke to the provider about training and they told us they were looking to source a new training provider. They had previously looked for specialist training in early onset dementia but had been unsuccessful in finding an appropriate course. After the inspection, the provider had approached a training provider and told us that they would ensure staff received specialist training. Whilst this demonstrated a response to our concerns, people living at the home with particularly complex needs were not supported by staff that were trained in how to support them.

Staff completed training in mandatory areas such as health and safety, moving and handling and infection control. The training followed the standards of the Care Certificate. This is a nationally agreed framework which sets a basic standard for the skills staff need to have in order to support people safely. Records showed that staff received an induction, however a new staff member said this had been rushed due to the demands of the service. Records showed that training in these areas was mostly up to date, but for newer staff some training had not yet been attended.

The lack of training for staff to meet the needs of people living at the home was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities 2014).

People's dietary needs were recorded. Information on people's allergies was clearly recorded and the kitchen had a list of people's likes and dislikes. People did finish the food that they were served, despite not being offered a choice on the day. People were being weighed regularly to identify any changes in health or nutritional needs. However, our observations on the day were that the food provided was not always sufficient to ensure that people's nutritional needs were met. This was because people were not always offered a choice and people's dietary needs were not always met in the most dignified way. We have

reported on these concerns further in the Caring and Responsive domains.

People had access to a range of healthcare professionals. People's records contained evidence of ongoing involvement of healthcare professionals such as physiotherapists, opticians and dentists. Where concerns were identified, staff regularly contacted the GP. We did see two instances where relatives had needed to prompt staff to take action. In both cases, contact had already been made with healthcare professionals but relatives had felt information given was not clear and had not covered all information relating to the person's health. Whilst we felt staff had already taken some appropriate actions, we identified that communication between staff, relatives and healthcare professionals could be improved. We have reported on this further in the Well-led domain.

Requires Improvement

Is the service caring?

Our findings

Relatives told us that they felt staff were caring. One relative told us, "They (staff) are very good with (person), always very gentle. They will quite often hold her hand to reassure her. It's nice, it's the sort of thing family would do." Another relative said, "I think they do treat (person) very well. I've never had any concerns that she wasn't treated kindly."

Despite these comments from relatives we found people were not always treated with dignity and respect. Staff were rushed at times and focused on tasks. For example, before lunch staff came to put clothing protectors on people. People sat down and staff put them around their necks without speaking to them or interacting with them. Another person was heard calling out during the inspection. We heard the person making a sound as if they were choking so we alerted staff. The staff member responded saying, "[Person] always does that." Staff told us that they 'checked' this person regularly but did not spend time engaging with them.

A number of complaints had been received from relatives about the cleanliness of the home and people's personal care needs not being met. This was consistent with what staff told us. One staff member said that they observed that people's dignity was not always maintained. They described how staff were sometimes, "sloppy with personal care." They said that staff don't routinely wipe people's faces or change their tops if they have food on them. We observed that most people's appearance was maintained on the day of inspection. However, we did notice a strong unpleasant odour in a communal part of the home regularly used by people.

Where people required a pureed diet, this was not done in line with best practice. We observed two people who had a pureed diet and noted that their whole meal was pureed together. This meant people were served an unappetising meal. This was not in line with accepted good practice in care homes and was not a dignified way for people to receive their food. We informed the provider of this and they confirmed that the kitchen staff working on the day of inspection had not been trained in how to serve pureed food in a way that would appeal to people. We noted that people living with dementia were asked what they would like for lunch the day before it was served. This restricted their ability to make an informed choice each day due to short term memory loss.

Some of the language used by staff in people's records showed a lack of respect and an understanding of how to promote people's dignity. Entries seen referred to people 'wailing' or 'bickering'. These types of descriptions of people's behaviour suggested there was a culture in which dignity was not at the forefront of practice.

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

We did observe some practice that was caring and compassionate. Staff joined in jokes with people and were seen joining in an activity which people enjoyed. Staff demonstrated a commitment to people, despite

the shortfalls in staffing that impacted on their ability to spend time with them. For example, one person living with dementia had become confused and was looking for their room. A staff member noticed that they were starting to become distressed and went over to them. The staff member talked to them about an activity and gently encouraged them to come with them.

Staff respected people's privacy. Where people needed support with personal care tasks staff were discreet in how they supported people. Staff were considerate of where they discussed people's personal information. The provider stored personal information safely and had systems in place to ensure that it was secure.

Staff were considerate of people's family, religious and cultural needs. Relatives told us that they were able to visit at any time and that staff were welcoming and offered them refreshments. Information about people's religion and culture were gathered at assessment and recorded in people's records. Religious activities took place each week in the form of hymns on a Sunday for people of Christian faith.

People had opportunities to be involved in their care. We noted people had been involved in choices about décor and the garden. People's rooms had memory boxes outside that reflected their backgrounds and interests. Records did not always show evidence of people and relatives being consulted and offered choices. We did identify concerns with how personalised people's care was and we have reported on this further in the Responsive domain.

Requires Improvement

Is the service responsive?

Our findings

Relatives gave us mixed feedback about how responsive the care was that people received. One relative told us, "The staff do a fantastic job because they're really not easy people to cope with. But they keep me informed and I have been involved with the care plan." Another relative told us, "They did write up a care plan, I am not sure it is always enforced though."

Care was not always delivered in a person-centred way. Where people had specific needs or preferences these were not always followed by staff. Care plans did record some of people's preferences but plans on how to respond to them were not person-centred. For example, one person who was living with dementia had expressed a wish to spend time in their room. They did not want staff support with eating and liked to spend time alone. Staff carried out regular observations on the person as they did not always use their call bell. The person's room was near the end of a corridor where it would take staff longer to notice if there had been any problems. When we observed the person they were sitting in their room in the dark eating their lunch on their own. Whilst the person had requested to eat on their own, this could have been achieved in a more person-centred and dignified way. Another person had slept late on the day of inspection. They woke up around lunchtime and were then served roast chicken by staff. The person was not offered a breakfast. This showed a lack of consideration to the person's routine and whether this was an appropriate meal to eat immediately after waking up.

Another person who was living with dementia was observed asking to leave the building. They believed someone was coming to pick them up. Staff disregarded what the person was saying, and did not try to orient themselves to the person's reality, instead they encouraged them to move away from the door. This showed a lack of understanding of the person's needs and the way in which their dementia impacted on them. We observed staff changing dressings on another person's legs. When asked staff told us that relatives liked this to be done. There was no information about this in the person's care plan. This showed that there was a lack of clarity on people's care needs.

Staff did not always respond to people's changing needs. One person had come to live at the home recently. During the assessment process relatives had provided information to staff about the person's usual daily routine and preferences. The person had always liked to get up early and was fairly active. Within days of moving into the home, the person stopped getting up and became less mobile. Staff did not identify this as a concern despite being given information about how the person usually acted. This meant that a change in need had not been identified as quickly as it could have. Staff contacted healthcare professionals but relatives told us they had to prompt staff to do this.

Activities were not always based on people's needs and interests. There was an activity timetable each week that contained a variety of group activities. These included quizzes, music, art and gardening. However, there was not always input for people on a one to one basis. The home employed two lifestyle co-ordinators. They took the lead on developing activities and working with people. In some cases people were supported to engage in activities that suited their needs and interests. Where one person with complex needs enjoyed woodwork and building, they had been involved in creating beach huts in the garden. Others

had helped in planting flowers and developing the garden. However, these types of activities were not always taking place with people. Where staff were too busy with other tasks they were less able to spend time with people outside of group activities. We observed a group activity taking place and people were engaging and participating. However, people who were not able to participate were observed walking around the home with little engagement from staff.

The lack of person-centred care was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities 2014).

Relatives told us that they knew how to complain. One relative told us, "I've never had to complain about anything and yes I do think they respond to what's needed." The provider kept a record of complaints and recorded what actions they had taken in response. Responses were made within the providers timescales and individual complaints were responded to. As we reported in Caring, there was a theme to complaints. We did not see any evidence of the provider analysing and learning from these complaints to address the themes identified.

We recommend that the provider reviews their processes for analysing complaints and using them as an opportunity to improve.

Inadequate

Is the service well-led?

Our findings

There was a lack of communication with relatives when incidents occurred. One relative told us, "The communication in the home is not very good, you can tell one person something and then when you come in next time you see a different face and the message hasn't been passed on." We heard from two relatives that they had not been told about recent incidents. In one case a person had been involved in multiple incidents before a letter was sent to the relatives informing them of these. This showed a lack of openness and transparency. We spoke to the provider regarding this and they said they usually send a letter. They understood our feedback and said they would consider alternative methods for communicating with relatives, such as telephone calls or meetings. Relatives also told us that information from healthcare appointments was not always relayed correctly and accurately. We saw one example where someone was due to see their GP and staff had not included all the information in the referral. Relatives then prompted staff who corrected their original referral.

We recommend that the provider reviews their systems for keeping relevant persons informed of important incidents or events in a timely manner.

There was a lack of leadership and management support for staff and staff told us that they felt unsupported by management. At the time of inspection, the registered manager was on long-term leave. Management cover had been arranged but this had not worked and an assistant manager had left. This meant that staff were not clear on where to go if they needed support or wished to raise concerns. Before the inspection, we had received concerns from staff anonymously. The concerns were about the culture amongst staff, as well as the care that people received. When we asked staff about this they all confirmed that they felt that there was a lack of support and leadership at the home and this impacted negatively on the culture at the home.

There was a lack of provider oversight and governance at the service which impacted negatively on the care that people received. For example, the concerns we found with responses to incidents were exacerbated by a lack of oversight of records. There had not been an analysis of incidents for three months at the time of inspection. This had meant patterns and trends to incidents had gone unnoticed which had exposed people to risks.

Audits were taking place at the home, but they had not identified the concerns that we found. Where we found issues relating to people's food and dignity, the provider's audits had not found these concerns. The provider had identified issues with medicines, but they had not been addressed robustly so the improvements were not in place at the time of our inspection. People's records were kept up to date in some cases, but there was a lack of oversight that meant some people's records did not contain important information about their routines and preferences. These were especially important for people living with dementia who were less able to inform staff of their wishes.

The home was not delivering the service that it had set out to. When registering new care homes, providers send CQC a Statement of Purpose. This document outlines the objectives of the service and how they will

meet them. In their Statement of Purpose, the provider said that they wished to provide specialist support to people living with dementia, including people under 65. We noted that the provider's website also advertises to the public and stakeholders as a specialist in dementia care. Based on our findings, the provider is currently not providing care in line with its own objectives.

The lack of leadership and governance and shortfalls in the provider's audits were a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had not met all of the requirements of their registration. When certain events occur, such as safeguarding, injuries or deaths, the provider is required to notify CQC of these. We found that in some cases notifications had not been submitted to CQC when required. We found a number of incidents where notifications had not been sent to CQC. For example, the police had been contacted due to incidents at the home on four occasions in the last two months. We received a notification in once instance but not in the other three. We found records of incidents where people's behaviour had affected other people and notifications had not been submitted to CQC.

The failure to submit notifications to CQC was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.
A requirement of registration with CQC is that providers must display their ratings both in the home and on their website. This is to ensure openness and transparency with the public and stakeholders. The provider's website did not make reference to the last CQC report and rating.

The failure to display their most recent CQC rating was a breach of Regulation 20A of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw evidence of meetings involving people and relatives in the running of the home, however we noted that there had not been a meeting since May. This meant that opportunities to involve relatives had been limited. Staff meetings were taking place, however the provider will need to review their effectiveness following the feedback that we received from staff that they felt a lack of support and involvement in the running of the home. The provider informed us following the inspection that they had arranged urgent meetings with staff and people to discuss our findings and identify a plan to address the concerns that this inspection identified.