Care Unlimited Group Ltd

Chaldon Rise Nursing Care Home

Inspection report

Rockshaw Road
Merstham
Redhill
Surrey
RH1 3DB

Tel: 01737642281
Website: www.careunlimited.co.uk

Date of inspection visit:
27 April 2017

Date of publication:
02 June 2017

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection was carried out on 27 April 2017. Chaldon Rise Nursing provides long term care and support for up to 34 older people some of whom have dementia, a mental health diagnosis, physical disability or learning disability. Short term placements are offered to provide respite care. At the time of our inspection there were 25 people living at the service.

There was a registered manager in post and present on the day of the inspection. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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.

At the previous inspection we identified a breach in regulation 11. People's consent was not always being gained before care was delivered. The provider sent us an action planned to say that this had been addressed however on this inspection we still found concerns.

People's consent was not always being gained in relation to the Mental Capacity Act 2005 (MCA), and the Deprivation of Liberty Safeguards (DoLS). These safeguards protect the rights of people by ensuring if there are any restrictions to their freedom and liberty, these have been authorised by the local authority as being required to protect them from harm. Assessments had not been completed specific to the decision that needed to be made around people's capacity. DoLS applications had been submitted to the local authority where it may have been appropriate however people's capacity had not been assessed before they were submitted.

There were not always enough staff deployed in the service provide safe care to people. There was not enough information to guide staff in how to reduce the risks to people. Incidents and accidents were not always followed up and actions were not always put in place to reduce the risk of incidents. Despite people stating that they felt safe they were not always protected from the risk of abuse. Safe recruitment practices were not always followed. The cleanliness of the premises and equipment was not well maintained which put people at risk.

People were not always receiving care from staff that were competent, skilled and experienced. There was a risk that people were receiving care from staff who were had not had training to meet the needs of people living with dementia, mental health and other health care needs. Staff competencies were not assessed as they did not always have appropriate supervision or appraisals.

People were not always provided with choices that met their reasonable preferences at meal times. People were not always treated with dignity and respect in relation to the care that they received. We did see times when staff were caring and considerate to people. People told us that staff were kind towards them.

The provider was not always responsive to people's needs. There was a lack of pre-admission assessments before people moved in which should have identified that the service could not meet their needs. There were also other people at the service whose needs could not be met. There was a lack of detailed information in some people's care plans around the support they needed. However in other care plans there was guidance for staff and staff received the appropriate care in relation to this.

There were not enough activities on offer specific to the needs of people. There were periods of time where people had no meaningful engagement with staff. People did not always have the opportunity to go out.

There were not effective systems in place to assess and monitor the quality of the service. Although an audit had been undertaken this had not been used to improve the quality of care for people. People were not given opportunities to be involved the in the running of the service or provide feedback to improve the quality of care.

People's medicines were being managed in a safe way however staff had not always been competency assessed in medicine management.

Personal evacuation plans were in place for every person who lived at the service and staff had received fire safety training. People at risk of dehydration or malnutrition had systems in place to support them however records that related to recording what people had eaten and drunk were not always maintained. People had access to health care professionals to support them with their health needs.

There was a complaints procedure in place. Where complaints had been received these were investigated thoroughly.

Services that provide health and social care to people are required to inform the Care Quality Commission (CQC) of important events that happen in the service. The provider had informed the CQC of significant events.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The overall rating for this service is 'Inadequate' and the service therefore has been placed 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 time frame. If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service.

This will lead to cancelling their registration or to varying the terms of their registration. For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the

service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

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.

There were insufficient staff at the service to support people safely. Recruitment practices were not safe and relevant checks had not been completed before staff commenced work.

People were not protected against the risk of abuse.

People did not always have risk assessments based on their individual care and support needs and were not always protected from environmental risks. Infection control procedures was not always being followed by staff.

There were aspects that risks to people were being acted upon by staff.

Medicines were administered, stored and disposed of safely. However staff were not always assessed as competent to administer medicines.

Is the service effective?

Requires Improvement

The service was not effective.

People were not always supported by staff that had the necessary skills and
knowledge to meet their needs. Staff did not always receive training and supervisions.

Staff were not applying the legislation that supported people to consent to care and treatment. Where restrictions were in place this was not always in line with appropriate guidelines.

People had enough to eat and drink and there were arrangements in place to identify and support people who were nutritionally at risk. However people were not always provided choices with meals.

People were supported to access healthcare services and healthcare professionals were involved in the regular monitoring of people's health.

Is the service caring?

Requires Improvement

The service was not always caring.

Staff did not always treat people with dignity and respect.

However we did see occasions where staff were kind and attentive towards people.

People's preferences, likes and dislikes had been taken into consideration.

People's relatives and friends were able to visit when they wished.

Is the service responsive?

Inadequate

The service was not responsive.

People's needs were not always appropriately assessed when they entered the home and on a continuous basis.

People did not always have access to activities that were important and relevant to them. People did not always have opportunities to go out on trips.

Complaints were investigated with the necessary action recorded and responded to.

Is the service well-led?

Inadequate

The service was not well- led.

The provider did not have effective systems in place to regularly assess and monitor the quality of the service. Although areas of breach around consent from the previous inspection had been addressed there were other aspects to the regulation that were not being met. Additional breaches had also been identified.

The provider had not actively sought, encouraged and supported people's involvement in the improvement of the home. Where relatives' feedback was sought, this was not always used to improve the quality of care.

People and relatives said that staff and management were always there to speak with when they needed to. Staff said that they felt supported.

Chaldon Rise Nursing Care Home

Detailed findings

Background to this inspection

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

This was an unannounced inspection which took place on 27 April 2017. The inspection team consisted of three inspectors and a nurse specialist.

We received anonymous concerns prior to the inspection about the quality of care that people received. Before the inspection we reviewed the information we had about the service. This included information sent to us by the provider, about the staff and the people who used the service. We reviewed notifications sent to us about significant events at the service. A notification is information about important events which the provider is required to tell us about by law.

During the visit we spoke with the registered manager and the provider, five people, six members of staff and two visitors. We looked at a sample of four people's care records, medicine administration records and supervision records for staff. We looked at records that related to the management of the service which included minutes of staff meetings and audits of the service.

After the inspection we spoke with one health care professional and one relative of a person that lived in the service.

Inadequate

Is the service safe?

Our findings

People told us that they felt safe at the service and that when they needed staff they were available. One person told us that when they used the call bell staff arrived promptly. They said, "I've got no complaints on that score." Another told us that they chose to spend most of her time in their room and that they used the call bell when they wanted staff and they came promptly. They said, "If you need someone, you can use your call bell or you can just shout." One relative told us, "I have peace of mind. I feel my (relative) is safe as staff are very caring." Despite these comments we found that people were not being cared for safely.

People were not always protected from the risks of unsafe care. Accidents and incidents were not always analysed with action taken to reduce the risks. For example one person had been found on the floor. The incident form stated that this was 'a one off' and no action was being taken to reduce the risk of this happening again. However the person had a repeat of the incident and action was only taken after the second incident. Gathering and analysing information on incidents and accidents helps to anticipate and prevent incidents and should be used to respond to problems once they have occurred. There had been eight incidents with one person over a five-day period. There was no evidence that these incidents had been analysed. The registered manager told us that they were not aware that they had to analyse these or other incidents and accidents to look for trends.

Appropriate infection control procedures were not always being followed, which put people at risk. There were commodes in people's rooms that had not been cleaned and smelled strongly of urine. The seat of one of the commodes was soiled with dried faeces. Bags of soiled clothes had been left in the garden in a large bin without a lid that could be assessed easily. There was also soiled clothing in a bag left in a bucket in one of the bathrooms that could be accessed by people. There was rust on the joints of handrails that helped support people when using the toilet and pieces of plastic wrapping were on the legs of a commode which prevented it from being cleaned properly. In one of the bathrooms there was no hand soap for people to wash their hands.

Some risks to people were not being managed appropriately. There were people at the service who smoked. In the area where people smoked there was no fire safety equipment for use in the event of an emergency. Their risk assessments did not show that they had been offered smoking aprons and the registered manager confirmed that this did not happen despite them being aware of the risks. There were people that had a diagnosis of diabetes. Testing the person's sugar levels in the blood helps identify if people are becoming unwell. However two of the people at the service were not having their blood sugar levels tested.

Risk assessments for people were not detailed and did not always reflect the most up to date needs for people. One person's care stated that they were at a high risk of falls but there was no evidence of appropriate action taken to minimise risk. The action plan in place to address this risk stated, 'Ensure my continence routine is effective.' There was no other guidance for staff around this. We identified from a care plan that one person was nutritionally at risk however they had not been weighed since December 2016. This was addressed on the day of the inspection.

As safe care and treatment was not always provided this was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were insufficient staff to meet people's needs. One visitor told us, "They appear to be short staffed." During the inspection people were left for long periods of time without the support from staff. We found that two of the care staff were providing one to one support to two people, leaving four care staff to support 22 people. Staff were task focused on the day and very little time was left for them to interact with people in any meaningful way. One person wanted to get up out of his chair however staff encouraged them to sit back down. This person had been trying to get up for some time and staff had repeatedly encouraged them to sit back down rather than encourage them to get up or ask why they wanted to move.

Staff told us that there were not enough staff working at the home. One member of staff told us, "Based on the challenging behaviour of people here we have not got enough staff." We asked what impact this had on people and they told us, "People are not getting enough time with staff." Another member of staff said, "Sometimes I feel there is not enough staff. We have a lot of one-to-ones (with people)." A third told us, "They need more staff, especially when they have so many one-to-ones. It affects the more independent people because we have to spend all our time with the more high needs people."

The registered manager told us that there should be six care staff and nurse one during the day to support people. They said that the numbers of staff had been calculated based on the number of people living at the home and did not take into account their individual support needs. One member of staff said, "The ratio should be based on the needs of people and not the numbers." We reviewed the staff rotas over an eight-week period and found that on 38 days there were less than the assessed numbers of staff required. In addition to this the registered manager advised us that they had on occasion worked without a nurse being on duty. As the service is a registered nursing home there is a requirement for there to be a registered nurse on duty 24 hours a day. The registered manager told us that they had struggled to recruit care staff and nurses and relied heavily on agency staff to fill the gaps. The provider told us that not having a nurse on duty was not acceptable and acknowledged that there should be a nurse on duty 24 hours a day. The registered manager told us that there were three people who needed one to one support from staff and that, "I feel (people) are getting unsafe care at the moment. On a normal day six carers are not enough." The provider told us, "Staffing is an issue." They told us that there were trying to get funding for two of the people to receive one to one care but that this was proving to be difficult.

As there were not sufficient staff to support people this is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not safeguarded against the risk of abuse. There were people at the service who had behaviours that challenged. These behaviours put other people at risk of being harmed. For example one person showed aggression towards people and staff on a daily basis. This impacted on the lives of people who lived there. The registered manager told us, "X does hit people over the head. We don't feel we can keep X safe or others." They told us that the person was now on a one to one with staff but that this did not prevent the incidents from occurring. There was a safeguarding policy in place that stated, 'The organisation will ensure that Service Users are safeguarded from abuse in all forms' and that 'Chaldon Rise Care Home has a duty to Safeguard people using the service' however this was not being followed. Not all staff had received training in safeguarding. We reviewed the records and found that 15 of the 35 staff employed had not received safeguarding training. This meant there was a risk that not all staff would have knowledge of what constituted abuse or how to respond if they suspected abuse.

There were people at the service that were unable to communicate and were unable to move

independently. There were frequent occasions during the inspection, in the lounge where these people were sitting, where other people were being verbally aggressive to each other. No steps were taken by staff to remove either the people that were being aggressive or the people having to endure this behaviour.

As people were not always being protected from the risks of abuse this is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not protected from being cared for by unsuitable staff because robust recruitment procedures were not in place. The providers policy stated that any potential member of staff would not be offered a position until 'At least two satisfactory written employer references have been received for that candidate, including one from the last employer..' and that 'one of which must be from the previous employer'. None of the three files we looked at had more than one reference. One reference only stated that the staff member had worked at the previous employment but had no other detail. There was no evidence of any character references for them. In another member of staff's file the reference had been obtained from their friend with no evidence of references from their previous employer. The member of staff had stated on their application form that they had previous care experience however the registered manager told us that when they contacted the care establishment they had not heard of them. Despite having this knowledge they had not recorded this in the recruitment file and had not followed this up with the member of staff. In the third file the reference had been provided by an ex-colleague and there was no evidence that the member of staff's previous employer had been contacted for a reference.

In another file there was no evidence of a Disclosure and Barring Service (DBS) check (that helps employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups). There was evidence in the file that the member of staff had criminal convictions however there was no evidence this had been followed up or considered before they were recruited. Neither the provider nor the registered manager were aware of this history. In this instance the provider told us that they were going to follow this up.

As safe recruitment was not always followed this is a breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The management of medicines was undertaken in a safe way. We examined the medicines administration records (MAR) and observed the dispensing of medicines. MAR sheets were up to date and properly completed. The member of staff was knowledgeable about the medicines they were giving. Medicines were labelled with directions for use and contained the date of receipt, the expiry date and the date of opening. Other medicines were safely stored in lockable cabinets. Medicines requiring refrigeration were stored in a fridge, which were not used for any other purpose. The temperature of the fridge and the room where it was stored was monitored daily to ensure the safety of medicines. However we noted that staff giving medicines had not been assessed regularly to assess their competency to do so. We discussed this with the registered manager on the day who advised us that this would be addressed.

Requires Improvement

Is the service effective?

Our findings

At our inspection in February 2015 we found that staff did not always follow the principles of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). At this inspection this had not improved.

People's rights were not protected because staff did not act in accordance with the MCA. The MCA is a legal framework about how decisions should be taken where people may lack capacity to do so for themselves. It applies to decisions such as medical treatment as well as day-to-day matters. No mental capacity assessments were undertaken to ensure people's rights were protected. In each person's care plan it stated whether the person did or did not have capacity to make decisions however there were no assessments to establish how they came to this conclusion.

The registered manager told us that one person lacked the capacity to make decisions about their care and health and that, "(The person) can make decisions but they are not in their best interest." There was no assessment of the person's capacity or evidence of best interest meetings to ascertain whether the person lacked capacity. Where people had medicines covertly (covert medicines is the administration of medicines in a disguised form) there were no mental capacity assessments to establish if the person had capacity to make an informed decision.

The registered manager told us that some relatives had lasting power of attorney over people's health and welfare. (A lasting power of attorney (LPA) is a legal document that allows appointees to help make decisions or to make decisions on a person's behalf.) However for one person the LPA was only for the person's finances yet the representatives had been making decisions about their family member's health. Staff were able to explain the principles of the MCA to us. One told us, "If they lack capacity they may not make decisions that are in their best interest." The service policy stated that 'Any assessment of someone's capacity will be decision specific and time specific to decide whether someone can make a particular decision at the time it needs to be made." It also stated 'There should never be a generalised statement that a person lacks capacity.' However despite staff knowledge clear guidance in the policy this was not being followed.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. These safeguards protect the rights of people by ensuring if there are any restrictions to their freedom and liberty, these have been authorised by the local authority as being required to protect the person from harm. The registered manager told us that applications for DoLS authorisations had been made to the local authority where restrictions were involved in people's care to keep them safe. For example when they wanted to leave the service or were refusing care however these were not supported with MCA assessments to establish if people had the capacity to make these decisions.

As care and treatment was not always provided with the appropriate consent this is a continued breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Not all staff were not suitably skilled and experienced to meet people's needs. Some of the people at the home were living with dementia or had mental health diagnoses. Some people exhibited behaviour that challenged as a result of their dementia. Other people had learning and physical disabilities. At the time of the inspection 16 of the staff employed had not received training in dementia, 33 had not had training in mental health or learning disability and 19 had not received training around challenging behaviour. One member of staff told us, "We could do with challenging behaviour training." They told us that they and other members of staff found it difficult to manage people's behaviours.

There was regular use of agency staff at the service who did not always have knowledge or understanding of people's needs. One member of staff said that agency staff were competent but that they did not always know people's needs. They said, "They are good but they don't know the clients. It doesn't matter how good you are if you don't know the place." This was reflected in the conversations that we had with agency staff on the day. They told us that they were given a brief handover in the morning but had not read people's care plans and did not have detailed knowledge about people.

There was a risk that staff did not have knowledge of care that was required for people. We asked the provider for the training matrix for staff. There were large gaps in the mandatory training for staff. For example, out of 35 staff 13 had not received any training in first aid, 24 had not received MCA training, seven had not received moving and handling training and nine had not received infection control training. Clinical staff had also not received up to date training. According to the training record, nurses had not received wound care, basic life support or catheter care training since working at the service for the last year. The provider's policy stated, 'All staff will receive training in their roles, and in this training will ensure that certain standards of competencies are met'. However the provider was not following their own policy in relation to this.

Staff did not always receive supervision to assess their competencies in their role. The provider's policy stated that supervisions needed to take place every two months. We asked for the evidence of all supervisions that were taking place at the service. Of the 35 staff we were only provided with the supervision details for 21 of them. Some staff had received regular supervision. Of the 21 staff listed two had not had a supervision for over four months. The nurse that worked on duty most days had not any clinical supervision despite having worked there for more than a year. There were areas of clinical practice that required improvement. Appropriate supervision may have identified where these practices could have been improved. For example the lack of blood sugar monitoring for people with diabetes, the lack of clinical notes in people's care plans and the lack of recorded catheter care.

As staff were not always receiving the appropriate training and supervision to undertake their role this is a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked people whether they liked the food at the service. One person told us, "The food is fine" whilst another said, "The food is great." One relative said, "The food always looks good. (Their family member) has put on weight since moving in."

We observed lunch being served. Collapsible picnic tables were brought into the lounge for four people. Other people were supported to walk into the dining room to eat their meal. We asked a member of agency staff why the collapsible tables were brought in to the room for some people. They told us that this was for people who could not mobilise who always ate in the room and did not go into the dining room. This meant that they were not given the choice of where they wanted to eat. When food was served to people no choices were offered and staff did not tell people what the meal was. One person was heard asking a member of staff what the meal was. Staff told us that people were asked in the morning what they wanted.

However consideration was not given for those living with dementia that may not be able to remember what they had chosen. Those that were on a restricted diet (for example a soft diet) were not given choices of a meal.

During the inspection three people asked us for a drink when we spoke with them and we had to ask for people in their rooms to be provided with drinks as the cups and jugs were empty. The provider told us that this was not acceptable and would ensure that people had access to drinks at all times.

The chef was unable to show us a list people's dietary requirements. They were able to tell us who required a softer diet but they did not have information around those that were diabetic or any other dietary requirements. The registered manager told us that this would be addressed straight away as the information should have been available to the chef.

People that needed assistance were supported to eat their meal by staff. Staff offered to cut meals up for people where needed. We could see that people were enjoying the meals that were provided. People eating in their rooms received their meals at the same time as people in the dining room. The food looked and smelt appetising. Nutritional assessments were carried out as part of the initial assessments when people moved into the service. These showed if people had specialist dietary needs. People's weights were recorded and where needed advice was sought from the relevant health care professional.

We recommend that people are provided with choices of meals and always have access to drinks throughout the day.

One relative told us that when their family member was unwell the staff, "Always call the GP. They are very hot on that." People's care records showed relevant health and social care professionals were involved with people's care. Records showed involvement of the GP, the mental health team, community nurse, Tissue Viability Nurse, dietician and Speech and Language Therapists. Staff followed the guidance provided by the health care professionals. One health care professional told us that staff always followed the guidance that they gave. They said that the staff always contacted them when it was appropriate to do so.

Requires Improvement

Is the service caring?

Our findings

People were not always treated in a dignified and respectful way. People did not always look clean and well groomed. One visitor told us that one person regularly looked unkempt and in need of a shower or bath. Another visitor told us that people that lived at the service did not always look clean. We noted that one person's dental hygiene was not being maintained. One member of staff told us that this persons dental hygiene needs were not being met. They said that on a good week people should be having three baths or showers a week. When asked how often this happens they said, "Most weeks people are only get one bath or shower a week. There is a schedule of when baths are done but carers don't have enough time. " There were rooms that smelled strongly of urine that remained throughout the day. This was specific to certain people's rooms which would have been unpleasant for those people living in them.. One visitor told us, "I can often smell urine when I come here now."

There were times during the inspection where staff were not attentive to people's needs. We observed care in the lounge and found that for more than an hour, of the nine people in the room, only two had any interactions and these were the people that were being supported on a one to one basis by staff. Staff were task focused for the majority of the time and there was no attempt to engage and talk with people in a meaningful way other than to offer people drinks. The nine people in the lounge were of varying ages yet during our observations the only music playing was from the 1940s. This being played at quite a loud volume which made it difficult for people to hear what was being said. One person asked if the music could be turned down, staff recognised that this is what they were saying but did not act upon this. One member of staff said the music was too loud but did not turn it down. We raised this with the registered manager who advised us that people should have been asked what music they wanted to listen to. They addressed this with staff straight away.

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

People and visitors were complimentary about the caring nature of staff. Comments included, "On the whole the staff are caring", "The carers are great", "Staff are nice. It's as if I'm at home", "They (staff) are very pleasant. I think they are very good. Everyone's been very friendly and helpful. The staff I've seen have been very caring." One relative said, "Staff are very caring. It's nice when they (staff) take the time to acknowledge (their family member)."

There were aspects of dignity and privacy that were maintained with people. When staff went into people's rooms they knocked on the door before entering. When personal care was being provided to people staff ensured that the curtains and doors were closed to maintain people's dignity. We observed one person wanted their glasses and staff immediately got them and gave them a clean before handing them to them. On another occasion staff noticed a person's trousers were slipping down and pulled them up for them.

There were times where staff showed concern for people's wellbeing in a kind and meaningful way. One member of staff assisted a person to eat sensitively and with encouragement. On another occasion a

person started gently poking another person in the ear who was asleep. Staff noticed this quickly and intervened to stop them from doing this. We saw staff acknowledged people when they walked past and asked them how they were. There were occasions where staff chatted to people in the registered manager's office and took an interest in what the person was saying to them. One member of staff told us, "I love working here."

There was evidence in people's care plans that people and relatives (where appropriate) were involved in the planning of their care. One relative said, "I feel very involved. When we have new care plans in place we are asked to read them to see if we agree with them." There was information around how people communicated, their likes and dislikes and whether they had a preference to a male or female carer. One visitor told us that the person they visited only wanted female carers and that this was adhered to. People had the choice of when they wanted to get up and where appropriate where they wanted to spend their time in the service outside of meal times. Relatives and friends were encouraged to visit and maintain relationships with people. We saw people visiting through the day.

Inadequate

Is the service responsive?

Our findings

Pre-admission assessments of people's needs were undertaken before they moved in. However these were not always used effectively in determining whether their needs could be met. One person had been at the service a short time and a decision had been made that staff were unable to meet their needs. The registered manager told us that after a short period the person was given notice to leave the service. Another person with challenging behaviour had been admitted to the service. The registered manager told us that they only admitted the person as suitable alternative placements could not be found by the local authority. Staff told us that they had difficulty in managing this person's behaviour. We asked to look at the pre-admission assessment for this person to determine what information was obtained before they moved in but this could not be located by the registered manager.

The provider's statement of purpose stated that 'A pre-admission assessment will be carried out to assess the suitability of the match between your needs and the Services facilities of the Home…Offer skilled care to enable people who live there to achieve their optimum state of health and well-being'. We looked at the pre-admission assessments for one person. They lacked detail around the people's needs and behaviours. In the pre-admission assessment completed by the registered manager it had been identified that they had an 'eating disorder' however the staff at the service had not had training around this condition. The registered manager told us that they had difficulty in managing the person with this condition. The provider's statement of purpose does not state that they can offer care to people with an eating disorders. There was another person that lived at the service whose care needs could not be met. The provider told us, "We should have been stricter when agreeing to take [person] into the home."

The provider had admitted people with dementia, several of whom exhibited challenging behaviour, people with mental health needs, people with nursing needs, people with learning disabilities and people with physical disabilities. The provider had not ensured that staff had the skills to meet people's individual needs

There was a risk that staff were not providing the most appropriate care to people due to a lack of care planning. One care plan stated that the person was incontinent and that there was a risk of infections as they had a catheter in place. There was no additional guidance for staff about the care required in relation to the catheter for example to record the input and output of fluids. Another person had a diagnosis of diabetes. Although the care plan detailed the effects of people's blood sugars levels being too high or too low there was no guidance for staff on what to look out for should they become unwell.

In one person's care plan there was a 'behavioural management strategy' that stated that staff should speak to the person slowly and try to distract them by asking if they wanted a drink or to go for a walk in the garden. We observed that staff tried these techniques when the person exhibited challenging behaviours but these strategies were not effective in managing the person's behaviours.

People did not always receive care and support that met their needs. The provider's statement of purpose stated 'Chaldon Rise Care Home has a policy of actively promoting the maintenance of Service Users normal social network and social activities'. We saw no evidence of this taking place on the day of inspection. During

the morning and the afternoon people did not participate in meaningful activities. In the main people were sat in the lounge whilst music was playing. One visitor told us, "Activities have died."

The provider was currently recruiting a new activities coordinator. They told us, "We know (activities) it's not right and where we want it to be." The registered manager told us they were not able to "Offer people opportunities to go on trips out as the home's vehicle needed maintenance." They acknowledged however that steps could be taken to arrange suitable alternative transportation for people. There had been seasonal events at Christmas and in the summer. People with a learning disability were also provided with a 30-minute exercise and mobility session from an external company once a week. Entertainers attended the service and people did have access to art therapy however on a day to basis the activities were lacking. One member of staff said, "We have music on but there is not enough for people to do. Behaviours from people would be different if there was more for them to do." One relative said, "They (people) could do with going out and sitting in the garden a bit more."

Care and treatment was not always provided that met people's individual and most current needs and people were not supported to follow their interests and take part in social activities This is a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

We did see other care plans that were detailed around the guidance staff needed to provide care. For example, one person had been diagnosed with a mental health condition. There were detailed instructions concerning how the person needed to be cared for and staff were following this guidance. Other people's care plans had a description of their medical history, moving and handling, skin care and sleep routine and how people needed and wanted to be supported.

Complaints and concerns were taken seriously and used as an opportunity to improve the service. One relative told us, "Any niggles are dealt with professionally and quickly." There was a complaints policy in place and people that we spoke with did not have any concerns with the care that they received. There had been four complaints since April 2016 and these had been investigated thoroughly and people and their relatives were provided with a detailed response with a plan of actions taken. For example one person complained that there was not sufficient fruit in the person's room. Staff were reminded to ensure that fruit was always available for the person. We saw that the person had fruit available to them on the day of the inspection.

Inadequate

Is the service well-led?

Our findings

There were aspects of the provider's quality assurance that were not effective and had not always identified the gaps that we identified during the inspection. In February 2017 a quality assurance visit was undertaken by the provider's quality manager. This audit had not identified the low numbers of staff on duty, the lack of mental capacity assessments and best interest meetings, poor recruitment practices and the lack of staff training. However there were aspects of the audits that had identified the lack of supervisions, the lack of updated information on behavioural care plans and the lack activities. These are areas that we identified during the inspection that had still not shown sufficient improvement. We were provided with additional audits that had been undertaken in relation to pre-admission assessments, risks, care planning and recruitment. However the audits had not identified the any of the concerns that we had raised.

We asked the registered manager to advise us of any concerns that they had where they felt improvements were needed. They told us at the beginning of the inspection that their main "challenge" was recruiting additional staff and keeping people safe from other people's behaviours. However no further detail was given around this until we raised with them our concerns over the lack of activities and poor record keeping. The registered manager told us that this was also a concern of theirs but they had not mentioned this to us when we asked at the start of the inspection.

Records at the service were not always kept up to date or accurate. The records kept in the main office were difficult to find and were disorganised. Records that related to one person's pre-admission assessment could not be located on the day of the inspection. We have still not been provided with this information. Food and fluid charts had not always been completed where appropriate. For example one person needed to have their fluid intake monitored as they were at risk of dehydration. We asked to see these on the day but they could not be located. The provider confirmed that these had not been completed and ensured that this was implemented on the day. The registered manager told us "Documentation was one of my worries."

Where there were hourly check sheets in people's rooms they were not always completed. On some days the checks were blank. Where it was recorded that people were awake through the night there was no accompanying documentation to confirm why this was. In one instance the member of staff had completed the sheet two days in advance of the care being provided. This meant that staff could not be assured the appropriate care had been provided. We could see from a staff meeting in December 2016 that the registered manager had reminded staff to complete the appropriate records of care.

Relatives and health care professionals were given an opportunity to complete surveys to provide feedback about the care being provided to people. The last completed survey was in 2016 and on the whole the feedback was positive. Concerns had been raised about the shortage of staff and the lack of activities however there was no action to show how this was being addressed or whether the people leaving these comments had been contacted about this.

People's input was not always asked to improve the quality of their home. People had not been supported to complete surveys and yet there were people that would have been able to give their feedback. The

bedrooms had recently been painted however people were not asked what colour they wanted their bedroom walls to be. All of the walls had been painted in the same colour. One member of staff told us that plans were in place to personalise more bedrooms but that, "People were not involved in the redecoration." The registered manager told us that residents meetings did not take place and that "I know that's not where it needs to be." They told us that plans were in place to address this.

There were people at the service of varying ages and disabilities. There was insufficient management oversight as the provider had admitted people whose needs could not be met. The impact of this was that several people had been given notice to leave soon after being admitted.

The lack of effective systems and processes in relation to quality assurance and lack of appropriately maintained records is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider told us, "I have noticed things are failing. We've got more to do." They told us, "There had been a restructure at Head Office as we tried to cut down on too much bureaucracy but the changes had not worked." The provider contacted us after the inspection with an initial action plan of areas that they were addressing. They told us that they were considering the appropriateness of the placements of some people at the service and that checklists for staff were to be implemented. They also told us that care plans and mental capacity assessments would be updated and that activities would be increased. They said that the commodes had been deep cleaned and, where appropriate, equipment replaced. We will check these actions have been undertaken at the next inspection.

People and visitors were happy with the registered manager and said that they could approach them when they needed to. We did see that the registered manager had an open door policy and saw people accessing the office through the day. One person said, "I'm happy with the way the place is run." A visitor told us, "She is a good manager and trying her best." One relative told us, "The manager is very accessible and so are all the staff."

Staff were also complimentary of the registered manager and felt supported. One told us "If I need to speak to her, she is very good." Whilst another said, "The manager really supports me. I have learned a lot and I feel valued as I get thanked." One relative wrote to the provider and stated, 'She has a great ability and gift in the way she treats residents and their relatives and how she guides staff.' One health care professional told us, "(The manager) has come in and provided good structure at the home."

There were audits that were being used to improve the quality of care. As a result of these audits there were action plans detailing the improvements being made. For example in relation to fire safety training, the safety of the environment and key workers being allocated to people. Staff attended regular meetings that were used to improve systems around the service. In one of the meetings it was discussed that better maintenance was required in the kitchen and this had been implemented. In another meeting staff were reminded to allow people the time to eat their meals and we saw that this was happening on the day.

Services that provide health and social care to people are required to inform the Care Quality Commission (CQC) of important events that happen in the service. The registered manager had informed the CQC of significant events at the service including safeguarding concerns and incidents and accidents.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider was not providing safe care and treatment.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The provider did not ensure that people were always treated with dignity and respect

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider did not ensure that appropriate consent was gained from people.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not ensured that safe care and treatment was always provided.

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

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 The provider had not ensured that there were robust quality assurance processes in place and that records were maintained appropriately.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider had not ensured that robust recruitment was being practiced.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had not ensured that there were sufficient staff to support people and that staff had received appropriate training and development