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Epsom Lodge

Inspection report

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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?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

This inspection was carried out on the 8 March 2017. Epsom Lodge is a residential care home without nursing for up to 13 people, most of whom are living with dementia. On the day of our inspection 10 people lived at the service.

There was no registered manager at the service. The manager that had been working at the service had not submitted an application to the Care Quality Commission (CQC) at the time of the inspection. A registered manager is a person who has registered with the 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.

There were not always enough staff deployed in the service at night to safely provide care to people. However there were sufficient staff on duty during the day.

Risk assessments for people were missing or incomplete and other assessments were not always detailed. There was not enough information to guide staff in how to reduce the risks to people and protect them from harm. Incidents and accidents were not always recorded or followed up and lacked detail and actions put in place to reduce the risk of incidents.

The safety of the premises and equipment was not well maintained to a safe standard and people were put at risk. People's medicines were not always being managed in a safe way as staff had not received training and had not been competency assessed in medicines management. Other aspects of medicines management was being managed in a safe way.

Personal evacuation plans were not in place for every person who lived at the service and staff had not received fire safety training.

Staff had knowledge of safeguarding adult's procedures and there was a safeguarding adult's policy in place. One person told us they felt safe.

Recruitment practices were not always safe and relevant checks had not always been completed before staff started work.

People's rights were not always met under 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 not always been submitted to the local authority where it may have been appropriate.

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. Staff competencies were not assessed as they did not have appropriate supervision or appraisals.

The environment did not meet the needs of people living with dementia.

People were not always provided with choices that met their reasonable preferences including at meal times and regarding what care they wanted. People at risk of dehydration or malnutrition did not have systems in place to support them. People had access to health care professionals to support them with their health needs.

We did see times when individual 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 no detailed information in people's care plans around the support they needed. There was a lack of guidance around care for people living with dementia or those that had challenging behaviours.

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.
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, staff and relatives were not given opportunities to provide feedback to improve the quality of care.

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 not informed the CQC of significant events.

There was a complaints procedure in place. No complaints had been received since the last inspection.

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 not enough staff deployed at the service to meet people's needs at night. However there were sufficient staff during the day.

People were not always safe because risks of harm had not always been managed. People were not always protected from environmental risks.

Safe recruitment practice was not being followed.

Staff did not always receive training in medicines management however medicines were administered, stored and disposed of safely.

People were protected against the risk of abuse and improper treatment. Staff were aware of their roles and responsibilities in how to protect people.

Is the service effective?

Inadequate

The service was not effective.

People were not always supported by staff that had the necessary skills and knowledge to meet their assessed need.

Staff did not understand how to apply legislation that supported people to consent to treatment. Where restrictions were in place this was not always in line with appropriate guidelines.

The environment was not suitable to meet the care needs of people living with dementia.

People had sufficient amounts to eat and drink. People were satisfied with the quality of the food. However people's dietary needs were not always recorded in the kitchen.

People were not always offered choices of meals and drinks.

People were supported to have access to 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.

People's preferences, likes and dislikes had been not always been taken into consideration and support was not always provided in accordance with people's wishes.

However we did see occasions where staff were kind and attentive. People told us that staff were caring.

Is the service responsive?

Inadequate

The service was not responsive.

People's needs were not always assessed when they moved in and on a continuous basis.

There was not always detailed information regarding people's treatment, care and support.

People did not have access to activities that were important and relevant to them.

There was a complaints policy in place.

Is the service well-led?

Inadequate

The service was not well- led.

There was no registered manager in post.

The provider did not have systems in place to regularly assess and monitor the quality of the service provided.

The provider had not met breaches in regulation from the previous
inspection.

The provider failed to seek, encourage and support people's involvement in the improvement of the home to improve the quality of care.

Appropriate notifications were not sent to the CQC.

Staff did say that they felt supported by the manager.

Epsom Lodge

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 the 8 March 2017. The inspection team consisted of two inspectors.

Prior to 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 also reviewed information from the Local Authority Quality Assurance team. Due to concerns raised to us about the lack of improvements at the service we inspected sooner than we had planned to. On that basis we did not have a Provider Information Return (PIR) to review prior to the inspection. 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. We also 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 one person, the provider, the manager and two members of staff. We observed care being delivered to people. We looked at a sample of three care records of people who used the service, medicine administration records and supervision records for staff. We looked at records that related to the management of the service. This included minutes of staff meetings and audits of the service.

The last inspection was on the 19 September 2016 where breaches were identified.

Inadequate

Is the service safe?

Our findings

On the previous inspections in April 2016 and September 2016 we had identified a breach in safe care and treatment. There had been some improvements to the way that medicines were administered however we found on this inspection that other aspects to the safety of care had not improved.

The person we spoke with told us that they felt safe. They said, "We have carers at night that support us and I don't have any fear of people getting in (to my room). If I press my buzzer staff come very quickly." Because other people using the service were unable due to their dementia to directly answer questions about how safe they felt we observed their care and reviewed relevant care documents.

Despite this person telling us that they felt safe there were aspects to people's care that was not safe.

The care plans did not contain detailed information about what actions staff were required take in order to provide safe care. Two people had recently moved in to the service more than a month ago and although one of the people had since moved out there had been no assessment of risks undertaken for either of them whilst they were there. One person was at risk of falls however there was no falls risk assessment despite staff knowing that the person's mobility was poor. Another person had a health care condition that staff had not risk assessed. Whilst the person was living at the service that person had become unwell however staff were unaware of the risks around this.

In a third care plan a person was at risk of falls and had fallen several times since moving into the service. However there was no falls risk assessment or appropriate guidance for staff on how to manage this risk. Where a risk had been identified for the person for example 'Risk assessment dementia' the care plan stated, 'staff should learn about Xs dementia. Work towards fitting and suiting X own individual needs.' There was no additional information about the person's dementia or how to provide safe care for staff. Staff told us that they had not had training in dementia and having this could help them to understand the support people needed. The manager told us they had started to complete MUST forms (Malnutrition Universal Screening Tool to assess people's risk of malnutrition) for people. The three care plans that we reviewed did not contain a MUST tool therefore staff would not know whether these people were at risk of malnutrition. One person (whose mobility was poor) was not being moved with a hoist; instead they were expected to stand with their frame despite staff knowing that they could not do this for long. One member of staff told us that they often would assist the person to stand which put pressure on the staffs backs. There were no assessments against the risks of pressure ulcers in any of the care plans that we reviewed.

People would not always be safe in the event of an emergency because appropriate plans were not in place. In the event of an emergency, such as the building being flooded or a fire, personal evacuation plans were not in place for every person at the service. Not all staff had been fire safety trained and those that had received the training this was undertaken in 2010. The service 'Fire training and Drills' policy stated 'All staff must attend fire training sessions as a mandatory part of their working here. The implications of us having a fire could be disastrous, so, we must all know exactly what to do if a fire should occur.' It goes on to say that staff will be provided with their training on their first day of work at the service however this policy was not

being followed. Three staff had started work at the service since the last inspection and had not had fire safety training. The provider contacted us after the inspection and informed us that training had been arranged. The provider contacted us after the inspection and notified us that the urgent actions had been addressed.

Accidents and incidents were not always recorded or followed up with a record of the action taken. Over a period of four weeks there had been 10 incidents involving one person. Only two of these incidents had been recorded on the appropriate forms. The remaining eight had been written in the person's daily notes but there was not sufficient evidence of what action was taken to reduce the risk of this happening or to protect the person from harm. On the two incidents forms that were completed there was no evidence to show what steps had been taken to reduce the risks of this occurring again. Staff told us that they knew they needed to complete incidents forms however they were not following their own procedures. The manager and the provider were unable to tell us why this was not being done.

There were aspects to the management of medicines that were not safe. We asked to review the records of medicine training for staff that were administering medicines. The provider told us there was no training record and that the only evidence of training was certificates on staff files. We checked for evidence of training and found that certificates were present for some staff however there was no evidence of a competency assessment for medicines management for any staff. This was despite the fact that the Local Authority Quality Assurance team had identified errors around medicine management in January 2017. There was a lack of clarity about which staff were authorised to administer medicines. The manager gave us the names of four staff who they told us were authorised to give medicines. There was also a written list of four staff authorised to give medicines in the medicines folder. The names on this list did not correspond with the names given to us by the manager. The manager told us two of the staff on the written list no longer worked at the service. This meant it was unclear which staff should be giving medicines and whether they had the correct training to do so safely. In addition to this there was no photo on the medication administration record (MAR) for one person and the allergy details was blank. The omission of this information is a risk because staff may administer medicine to the wrong person or give a person something they may be allergic to.

As care and treatment was not always being provided in a safe way this is a continued breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

On the previous inspection in September 2016 we had identified a breach in the recruitment checks for staff. This had not improved on this inspection.

People were not always protected from being cared for by unsuitable staff because robust recruitment was not in place. In one member of staff's file there was no evidence of a criminal records check. The provider told us that they were still waiting for the result of this check however the member of staff had been allowed to start work despite the absence of this. There was no risk assessment in the member of staffs file to risk assess them being able to work. We have asked the provider to address this urgently. There were two references for the member of staff but neither of these related to their previous employment. The manager told us that they could not get a reference from their previous employer and did not know who the referees were in relation to the member of staff. We asked to see evidence that a new member of staff had gone through safe recruitment checks, however their file could not be found. In another staff file there was no completed application form.

As recruitment checks were still not meeting the regulation this is a continued breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Premises and equipment was not always maintained and secure to keep people safe. The provider had commissioned an external provider to undertake an audit of the safety of the premises and equipment in December 2016. Where concerns had been identified these had not been addressed. It had been identified that to prevent the spread of fire, plasterboard needed to be fitted to the wall faces of the lift, a window restrictor needed to be placed on a large window on the landing of one floor and PAT (Portable appliance testing is the term used to describe the examination of electrical appliances and equipment to ensure they are safe to use) was required on electrical items in one person's room. The provider confirmed that none of this had been undertaken. We established that there were windows in people's room that had no window restrictors in place. The manager told us that people could easily open the windows wide. There were no alarms on the outer doors to the service so if people did open these no alarms would sound. We have contacted Surrey Fire and Rescue about these concerns.

As the premises and equipment was not maintained to a safe standard this is a breach of regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us that staff were always there when they needed them. On the day of the inspection people's needs were met because there were enough staff deployed at the service. The manager told us that three carers were required on duty each day and two members of staff at night. However there were people at the service whose behaviours at times challenged. Although we didn't see any of these behaviours on the day of the inspection we saw from the people's records that their behaviours were frequent at night. The manager told us that two of the people at the service required more one to one care from staff at night to reduce the risk of the behaviours. We saw from records that the behaviours of two people were more frequent through the night and there were increased incidents and accidents. One member of staff said, "With X and X it can be a struggle and the night staff are struggling." Whilst the two staff on duty were supporting the two people that became more anxious at night this left other people unsupported.

We recommend that staffing levels are assessed based on the needs of the people that live at the service.

Staff understood safeguarding adults procedures and what to do if they suspected any type of abuse. One member of staff said, "If I suspected any abuse I would report it straight away. I would feel comfortable whistleblowing." Staff described the different types of abuse that may occur and how to support people. Staff said that they knew about the whistleblowing policy and would have no hesitation in reporting concerns. There was a safeguarding adults policy that staff were able to access and staff had received training in safeguarding people.

There were aspects to people's medicines were being managed in a safe way. Where there had been gaps in the MAR charts staff had filled them to state why there were was a gap. We noted MAR charts contained relevant information about the administration of certain drugs. In addition, each person taking 'as needed' medicines, such as pain killers, had an individual protocol held with their MAR chart.

Inadequate

Is the service effective?

Our findings

On our inspections in April and September 2016 we found that staff did not always follow the principles of the Mental Capacity Act (MCA) and Deprivation of Liberty (DoLS). The requirements were still not always being followed.

People's rights were not always protected because the staff did not always act in accordance with the MCA. 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. Mental capacity assessments were not undertaken correctly to ensure people's rights were protected. In one person's care plan there was a signed consent to receiving medicines form however it had been signed by their husband. The form stated, 'This form should only be used for service users who are able to fully understand the issues relating to the care and treatment proposed and give their informed consent. Where a service user is suspected of lacking the capacity to give informed consent, a MCA consent form should be used instead. 'The manager told us that, in their opinion, the person lacked the capacity to give informed consent to care due to their dementia. The manager said the person was reluctant to take their medicines or accept any care from anyone but their relative. The person's daily care notes made clear they did not want to take their medicines. No mental capacity assessments had been carried out to determine whether people had the capacity to consent to their care. The manager told us no best interests meetings had been held to ensure that decisions were made in the best interests of people who lacked capacity.

In another care plan there was reference throughout that the person lacked capacity to make decisions. However there was no evidence that a capacity assessment had taken place. We saw daily notes for this person where reference was made to the person not wanting to live at the service. Staff had not all been provided with training in MCA. The staff we spoke to on the day were unable to tell us what MCA was or the principles behind it. Neither the manager nor the provider demonstrated an understanding of MCA.

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. We noted that DoLS applications had not been completed in line with current legislation to the local authority for people living at the service. We noted from records that two people wanted to leave the service and made attempts to leave. One non-urgent application had been submitted for one person and no DoLs application had been submitted for the second person. The manager acknowledged that there were restrictions on people that they had not considered and for whom they had not applied for DoLS authorisations. For example people were not able to leave the service unaccompanied and required constant supervision.

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

Staff were not suitably qualified, skilled and experienced to meet people's needs. There were people at the

service that were living with dementia and others that had challenging behaviour. Two members of staff told us that they were not equipped to deal with some of the people that lived there and had not had training around dementia or challenging behaviour. At the time of the inspection none of the staff had received training in dementia despite most of the people having this diagnosis. One member of staff said, "If I have the dementia training it would help me understand more and I can provide better care." Another member of staff said, "Challenging behaviour training would be great. We don't know how to deal with Xs behaviours."

We asked the provider for the training matrix for staff. They told us that they did not have one and that we needed to review the training certificates in the staff files. However we could not locate the files for every member of staff. We saw that some staff had received training in safeguarding and infection control. The manager told us all staff that had been recruited since the last inspection had not received training in Health and Safety, MCA, moving and handling, dementia awareness and fire safety training. There were people at the service that had diabetes. We saw from the notes of a health care professional that one person had been given high sugar food and had to remind staff what foods were best for the person as their blood sugar levels were not safe. None of the staff we spoke to had received training in diabetes and were unaware of the signs to look out for should people become unwell.

We asked about how staff were formally supervised and appraised by the manager. Staff we spoke with had not had a formal supervision since they started at the service. Neither had met with their manager to discuss their performance and whether they required additional training. Both staff felt that this should have taken place. One member of staff said, "It would be good just to see if I'm good for them and whether what I am doing is wrong or right." The only member of staff that had received a supervision (according to the records) since the last inspection was the manager. The manager confirmed that they had not undertaken supervision meetings with staff.

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

It was not easy for people living with dementia to find their rooms or their way around the service as all areas looked the same. Areas of the service were not easily identifiable. The flooring varied in different parts of the service and could cause confusion for people. There were no signs on the doors describing rooms and toilet doors. We read from peoples care notes that there were times when people at night would go into other people's rooms and were disorientated. An environment decorated in contrasting colours and with appropriate signage may help people's orientation and support people's independence.

The environment did not meet the specific needs of those people living with dementia. The majority of people being accommodated and cared for had needs associated with their dementia. There were no areas containing reminiscence objects or pictures of interest and no equipment that could assist relaxation or stimulate people's senses. There are many sources of information about creating 'dementia friendly' environments available. The provider could have accessed and used these to enhance people's quality of life and respond to the needs of people living with dementia.

The environment was not designed to meet the care needs of people living with dementia; this is a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked people about the food on offer at the service and we also observed care in communal areas at lunchtime. One person told us, "You get a selection and you can always have more if you want it."

Nutritional assessments had not been carried out on all but one person that lived at the service. There was evidence that people had been weighed. People's weights were recorded and where needed advice was sought from the relevant health care professional. However it was noted that the chef did not have a record of peoples dietary needs apart from information recorded on the wall in the kitchen of one person's soft diet. There was no recorded information on allergies, suitable food for diabetes and people's likes and dislikes. They told us that they relied upon staffing providing this information. The chef was aware of two of the people's dietary needs but did not have any other information to hand. The manager told us that they had raised this with the kitchen staff before and knew that this information should have been recorded in the kitchen. We observed a meal being provided and noted that people enjoyed the meal. The meal did look appetising and people were provided with drinks and snacks through the day.

We recommend that the provider ensures that all staff are provided with information and guidance on people's dietary needs.

We looked at care plans in order to ascertain whether people's health care needs were being met. We noted the provider involved a wide range of external health professionals in the care of people. These included community nurses and the GP. One person told us that as soon as they become unwell a GP is called to see them.

Requires Improvement

Is the service caring?

Our findings

On our inspection in September 2016 we found that people did not always have the opportunity to make choices in their day to day lives. We recommended at that inspection that this was addressed. We found on this inspection that this had not improved.

The people we spoke with told us that staff were caring. One person said, "(The staff) are very good. Staff are very caring. I couldn't wish for better care. I couldn't be happier and I get the attention I need."

Despite this there were aspects to the delivery of care that did not put people first or give people the choices around their care. There was no evidence in people's care plans that people and relatives (where appropriate) were involved in the planning of their care. There was a lack of information around their spiritual needs, their likes and dislikes or their background. People were not asked what time they wanted to get up, go to bed or what was important to them. There was a lack of understanding by the provider of people living with dementia. When meals were provided people were not given a choice at the time but were asked to give their meal preference at 9.30 in the morning. Most people in the service had short term memory loss and had no knowledge of what they had chosen. There was a board in the living room showing the choices of meals on offer however this option was not open to them once they had made their choice at 9.30. One person was heard to ask the manager at 12.30 what the meal options were. They were told the two options but they were not given the opportunity to make a decision but were told, "I suggest you have the roast." There was no other option being cooked at that stage.

People were not given a choice of drinks at lunch time and a large plastic jug of juice was placed on the table. People were given blue plastic cups to drink out of. We asked the manager why people were given plastic cups instead of glasses and they said, "That's the way it has always been." They said that one person found it easier to hold a plastic cup but there was no reason why other people could not have been given the option of a glass if they wanted.

The provider had not ensured that care and treatment was provided that met people's individual and most current needs. This is a continued breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff at the service did show care and compassion to people and spoke about them with affection. We heard one member of staff kiss each person when they arrived on duty and this gave people comfort. One member of staff said, "I like working here" whilst another said, "I love working here. The residents are lovely." We saw staff encourage people when they were undertaking an activity and when they had time they would go into people's rooms to say hello. People's rooms were personalised and the rooms felt homely.

People were treated with dignity and respect by staff. When staff entered people's room they knocked on the door before they entered. People's appearance was maintained and staff spoke to people in a dignified way. When personal care was being delivered this was done behind closed doors to maintain their dignity. Staff approached people discreetly when offering them personal care.

Inadequate

Is the service responsive?

Our findings

At the previous inspections in April and September 2016 we identified a breach in regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People's care plans did not always contain a pre-assessment of their needs. Detailed guidance for staff was not always available around people's needs and there was a failure to provide activities which suited people's needs and preferences. This had not improved sufficiently on this inspection.

The provider and manager could not be sure that people's needs could be met at the service before they moved in. There were people that had been admitted since our last inspection without an assessment of their needs being carried out. One person had a health care condition that had not been identified by the provider. The person became unwell after they moved in and it was only at this stage staff became aware of this condition. The manager provided us with the care plan of one of the people that had moved in however the only information recorded was the person's name, date of birth, next of kin details and medicines taken. The manager told us, "X was on respite but now it's been decided X is staying so we'll have to write a care plan." The provider told us that they were in the process of writing the care plan however the person had been living at the service for a number of weeks. There was no guidance for staff about how they should support this person with their anxiety or how to best manage behaviour that caused others to become distressed. Their daily notes stated, '(X) very agitated, wandered all around the house trying every door to get out and go to her house. Tried to reassure X but X still wants to go home. In and out of all residents' rooms screaming at them. Very aggressive to staff member, calling for (their family) all night.' The provider contacted us after the inspection and confirmed that a care plan was now in place for the person. However the care plan lacked appropriate guidance for staff around the person's mobility and behaviours.

Care plans were not detailed about the specifics needs of the person and there were standard phrases used frequently in care plans about people having dementia. One person had diabetes; there was no care plan detailed for staff with guidance about the signs to look out for should they become unwell. Staff were unaware that the person had a heart condition that needed to be monitored carefully and there was no care plan for this. Where it had been identified that people had behaviour that might challenge there was no detailed guidance on how best to manage the behaviour. For example one person was awake a lot at night and had anxieties. There was no guidance for staff on how best to manage this other than about his and others safety. There was no guidance about people's emotional and psychological needs or how staff should meet these. The manager told us that they were in the process of updating people's care plans but knew that this was an area that required a lot of work.

At our last inspection people did not have access to meaningful activities. There was no activities co-ordinator employed and there was a lack of appropriate activities to keep people occupied and engaged. At this inspection we found the availability of activities had improved but there were still long periods of time when people were without interaction with others or engagement from staff.

Whilst the increase in the activities available to people was positive, we observed that people remained without interaction or engagement for long periods outside the time of the planned activity. Some people

were cared for in their rooms either through personal choice, illness or infirmity. There was no evidence that activities had been planned to ensure these people did not experience social isolation. One member of staff said, "The main activities are drawing" whilst another member of staff said, "I don't feel there is enough meaningful activities. Maybe we could do individual activities."

Daily records were completed to record support provided to each person; however these were written in a very task orientated way. There was no information about people's well-being, interactions, activities or mood, providing a picture of the person's day and highlighting any issues. This showed us that although there was up to date information about the support provided, the information was not person- centred which would enable staff to monitor any issues that might arise and require additional or different care and support. For example over a period of four weeks daily notes for one person stated that the person was 'sitting in the lounge watching telly'. There was no information about what the person's emotional state or behaviours were during the day. There was no information on what activities the person had been encouraged or supported to participate in.

Care and treatment was not always designed or provided to meet people's individual and most current needs. This is a continued breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was a complaints folder and policy in place however there had been no recorded complaints since the last inspection.

Inadequate

Is the service well-led?

Our findings

There is a history of non-compliance with the regulations and we do not have confidence that the provider is able to make, sustain and embed the improvements required. In April and September 2016 the service required improvements and breaches were identified in a number of areas. As a result a warning notice was issued for breach of regulation 17 Good Governance. On this inspection the warning notice and the other breaches identified had not been met and further breaches had been identified. Therefore instead of improving the service and care people received the provider had allowed the service to deteriorate further and had failed to take action in a timely way. They had submitted an action plan to us after the last inspection however all the actions they said had been addressed had not been. There is a history of non-compliance and lack of action by the provider to improve the care.

At the previous inspection we identified breaches in regulations around safe care and treatment, person centred care, the lack of MCA assessments, lack of training and supervisions for staff, the deployment of staff and the lack of robust recruitment procedures. The provider had not taken the appropriate action to address these breaches.

There were aspects to the quality assurance that were not used to drive improvement. There was no system in place to identify and mitigate risks or to analyse accidents to learn from these to prevent them reoccurring. Of the accidents such as falls or incidents (that were recorded by staff) they had not been investigated to look at the possible causes. Behaviours displayed that were recorded on people's daily notes were not analysed to look at trends for possible causes to the behaviours.

There had only been one audit that had taken place since the last inspection in September 2016. This had not been used to make improvements to the service. Where gaps had been identified to the safety of the environment in the audit the provider had not taken responsibility to ensure that the appropriate work was carried out. We asked the provider whether resident and relatives meetings had taken place. They said that they had and that we would find the copies of the minutes of the meetings. However these meetings had not taken place. One person confirmed that they were not invited to a residents meeting. There were no systems in place to gain feedback from people and relatives to make improvements to the service.

There were no systems in place to identify the key risks described in this report about inappropriate or unsafe care and support, lack of care planning, lack of activities, staffing levels, staff training and lack of one to one supervisions.

Staff attended meetings however these were not used as an opportunity to improve the quality of the service provided by them. In the last meeting in November 2016 staff were reminded to provide more activities for people however this had not happened.

The provider sent us an action plan after the inspection to detail actions that were being taken to make the necessary improvements. We are unable to comment on these improvements.

As systems and processes were not established and operated effectively this is a continued breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 not informed the CQC of significant events in a timely way. This meant we could not check that appropriate
action had been taken. Notifications had not always been sent in relation to injuries sustained to people at the service.

The lack of notifications being sent to the CQC is a breach of regulation 18 of the Health and Social Care Act 2008 (Registration) Regulations 2009.

The staff at the service did say that they felt supported and that they were able to go to the manager whenever they needed to. One told us, "The manager is brilliant. Any support I need I get it." Another member of staff said, "I do feel supported. We can always ask (the manager)." However it should be noted that the manager had failed to provide adequate training or supervision to staff and the provider had failed to ensure this was taking place.