

Mr R C Sohun & Mrs A Sohun

Southlands Rest Home

Inspection report

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Date of inspection visit:
21 July 2016

Date of publication:
07 September 2016

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

Southlands Rest Home is registered to provide care and accommodation for up to 19 people who may be living with dementia or have mental health conditions.

The Home is located in Redhill and is close to local amenities. On the day of our inspection there were 17 people living at the service. The home is owned by Mr and Mrs Sohun. Mrs Sohun is also the registered manager.

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

Risks were not well managed. When risks to people were identified assessments were not always put in place to minimise the risk of harm to people. These were not supported with guidance for staff to follow to help keep people safe.

There were not sufficient numbers of staff employed to meet the needs of the people who lived at the home which meant people were left unsupported and at risk of harm. Staff recruitment procedures were robust to ensure that staff had appropriate checks undertaken before they commenced employment.

People were not protected from the risk of abuse. Staff had received training in safeguarding adults. They told us they would report anything they were concerned about to the registered manager. We noted an incident in the home the previous week had not been managed well by the registered manager and had not been referred to the local authority in line with safeguarding procedures.

People told us they had their medicines when they needed them. All medicines were administered and disposed of in a safe way.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. When people's liberty was restricted to keep them safe the provider had applied for an authorisation to the local authority. However they had not followed the principles of the Mental Capacity Act and had not undertaken a mental capacity assessment or held a best interest meeting prior to making the application or to ensure that people could consent to care and treatment.

Health care needs were being met. People had access to a GP, chiropodist, optician and a community psychiatric nurse. Specialist input was also in place on referral from the GP. Staff had received training and supervision. However the registered manager was not able to provide us with a training record or supervision plan as this was not available on the day of our inspection.

People were not involved in their care planning and care plans were not reviewed regularly. People's bedrooms had mainly been decorated to a good standard and were personalised with their own possessions. People were generally satisfied with the food however nutritional plans were not updated when dietary needs changed which did not provide staff with up to date information.

People were treated with dignity and respect. Staff were polite and addressed people by their preferred name. Personal care was undertaken in private however staff did not have time to spend with people or undertake activities with them.

People told us they sometimes felt unsupported by the registered manager. They felt they were not being listened to and their concerns not acted upon. People and relatives were aware of the complaint procedures and told us they would know how to make a complaint. However people had complained about the activities and not being able to watch television and said no action had been taken to address this.

The registered manager had not ensured that accurate records relating to the care and treatment of people and the overall management of the home were maintained. For example risk assessments were either not in place or not up to date, accidents and incidents were not being managed appropriately, care plans were not being reviewed and quality auditing processes were not being undertaken. There were not robust audits taking place that should have identified the concerns found at this inspection.

The overall rating for this service is 'inadequate' and had 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. If not enough improvement is made within the time frame so that there is still a rating of inadequate for any key questions 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 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 the service. This will lead to cancelling their registration or varying the terms of registration. For adult social care services the maximum time for being in special measures will usually be no longer than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer inadequate for any of the five key questions will no longer be in special measures.

During our inspection we found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) 2014.

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.

Risk of harm to people were not always assessed and managed well. Risk assessments did not provided clear information and guidance to staff. The registered manager did not respond to accidents to keep people safe, and prevent them from happening again.

There were not enough staff employed to safely meet people's needs. Staff were recruited safely, the appropriate checks were undertaken to help ensure suitable staff worked at the home.

People were not protected from the risk of abuse because there were not robust processes in place to ensure appropriate referrals to the local authority had been made.

People received their medicines as prescribed. We recommended staff received updated medicine training to administer medicine safely.

Is the service effective?

Requires Improvement ●

The service was not always effective.

Mental capacity assessments and best interest meetings were not undertaken. Before DoLS applications were made where people's freedom was restricted the requirements of the Mental Capacity Act were not followed.

Staff had not received up to date mandatory training and supervisions.

People liked the food that was provided and their nutritional needs were being met

People's health care needs were met. Access to healthcare

professionals were sought appropriately when specific needs had been identified.

Is the service caring?

The service was not always caring.

Whilst staff were sensitive to people's needs they did not have enough time to spend with people.

People's privacy and dignity was maintained.

People were encouraged to be as independent as possible.

Visitors were welcome in the home at any time.

Requires Improvement ●

Is the service responsive?

The service was not responsive.

People's needs assessments had not always been updated when their needs had changed.

Care plans were not consistent with the care being provided and not person centred. People with specific conditions did not have appropriate care plans in place.

There was little in the way of activities and some people were bored and unoccupied.

Complaints were not recorded or acted upon.

Inadequate ●

Is the service well-led?

The service was not well led.

There were ineffective systems in place to monitor the quality of the service provided.

The registered manager had not maintained accurate records relating to the overall management of the service.

The registered manager did not always notify us of events that happened in the home.

Staff said they felt supported by the registered manager.

Inadequate ●

Southlands Rest 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. We had also received concerns from the local authority about the cleanliness of the home.

This inspection took place on 21 July 2016 and was unannounced. The inspection team consisted of three inspectors.

Before the inspection we reviewed all the information we held about the provider. This included information sent to us by the provider in the form of notifications and safeguarding referrals made to the local authority. Notifications are information about important events which the provider is required to send us by law. The provider sent us a Provider Information Return (PIR) before the inspection. The PIR is a form that asks the provider to give some information about the service, what the service does well and improvements they plan to make, and it helps us to see if there were any areas we needed to focus on.

We used a number of different methods to help us understand the experiences of people who used the service. We spoke with 10 people, three members of staff, the registered manager, the deputy manager, two relatives and two health care professionals.

We spent time observing care and support being provided. We observed lunch in the main dining room. We read five people's care plans, medicine administration records, and risk assessments for people who lived in the home. We also read other recorded which related to the management of the service such as training records, recruitment files, policies and procedures and quality auditing systems.

The last inspection of this service was 16 May 2014 and we found no concerns.

Is the service safe?

Our findings

People were not safe from harm because the provider did not manage risks to people safely. Risk assessments had not been updated and reviewed when people's needs changed, and did not contain enough detailed information to be relevant and appropriate to ensure people's safety. For example we noted one person's fall risk assessment stated in April 2016 that they were at high risk of falling. A subsequent assessment in June 2016 rated the risk as medium risk. There was no reason given for this change and no evidence that this was appropriate. Since their last assessment the person had fallen and sustained facial injuries whilst they were being moved by staff. There was no record of this fall in their care plan and no amendment or review of their risk assessment to ensure their safety.

The deputy manager told us at the start of our visit that one person had a pressure ulcer. We looked at this person's care records and noted there was no risk assessment in place or information for staff to follow to minimise the risk and prevent further deterioration of the wound. In addition it was recorded this person had behaviour that challenged and they could become verbally abusive, agitated, and could 'lash out'. However there was no information concerning possible triggers to this person's behaviour, nor any specific de-escalation techniques staff could follow to keep the person and others safe.

Some accidents were recorded on accident forms and retained in people's care plans for information. It was difficult to establish how many accidents had been recorded in the past six months. One person was sitting in a chair when we arrived and had sustained an injury. A staff member said "It must have happened this morning when they had a fall." There was no record of this fall or any update of the person's risk assessment in relation to falls. The staff member then put a dressing on the wound.

The registered manager told us they did not keep a log of accidents and incidents and did not conduct an analysis of accidents on a monthly basis. They were unable to provide us with the number of accidents or incidents that happened over the past two months. The registered manager had not taken action or put any measures in place to minimise any reoccurrence. Falls were not monitored and referrals were not made for appropriate support to be provided.

There were no up to date personal evacuation plans (PEEPS) in place for people so staff would not know who they were responsible for in an emergency. The most recent evacuation plan was dated 2009 and most of the people were no longer living in the home. Fire evacuation plans were out of date and the list shown to us only had four people who were still living at the home. We asked the registered manager to send us an updated emergency fire evacuation by the following day so we could be sure that people would be safe in the event of a fire. We received this document the day after our inspection.

The failure to ensure that risks to people's safety were identified and managed meant that people were not receiving safe care. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The administration of medicines did not follow the home's medicine policy and guidance from the Royal Pharmaceutical Society. We noted the medicine trolley was left unlocked for the entire medicine round at lunch time. The staff member administered medicines to people in the dining room, which was where the trolley was stored. For most of the time the staff member was in the same room as the trolley but on one occasion left the trolley for several minutes unattended. They asked a colleague to "keep an eye on it." The staff member in question was serving meals and was distracted several times. During this time it would have been possible for people to gain access to the trolley and its contents. This did not promote safe practice around medicine administration.

We asked several times to look at medicines audits undertaken by the registered manager who was unable to produce them or describe the process by which they were done. Two people told us they received their medicine in a timely way as prescribed by their doctor. Staff did not sign medicine administration recording (MAR) charts until medicines had been taken by the person. There were no gaps in the MAR charts. We noted MAR charts contained relevant information about administration of certain drugs, for example antidepressants. Staff were knowledgeable about all the medicines they were giving. Information regarding people's allergies, if they had them were clearly shown on the MAR charts. In addition each person taking 'as required medicines' such as pain killers had an individual medicine plan. This described the reason for the medicines use, the maximum dose, minimum time between doses and possible side effects.

All medicines were delivered and disposed of by an external provider, so people's medicines were managed and stored in a safe way. Medicines were labelled with directions for use and contained the date of receipt, the expiry date and the date of opening. Creams, dressings and lotions were labelled with the name of the person who used them, signed for when administered and safely stored. Other medicines were stored in lockable cabinets. There was no dedicated medicines fridge so those requiring refrigeration were stored securely within the kitchen refrigerator

There were not enough staff employed in the home to keep people safe. The registered manager told us staffing levels in the home were based on a dependency tool called the 'staff residential forum'. This was used to determine a recommended level of staffing according to people's assessed needs. The registered manager was unable to locate this tool to demonstrate how they decided on staffing levels. They told us they did not routinely review staffing levels. Seven people needed help with personal care and three required 2:1 staffing to undertake their personal care needs. We looked at the staff duty rota for the previous four weeks which did not reflect the staffing numbers the registered manager said were in place. There was three care staff on duty when we arrived at the home and the duty rotas detailed there should have been five. The three care staff also did the cleaning, laundry and the cooking. This had an impact on people's safety as staff were not available in the lounge area when people needed support. The registered manager told us that there were a number of staff on annual and maternity leave which had affected staffing levels. They said that they had not used agency staff to fill any shortfall.

We observed interactions in the lounge in the morning over a period of an hour. There was no permanent staff presence in the lounge for the period observed and no staff presence at all for several minutes at a time. On one occasion we noted one person called out for staff without response. After a few minutes they got up using a walking aid unaccompanied. Two people were particularly unsteady on their feet, one of whom stumbled but managed to right themselves before sitting down. One person had to navigate the steps onto the patio to have a cigarette however they were at risk of falling. There were no staff present when they went out and when they walked back to the living room we had to intervene and hold their arm to steady them as no staff were present. The deputy manager called the maintenance person to work in the home as a member of care staff mid-morning to increase the staff levels to four staff.

People were not provided with individual call bells when they sat in the lounge. There was a call bell located on the wall at the entrance to the lounge. This could only be operated by someone who could walk to reach this, therefore people who required assistance relied on a person who could walk to do this on their behalf. This meant people could not access staff support when they wanted to. One person told us they had a call bell in their room and they used this at night to call for assistance. Staff were busy throughout the day undertaking other duties that took them away from providing safe care to people. We saw staff had to clean and cook as well as try to care for people.

Failure to employ enough staff to meet people's needs is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

The staff recruitment procedures in the service were safe. Staff employment files contained information that showed the provider had taken the necessary steps to ensure they employed people who were suitable to work at the home. Staff files included a recent photograph and a Disclosure and Barring Service (DBS) check. The DBS checks identify if prospective staff had a criminal record or were barred from working with adults at risk. There were also copies of other relevant documentation including references, employment histories, photographic identification, job descriptions, and staff contracts in staff files. Appropriate checks were undertaken before staff began work.

People were not safe because staff did not understand their roles with regard to safeguarding people from abuse. Two staff we spoke with had undertaken safeguarding adult training within the last year. We saw certificates were awarded to them on completion and were retained in their personal files. One staff said they would report anything they were unhappy with to the registered manager. Another staff member said they had no understanding of what the local authority role was in relation to safeguarding. The home had a copy of Surrey's Safeguarding Adults Procedures in place which staff had access to however this procedure had not been followed.

A person told us of an incident that occurred at the home the previous week involving them and another person living at the home. They showed us bruising they had sustained as a result of this incident. We asked the registered manager for documentation of the incident and the outcome of the safeguarding investigation. They told us "We tried to deal with this ourselves as this is not the first time this has happened." This is contrary to the safeguarding procedures. There was no record made in relation to the incident and no referral had been made to the Surrey Safeguarding Team. This meant that the incident had not been investigated and there was a risk of it happening again. We asked the registered manager to notify the local authority during our inspection about the incident which they did. The registered manager did not understand their role and responsibilities or the procedures to follow regarding safeguarding people in their care from abuse.

Systems and processes were not operated effectively to protect people from abuse. This is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Before our inspection we received concerns regarding the standard of cleanliness in the home and the lack of cleaning staff. The registered manager told us there had not been a cleaner employed in the home for six months and that the care staff undertook this role. We looked at the daily cleaning schedules in place and noted bathrooms and toilets were cleaned daily and general cleaning of communal areas were also undertaken daily. We saw this in progress throughout the day. More specific areas for example individual bedrooms were cleaned on allocated days. Monthly cleaning tasks for example the laundry and kitchen had not been undertaken since March 2016.

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to make a particular decision any made on their behalf must be in their best interest and as least restrictive as possible. The registered manager sent us a provider information return (PIR) before the inspection giving us information regarding their home. They told us there were nine people living in the home with dementia and eight people who had mental health conditions. The registered manager told us on the day of our visit that they had not undertaken any mental capacity assessments for people to determine if they had capacity to make decisions in relation to their care and treatment. When asked about one person who was living with dementia the registered manager said they "Didn't know why" an MCA assessment had not been completed.

People can only be deprived of their liberty to receive care and treatment when this is in their best interest and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called Deprivation of Liberty Safeguards (DoLS). We found the provider was not working within the principles of the MCA. Two people required authorisations to deprive them of their liberty. In each case the provider had not acted appropriately as they had requested a Deprivation of Liberty Safeguards (DoLS) assessment and authorisation, but had not undertaken a mental capacity assessment or held a best interest meeting prior to the application being made.

Staff had limited understanding of consent and the MCA. One of the three staff members we spoke with told us they had undertaken recent specific training in this area but two others were not clear about their responsibilities about when it would be necessary to act in people's best interest.

The provider had not gained consent to act in the best interest of the people in their care and had not carried out assessments of people's capacity. This is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

We saw that staff had obtained informal consent from people and asked their permission before they undertook personal care.

People felt staff knew how to look after them and one person said "They seem to know what they are doing." We spoke with staff about the training they had undertaken. One staff member said "Yes I've done training and it was fine." Another staff member told us "I'm doing my NVQ level 3 now so I'm learning a lot." We asked the registered manager for their training record to examine training provision for all staff but they told us there wasn't one. The registered manager said "It's all in my head." We looked at staff files in order to gain insight into training provision. Staff training was undertaken by an external provider and certificates were issued in May 2015. On one occasion we saw training in the role of the carer, personal development, duty of care, person centred care, handling information, communication, and privacy and dignity were delivered on

the same day. We noted training in food hygiene, health and safety, safeguarding adults from abuse, MCA and DoLS, dementia awareness and fire safety were delivered on the second day. We asked the registered manager to send us training records so we could understand the training provided and if this had sufficient detail given the time allocated to this. We did not see an induction training programme in place and did not receive a copy of the training records.

Staff were supported to have supervision and appraisals to ensure they could meet people's needs. One staff member said "Yes I have had supervision. It was open and honest I would say." Another staff member told us "Yes it's fine, I can say what's on my mind." We asked the registered manager how supervision was planned as there were no records of this. They told us supervision took place and further supervision sessions were arranged with individual staff members. There were no records in place to verify this and no systems in place to ensure all staff members were up to date with supervision requirements.

People were supported to keep healthy. When a specific health care need had been identified people were supported to access specialist input. For example two people had diabetes and had support from the diabetic clinic as required. They had regular blood tests to monitor their glucose levels and had chiropody treatment every three months to manage their foot care. Another person attended the Parkinson's clinic to monitor their condition and mobility needs. The community psychiatric nurse visited individual people to monitor mental health issues and provide ongoing support. The district nurses visited the home at least three times a week to undertake dressings and catheter care. People were registered with a local GP and were able to arrange appointments at the surgery or home visits when required. People felt satisfied with the level of support they got from health care professionals.

People gave us mixed feedback regarding the food that was provided. People told us there was always a choice of something and that they could have an alternative to the menu if they wanted. One person told us "The food is very good. I like meat pie best. " Another person said "I don't eat meat so they always provide something else." Whilst another said the food was "Okay".

People ate their meals in various locations within the home. Most people ate their lunch in the dining room but there no windows and little natural light. There was a social atmosphere with people interacting and chatting with each other during their meal. Tables were laid with table cloths and napkins and there was a choice of drinks available to people. One person ate their meal in their room while another person was supported to eat in the lounge.

Staff asked people what they wanted to eat during the morning for lunch and they were offered a choice of two meals. On the day of our inspection the choice was cottage pie with mashed potatoes and mixed vegetables or lasagne. This was followed by yogurt, fruit or cake. Menus were not displayed but a record of the food provided was kept in a daily food log. Care staff also cooked meals as there was no chef or catering staff employed by the home which meant that staff were rushed whilst providing support. People's weight was monitored monthly and any weight increase or weight loss was reported to the registered manager for action. One person had been referred to the dietician to address weight loss.

Is the service caring?

Our findings

People were very positive about the staff. One person said "Staff are nice." Another person said "Staff are caring everything is fine here." A further person said "I like living here." A health care professional told us "My last involvement before this with the home was about a year ago. It's a much friendlier and more caring place now then it was then." A relative said "From what I can see they are well cared for. I have been visiting for a few years and am pleased with the way my relative is treated." Despite these positive comments people were not always cared for well due to the lack of staff and activities available.

Staff were task orientated for a large part of the day as they had to undertake other duties as well as caring. However when they did have time staff interacted with people in a positive and caring way. One staff member said "I love my job." They said "I would like to spend more time with residents" and told us it was difficult sometimes because of all the other tasks they had to undertake. Interactions with staff were positive and people were spoken to calmly by care staff however there were instances when staff did not explain what they were doing when they supported people. For example one person was moved in their wheelchair by staff but they did not tell them why or what they were doing.

People who were able to could choose where to spend their time. The layout of the home enabled people to spend time on their own if they wished. This meant that people had access to privacy when they needed to be alone. We observed people going to their rooms, sitting in different areas such as the smoking room, patio, lounge or dining room. One person said "I please myself. I like to be alone and staff understand. They will put a meal in the fridge and I will eat it when I am ready."

People were encouraged to be independent and some were able to go to the local shops for cigarettes or a newspaper. Visitors were welcome in the home and a relative told us there were no restrictions on when they could visit.

People looked well cared for. One person told us they were able to undertake their own personal care and went to the hairdresser in Redhill with the registered manager to have their hair cut. Another person told us until recently the home engaged the services of a hairdresser but this had now stopped. They said "I would like my hair cut it is getting too long." We fed these comments back to the registered manager who assured us they would be acted on. One person said he needed help to shave and had not yet had a shave that day. They said staff did not always have time but they "Didn't worry."

People told us their privacy and dignity was respected. We observed when staff were undertaking personal care doors were closed and curtains were drawn. Locks were provided on bathroom and toilet doors. Some people had a key to their bedroom and the deputy manager told us these were always provided on request. We noted people were addressed by their preferred name which was usually their first name.

People's private information was held securely. Care plans were kept locked in a cupboard in the dining room when not in use.

Bedrooms were mainly pleasantly decorated. People had the opportunity to bring personal possessions, photographs, ornaments with them into the home to make their room personal to them. This varied according to people's capacity and the support they needed from staff and family. However some rooms needed to be redecorated and were in need of refurbishment. One room was cluttered and a profile bed had been provided for changing health needs but the old bed had not been removed. Surplus items of furniture also needed to be removed to enhance the appearance and to promote a personalised environment. People who wanted them had television sets and had set routines of what they liked to watch. People were supported to maintain links with family and friends and some had their own mobile phone or could use the home's phone.

Is the service responsive?

Our findings

People had needs assessments undertaken before they were admitted to the home in order to ensure the service had the resources and expertise to meet their needs. People and their relatives had been consulted and included in these assessments as much as possible. This was to ensure the service had as much information as possible about the person they were going to be providing care for.

Care plans were written on information gathered from the needs assessment and from people's involvement whenever possible. The care plans we saw were mainly focused on people's clinical needs and they lacked individuality around emotional and social needs. They did not include people's past life history that would enable staff to build a picture of that person and ensure that care was delivered in a person centred way. We asked staff what they understood by the term 'person centred care'. Two of the three staff we spoke with did not understand what this meant. For example one staff member told us "It's making sure everyone has proper care." A second staff member told us "Person centred care is for people who can't care for themselves." A third staff member said "It's about care based on the individual person's needs. What might be good for one person won't suit another."

Contradictions were seen in some people's care plans. For example one person's plan stated they required a soft diet as they were at risk of choking. We saw this person's needs had changed and the care plan had not been updated to reflect their changed needs. Another person's care plan had two mobility care plans each with varying degrees of mobility that provided misleading information for staff. Two of the care plans we saw were last reviewed over a year ago whilst another was last reviewed four months ago in March 2016. This meant staff were not provided with the most up to date information to deliver personalised care.

Nutritional care plans were not up to date. We noted one person was assessed as requiring a soft textured diet and this person was also a diabetic. We saw them being offered a 'normal' diet at lunch time. When we asked staff about this they informed us they had been discharged from the speech and language therapist (SALT) team and no longer required a soft diet. Their nutritional care plan had not been updated to reflect this change. This meant that staff may not always have the most up to date information regarding people's nutrition.

Where people had specific needs such as Parkinson's there was no care plan in place to guide staff. One person had been recommended by an occupational therapist that they needed a particular wheelchair but this had not been provided. One person had a mental health condition which affected their mood and led to erratic sleeping patterns. There was no mood or behavioural charts used to monitor this or to give staff guidance on how to manage this.

There was no activity programme in place. The registered manager told us they engaged the support of external people to provide entertainment on a sessional basis. One person said "We have someone playing music on Monday afternoons. This is good fun. We can request our favourite songs and he plays them." One person said the home was "Boring" They said the news was always on television and the remote control was

kept by one person so there was no choice for other people. Another person said they had a television in their room and went there to watch their "Special programmes in peace." Another person told us they liked bingo and going shopping. A group of people spoke enthusiastically about making cakes in the kitchen and icing them with various colours and decorations. The deputy manager took one person for lunch and a drink to the local pub weekly and the person said they looked forward to that. Some people were able to go out alone and kept themselves busy.

There was no individual plan in place to provide people with responsive and meaningful activities to keep them occupied and prevent them from becoming bored. During the morning we saw up to 10 people sitting in the lounge. Two were sleeping and others were talking amongst themselves in a group. There was no staff input at this time as they were allocated to cleaning and cooking duties. The registered manager told us staff would undertake activities after they had performed their other duties but this was not done due to the staffing levels in place.

Care plans were not personalised or reviewed to show the current needs of people. Activities that people wanted were not undertaken. This was a breach of Regulation 9 of the Health and Social care Act 2008 (Regulated Activities) 2014.

The registered manager told us people had been provided with a copy of the provider's complaints process when they moved into the home. There was no complaints policy displayed in the home for people or relatives to access. We asked people if they knew how to make a complaint. One person said "If I was worried about anything I would talk to the manager", "I was given something when I moved in." People felt they were not listened to when they raised concerns. One person said "I complained about having no hairdresser but nothing was done." Another person said "I complained about not being able to watch TV but nothing got done." One person said "I complained about not having trips out and nothing to do but nothing was done about it."

Another person told us they had a good activity person in the home who had now left. They said "We used to have meetings with her and she would make a list of our moans and take them to the manager, we miss that."

We asked the registered manager if they held residents meetings and they said these had not been well attended so they were infrequent. The last meeting took place over three months previously and was attended by nine people. Menus were discussed and changes were made to the menu as a result. For example shepherd's pie and omelettes were now provided. Summer outings were also discussed together with a BBQ which had not been acted on.

We looked at the complaints log which was empty which meant that no complaints informal or otherwise had been recorded for over two years. This meant that people's complaints were not being recorded and acted upon to improve the quality of care people received.

As there was no system to identify and handle complaints this is a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Is the service well-led?

Our findings

There was a registered manager in post who is also the provider who was supported by the deputy manager. People told us the registered manager had daily contact with them but did not always listen to what they were saying. The registered manager knew individuals well but when asked to provide written information this was either not available or they could not find it.

The registered manager did not have a comprehensive oversight of the service and there were no systems in place for monitoring service delivery. The registered manager had not undertaken a number of audits such as care plans, risk assessments, medicine audits and nutritional audits. This meant that any shortfalls in people's care were not identified and action had not been taken to ensure people were receiving, safe, effective and responsive care in an appropriate way.

Records relating to care and treatment of people were not accurate or up to date. Risk assessments had not been updated or implemented when risks of harm to people had been identified. Care plans were not being reviewed or up dated and gave conflicting information making it difficult for staff to follow. These issues would have been identified had there been a robust auditing system in place.

The registered manager did not have effective systems to monitor quality. The service had a system in place called 'putting people first' which is a one to one quality auditing system used to monitor quality of provision in care services. The system is based on questions such as choice, care planning, fees, entertainment, laundry, cleanliness, staffing, health, and food. This had been completed in 2015 but provided little information in the way of people's comments. The feedback we did see from people who used the service were not used to make positive changes to the home. People said they were not listened to and when they were no changes were made. These comments were mainly around entertainment and activities in the home.

The registered manager had not taken responsibility for the reduced staffing levels in the home. They accepted that they were understaffed but had taken no action to address this. For example they made no provision to cover leave or recruit to the cleaning post that had been vacant for six months. They had not used agency staff to cover the staffing shortfalls which had impacted on the quality of care people received.

On the PIR submission that was completed the registered manager stated that they used a dependency tool to set the staffing levels in the home, risk assessments were comprehensive, care plans were reviewed monthly or sooner if peoples needs changed, staff were knowledgeable about the MCA, complaints were responded to within seven days and notifications were submitted to the CQC appropriately. This is not what we found to be the case during the inspection.

Records relating to the care of people and the management of the home were not well managed or clear. The lack of records around accidents meant the registered manager was not taking appropriate action to lead the staff team to minimise accidents from reoccurring. There had been no analysis completed of incidents in the home as these were not being recorded. We asked the registered manager if they analysed

accidents and incidents. They told us "No I haven't at the moment. There are gaps in recording." They added that "There is a lot to do."

Due to the lack of records we were unable to identify what the staffing levels should be and what training and support staff had. There were gaps and omissions in records that were fundamental to keeping people safe such as PEEPs. When we asked for information about a number of areas during the inspection they were not able to provide this to us.

The lack of robust auditing meant that effective systems and processes were not in place to assess, monitor and improve the quality and safety of the service. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Basic health and safety audits were undertaken by the maintenance person to promote safety and to monitor health and safety of the service. These included monthly checks on emergency alarm systems, checks on window restraints and call bell system. Three monthly checks were undertaken on utilities for example hot and cold water systems. We saw records were maintained accordingly.

Staff told us they felt supported by the registered manager. One staff member told us "The registered manager and deputy manager work with us we are a team."

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 always informed CQC of significant events that happened in the service in a timely way. The managed had not provided us with regular updated accidents and falls. This meant we were unable to monitor that appropriate action had been taken.

Failure to notify incidents is a breach of Regulation 18 (Registration) Regulations 2009.

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	Regulation 9 HSCA RA Regulations 2014 Person-centred care Care plans were not personalised to show the current needs of people. Activities that people wanted were not undertaken.
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Systems and processes were not operated effectively to protect people from abuse.
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider had not gained consent to act in the best interest of people in their care, and had not carried out assessments of people's capacity.
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints As there was no system to identify complaints this is a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) 2014

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The failure to ensure that risks to people 's safety were identified and managed meant that people were not receiving safe care.

The enforcement action we took:

Warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The lack of robust auditing meant that effective systems were not in place to assess, monitor and improve the quality and safety of the service.

The enforcement action we took:

warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Failure to employ enough staff to meet people's needs was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

The enforcement action we took:

Warning notice