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Clifton House

Inspection report

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Date of inspection visit:
01 November 2017
02 November 2017

Date of publication:
28 December 2017

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 1 and 2 November 2017 and was unannounced. The last Care Quality Commission (CQC) comprehensive inspection of the service was carried out in October 2015. At that inspection we gave the service an overall rating of 'good'. However when answering the key question 'is the service safe?' we rated the service as 'requires improvement' because we found the provider in breach of the regulations. They had not formally recorded the outcomes of safeguarding referrals investigated by the local authority so they could not be certain that these outcomes enabled people to feel safer or reassured.

Clifton House is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Clifton House accommodates up to 16 older people in one adapted building.

The provider was a partnership. One of the partners was 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 2008 and associated Regulations about how the service is run. For the purposes of this report where we have referred to the provider we are referring to the person that is also the registered manager.

At this inspection we found new risks to the health, safety and wellbeing of people at Clifton House. The provider's arrangements for assessing and managing risks to people posed by their healthcare conditions and by the environment were ineffective. They had not considered the impact of changes in people's health and how these posed new risks to people's safety. Environmental risks were not appropriately managed. Aspects of the environment posed a risk of injury or harm to people from trip and slip hazards, missing or inappropriate restrictors on windows, potential exposure to sharp items and poor cleanliness and hygiene around the premises. The provider had not considered risks posed to people from furniture and items they had stored inappropriately around the environment and from the use of free standing oil filled radiators brought in to provide additional heating. Notwithstanding these issues we found the provider continued to maintain a servicing programme of the premises and equipment used by staff so had taken action to ensure those areas of the service covered by these checks should not pose unnecessary risks to people.

People's care records and associated risk assessments were out of date and/or inaccurate so staff did not have access to current information about how to keep people safe. Staff did not fully understand how to support people with their healthcare needs and conditions and the provider did not use best available evidence to ensure people experienced good health outcomes. Staff did not always respond quickly when people's health changed to seek appropriate medical support and assistance. People were not involved in planning their care and support needs and their records showed limited information about their preferences and likes and dislikes. This meant people may have experienced support that did not reflect their diverse needs, wishes and choices for how this was provided.

There were enough staff deployed during our inspection to keep people safe. But staff did not always have time to spend with people in a meaningful way and support them to communicate their needs and wishes. There was not enough for people to do to meet their social and physical needs and people who chose to spend time alone were at risk of becoming socially isolated. The provider did not routinely assess and review staffing levels as the level of dependency at the service changed. This meant they could not be assured that there were enough staff to meet people's needs at all times.

People received the medicines that had been prescribed to them. However we saw some elements of current working practices increased the risks of administration errors being made due to a lack of detailed information about people's preferences for when they took their medicines and the way some medicines were administered and stored.

The provider maintained adequate recruitment procedures to check the suitability and fitness of any staff employed to work at the service. However they did not routinely undertake criminal records checks on existing permanent staff so they could not be fully assured of their continuing suitability to work at the service. Support for staff to help them to meet people's needs was variable. Staff had received training in topics and subjects relevant to their work. However staff told us supervision (one to one meetings) were not always effective in helping them to continuously improve their work based practice.

People did not always experience support that was kind and respectful. Staff were not always attentive to people's needs and mealtimes did not always provide for a comfortable and dignified experience for people.

The provider had limited oversight of the service. Their quality assurance systems were ineffective and did not identify numerous shortfalls we found at the service. The provider did not always promote an open, inclusive culture in which people and staff had effective means to communicate their views and experiences. They had not met their legal obligation to submit notifications to CQC of events or incidents involving people at the service so we could not check they had taken appropriate action to ensure people's safety and welfare in these instances. At this inspection we also found the provider had not taken action to improve to ensure they met the breach in legal requirement we found in October 2015.

The provider demonstrated they could be responsive in making some improvements when needed. During our inspection they made improvements that immediately reduced some of the risks we found to people's safety and wellbeing. They had also reintroduced a programme of activities after our inspection to improve the quality of opportunities for people to have their social and physical needs met. However it was too early to judge whether these improvements could be sustained and maintained. There was some evidence that the provider sought people's views about the quality of the service and took action to make improvements when these were suggested. They maintained arrangements for dealing with people's complaints or concerns if these should arise.

The provider continued to support staff to keep people safe from abuse. Staff had been trained in safeguarding adults at risk. The provider sought assurances that temporary agency staff had completed appropriate training in this area. Staff understood their duty to observe and report any concerns they had about people if they thought they were at risk of abuse.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice. People were supported to be as independent as they could be. Staff encouraged people to eat and drink enough to meet their needs and people were happy with the meals they ate. The design and set up of the environment provided people with a degree of flexibility in terms of how they wished to spend their time when at home.

People were given space and privacy to meet with their visitors if they wanted this. Around the environment there was signage to help people orientate.

At this inspection we found the provider in breach of legal requirements with regard to person centred care, safe care and treatment, meeting nutritional and hydration needs, premises and equipment, good governance and notification of other incidents. We are taking enforcement action in relation to the breaches of legal requirements with regard to safe care and treatment and governance and we will report on this when our action is complete. You can see what action we told the provider to take with regard to the other breaches at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe. Risks posed to people were not appropriately assessed and managed. Aspects of the environment posed a risk of injury or harm to people and not always clean and hygienic.

There were enough staff to keep people safe but staffing was not reviewed as people's needs changed. Checks were made on staff when they started work but their on-going suitability was not checked.

Although people received their medicines as prescribed working practices increased risks of errors being made.

Staff knew what action to take if they suspected a person was at risk of abuse.

Is the service effective?

Requires Improvement

The service was not always effective. Staff did not fully understand how to support people with their healthcare needs. They did not always respond quickly when people's health changed.

Staff received training and understood their responsibilities in relation to the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS).

Staff supported people to eat and drink enough to meet their needs. The design of the environment gave people flexibility in how they wished to spend their time at home.

Is the service caring?

Requires Improvement

The service was not always caring. Support was not always provided in a way that was kind, dignified and respectful.

Staff did not always have time to support people to communicate their needs and wishes.

People who wished to be independent were supported to be so.

Is the service responsive?

Requires Improvement

The service was not always responsive. People's care plans were not personalised or reflective of their choices and preferences. People's needs were not reviewed regularly to ensure they continued to receive the right level of support.

There was not always enough for people to do to meet their social and physical needs and reduce risks to them from social isolation.

The provider had arrangements in place to deal with any concerns or complaints people may have.

Is the service well-led?

Requires Improvement

The service was not always well led. The provider had limited oversight of the service. Their quality assurance systems were ineffective and did not identify numerous shortfalls we found at the service.

The provider did not always promote an open, inclusive culture in which people and staff had effective means to communicate their views and experiences.

The provider had not taken appropriate action to meet legal requirements. However they demonstrated they could be responsive in making some improvements when needed.

Clifton House

Detailed findings

Background to this inspection

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

This inspection took place on 1 November and 2 November 2017 and was unannounced. The inspection team consisted of two inspectors and an Expert by Experience. This is a person who has personal experience of using or caring for someone who uses this type of service.

Before the inspection we reviewed the information we held about the service. We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We also looked at reports from previous inspections and statutory notifications submitted by the provider. Statutory notifications contain information providers are required to send us about significant events that take place within services.

During our inspection we spoke to six people using the service and a visiting relative. We spoke to the provider, which was a partnership. One of the partners was the registered manager. The other partner was the deputy manager. We also spoke to four care support workers. We looked at records which included five people's care records, medicines administration records (MAR) for all the people using the service, four staff files and other records relating to the management of the service.

We undertook general observations throughout our visit and used the short observational framework for inspection (SOFI) during lunchtime. SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

After the inspection the provider wrote to us and provided their quality assurance plan, responses from their annual quality survey, an estimate for building works and details of activities that were recommencing at the service.

Requires Improvement

Is the service safe?

Our findings

People were at risk of injury or harm because the provider's arrangements for assessing and managing risks to people posed by their healthcare conditions and by the environment were not effective. This was because the provider was not routinely assessing and reviewing risks and people's care records and associated risk assessments were out of date and/or inaccurate. We saw for one person who had suffered a fall in the previous month, the provider had not reviewed whether the person's reduced mobility following the fall posed new risks to them in terms of their health and from the environment. This meant staff did not have access to current information about how to keep the person safe from a risk of falls due to this change in their needs.

The provider had not assessed and reviewed risks to four people who had moved into Clifton House in August 2017 following the closure of one of their other services. The provider told us as this was an 'internal transfer' they did not feel this had been required. This meant they had not considered the impact that the move may have had on these people in terms of their health and wellbeing or done enough to check that the new environment did not pose risks to people's safety. The provider could not be certain in these instances that people were safe from injury or harm from new and emerging risks to their health and safety.

People were at risk because aspects of the premises were unsafe. The provider had assessed the risk of people falling from height from first floor windows at the service and had identified to reduce this risk, window restrictors should be fitted to limit the window openings to a maximum of "six inches". This did not meet the Health and Safety Executive's recommended safe level of 100 millimetres. The window in the first floor bathroom exceeded the recommended safe level. We also found in people's bedrooms on the first floor although window restrictors had been fitted on the large side windows that only opened to within the safe level, the smaller top window had no such restrictors. This meant people were not sufficiently protected from the risk of injury or harm that could result from a fall from height from these windows.

Other aspects of the environment posed risks of injury or harm to people. On the first day of our inspection we saw two sharps bins for the disposal of used needles within easy reach of people in the communal dining area. The lid on one of the bins was broken so people could easily tip out the contents and risk incurring a needle stick injury. In the ground floor bathroom a plastic box containing used disposable razors capable of causing cuts and injury to people if handled inappropriately, was stored in a cabinet with a broken off door. In the kitchen a cupboard that was meant to be kept locked at all times due to sharp items inside that could cause injury to people, was open and easily accessible. Signs on the ground floor doors leading to the garden warned people that the upper level of the garden was out of bounds due to building rubble and that they should not cross the 'red and white' tape for their own safety. There was no such tape in place to warn people of this hazard.

Communal areas such as the lounge, dining room, ground floor corridors and the rear garden were cluttered with furniture and items brought in to the service by the provider following the closure of their other service. This had increased the risk of injury or harm to people as these items restricted the ability of people to move freely and safely. We saw one person trip after getting up from the dining table and fall into an armchair due

to the limited space between the table and armchair. There were also a number of free standing oil filled radiators in people's rooms being used by the provider as an additional heat source. However the provider had not undertaken formal risk assessments of the use of these radiators to manage the risk of burns to people from contact with these.

We gave the provider detailed feedback on the first day of our inspection about what we had observed around the environment. On the second day of our inspection we noted the provider had taken some action to make improvements. Sharp items had been removed out of reach and the environment had tidied to remove potential trip and slip hazards. In the garden red and white tape had been put up to warn people of the hazards presented by the building rubble.

Although the provider had made some improvements to make the environment safe for people, the issues we found constituted breaches of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were at risk of acquiring infectious diseases as parts of the environment were unclean and unhygienic. On the first day of our inspection we saw a build-up of dust in communal areas around skirting boards and grab rails. In one person's room their armchair was dirty, their en-suite toilet required a deep clean and there was a strong malodorous smell present from an unidentified source. We saw a build-up of dust in a further two bedrooms on shelves, skirting boards and lampshades. In another room we saw what appeared to be mould on the grouting around the hand basin. Tiles in the ground floor bathroom were cracked and as such difficult to keep clean and free of potentially hazardous bacteria. On the second day of our inspection we noted the provider had taken some action to clean rooms and communal areas.

Although the provider had taken steps to make the environment cleaner and more hygienic these issues constituted breaches of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People had mixed views about whether there were enough staff to keep them safe. Two people said there were. However one person said they didn't think there were enough staff at times. During our inspection we observed staff were visible and responding promptly to people's requests for assistance. We discussed staffing levels with the provider. The provider used a mix of permanent staff and temporary agency staff to meet people's needs. They told us to ensure some continuity for people they used the same temporary staff wherever possible.

We found the provider did not routinely assess and review staffing levels as the level of dependency at the service changed. They told us staffing levels were calculated according to funding from the local authority. This lack of flexibility meant the provider would not be able to respond quickly to people's changing needs. We saw during our inspection one person had recently become ill and required support from two members of staff with aspects of their personal care. The provider had not considered how this impacted on staff's ability to provide adequate levels of support to all the people at the service. This meant they could not be assured that there were enough staff to meet people's needs at all times.

People received the medicines that had been prescribed to them. The provider used a computerised system to manage and administer medicines. Our checks of stocks and balances of medicines and people's individual medicines administration record (MAR) indicated that people had received their prescribed medicines. All permanent staff had received training in the last six months to administer medicines. However we saw some elements of their working practices increased the risks of administration errors being made. For example the system showed two people received their medicines at a different time from when

the dispensing pharmacy had stated they should be administered. Staff told us this had been people's choice based on their personal preferences. However this was not recorded on people's records. There was no evidence that the provider had discussed with people and the dispensing pharmacist whether these changes posed any risks to people.

We observed the deputy manager administer medicines to one person but this was signed off on the computerised system by another staff member. This was not good practice and did not provide for a clear, auditable record for who had administered the medicine. We found one person was receiving eye drops to be used within 28 days of opening. However the date the drops were opened had not been noted. Although staff told us they changed the eye drops every 28 days there was a risk that the drops could continue to be used after this date. We found a prescribed cream for one person, that was no longer being used, in the lower ground floor bathroom rather than in more appropriate safe storage.

The provider maintained adequate recruitment procedures that enabled them to check the suitability and fitness of any new staff employed to work at the service. This included appropriate criminal records checks. For all temporary agency staff the provider obtained from their employment agency confirmation of criminal records checks and evidence of their qualifications, experience and completed training. However the provider did not undertake on-going criminal records checks on all existing permanent staff so they could not be fully assured of their continuing suitability to work at the service.

The provider continued to support staff to keep people safe from abuse. All permanent staff had been trained in safeguarding adults at risk within the last six months. The provider sought assurances that any temporary agency staff used by the service had also completed appropriate training in this area. Staff understood their duty to observe and report any concerns they had about people if they thought they were at risk of abuse.

Notwithstanding the issues we found above in respect of risks posed by the environment we saw the provider continued to carry out some checks of the premises and equipment. We saw evidence of recent checks made of fire equipment, alarms, emergency lighting, call bells, hoists, the lift, wheelchairs, portable electrical appliances and the gas heating system. The provider also carried out regular checks of hot water temperatures from outlets to ensure these did not pose a risk of scalding to people.

Requires Improvement

Is the service effective?

Our findings

People did not receive timely support to access appropriate healthcare professionals and services when they suffered an injury or became unwell. We found for one person that had experienced a fall whilst out in the community, staff did not seek support or advice from the GP until nine days after the incident despite the person asking for pain relief for pain in their foot during this period. When the person was referred by the GP to hospital for an x-ray, fractures were found in their toes. We met another person on the first day of our inspection who was unwell. Staff told us they had been seen by the GP two days previously and prescribed a short course of medicines. Staff acknowledged the person's health had deteriorated since being seen by the GP but had not contacted them for further advice and guidance about why this might have been. On the second day of our inspection we were informed by staff that the GP had been called that morning as the person's health had deteriorated further. In both these instances the delay in staff seeking prompt support for people could have unnecessarily prolonged people's pain and ill health.

These issues were a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People who required a specialist diet were at risk of becoming unwell. The provider had not ensured there was up to date guidance for staff on how to support people to manage their food and drink choices to reduce the risk of aggravating their specific healthcare conditions. One person had a healthcare condition that could be triggered by dairy products. The person was provided tea with milk on a number of occasions during our inspection but staff did not check that they were aware of the risk of this aggravating their condition nor did they offer a suitable alternative which indicated the person was not receiving effective support with their dietary needs. In their old paper care records there was information for staff on how to support the person to reduce this risk by encouraging the person to avoid dairy and eat a diet high in fibre and fresh fruit and vegetables. However when the provider moved to using a computerised records system in July 2017 this information was not transferred over to the person's new electronic care record so staff no longer had access to this information.

This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

When assessing people's needs, the provider had not considered information and guidance, based on best available evidence, to support people to experience good outcomes in relation to their healthcare needs and conditions. We saw for one person the provider had not sought external advice from appropriate sources on how to support the person to manage their healthcare condition effectively. As a result there was no guidance for staff on how to help the person to manage their condition through for example promotion of a healthy diet and active lifestyle. There was also no information for staff on how to recognise the signs that would indicate the person was experiencing a medical crisis due to their healthcare condition and how they should be supported with this. This could put the person at risk of not receiving prompt medical support from healthcare professionals in this instance.

This issue was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People had mixed views about whether staff had the skills to could meet their needs. Two people said that they could. But one person told us, "Not really." The support provided to staff by the provider to help them to meet people's needs was variable. All permanent staff members had received training in topics and subjects relevant to their work over the last six months to support staff to work consistently and with regard to current best practice in meeting people's needs. A staff member said, "The provider is good on the training. Mine is up to date." The provider's records also indicated all permanent staff received support from the provider through a supervision (one to one meeting) and appraisal programme. These meetings should provide staff opportunities to discuss their work performance, reflect on their practice and identify areas where they could further develop. However one staff member told us these meetings were not as effective as they could be in terms of helping them to continuously improve their work based practice. They said, "[The provider] has never seen how I work, what I do." During our inspection we saw a temporary staff member about to use inappropriate moving and handling procedures on one person before being stopped by a permanent staff member. We raised this with the provider who acknowledged they did not routinely observe staff's working practices. This meant the provider could not be fully assured that all staff employed at the service demonstrated the relevant skills, knowledge and experience to support people effectively.

Notwithstanding the issues we found above about the support for people with a specialist diet, people were supported to have enough to eat and drink. People were happy with the meals they ate at the service. One person told us, "Yes, had a nice dinner yesterday." Another person said, "Yes there's enough…sometimes I say 'can I have such and such?' and they are very good." And another person told us they were offered meals that met their cultural preferences. During mealtimes we saw people ate well. Staff told us if they had concerns about a person's food and drink intake they would observe and record what people ate and drank to help them monitor people were eating and drinking enough to reduce risks that could arise from malnutrition and dehydration.

The design and set up of the environment provided people with a degree of flexibility in terms of how they wished to spend their time when at home. The layout of the large lounge diner provided people with different options to spend time alone or with others. People were given space and privacy to meet with their visitors if they wanted this. At the time of this inspection the rear garden was not accessible due to building work but we could see that this would be a peaceful and relaxing space for people to spend time in once the works were completed. Around the environment there was appropriate signage to help people orientate and people's bedroom doors had their photo and name displayed, where they had consented to this, to help people locate their room more easily.

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 take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. All staff had received training in the MCA and DoLS and understood their responsibilities under the act. We saw from records the provider was complying with conditions attached to

applications which had been authorised by the appropriate body. Where the provider was waiting for the outcome of applications made they were in contact with the authorising body to check on progress to ensure these were not subject to unnecessary delays.

Requires Improvement

Is the service caring?

Our findings

People may not have always been given the time they needed to talk to staff and be listened to. People had mixed views about whether staff had enough time to spend with them. One person said, "Yes." But another person told us, "Not really." A staff member told us, "I make time to spend with people." However they also said in order to stay on top of their duties they spent a lot of their time updating the computerised records system rather than with people which indicated the provider did not always ensure staff had the time they needed to support people to communicate their needs and wishes.

People did not consistently experience support at Clifton House that was kind, dignified and respectful. Some people told us staff were caring. One person said, "Oh yes!" Another person told us, "They seem to be." However another person said staff appeared caring "to others" but they did not feel particularly cared for. We observed some staff were kind and caring. We saw a staff member engaging in conversation with one person in which the staff member prompted them to talk about their life experiences. There appeared to be genuine warmth and laughter between the person and staff member who was patient, kind and gave the person their full attention throughout the conversation. During both days of our inspection this staff member continually checked that people were ok, that they were comfortable and provided appropriate support to people when they needed this.

However we saw other staff did not treat people with dignity and respect. During the lunchtime meal on the first day of our inspection we saw one staff member cut up a person's food and then stood over them when supporting them to eat their meal. The deputy manager told the staff member to sit down and pulled out a chair for them so that they could provide the person with support in a more dignified way. Although the staff member did sit down, they did not speak to or acknowledge the person throughout the whole time they were supporting them to eat.

The overall mealtime service lacked thought, attention to detail and did not always provide for a comfortable and dignified experience for people. On the first day of our inspection during the lunchtime meal we saw dining tables had a clear plastic covering which was torn in places. One table had no condiments for people. The meal that was served did not reflect the pictures on the menu board which would have been confusing for people. The board showed a chicken burger served in a bun with lettuce and tomatoes. People were served a chicken burger with boiled potatoes, cauliflower and carrots. Gravy to accompany the meal was brought out in a measuring jug with the fork used to mix up the gravy granules still in it. As people ate music was playing loudly which inhibited conversation. For dessert although the menu board showed fruit pie or fruit cocktail, people were offered lemon drizzle cake or a choc ice. Again, this could have been confusing for people. We saw one person clearly enjoyed their dessert but were not asked if they would like more. Whilst people were eating their lunch we observed a staff member sweep the lounge area which was unpleasant for people as dust and dirt was swept up around them. Another staff member sat at an empty table and did not engage or talk to people. They got up once people had eaten their meals to clear away their plates. We gave the provider detailed feedback on the first day of our inspection about what we had seen and observed during the lunchtime meal.

On the second day of our inspection we saw the mealtime experience had improved which indicated the provider had taken on board our comments and feedback. The meals that were served on this day reflected what was displayed on the menu board so it was clearer and easier for people to understand what they were eating. Staff were more attentive and providing people with appropriate support. They checked with people if they had enjoyed their food and asked if they would like more to eat. One person after the meal told us, "Lunch was nice, I thoroughly enjoyed it."

We saw other examples where some staff had not always been considerate to the needs of people. On the first day of our inspection one person spending time in their room told us they were cold. The window in their room was open, the radiator was turned off and it was clearly cold in their room. The person told the provider in our presence that a staff member had turned off the radiator the previous day as they (staff member) had said the room was too hot for them to work in. The staff member had not turned the radiator back on after completing their tasks which meant the person had had no heat in their room since the previous day. Staff that had supported the person that morning with their personal care had not noticed the radiator was not on. We found in three other people's bedrooms, windows were open, radiators were turned off and the rooms were uncomfortably cold. On the second day of our inspection we saw the provider had addressed these issues by ensuring the thermostat was turned up to an appropriate temperature. During a tour of the building we found radiators were on, windows were shut and the environment was warmer and more comfortable than the previous day.

People were supported to be as independent as they could be. One person told us they were very independent and able to manage many aspects of their care and support needs with minimal support from staff. They had been provided their own key to their bedroom which they preferred to keep locked at all times. Staff respected their wishes and did not enter their room without first seeking their permission to enter. The person told us they were able to come and go as they pleased and went out often to the local shops.

Requires Improvement

Is the service responsive?

Our findings

People told us they were not involved in planning their care and support needs. Our checks of people's current electronic care records showed there was a lack of information about people's personal preferences and their likes and dislikes for the support they received. This meant there was a risk that people would experience support that did not reflect their diverse needs and wishes and choices for how care was provided. For one person we saw no specific information about their likes and dislikes particularly with regards the meals they ate. This person had a poor diet. The lack of personalised information meant any new staff unfamiliar with the person may not be fully able to support them to eat enough of the foods they liked to help them meet their nutritional needs.

When people's needs changed the provider was not undertaking a review of their care to check if any changes were needed to the level of support they required. For example for one person who had had a recent fall the provider had not reviewed their current care and support needs despite the fact the person now had reduced mobility as well as a noticeable change in their behaviour that had affected their emotional health and wellbeing. This meant that staff may not be providing them with the appropriate level of support they required in response to their changing needs. Our checks of other people's records showed the provider was not routinely reviewing people's care and support to ensure the level of support provided continued to meet their needs.

These issues were a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was not enough for people to do to meet their social and physical needs and reduce risks to them from social isolation. The provider told us group based activities were provided by staff twice a day at the service. On the first day of our inspection we observed two staff members initiate a game of 'hoopla' with people in the communal lounge in the morning. Staff did not ask people if they wished to play this particular game or if they wanted to take part. Whilst the activity was underway the radio was playing which made it difficult for some people to hear what was going on. One person refused to take part but staff continued to ask them to join in and eventually they did but appeared to be reluctant to do so. Staff did not ask them at any time if they wished to do another activity of their choosing.

In the afternoon people were told by staff they were going to do another activity. The television was turned off whilst people were still watching this and people were not offered a choice if they wished to continue watching television or take part in the group activity. Staff did not explain to people what the activity was, which was knocking down stacked cans with bean bags. Whilst some people appeared to be enjoying the activity, others appeared to be disinterested. One person dozed off in their chair.

For people that chose to spend time alone in their rooms, staff checked on them but did not spend any length of time with them on one to one activities. This meant people who chose to spend time alone were at risk of becoming socially isolated. Staff told us they tried to provide activities to keep people engaged and stimulated but they found this difficult at times as they were responsible for providing people with care as

well as domestic duties such as cleaning and cooking meals three days a week. The other four days of the week, the deputy manager cooked the meals at the service.

We gave the provider detailed feedback on the first day of our inspection about what we had seen and observed. They told us they had previously used external activity providers to come into the service five days a week to deliver a range of activities such as arts and crafts, exercise classes, quizzes and games and hand and foot massages. They had stopped this provision when the number of people using the service had decreased earlier in the year but had not considered reinstating this when the number of people increased again in August, with the closure of another of their services. After this inspection the provider wrote to us to tell us the external activity provision had been reinstated in the week following our inspection. We will monitor and report whether this improvement was made and sustained at our next inspection of the service.

A relative told us when they had raised any issues or concerns with the provider, these had been resolved. We saw the provider maintained arrangements for dealing with people's complaints or concerns if these should arise. We noted the complaints procedure was not visibly on display at the service. The provider told us this was taken down when the communal hallway was recently redecorated and said they would ensure the procedure was put back up on display after our inspection.

Requires Improvement

Is the service well-led?

Our findings

The provider had limited oversight of the service and did not ensure that people using the service experienced good quality outcomes. The system they had in place to assess and monitor the care and support provided was not robust or comprehensive and did not routinely review key aspects of the service that would have indicated whether people experienced safe, good quality care. For example the provider did not undertake regular audits of people's care records to check these were accurate and up to date. We identified a number of issues at this inspection about the quality of these records including out of date or missing information about the support people required and inaccuracies or lack of detail about the risks posed to people and how they should be supported to stay safe.

The provider did not formally observe and review the competency of staff to assure themselves that they had the skills, knowledge and experience required to support people and that they followed best practice. We identified issues around staff's ability to respond quickly to people's changing healthcare needs and their overall understanding of people's current healthcare conditions and how they should be supported with these. We also identified an issue around the quality of their practice in relation to moving and handling techniques and their adherence to best practice in relation to safe handling and management of medicines.

The provider's quality checks to assess and monitor the safety of the environment were not robust. We found a number of environmental risks posed to people including trip and slip hazards, missing or inappropriate window restrictors on first floor windows, exposure to sharp items and issues around the cleanliness and hygiene of the environment. The provider had not considered and assessed risks to people after they brought in furniture and items that they had stored inappropriately around the environment.

The provider did not take appropriate action, when required, to continuously improve the quality of the service for people. After our last inspection in October 2015 we found a breach in a legal requirement. At this inspection we found this legal requirement had still not been fully met. The provider had not updated the service's safeguarding procedure to inform staff of their duty to record the outcome of any safeguarding investigation undertaken by the local authority. The provider could not give us a satisfactory explanation of why this had not been done. This indicated the provider did not fully understand their responsibility to ensure legal requirements were adequately met when required.

The numerous shortfalls we identified during this inspection put people at unnecessary risk of inappropriate and unsafe care. These issues were a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had not met their legal obligation to submit notifications to CQC of events or incidents involving people at the service. We found they had not notified us of a serious injury sustained by one person in September 2017. We also saw they did not notify us of the outcome of an application made to a supervisory body for a standard authorisation to lawfully deprive one person of their liberty which they were informed about in June 2017. Failure to notify CQC of these events and incidents meant we could not check that the provider had taken appropriate action to ensure people's safety and welfare in these instances.

This issue was breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009 (Part 4).

The provider was not always ensuring there was an open and inclusive culture within the service which fully involved and supported people and staff. People's feedback indicated that managers were not always available to them. Two people told us they rarely saw managers at the service. Another person described the management of the service as "efficient" but also said "sometimes feel [there] could be more care of the emotional sort." This indicated the provider was not always approachable and accessible to people so there was a risk they would not have full oversight of people's views and experiences about the quality and safety of the service.

Staff said managers were not always supportive when they needed them to be. One staff member said, "If [the provider] was more hands on and realised what we do…doesn't understand why I don't achieve all my tasks. Then I get into trouble." Staff team meetings were not planned in advance and when they did take place they were not minuted. We could not check in this instance if these provided staff opportunities to say how the service could be improved for people so that they experienced good quality outcomes.

There was some evidence that the provider sought people's views about the quality of the service. A quality survey had been sent to people and their relatives in November 2016 and from the responses received we saw people had stated they were satisfied with the support provided by the service. When one person had made a suggestion for how an aspect of the service could be improved the provider took action and made the changes they suggested.

The provider demonstrated they could act responsively when required to make improvements when these were needed. During our inspection the provider took on board our feedback and made improvements that immediately reduced some of the risks we found to people's safety and wellbeing. They had also reintroduced external activity provision after our inspection to improve the quality of opportunities for people to have their social and physical needs met. However it was too early to judge whether these improvements could be sustained and maintained.

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 18 Registration Regulations 2009 Notifications of other incidents The provider had not notified the Commission without delay of an injury to a service user. Regulation 18(2)(b). The provider had not notified the Commission without delay of the outcome of request to a supervisory body made pursuant to Part 4 of Schedule A1 to the 2005 Act for a standard authorisation. Regulation 18 (4B)(c).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider did not ensure the care and treatment of people was appropriate, met their needs and reflected their preferences. Regulation 9(1). The provider did not carry out assessments of the needs and preferences for care and treatment of people taking account of nationally recognised evidence based guidance. Regulation 9(3)(a).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs The provider was not ensuring receipt by a service user of suitable and nutritious food and hydration which is adequate to sustain life and good health, Regulation 14(4)(a).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The provider had not ensured the premises were clean, Regulation 15(1)(a). The registered person had not ensured in relation to such premises and equipment, maintained standards of hygiene appropriate for the purpose for which they are being used. Regulation 15(2).

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 provider was not assessing the risks to the health and safety of service users of receiving the care or treatment; Regulation 12(2)(a) The provider was not doing all that is reasonably practicable to mitigate such risks; Regulation 12(2)(b). The provider was not ensuring the premises used by the service provider are safe to use for their intended purpose and used in a safe way; Regulation (12)(d).

The enforcement action we took:

A warning notice was issued.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services);Regulation 17(2)(a) The provider did not assess monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity; Regulation 17(2)(b) The provider did not maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care

and treatment provided; Regulation 17(2)(c)

The provider did not evaluate and improve their practice in respect of the processing of the information referred to in sub-paragraphs (a) to (e). Regulation 17(2)(f).

The enforcement action we took:

A warning notice was issued.