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Epsom Lodge

Inspection report

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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

Epsom Lodge is registered to provide accommodation with care for up to 13 people. At time of our inspection there were nine people living at the home. The majority of the people who live at the home are living with dementia. The accommodation is provided over two floors that are accessible by stairs and a lift.

The inspection of Epsom Lodge took place on 19 September 2016 and was unannounced. This inspection was to follow up on actions we had asked the provider to take to improve the service people received.

At the time of the inspection Epsom Lodge did not have a registered manager in post. 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. We were informed that the manager had commenced the application process to be registered as manager with the CQC.

At our previous inspection on 8 and 11 April 2016 we found breaches of five regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We asked the provider to take action in relation to infection control, risk management, obtaining consent in accordance with the requirements of the Mental Capacity Act 2005, deployment of staff and assessing and monitoring the quality of the service provided. The provider sent us an action plan and provided timescales by which time the regulations would be met. They stated that the actions would be completed by 2 August 2016.

During this inspection we found that some improvements had been made. However, they were not sufficient enough to meet the requirements of the regulations.

The management of medicines had improved but there were areas that still required further action. Although people got their medicines as prescribed, the conditions medicines were stored in needed improving. Staff had not completed the Medicines Administration Records correctly in line with current guidelines.

People's risk of infection or cross contamination was reduced due to the improvements made. Although staff followed best practises in infection control and maintained appropriate standards of cleanliness, there were still areas that needed to be addressed.

People were not always safe because there were a number of inconsistencies in the systems and arrangements to protect people from harm. Robust and up to date risk assessments were not in place to identify, assess and manage risk safely and to minimise the risk of harm to people. Although environmental risks around the home had reduced, there were still improvements needed. The management team did not monitor trends or identify patterns in regard to accidents or incidents.

People were not always protected from being cared for by unsuitable staff because although recruitment processes were in place, they were not always followed.

Although additional staff had been employed and people told us they were happy with the staffing level at the home. The employment and deployment of staff still had an impact on the care people received and the range of activities provided.

Staff did not have a clear understanding of their responsibilities regarding the Mental Capacity Act or Deprivation of Liberty Safeguards. Where people lacked capacity they were not fully protected and best practices were not being followed.

Staff received the training and skills they needed to meet people's needs. However they did not receive appropriate support such as supervision and appraisals that promoted their professional development or reviewed their performance.

People were supported to have access to healthcare services and healthcare professionals to support their wellbeing. The service worked effectively with health care professionals and referred people for treatment when necessary. However, where people had specific health care needs these had not been taken into account when planning the care or identifying what support they needed. There were inconsistencies in the monitoring of people's health and support needs

Care records did not contain relevant information regarding people's care or support needs which meant new or agency staff who did not know people might not be working to the most up to date information. Care planning was not always based on individual needs, care and treatment.

People had access to activities, however there were mixed feelings about the activities provided. The range of activities available was not always appropriate or stimulating for people.

There were no robust quality assurance systems in place, to review and monitor the quality of the service provided. Audits did not identify or take action to improve poor care practices. The management and leadership of the home were ineffective. The provider did not actively seek, encourage and support people's involvement in the improvement of the service. The continuous breaches demonstrated that the home was not managed appropriately.

People told us that they felt safe at Epsom Lodge. People told us, "Yes I am safe here." Staff had a good understanding about the signs of abuse and were aware of what to do if they suspected abuse was taking place. Fire safety arrangements were in place to help keep people safe. The service had a business contingency plan that identified how the home would function in the event of an emergency such as fire, adverse weather conditions, flooding or power cuts.

People had enough to eat and drink throughout the day. Where people needed support with eating, they were supported by a member of staff.

Staff treated people with compassion, kindness, dignity and respect when providing care. Staff told us they always made sure they respected people's privacy and dignity before personal care tasks were performed.

There were inconsistencies in the choices people were able to make. People were able to make choices about when to get up in the morning or go to bed, what to eat for breakfast and what to wear. However people did not always have a choice of what to eat at lunch or supper time and we saw that people were not

asked what programme they would like to watch on the television. We made a recommendation that the provider ensures that people are always given the opportunity to make choices in their day to day lives.

People were able to personalise their rooms. People's relatives and friends were able to visit.

People were able to express their views and were given information how to raise their concerns or make a complaint. People told us if they had any issues they would speak to the manager. People told us the staff were friendly, supportive and management were always visible and approachable.

During this inspection we found six breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We also made one recommendations to the provider. You can see what action we told the provider to take at the back of the full version of this 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 consistently safe.

Risks to people were not managed safely and in accordance with their needs.

Staffing levels were not appropriate to meet the needs of people. This had an impact on the level of care and support provided.

Medicines were administered by staff in a safe manner; however there were inconsistencies in regards to the storage of medicines and medicines records.

Safe recruitment practices were not always followed.

There were effective safeguarding procedures in place to protect people from potential abuse. Staff were aware of their roles and responsibilities.

There was a contingency plan in place in the event of an emergency.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff did not have a clear understanding of the Mental Capacity Act (MCA) or Deprivation of Liberty Safeguards (DoLS) or their responsibilities in respect of this.

Staff received the training and skills they needed to meet people's needs. However they did not receive appropriate support that promoted their professional development or reviewed their performance.

Where people had specific health care needs these had not been taken into account when planning the care or identifying what support they needed.

People had enough to eat and drink. People were supported to have their nutrition and hydration needs met.

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

Is the service caring?

Requires Improvement

The service was not always caring.

Individually staff treated people with compassion, kindness, dignity and respect when conducting tasks including personal care; however people were not at the heart of the home.

People's privacy was respected and promoted.

There were inconsistencies in the way people were able to make choices.

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

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's care was not always based on individual's care and support needs.

People were supported to participate in a range of activities; however there was a lack of individualised stimulation.

People were able to express their views and were given information how to raise their concerns or make a complaint.

Is the service well-led?

Requires Improvement

The service was not well-led.

There was a lack of effectiveness of the management and leadership.

Quality assurance systems failed to identify and manage risks in the home and for people living there.

The provider did not actively seek, encourage and support people's involvement in the improvement of the service.

People told us the staff were friendly, supportive and management were always visible and approachable.

Epsom Lodge

Detailed findings

Background to this inspection

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

We carried out an unannounced inspection to the home on 19 September 2016. The inspection was conducted by two inspectors.

Before the inspection we reviewed the provider's action plan which they had supplied to tell us how they had met or intended to meet their legal requirements in relation to the breaches of regulations we found at our last inspection.

Prior to the inspection we reviewed the previous inspection report. We gathered information about the home by contacting the local authority safeguarding and quality assurance teams. We also reviewed records held by the Care Quality Commission which included notifications, complaints and any safeguarding concerns. A notification is information about important events which the service is required to send us by law. This enabled us to ensure we were addressing potential areas of concern at the inspection.

We did not ask the provider to complete a Provider Information Return (PIR) as we were following up on action taken in regard with the concerns found at the last inspection. The PIR is a form that asks the provider to give some key information about the home, what the home does well and improvements they plan to make.

During the inspection we spoke to five people, one member of staff, the manager and the registered providers. We observed care and support in communal areas; looked at two bedrooms with the agreement from the relevant people. We looked at four care records, risk assessments, medicines records, accident and incident records, minutes of meetings, seven staff records, complaints records, policies and procedures and external and internal audits.

We last inspected this home on 8 and 11 April 2016 when we found five breaches of the Health and Social

Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe and secure at the home and with the staff who provided care and support. A person told us, "I feel safe because I'm on the ground floor, the doors are open and carers are here all night, if you press your buzzer they will come." Another person told us, "I feel safe, I don't worry about how staff treat me." Despite the positive comments from people about how safe they felt we found that improvements were still needed to ensure people were always protected from harm and risk.

At our last inspection on 8 and 11 April 2016, we identified a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Regulation 12 covers a wide range of requirements, so we have broken down the breaches into specific sections. People were at risk of harm because safe medicines management procedures were not in place. We found during this inspection that some improvements had been made in regard to the safe storage of medicines but there were still issues around the refrigeration, temperature monitoring and the recording of people's medicines. As these issues still needed to be rectified, people were still at risk of harm; this meant the provider had not met the requirements of the safe management of medicines and therefore there was still a breach of the regulation.

People's medicines were not managed safely. We found prescribed creams were not always labelled or an open date recorded. This is important to ensure that creams are administered to the right person and that creams are not used past their expiry date. There were inconsistencies in the way medicines were stored. Although medicines were stored in lockable cupboards the temperature of the environment was not monitored or controlled which could have an impact on the efficiency of the medicines. Where medicines required refrigeration, the refrigerator was not suitable to store them correctly as the temperature could not be controlled.

People's medicines records were not completed accurately. Staff had not completed people's Medicine Administration Records (MARs) correctly as they had not initialled the MAR correctly and they had signed the MARs even when medicines had not been administered. Where people refused their medicines, the reason for this was not recorded. No one who had topical creams (medicines in cream form) had charts completed to show that this had been administered and where. Where people required PRN [as needed] medicines information including the dosage of the medicines was recorded but there was no staff guidance around what to look for when people may require PRN medicines.

At our last inspection on 8 and 11 April 2016, we identified a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We found that people were at risk as the premises were unsafe and there was a lack of infection control procedures in place. During this inspection improvements had been made to the premises and although infection control procedures were being followed, there were still areas that needed to be addressed. Because of these there was still some potential risk to people and therefore still a breach in the regulation.

People's risk of infection or cross contamination was reduced due to the improvements made. Staff were usually following best practises in infection control and were maintaining appropriate standards of

cleanliness. However there was one incident where a member of staff was not wearing gloves, whilst carrying a red bag containing soiled items. This showed that this member of staff was not following the policies or putting their training into practice. There were still no designated areas for dirty and clean clothes so people were at risk of cross contamination.

The environmental risks around the home had reduced. Clothes were no longer hanging in the cupboard containing the gas boiler which had been a fire hazard. However the cupboard containing hazardous products (such as bleach) was unlocked and easily accessible to people.

The failure to have effective medicines management systems and failing to protect people from the risk of infection is a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection on 8 and 11 April 2016, we identified a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The deployment of staff affected how people's needs were met safely. During this inspection, some improvements had been made as more staff had been employed. However the staff on duty were still covering absences and providing care to people over two floors, which meant there was still insufficient staff to meet people's needs. Staff provided people with personal care but they did not have the time to engage in meaningful interactions with people. Although some improvements had been made, the deployment of staff had an impact on the care provided and therefore there was still a breach of the regulation.

The employment and deployment of staff had an impact on the range of activities and the quality of care provided. People told us about the staffing levels at the home, "At the moment there are enough staff as there are less people here now." and "They have occasional trouble getting staff on the whole they manage really well." However despite people's relatively positive comments, we found that although there were less people living at the service the employment and deployment of staff had an impact on quality of life and care. The provider was not able to evidence how they assessed people's needs and provided the correct staff to meet those needs. The provider informed us that there were five staff on duty, which included the manager and themselves. Four staff were allocated to provide care and support to nine people however during the day the manager and two care staff provided care whilst other staff spent time in the kitchen or on other duties. Some people required two staff to help with all aspects of their care which left one member of staff caring for people on different floors at these times. A number of people on different floors preferred to stay in their rooms all day and staff were unable to regularly check on them or spend meaningful time with them outside carrying out basic personal care tasks. Staff were busy and rushed and did not have time to give personalised care. Also because staff were rushed providing basic care most people spent the majority of the day sitting in the lounge watching television. Staff did not have time to sit and chat or provide one to one time with people.

Failure to have sufficient number of staff deployed to meet people's needs was a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not always protected from being cared for by unsuitable staff because although recruitment processes were in place, they were not always followed. Records contained an application form which recorded employment and training history, provided proof of identification and contact details for references. However, the provider had not obtained any explanation for gaps in people's employment history. Three out of the seven files we reviewed did not have references. The manager stated they would look for the references as they believed staff had provided them. We have not received any information in regard to the missing references. All files contained information about a Disclosure and Barring System

(DBS) check. DBS checks identify if prospective staff have a criminal record or are barred from working with adults at risk.

The failure to have effective and established recruitment procedures in place to ensure that people employed meet the conditions as specified in the regulation is a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Risks to people were recognised and managed by staff who were knowledgeable about people's needs. However risk assessments recorded basic information about people's needs and where people had a pacemaker or catheter fitted, there was no assessment in place to identify possible risks. Although we did find that risks and any healthcare issues that arose were discussed with health care professionals such as the GP or district nurse, these were not included in an assessment to guide staff on how best to prevent risks occurring. We found that staff were knowledgeable about people's needs and risks and what action to take to protect them despite the lack of recorded guidance. However new or agency staff would not have this knowledge or be able to access to up to date information to provide appropriate and safe care to people.

Fire safety arrangements were in place to keep people safe. Each person had a personalised emergency evacuation plan and staff carried out regular fire drills and evacuations so they knew what to do in the event of a fire. There was a business contingency plan in place; staff had a clear understanding of what to do in the event of an emergency such as adverse weather conditions, power cuts or flooding.

People had access to specialist equipment. Equipment was available in sufficient quantities and used where needed to ensure that people were assisted to move safely and staff were able to describe safe moving and handling techniques. Staff supported people to move from wheelchairs to armchairs using a hoist or walking frame. They explained the process to people, telling them what was happening and provided reassurance.

People were protected against the risks of potential abuse. Staff had access to a copy of the most recent local authority safeguarding policy and company policy on safeguarding adults at risk. This provided staff with up to date guidance including contact details about what to do in the event of suspected or actual abuse. Staff knew that the manager would contact the safeguarding team to report any concerns. Staff told us that they had received safeguarding adults training since our last visit and were aware of their role in reporting suspected abuse. A member of staff told us, "I would go to the manager."

Risks to people were recognised and managed by staff who were knowledgeable about people's needs. Risk assessments recorded basic information about people's needs. Where people had a pacemaker or catheter fitted, there was no assessment in place to identify possible risks. Although we did find that risks and any healthcare issues that arose were discussed with health care professionals such as the GP or district nurse, these were not included in an assessment to guide staff on how best to prevent risks occurring. We found that staff were knowledgeable about people's needs and risks and what action to take to protect them. However new or agency staff would not have this knowledge or be able to access to up to date information to provide appropriate and safe care to people.

Staff had a good understanding of how to keep people safe and their responsibilities for reporting accidents and incidents. A system was in place to report and record incidents and accidents. Each accident had an accident form completed, which included clear outcomes and actions taken.

Requires Improvement

Is the service effective?

Our findings

People spoke positively of the staff working at the home. One person told us, "They give you service – they listen and are kind to me." Another person told us, "Staff will wash my back and legs for me, they are very helpful." Despite people's positive comments we found that improvements were still needed to ensure people received effective care.

At our last inspection on 8 and 11 April 2016, we identified a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People's rights were not upheld in line with current guidelines in relation to the Mental Capacity Act (2005) (MCA) and Deprivation of Liberty Safeguards (DoLS). During this inspection we found no improvement had been made. People's mental capacity had not been assessed correctly in line with current guidelines to protect people. This meant that people's rights were still not upheld and therefore was still a breach of the regulation.

People's rights were not protected because staff did not act in accordance with the MCA. Where important decisions needed to be made mental capacity assessments were not completed to see if people could make the decision for themselves. The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When 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. Best interests were not always considered when specific decisions that affected people were made. One person had a chronic health condition and the family had decided it was in their relative's best interest not to have any treatment. No documentation had been completed to record any discussions in regard to the decisions made. Where people had regular blood tests and lacked capacity to consent to treatment there was no documentation around consent. This meant people's rights had been affected.

The provider and staff did not have a clear understanding of their responsibilities under the MCA and DoLS, although records viewed confirmed staff had received training, they were unable to put their knowledge into practice. One staff member said, "It's about them making decisions, I wouldn't assume capacity, I would get a second opinion." This demonstrated that staff did not have an understanding as in the first instance staff should always assume people have capacity to make a decision, where there is a reason to assess that someone lacks capacity then the above process must be initiated.

The Care Quality Commission monitors the operation of DoLS which applies to care homes. These safeguards protect the rights of people by ensuring if there are any restrictions to their freedom and liberty, these have been authorised by the local authority as being required to protect the person from harm. Records confirmed that DoLS applications had been submitted to the local authority which included where people had a preference of staying in their room due to their anxiety and disability. However, some people may have their freedom restricted without staff following the correct processes. One person told us, "I desperately wanted to go out on my own or even go out but I am told that I can't go out without a member of staff." There was no information recorded as to why this person would need to be accompanied in their

best interests

Failure to meet the requirements of the Mental Capacity Act 2005 was a continued breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff did not have the opportunity to have one to one meetings with their line manager. The meetings would provide appropriate support that promoted staff's professional development or reviewed their performance. Staff told us they had been supported by manager. We reviewed the provider's records and there was a lack of current information related to discussions to show that staff had discussed their work practices, training and role with their manager. The provider confirmed that supervisions and appraisals had not taken place.

Failure to provide appropriate support, professional development, supervision and appraisal to enable people to carry out duties they are employed to perform is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were supported to make their own decisions and their consent was sought before simple personal care was provided. Staff checked with people that they were happy with the support being provided on a regular basis and attempted to gain people's consent. Staff waited for a response before acting on people's wishes. Staff maximised people's decision making capacity by seeking reassurance that people had understood questions asked of them. Where people declined assistance or choices offered, staff respected these decisions.

Staff confirmed they had received training and that they had sufficient knowledge to enable them to carry out their role. Staff provided us with information about people's care and support needs and how they met these. During our observations, we saw staff assisted people to stand up from chairs using their walking frames and further observation of transfer techniques confirmed that staff had sufficient knowledge to enable them to carry out this task safely and effectively. The provider's records confirmed that all staff had received mandatory training such as safeguarding adults; administration of medicines; food hygiene; health and safety and infection control. New staff confirmed they had attended induction training and shadowed an experienced member of staff until they were competent to carry out their role. A staff member told us, "My induction was intense, I did a 3 day induction looking through care plans. I was introduced to the residents. I knew what everyone needed."

People told us about the food at the home. One person told us, "The food is nice, sometimes you get a choice but I'm not worried about getting a choice." Another person said, "We don't have any trouble with food, the food is a bit too soft though." A third person told us, "We don't get asked if we like the food, we don't get choices, I would like to have a choice." During our visit, people confirmed that although they were given a choice at lunchtime (which pie they would like), people told us they did not always get a choice.

Lunchtime was observed as a quiet occasion. People were able to choose who they sat with and some people enjoyed their lunch together in the dining room, whilst others were in their room. People were provided with pureed meals, in accordance with their care plan, to reduce the risk of choking. We observed the meals were well presented. Staff confirmed that a dietician was involved with people who had special dietary requirements. People's dietary needs and preferences were documented and known by the cook and staff.

People were supported to have their nutrition and hydration needs met. Where people needed support with eating, they were supported by a member of staff at a slow and steady pace. People who were able to eat

independently were prompted and encouraged to do so. Throughout the day people were encouraged to take regular drinks to ensure that they kept hydrated.

People had access to healthcare professionals such as the GP, district nurse, optician, dentist, physiotherapist and speech and language therapist to support their well-being. People told us they could see a doctor when they needed to. We saw from records that if people's needs had changed, staff had obtained guidance or advice from the person's doctor or other healthcare professionals. Outcomes of people's visits to healthcare professionals were recorded in their care records.

Where people required their health needs to be monitored and recorded this was not always put into practice. This indicated that there was no system in place to monitor people who were at risk of malnutrition.

Requires Improvement

Is the service caring?

Our findings

People told us that staff were caring and considerate. People were happy whilst enjoying being in the company of staff. A person told us, "Staff are very caring, they listen to me, because of my age they think I'm amazing." Another person told us, "Staff are kind, on the whole they are alright." Despite people's positive comments, we found that improvements were still needed to ensure people received individual personalised care.

We observed that individual staff genuinely cared about the people living at the home, but the care provided was task orientated. For instance people were well groomed, clean, they had access to sufficient food and drink and staff supported them with their personal care. Staff knew people's care and support needs but their care was not centred on ensuring that people are at the heart of what they do.

There were inconsistencies in the choices people were able to make. People were able to make choices about when to get up in the morning or go to bed, what to eat for breakfast and what to wear. One person told us, "I'm an early bird. They (staff) give me time to drink my tea in the morning." People's rooms contained personal items and furniture to they were surrounded by things familiar to them. One person said, "I have brought my own mattress, chair and bedside cabinet. I can make the room my own." However people did not always have a choice of what to eat at lunch or supper time and we saw that people were not asked what programme they would like to watch on the television. Where people may have been unable to make this choice, it was not based on an individual understanding of the person and what they may have wanted to watch or been interested in.

We recommend that the provider ensures that people are always given the opportunity to make choices in their day to day lives.

There was a consistent staff team who had built up a good rapport with people which enabled staff to acquire an understanding of people's care and support needs. Staff talked about people; their likes, dislikes and interests and the care and support they needed. Information was recorded in people's plans about people's personal preferences, the way they would like to be spoken to and how they would react to questions or situations.

People were cared for by staff who showed kindness and compassion. One person told us, "The boss has been so kind to me." Staff treated people with dignity and respect, such as ensuring their clothes were hanging correctly and untangled when they got up from their chair. Personal care was provided in private. Throughout the day when asking people if they wanted a drink, or providing personal care staff checked people were alright and spoke to people in a respectful and friendly manner.

There were inconsistencies in how people were involved in making decisions about their care. A person told us, "They have involved me in my care planning and I can make my own decisions." When staff asked people questions, they were given time to respond such as when they were being offered drinks. Staff did not rush people for a response, nor did they make the choice for the person. However, not everyone was

involved in the choices about their healthcare or treatment. Where treatment was refused there was no documentation to record the options discussed. Relatives, health and social care professionals were involved in individual's care planning.

People were able to maintain relationships with family and friends and visitors were welcome. People confirmed that they were able to practice their religious beliefs, because the provider had religious services held in the home and these were open to those who wished to attend. A person told us, "I'm catholic, I take communion here every week, I can't expect staff to take me to church, and communion here is a god send."

Requires Improvement

Is the service responsive?

Our findings

People told us they were happy with the support they received. One person told us, "I'm not steady on my feet, but I am able to walk around the home with ease." Another person told us, "The carers are very good, couldn't wish for better treatment, you ask for anything and you will get it day or night." Despite people's comments, since the last inspection people were still not receiving responsive personalised care that met all of their needs or preferences.

At our last inspection on 8 and 11 April 2016, we identified a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People's care plans did not always contain a completed pre-assessment or reflect up to date information regarding people's care and support needs. Although activities took place, they were not delivered on a daily basis and were not person centred or according to people's preferences. During this inspection we found no improvements had been made in regard to care plans and activities. As no improvements had been made, this had an impact on the care provided and the quality of people's day to day lives. Therefore the provider continued to breach this regulation

Staff were knowledgeable about people's every day care needs but they did not have a full understanding of people's specific needs or potential risks. There was no change to the information recorded in people's care plan since our last inspection; people's care was not always based on individual's needs and care. Where people had specific care needs such as living with dementia these had not been taken into account when planning the care or identifying what support they needed. One person had a recent bereavement but there was no information in their care plan about their loss. Another person had behaviour that could be challenging, abusive and violent at times. Although there was information in place to guide the staff in what support this person should receive to meet their specific needs, there was no mental health or behavioural support guidelines. Although experienced staff knew how to support the person, new or agency staff would not. Where a person had a pacemaker, there was no information provided to staff and not all staff were knowledgeable about how to identify possible risks.

Where people refused care this information was recorded in their care plans and staff had guidance on what to do in such situations. However where people refused their medicines, the reason for this was not recorded. This demonstrated that there was no system in place to monitor why people were refusing their medicines and the possible effects on their well-being.

People's daily records were not written in a person-centred way. Although daily records were completed these did not record information about a person's well-being, interactions, activities or mood. This meant that although information was up to date it did not provide a full picture of the person to enable staff to monitor the person's wellbeing.

People were disappointed with the activities provided, they were not stimulating or in accordance with their interests or preferences. This was an area were staffing levels had an impact on the type and frequency of activities provided. People told us that the activities that were provided could be improved. Comments

included, They told us, "I watch the TV in my room because I can have the subtitles on." They went on to say, "We have a sing song now and again, we have exercises on a Tuesday afternoon, they don't do outings here though." Another person said, "I think we could do more, we very seldom hear music; it's so quiet here. I would like to hear more music."

There was no change to the activity programme since our last inspection. Activities were still not delivered on a daily basis and were not person centred. They consisted of bingo, exercise, board games, and arts and crafts and did not take into account people's interests such as going out for walks. Some people's capabilities were limited due to living with dementia and this had not been taken into account when organising activities. Although an activity took place during the inspection this did not include the majority of the people and we did not see any one to one activities taking place. These are important as they provide social interaction and reduce isolation to people who remain in their rooms or who do not wish to participate in group activities.

Failure to provide care and treatment in a person centred way that takes account of service users preferences and needs was a continued breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People knew how to make a complaint and information about the complaints procedure was displayed in the home to help people if they were dissatisfied with the service. One person told us, "I would make a complaint if I needed to, I would speak to the carers." We looked at the provider's complaints policy and procedure to review their processes. We reviewed the manager's complaints log and noted that no complaints had been received. Staff had a clear understanding of what to do if someone approached them with a concern or complaint and had confidence that the registered provider would take any complaint seriously.

Requires Improvement

Is the service well-led?

Our findings

At our last inspection on 8 and 11 April 2016, we identified a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Effective management systems were not in place to assess, monitor and improve the quality of service people received. The provider sent us an action plan and provided timescales by which time the regulations would be met. They stated that the actions would be completed by 2 August 2016. The action plan stated that all records have been updated and are monitored on a weekly basis. During this inspection although, slight improvement had been made to employing staff, infection control and safety of the home, little other action had been taken to improve the care and service based on the providers own monitoring of quality. There were still shortfalls in the quality assurance monitoring systems as they had not identified where action was required. This included missing information in care plans and where best practices and recruitment procedures were not always being followed. We have also identified a number of breaches some of which are continuous since the last inspection and some of which are new at this inspection which demonstrates that the home is not being well- led.

There was a lack of effective management and leadership in the home. The manager's time was taken up with providing care and support to people instead of reviewing and monitoring the service provided. Although policies and procedures were in place it these were not always being followed by staff and there was a lack of management oversight to check staff practices. People were at risk as staff were not always following best practices in infection control and management of medicines.

There were no health and safety audits carried out to help ensure people were not at risk of harm. It is important to have effective systems in place to ensure that the environment is safe for people to live in. For instance checks regarding legionella, slips, trips and falls, water temperature, hazardous substances and infection control.

Care records did not always contain relevant information regarding people's care or support needs. Although experienced staff were able to inform us of people's needs, new or agency staff who did not know people would not have access to sufficient information to care for people safely or effectively. Where people had experienced bereavement up to date information was not recorded in how to support them. Experienced staff knew that the person did not want to talk about their loss but this was not documented. Records were completed in an inconsistent way which meant people's care and support could be affected.

Risk assessments were not always person centred or relevant to the person's health needs. Where risks were identified, information and checks were not always carried out, updated or monitored to minimise risk. People's care plans lacked information on how to identify and manage these situations.
Risk assessments recorded basic information about people's needs. Where people had a pacemaker or catheter fitted, there was no assessment in place to identify possible risks. Although experienced staff knew how to support them, new or agency staff would not have this knowledge or be able to access to up to date information to provide appropriate and safe care to people.

At our last inspection we identified that the systems in place to monitor and identify patterns in regard to

accidents and incidents were ineffective. No improvements had been made to the system. Although there was a system in place to report and record incidents and accidents they were not monitored to identify patterns or trends, to ascertain whether they happened at a particular time or day, which would enable staff to take action to minimise or prevent further incidents occurring.

Where people required their health needs to be monitored and recorded this was not always put into practice. Although the provider had identified that people were not being weighed there was no evidence to show how this was being addressed. This indicated that there was no system in place to monitor people who were at risk of malnutrition.

People and those important to them did not have opportunities to feedback their views about the home and quality of the service they received. People were not involved in how the service was run but expressed the view that they would like more involvement. One person told us, "We don't have residents meetings but we wouldn't be frightened to ask for things, I suppose it would be nice to have a meeting." Some people had expressed to us a wish to have more activity which suited them. Although they had not made formal complaints the failure to actively seek feedback meant their views had not been used as an opportunity to learn, involve people and improve their care

We reviewed the provider's records and there was a lack of current information related to discussions to show that staff had discussed their work practices, training and role with their manager. The provider confirmed that supervisions and appraisals had not taken place.

Failure to assess, monitor and improve the quality and safety of the service and to maintain accurate contemporaneous records was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The manager was aware of the requirements in relation to the Care Quality Commission (CQC). The manager had notified CQC about a number of important events which the service is required to send us by law. This enabled us to effectively monitor the service or identify concerns.

There was no registered manager in place at the time of our inspection which is a condition of registration with CQC. However, we were informed that the manager had commenced the application process to be registered as manager.

People and staff told us that the management team were approachable and would discuss issues with them. One person said, "The owners are very good and the manager is very good as well." A staff member told us, "I feel very supported, I feel valued, you can tell they appreciate you, they are always saying thank you." The management team engaged with people, they were polite, caring towards them and encouraging to people.

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 The registered provider failed to people's care and treatment be appropriate, meet their needs and reflect their preferences. Regulation 9 (1)(a) (b) (c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The registered provider failed to gain appropriate consent in accordance with the requirements of the Mental Capacity Act 2005 and associated code of practice. Regulation 11 (1)(2) (3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered provider failed to have systems and arrangements in place to protect people from the risk of harm. The registered provider failed to manage medicines safely. Regulation 12 (1) (2) (a) (b) (d) (g)

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Regulation 19 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Fit and proper person employed The registered provider failed to have effective recruitment and selection procedures that comply with the requirements of this Regulation. Regulation 19 (2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Staffing The registered provider failed to deploy sufficient numbers of suitably qualified, competent, skilled and experienced staff to make sure that they can meet people's care and treatment needs. The registered provider failed to provide appropriate support, professional development, supervision and appraisal to enable people to carry out duties they are employed to perform Regulation 18 (1) (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 17 HSCA RA Regulations 2014 Good governance The registered provider had not ensured good governance in the home.

The enforcement action we took:

A warning notice was issued