Care Unlimited Group Ltd

Chipstead Lodge Residential Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

Chipstead Lodge Residential Care is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Chipstead Lodge is registered to provide accommodation and personal care for up to 36 people. There were 26 people living at the service at the time of our inspection.

This inspection site visit took place on 31 July 2018 and was unannounced.

There was a registered manager in post on the day of the inspection. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At the last inspections in July 2017 we asked the provider to make improvements in relation to the safety of care to people, the requirements of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS), activities for people, lack of detailed care plans, staff training and supervisions and quality assurance at the service. At the focused inspection in September 2017 we asked the provider to make improvements in relation to the safety of people. We issued a warning notice to the provider in relation to this. We found that actions from these inspections had not be sufficiently addressed.

The premises and equipment was not maintained to a safe standard. In the event of an emergency there was not up to date information on the support people required to evacuate the building. There were areas around the service that smelled strongly of urine and furniture did not feel clean. Audits were not effective in identifying these shortfalls.

Risks to people were not managed safely. There was a lack of detailed guidance for staff to assist them to manage people and their behaviour due to their mental health or dementia. Monitoring tools were not used effectively where people were at risk of malnutrition and dehydration. After the inspection the provider sent in evidence that they had addressed the most urgent concerns.

The management of medicine was not always safe which put people at risk. Accidents and incidents were not always recorded and appropriate analysis was not undertaken to look for trends to try to prevent future accidents.

Staff were not always working within the principles of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). Information about people's care was not always being communicated effectively between staff.

The premises adaptation did not meet the needs of people that were living with dementia.

Care plans were difficult to navigate which meant that new staff and agency staff may not easily find the most up to date information on people's care needs. Staff had received training in relation to their role and had the opportunity to meet with their manager. However, as staff were not always practicing safe care this training and supervision was not always effective.

There were varied responses from people about the caring nature of staff. At times people felt ignored. We found that people were not always involved in the planning of their care and did not have choices in their day to day care. People were not always supported with their independence.

Activities were not always person centred and people did not have appropriate opportunities to go out. Care plans were not always detailed and lacked guidance around people's diagnosis.

Records of complaints were not kept and people did not always feel that their complaints were responded to. Quality checks that were taking place were not effective and audits did not always identify the shortfalls that we identified. Improvements were not always made as a result of feedback. Records at the service were disorganised and therefore difficult to navigate.

There were aspects to people's care that was safe including a robust recruitment processes, safe levels of staff that were always maintained, staff protected people from the risk of abuse and there was a business continuity plan in place in the event of an emergency.

There were mixed responses from people about the quality of the food. People were offered choices of meals and drinks. People were supported to maintain their health and had access to health care professionals. Before people moved in to the service a full assessment of their needs took place.

We did see examples of people being treated in a caring and respectful way by staff. People were supported to practice their faith and visitors were always welcome to the service.

Staff told us that they felt supported and listened to by the manager. Where appropriate, notifications regarding significant events were sent to the CQC.

The overall rating for this service is 'Inadequate' and has been placed into 'special measures.'

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not, enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as

inadequate for any of the five key questions it will no longer be in special measures.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Risk assessments were not always being undertaken where there was a need. Medicines were not always managed in safe way.

Staff were not always following good infection control. The environment was not always being maintained in a safe way.

There were not appropriate plans in place in the event of an emergency at the service.

There were sufficient staff to meet the needs of people.

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

Robust recruitment checks were in place that ensured that only suitable staff worked at the service.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff were not acting in accordance to the MCA 2005. People's capacity had not always been assessed and DoLS applications had been made for people that had capacity.

Staff were not always competent to carry out their role although training and supervisions had been provided.

Staff did not always effectively communicate across the service.

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

People had mixed views about the food at the service.

People had access to health care professionals specific to their needs.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Staff did not always have time to spend with people. People did not always have a choice around their care delivery.

People's rooms were not personalised.

Staff did treat people with dignity and we did see occasions where staff were kind and attentive.

People's relatives and friends were able to visit when they wished and people were able to practice their religion.

Is the service responsive?

Inadequate

The service was not responsive.

People and their relatives were not involved in detailed discussions about end of life care. There were some aspects of care planning that required more detailed guidance.

People did not always have access to person centred activities and people were not able to go out when they wanted.

Complaints were not always investigated, recorded and responded to in a timely way.

Other information regarding people's treatment, care and support was reviewed regularly and shared with staff.

Is the service well-led?

Inadequate

The service was not well- led.

The provider continued to breach regulations from previous inspections and had not met the warning notice.

There was not adequate management and leadership at the service.

Quality assurance processes were not being used as an opportunity to make improvements. Audits were not robust in identifying shortfalls.

Staff told us that they felt supported.

Notifications that are required to be sent to the CQC were being

done.

Chipstead Lodge Residential Care Home

Detailed findings

Background to this inspection

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

This inspection site visit took place on 31 July 2018 and was unannounced. The inspection team consisted of two inspectors and a nurse that specialised in the care of people with a mental health diagnosis.

Prior to the inspection we reviewed the information we had about the service. This included information sent to us by the provider, about the staff and the people who used the service. We reviewed notifications sent to us about significant events at the service. A notification is information about important events which the provider is required to tell us about by law.

We reviewed the Provider Information Return (PIR). The PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

During the visit we spoke with the registered manager, a director, nine people, two relatives and seven members of staff. There were people that were unable to verbally communicate with us; instead we observed care from the staff at the service. We looked at a sample of eight care records of people who used the service, medicine administration records and training, supervision and three recruitment records for staff. After the inspection we were sent further evidence that related to safety checks at the service.

Inadequate

Is the service safe?

Our findings

At the previous inspection in July 2017 we found that the equipment at the property was not well maintained and the environment was not clean or kept in good order. At the previous inspection in September 2017 we issued a warning notice in relation regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This related to the safety of people living at the service. We found on this inspection that this had not been met. Instead we found that the safety and quality of care had deteriorated.

We asked people whether they felt safe living at the service. Responses included, "In the main", and "I feel safe, I know most of the people [people living at the service]." One relative said, "You never see anyone nasty to anybody." Despite people telling us that they felt safe there were practices at the service that put people at risk.

At the previous inspections in July 2017 and September 2017 we identified that people were being put at risk as appropriate measures were not in place to ensure their safety. Staff were not always following good infection control. Where people were at risk of leaving the home unobserved by staff there were no systems in place to reduce the risks. On this inspection these areas had not improved. We found that there were additional risks around the care of people.

We had been informed prior to the previous inspection in September 2017 that there had been a fire at the service and a person had left the home un-noticed by staff. They were returned to the service within a few days. We were advised by the registered manager after this inspection that new systems were in place to ensure people's safety. The PIR stated, "A two-hour check list sheet ensure that all residents are accounted for and safe, at risk residents are in eye sight, PEEP (personal emergency evacuation plans) checked monthly." However, on this inspection a member of staff told us that two-hour checks on people during the day had ceased and that these checks only happened at night. This was despite there being people at the service that were at risk of wanting to leave without staff knowledge. The PEEPs for people were not up to date as there were two people's information not on the file. This meant that in an emergency the emergency services may be given incorrect information on who was at the service and what support they needed. We were provided with evidence after the inspection that these had now been put in place.

People were not always protected against the risk of infection as appropriate measures were not in place. The provider had employed an external company to complete a deep clean in the kitchen the month prior to the inspection. We found evidence of grime in the fridge and freezer seals, the kitchen door threshold had a thick layer of dirt and the dishwasher had an area where the casing had fallen off which was dirty. The report from the company stated that not all surfaces had been cleared for them to complete the deep clean so they worked around these. Therefore, there were still areas of the kitchen that had not had a deep clean. Other areas that were at risk of cross infection included, a toilet roll being stored on a bin in one of the bathrooms with no pedal on the bin, faeces on another toilet that remained there all day, the laundry cupboard was untidy with laundry being stored on the floor and there were paper towels stacked behind a toilet despite there being a towel holder to put them in.

There were infection control audits taking place but these were not effective in identifying the shortfalls in cleanliness. Where the audits identified areas that required improvement there was no deadline for these actions or information to identify whether these had been addressed. There were strong smells of urine in three of the rooms that we went into and one of the downstairs bathroom had a strong persistent smell throughout the day. Tables and chairs felt sticky and required cleaning. The registered manager told us that they were also not satisfied with the cleaning. They said, "I know it's not 100%." They told us that they needed to recruit another cleaner as there was only one working at the service. They said that there had only been one cleaner for the past year. They said, "We are a bit financially restricted using more than one agency cleaner."

Risks to people's care were not always managed safely. There were people at the service that had diagnosed mental health conditions that had behaviours that challenged. We found that there were no risk assessments or management plans around this that staff could follow to provide safe care. One person (according to the Local Authorities assessment) had behaviours that put them and others at risk. However, no care plan had been developed around this.

Where risk assessments were in place, they were not always appropriately used by staff. One person required a food and fluid chart to ensure that they were meeting their nutritional and hydration needs. However, staff did not total the amount of fluid intake and output of that person daily to identify if any further action was required. One person required re-positioning in bed every two to four hours. However, their turning chart showed time gaps longer than this on several occasions, meaning that this person would be at a higher risk of developing pressure sores. There were people at the service that were unable to use their calls bells. There were no risk assessments in place for them. On two occasions we heard people calling out and had to ask staff members to support them as they had been unable to use their call bells. We heard one member of staff tell one of these people, "Your bell is here, when you need me call me." However, there was no recognition that they person may forget that their call bell was there to use.

People's nutritional and hydration risks were not always managed safely. Nutritional assessments that should have been completed monthly were not always being done. For example, the assessment for one person was not completed in Aug 2017, Sept 2017, Oct 2017, Jan 2018, Feb 2018, March 2018 or April 2018. It had been completed in May 2018 and July 18 and it was identified that the person had lost four kilograms during this period. Staff had not completed the rest of the form such as the percentage weight loss and BMI in order to conclude if any action needed to be taken. One member of staff told us that they weighed every person monthly. If people refused (we saw that they did on occasion) they would wait another month before they asked the person again rather than asking them the next day.

The PIR stated, "The service has policies and procedures in place, which are followed by staff, monitored and audited these include risk management, health and safety." We found that this was not always the case. The service's policy around smoking stated that staff should keep possession of any lighters and people should only smoke in the designated area of the home. However, an incident noted on 21st July 2018 stated that one person came downstairs with burns to their hair and shirt. The follow up action stated that the lighter had been given to staff. Therefore, the service was not adhering to their own policy around the risk management of smoking.

We were notified after the inspection that the lighter had been given to the person by a relative. We have asked them to update their incident form with this information.

There were aspects of the administration of medicines that were not safe. Staff we spoke with did not have knowledge of what the safe temperature levels were for the medicine room. We found records were not

being done to check the temperature of the room. The temperature is important as it can affect the fitness for use of certain medicines. There were creams that did not have the opening date on them to ensure that they were still safe to apply. There were gaps on the Medicine Administration Records (MAR) where staff had not signed to say that the medicine had been given. People's allergies were recorded as, "Not known." There was no record to show whether the person had been asked about allergies. One person's MAR had no photo despite the fact they had been at the service for several months. This meant there was a risk that medicine may be given to the wrong person.

Where paracetamol had been given for one person staff were not recording whether one or two tables where being administered as per the prescription. There were not always PRN (as and when medicine) guidance in place for each person which meant that staff may not always give medicine when needed, or in the correct doses. There was one person that was regularly being given a laxative despite staff recording that the person had loose stools. A member of staff was unable to explain this to us and there was no evidence that this had been reviewed with the person's GP. We also observed that the carer administering medication did not wear a 'do not disturb' red apron on the day of the inspection. This is a practice which reduces the risk of errors being made.

There was insufficient analysis of accidents and incidents to monitor trends to try to prevent future accidents and incidents. There was inconsistency of how the incidents were reported. Some incidents were reported on short summary forms and others that were being completed on accident and incident forms. Where incident forms were completed there was not always information on what actions had been taken to reduce further risks. For example, one person became aggressive when staff went to remove dirty crockery from their room. There was no additional information on what actions were taken as a result. We found evidence of incidents recorded in the staff communication book that had not been recorded onto incident forms.

Failure to safely mange risks to people and the poor management of medicines is a continued breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were aspects of care that was safe. Assessments were undertaken to identify other risks to people. The care records had risk assessments in place including skin integrity and moving and handling. In one care plan there was a "Behaviour management" strategy in place identifying the triggers and de-escalation techniques for the person.

The premises and equipment was not always maintained appropriately to keep people safe. Although the service employed a maintenance staff member two days a week we found that this was not effective. Staff were required to enter into the maintenance book things that required fixing. We found that staff were not always entering information onto the maintenance book. The handle of a window in the small lounge had broken off which meant that the window could not be opened. The registered manager told us that this had been reported several days before the inspection and did not know why it had not been addressed. Other items we identified as broken included a broken knob on the stove that had tape over it, a section of the dishwasher had broken off, no lids on taps in three of the bathrooms, a toilet flush in one of the bathrooms was missing and toilet seats in the communal bathrooms needed replacing as they were either stained or broken. None of these issues had been written in the maintenance book and the risk was that cleaning could not be undertaken to a satisfactory standard.

There was equipment and furnishings in the service that needing replacing or updating. The hood of the upright hair drier was cracked however this was still being used putting people at risk from being scratched by the broken plastic. We brought this to the registered manager attention who assured us that this would

no longer be used. The hair salon was being used to store equipment included a sideboard with a person's clothing in. The communal carpets were stained which was identified at the previous inspection. The communal wet room was being used to store a chair and a wheelchair. A large water bubble had appeared under the wallpaper in the newly decorated landing. We brought this to the attention of the registered manager who acted to address this. In one of the shower rooms there was no window restrictor and people could climb out onto the roof directly outside. We found that a charger for the hoist that had been plugged in had not been safety tested for over a year so the staff at the service could not ensure that they were using a safe piece of equipment.

After the inspection we asked the provider to address the most significant concerns that put people at immediate risk. They have since sent in an action plan with photos to show that urgent maintenance work has taken place.

As the environment had not been well maintained which did not promote safe care this is a continued breach of regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was a business continuity plan in the event the building needed to be evacuated. People would be supported by the providers other care homes. We did see staff washing their hands regularly and using gloves when attending to people's personal care needs. The laundry room was clean and well set up and laundry was washed adhering to correct infection control.

Staff had the knowledge and confidence to identify safeguarding concerns and acted on these to keep people safe. There was guidance and policies available to remind staff of the correct procedures and who to contact if they suspected abuse. One member of staff said, "I would report [concerns] to the manager. It could be a carer or a resident." They went on to describe different types of abuse. Concerns had been appropriately reported to the Local Authority.

People were protected from being cared for by unsuitable staff because robust recruitment was in place. All staff had undertaken enhanced criminal records checks before commencing work and references had been appropriately sought from previous employers. Application forms had been fully completed; with any gaps in employment explained. The provider had screened information about applicants' physical and mental health histories to ensure that they were fit for the positions applied for.

We observed that there were enough staff to meet people's needs throughout the day. The registered manager told us that they used agency staff to fill any shortages in staff where needed, such as sickness or vacancies for permanent roles. They also used agency members of staff for one person who required one to one care. We checked the rotas and found that there was always the safe level of staff on duty. When call bells were used staff attended to people quickly.

Requires Improvement

Is the service effective?

Our findings

On the previous inspections in July 2017 we had identified a breach the requirements of the Mental Capacity Act (MCA) There were a lack of decision specific mental capacity assessments for people and consent for people was not always being sought. On this inspection improvements were still required.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making 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 a person lacks the mental capacity to make a decision, any made on their behalf must be in their best interests and the least restrictive option available. There was an inconsistent approach to how mental capacity assessments were completed. For example, one person's capacity assessment stated, that they were, 'Able to understand information, able to retain information, able to weigh up information and able to communicate' however the recommendation was, 'X does not understand the medication prescribed and the reason why she is taking it.' This identified a lack of understanding of how to apply the principles of MCA assessments. Decisions should not be made on behalf of the person if their capacity has not been assessed correctly.

Another person's care plan stated that they had short term memory loss and brain damage to one side of their brain. The mental capacity assessment for their finances stated they were able to retain information but the question around permanent damage to the brain was not answered. Their MCA assessment around leaving the service unaccompanied stated that they had no impairment to the brain. The MCA assessments were not completed accurately so the capacity of the person could not have been accurately ascertained.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. These safeguards protect the rights of people by ensuring if there are any restrictions to their freedom and liberty, these have been authorised by the local authority as being required to protect the person from harm. At the last inspection we identified that DoLS applications were being applied for people that had capacity. On this inspection this was still happening. The registered manager advised us that they continued to apply for DoLS for people that they told us had capacity to make their own decisions. They did not explain why they were still doing this. There was a risk that people were being inappropriately restricted. For example, in relation to leaving the service without staff being with them.

Staff's understanding of MCA was inconsistent. One member of staff told us, "Sometimes people can't make their own decision so if not, we have a best interest decision and bring in an advocate or solicitor if needed. DoLS are where someone needs support to leave the home. This showed a lack of understanding of the legislation and guidance around MCA and DoLS despite there being a service policy that had detailed information around the principles.

There were examples however of decision specific assessments for people that lacked capacity and this included decisions around finances, medicines and day to day care. These were accompanied with evidence of best interest meetings to decide on the most appropriate care.

As the requirements of MCA and consent to care and treatment was not followed this is a continued breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Information regarding people's needs was not always communicated effectively between staff and other organisations. We identified from their care plan that one person had blood in their urine two days prior to the inspection. However, staff [including the registered manager] present on the day of inspection were not aware of this. No follow up action had been taken such as referring them to their GP to check for a medical issue that may need addressing. A member of staff did contact the GP about this before we left the inspection. On the day of the inspection a visiting health care professional (HCP) arrived at the service to take a blood sample from a person. The HCP was unable to tell the member of staff why they needed to take the sample and the member of was not expecting the HCP. The member of staff allowed the HCP to take the blood without taking steps to call the GP to ensure that this was correct. At the end of the inspection the member of staff did then call the GP and it was correct that the blood needed to be taken. However, this call should have been made before the HCP took any action.

The design and adaptation of the premises did not always meet the needs of people. There were people that were living with dementia where improvements were required to ensure their needs were being met. Bedroom doors were all the same colour and did not always have the person's name, photo or memory boxes to help orientate them. There was a lack of age appropriate points of interest for example photographs or artworks of a size that could easily be seen, along the corridors. The registered manager told us that they had thought about putting memory boxes on or near the bedroom doors but this had not taken place yet.

As staff were not always communicating effectively and the environment did not always meet people's needs this is a continued breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the previous inspections in July 2017 we identified that staff did not always have the skills and knowledge to provide effective care. We found that whilst there had been improvements with training and supervisions, new and agency staff may not always have the knowledge required to provide appropriate care.

Care plans were not clear and concise making it difficult for any new or agency staff to gather the essential information they require to effectively meet a person's needs. We found that care plans contained a lot of out of date or duplicate documents that made them difficult to look through and gather information. For example, one care plan did not have a detailed assessment of the person's needs. Another care plan had conflicting information about the person's needs.

All staff received the service mandatory training including mental health, moving and handling, safeguarding and first aid. Staff received one to one supervisions with their manager on a regular basis. However, training and supervisions were not effective as staff were not always following best practice on the day of the inspection. For example in relation to the competency around the management of medicines, infection control, the cleanliness and the application of MCA.

We recommend that information for about people's needs are clear and up to date to ensure that staff have the knowledge and skills needed to provide the most appropriate care.

There were mixed responses from people regarding the food at the service. One person told us, "The food is not bad. You get options." Another said, "The food is dreadful. Very poor quality." Other comments included, "Omelettes are very good", "Sometimes I don't like all the meals" and "It's [the food] alright."

People told us that they were not involved in helping to design the menus. One person said, "I would like to be asked [for input into the menu]." Another person said, "I don't help to devise the menu. I have never been asked." The chef told us that menu choices were discussed at 'resident's meetings' with the activities coordinator. We asked to see the minutes of the meetings however these could not be located.

We observed lunch on the day of the inspection. A choice of drinks were offered to people. One person requested a cup of tea with their lunch which was provided. People were asked if they would like to pour their own gravy. People were given the choice of the two available meals in the morning however for those people that were living with dementia, no visual representation was given to them to help them decide. The registered manager told us that they would look into this. People that required a soft diet were seen to be having them, along with support for people who required assistance with eating. One person requested a fried egg sandwich and staff accommodated this. People told us that they could have food whenever they wanted and biscuits and cakes were offered between meals. The chef had up to date information about people's nutritional needs and ensured that people on restricted diets were also offered a choice of meals. One member of staff said, "If people are not eating very well then you make sure that you monitor what they are eating and drinking." The member of staff was able to tell us about people's dietary needs.

Assessments of people's needs were carried out before they moved in to the service to ensure their needs could be met. Care plans also contained assessments completed by the local authority where they were provided. People did have the input from health care professionals where needed. There was evidence in care plans that a range of healthcare professionals were involved including district nurse, GP (with the exception of the person mentioned above), occupational therapist, mental health team, physiotherapist, optician and dentist. Care passports were in people's care plans. These documents provide a summary of a person's care and well-being needs that can be taken with them on any hospital admission. This allowed important information to be shared between organisations. On the day of the inspection, one person was complaining of a sore throat. Staff had called the GP for them and confirmed they would be visiting in the afternoon.

Requires Improvement

Is the service caring?

Our findings

At the previous inspections in July 2017 we reported that until the service provided fully responded to people's needs for activity and stimulation we could not rate the Caring domain as good. On this inspection people were not always complimentary about the caring nature of staff and people were not always involved in decisions about their care.

We asked people whether they thought the staff at the service were caring. There were varied responses to this. One person told us, "Staff are generally not caring. It's their whole attitude." Another person said, "Staff are nice to me." A third told us, "I say excuse me to staff [to get their attention] and they just keep on walking." A fourth told us, "All of them are nice, they talk to me."

People were not always supported to be involved in their care. One person told us, "I don't feel listened to." The registered manager advised us that people's rooms were recently painted. However, people were not asked what colour they would like their room painted. When asked why people were not allowed their own colour choice the registered manager told us that people were happy with the neutral colour. They told us that people were asked what, "Soft furnishings" they wanted. One person showed us their newly decorated room. This lacked any personalisation other than two pictures on the wall. The person had interests in music and culture however no actions had been taken to make their room personal to them based on this. Another person told us, "I have never been asked about décor and I would like to be asked." The majority of the rooms that we looked at lacked personalisation and did not look homely.

Where care plans had been reviewed, there was no evidence that people had been involved in the process. Reviews to care plans were merely any additional information added as a sentence to the care plan with a date next to it. There was no review document to show who had been involved in the process and what changes to care plans had been discussed and agreed. We asked one member of staff how things had improved since the last inspection. They told us, "By giving people choice." However, people were not always given choices about when they wanted to get up or when they wanted to have breakfast. We saw from the staff communication book in May 2018 that night staff were required to, 'Wash and dress' eight people before they went off shift. The book detailed which eight people these needed to be. The book also stated that a particular nine people were to be given an 'Early' breakfast and, 'Any other resident that is awake.' The minutes of an April 2018 staff meeting stated that three people (the minutes specified which), 'Should be fed ie b/fast before day staff.' The showed that this was about managing staff workload rather than people having choices

People were not always supported with their independence. One person told us, "I would like to be able to cook and make my own meals." There were no systems in place for people to be able to make their own meals.

As people were not always involved in their care planning, did not always have choices around their care and were not always encouraged to be independent, this is a continued breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw examples of staff acting in a caring way towards people. One member of staff brought a person their breakfast to their room. They greeted them in a cheerful way and asked the person if there was anything else they could bring them. We observed staff greet people whilst walking past them. One person said to a member of staff, "I think you are great." The member of staff thanked them and asked if there was anything they could do for them. We observed a member of staff sitting with a person in their room offering them reassurance as they had become upset. We saw the person respond positively to this and started to smile and thanked the member of staff. When we arrived at the service one person was sitting in reception and staff had put music on for them to listen to that the person liked.

Aside from people not always have a choice around their care we did see examples of being treated respectfully. We observed staff knocking on people's door and asking, "Can I come in?" before entering their rooms. A person had asked for a privacy curtain to be placed on the window on their door and this had been done. We saw people being discreetly asked by staff if they wanted to go the bathroom. People were supported to practice their religion. There was a service held at Chipstead Lodge once a month. Relatives and friends were welcomed at the service to visit people. We saw families visiting on the day of the inspection.

Inadequate

Is the service responsive?

Our findings

At the previous inspection in July 2017 we found that people did not receive person centred care. Care plans lacked guidance and there were not sufficient activities for people. We found that whilst there had been an increase in the activities in the service, improvements were still needed. Care plans still lacked specific guidance for people.

We asked people whether they felt there was enough for them to do at the service. One person told us, "There could be more in the home, play games." Another person said, "I'm getting more activities, sewing and knitting. I'm going to do photography and music." A third told us, "They [the activities] are patronising. I would like to have more group discussion." A fourth said, "I do get bored. I would like more singing."

The PIR stated, 'To continue with the Rah Rah Theatre group and to be more involved in the community, such as join the local library, contact with other facilities in exchange morning coffee and afternoon tea. we have researched local activities such art group, attend the groups session for people with disabilities locally.' We did not see sufficient evidence of this taking place.

Activities were not always person centred. One person told us, "There's only really TV for the men, and for the women there is knitting if you like it. Even table tennis or billiards would be a good thing." The registered manager told us that us that care plans have been updated in relation to activities and an occupational therapist came in to give staff training around therapeutic exercises and activities. However, we did not see any evidence of this on the day. One member of staff told us that there was no structure to the activities. They said, "We need another member of staff to assist with them. It would make such a difference to improving their [people's lives]. Some residents are bored."

The activity coordinator described how they tried to meet each person's needs and worked with people with similar level of functioning in small groups or one to one. They stated this had shown good results. Despite this we observed that there was limited interaction between the staff and people. The consequence of this is that people appeared under stimulated within the environment. One person told us, "I'm lonely. It's so vast yet so small here." One member of staff told us, "They [people] get what they need." When asked if they provided any one to one activities with people the member of staff said that providing personal care is one to one interaction as they talk to them. There was no recognition that providing personal care to people should not replace a meaningful activity. We saw from the activities diaries that people were encouraged to participate in group activities but where people were often refusing there was no evidence of one to one activities being offered instead.

The PIR stated, "Make better use of the garden area (upgrade the green house) make shed safe and accessible for storage. Some residents can help in preparing the ground planting seeds while other give advice and supervise, it would give them an interest and a purpose. Activities, more activities community based, such as afternoon tea at the local churches, garden centre, trips to the local market." We found that this was not happening.

People fed back to us that their wish to was to be able to go out more. One person told us, "We are sat here like storage. Would like trips out. It would mean hanging on to the remainder of life. Not letting it slip away just waiting for the undertaker." Another person said, "I just want to go out more." One relative said, "The best thing [for their family member] is to go out as much as possible. He wouldn't feel so restless." The registered manager told us that trips out where less frequent at the moment as there was a lack of staff that were able to drive. There was no consideration that taxis or a mini bus could be hired to take people out. One member of staff told us, "X likes to go out and sometimes she doesn't get to." The registered manager told us that more steps were being taken to involve people in the community more including contacting church groups and day centres.

Care plans did not always reflect people's physical, mental, emotional and social needs. The registered manager told us that 14 people that lived at the service had a mental health diagnosis. Their care plans did not always reflect the level of care that was needed nor were they individualised to the needs of the person. There was insufficient detail within the care plans around identifying triggers and what interventions need to take place to assist people with a mental health diagnosis. Although each person was allocated a key worker they were not involved in writing the care plans which where for the most part written by the registered manager. There was one person at the service that required one to one care from a member of staff. There was no information in their care plan on why this one to one was required. One person had moved into the service in March 2018. However, there was still no detailed care plan for them. The registered manager told us, "I guess it hasn't been done."

Where people had a diagnosis of dementia there was no information on the most appropriate care. There were a number of people who did have care plans in place however these were not being reviewed regularly. Where they had been reviewed there was not always a date to show when this had been done. There was an increased reliance on agency staff due to care staff vacancies so it was important that specific and accurate care plans were in place for these staff to refer to. One person told us, "I'd rather be somewhere else. Staff don't understand me or my needs." The daily handover records reviewed focused on people's physical health care and did not refer any support being provided regarding the mental health needs.

There were no care plans in place to show that discussion had taken place with people around their wishes nearing to the end of their life. We asked one member of staff if anyone had an end of life care plan. They told us that one person had expressed their wishes, "When her time comes, she just wants to be left to go so has a DNAR is in place." We advised the member of staff that End of Life care is more about personal preferences. They responded that the person would like their family around them which they said was recorded in their care plan. We checked the care plan and there was no note of this.

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

Complaints were not always recorded, investigated and responded to appropriately. The PIR stated that two complaints had been received since January 2018. It goes on to state, "The home has a very low number of complaints, but each complaint is seen as an opportunity to learn and grow." However, on the day of the inspection the complaints folder could not be located. After the inspection we were informed by the provider that these could still not be found. The service complaints policy stated, "A full record will be held of all complaints received regardless of the level of seriousness and means of communication." Neither of the two complaints reported in the PIR were recorded so we were unable see how they were investigated and responded to. One person told us that they had recently made a complaint to the registered manager about a member of staff. They told us that nobody came back to them about this. There was a complaints

policy in reception for people to refer to.

As complaints were not always recorded, investigated and proportionate action taken this is a breach of regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

At the previous inspection in July 2017 we identified that there was a lack of robust quality assurance processes in place. After the inspection the provider sent us an action plan to advise that all of these actions had been addressed. However, on this inspection we found that this was not the case and sufficient improvements had not taken place. At the previous inspection we issued a warning notice in relation regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This related to the safety of people living at the service. We found on this inspection that this had not been met. Instead we found that the safety and quality of care had deteriorated.

The PIR stated, 'The manager makes herself available during the working day, when the senior in charge takes over, to see residents, relatives and staff. I communicate by email or telephone to relatives as this is their preference.' At the last inspection we raised with the registered manager that when they were sat in their office they were not always accessible to people as the door was always shut. At this inspection this had not changed. The door to the registered managers office was shut and was only accessible with a key code or by knocking on the door.

There were insufficient quality assurance processes in place to ensure the best delivery of care. Surveys had taken place with relatives and staff to gain their views. Where shortfalls had been identified there was no clear plan in place to address these. For example, in the September 2017 relatives survey (completed by three relatives) they had raised that, 'More could be done to provide further entertainment in the home.' The action plan stated that more entertainers would be invited into the home. There was no completion date to indicate that this had now been actioned. In the staff survey completed in September 2017 there were positives comments from staff. However, where it had been identified that only 63% of staff felt valued and appreciated there was no action to indicate how this was going to be addressed. Where recommendations had been made this were not always followed through. For example, "To ensure that all staff are involved in the care planning process and to make valid contributions." No action had been taken to address this. This meant that opportunities to make improvements were not always being used.

Audits that were taking place were not always effective in identifying areas that required improvements. One person told us, "The building is too run down. Everything is falling down." The provider undertook a window safety risk assessment in July 2017. It stated that all windows above the ground floor had been fitted with a window restrictor. However, we found a window in a first-floor bathroom (that people used) could be opened fully which put people at risk. The provider met with the registered manager weekly at the service however there was no evidence from the minutes of the meetings that the provider was identifying the concerns that we have identified.

The registered manager told us that they did a, "Walk around" once a week to check that the internal environment was safe and that all staff logged any issues in a maintenance log. However, both the registered manager and staff had not picked up on a lot of the issues we had found whilst walking around the building. The registered manager confirmed that they did not do checks of the external environment. The infection control audits were not thorough and were ineffective in identifying the shortfalls in

cleanliness. The registered manager told us that they are still working on an action plan such as getting lids put on the taps. However, this had been ongoing since the last inspection and significant improvements had still not been made. There was no evidence of medicine audits that could have identified the shortfalls that we found.

The PIR stated, "Resident meetings are held every three months, usually chaired by the home manager. Standing items on the agenda include food, and activities. Residents are able to comment and make suggestions in relation to menus etc, and we try to incorporate such suggestions in future menus." However, people told us that they were not asked for feedback. We asked the registered manager for minutes of the meetings and they were unable to locate them.

Staff were not following the correct policies and procedures, the meds policy stated, 'A formal procedure to organise prescription orders with each GP practice should be established. Documentation of these processes should be available to include internal staff training and for access for staff members who may be less familiar with the systems required by each person.' There was no formal procedure in place. A member of staff told us that there was no written procedure for ordering medicines. The Infection Control policy stated, "Chipstead Lodge takes its responsibilities in relation to blood-borne viruses seriously. It will make sure that risks are identified and measures to control or prevent these risks are clearly documented and cascaded to all staff, Service Users and key stakeholders." This was not happening when we inspected.

The Local Authority Quality Assurance team had visited the service in November 2017 and March 2018. Where they had identified shortfalls these still had not been addressed on the day of our inspection. For example, they had identified that the maintenance book needed to reflect what work had been done or was pending, recording of the medicine room temperature needed to be maintained, that accidents and incidents needed to be reviewed and that care plans needed more detail. They had also recommended that the service used the 'Herbert protocol' (where staff compile useful information which could be used in the event of a vulnerable person going missing). This had not been done despite the fact that people had left the service without staff knowledge.

The records at the service were disorganised and chaotic. It was difficult to find the most up to date information on people's needs. The book used to store information on people's medicines was falling apart. Records of people's care were kept in several different places and there was a risk that staff would not have the most accurate information.

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

Staff we spoke with did tell us that they felt supported and valued by the registered manager. One told us that the registered manager was approachable. They said they could go to them with any issues. Another member of staff said, "[The registered manager] is very approachable. Even if her door is shut I just knock on it and she lets me in and we chat." A third told us, "I feel listened to. I bring points to handover and she [the registered manager] makes sure it is done. When I do something good I get thanked and they say nice things to me."

There was evidence that the provider was working with external organisations in relation to the care provision. For example, the provider had regular contact with the GP, SaLT, dieticians and other community care teams.

Services that provide health and social care to people are required to inform the CQC of important events that happen in the service. We found that notifications were being submitted to the CQC where it was appropriate to do so.