Southern C C Limited

St George's Nursing 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?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

The inspection took place on 20 and 21 April 2016 and was unannounced.

St George's Nursing Home is a care home and the provider is registered to provide both nursing and residential care with accommodation for up 43 people. People who live at St George's Nursing Home all had needs relating to their older age, and some people were also living with dementia. At the time of our inspection there were 19 people living at the home.

A registered manager was not in post at the time of our inspection. 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. The provider had recruited to the role of home manager and this manager was present at the time of our inspection.

At this inspection we found the provider was in breach of four of the health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These were Regulation 12 in relation to safe care and treatment, Regulation 18 in relation to staffing, Regulation 9 in relation to person centred care and Regulation 17 in relation to the governance of the service. These breaches in Regulations are described throughout all sections of this report.

People were not always kept safe from harm as risks to their wellbeing and safety were not identified and managed with timely action taken. The provider's systems and staff practices did not provide assurances all incidents which placed people at risk of harm had been reported with the appropriate action to keep people safe.

People were put at increased risk of infections because the provider's systems and staff practices did not ensure people lived in a clean and hygienic home. This included the equipment staff used to assist people and the furniture in the home to make sure people were not at risk from cross infections. Staff practices around carrying used needles around the home when they should be place straight after use in the appropriate container did not promote people's safety from injuries or infections.

People's safety and wellbeing was not promoted as there were hazards around the home environment and action had not been taken to reduce these. Staff practices did not make sure people were provided with safe and effective care due to the provider's inconsistent water supply which meant staff carried hot water around the home increasing the risks of scalds.

People were supported with their medicines. Medicines were ordered, stored, administered and disposed of safely. Staff did not have detailed information about people's when required medicines

People received healthcare support to maintain their nutritional needs when required. The manager

showed they led by example and was ensuring staff consistently assisted people with their meals where this was required as some people had been losing weight.

People were supported to make choices about their everyday care and support. There were some procedures in place to ensure where people were not able to make specific decisions themselves in their best interests. These were not always effectively organised to enable staff to easily access this information and to ensure people's rights were upheld through staff practices.

Staff had some positive caring conversations with people which enhanced their wellbeing. Other staff practices were based around tasks as opposed to considering each person's feelings. People's privacy was promoted by staff who recognised and respected.

Staff did not have the confidence or knowledge to respond to the identified needs of some people who had come to live at the home. The provider had not made sure before agreeing individual people's needs could be met at the home they had increased staff's knowledge and tested their competence in providing the individual care people required.

The provider did not show they were caring and accountable as they had not informed the Care Quality Commission when they decided to provide care to people with learning disabilities and specific mental health conditions.

The provider failed to make improvements to the service which had been brought to their attention by a number of different agencies. Insufficient systems were in place for the provider to monitor the quality of the service to ensure people consistently received safe and effective care.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this 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 any 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.

People could not be assured they would be protected from the risk of harm and or injury due to the ineffective staff practices and the procedures the provider had in place.

People were at risk from infections as the staff practices and the provider's arrangements were ineffective. The home environment and equipment was unclean and unhygienic.

Medicines were managed and administered to meet people's health needs.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff had not received all of the training and support they needed to enable them to be able to effectively provide consistent safe and effective care.

People's nutrition and hydration needs had not always been reliably monitored to ensure their health was not impacted upon. Improvements had been made but they were still in their infancy so we were unable to reliable test their effectiveness.

People were asked for their day to day consent. The arrangements in place to ensure people's rights were consistently considered and any restrictions in place was not robust due to the lack of robust procedures in place.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People could not be certain they would consistently receive individual support in a kind and caring as the focus of staff's attention was on doing tasks.

People's privacy and dignity was promoted.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People's needs were not consistently responded to in an effective way as the provider had agreed people's needs could be met without ensuring the staff teams abilities to be able to do this.

There were some arrangements in place to make sure people were supported with fun and interesting things to do.

There were procedures in place to respond and resolve complaints.

Is the service well-led?

Inadequate

The service was not well led.

People had not benefited from staff receiving and acting upon good practice guidance and having the right skills and knowledge.

There had not been effective and or consistent leadership.

Quality checks had not reliably identified and resolved shortfalls in the care and facilities provided in promoting safe and effective care.

St George's Nursing 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 took place on 20 and 21 April 2016 and was unannounced.

On the first day the inspection team consisted of two inspectors, two members of the CQC medicines team and two specialist advisors. The specialist advisors had specialist knowledge and experience in different subject fields, infection protection and control, learning disabilities and mental health. On the second day one inspector concluded this inspection.

We looked at the information we held about the provider. This included statutory notification's received from the provider about deaths, accidents and potential incidents of abuse. A notification is information about important events which the provider is required to send us by law.

We asked the local authority and the clinical commissioning group, who purchases care and support from the provider on behalf of people who lived at the home. We did this to obtain their views on the quality of care provided at the home. In addition to this Healthwatch who are an independent consumer champion who promote the views and experiences of people who use health and social care were asked if they had any information to share with us.

We spoke with seven people who lived at the home and two relatives. We spent time looking at the care people received in the communal areas of the home where people were happy to share their experiences of life at the home. We also used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk to us.

We spoke with the manager, quality assurance manager, the nominated individual and 10 staff including the chef and housekeeping staff. We looked at sections of care records of 12 people, medicine records of nine people and at a range of records related to the running of and the quality of the service. These included staff

training information, staff duty rotas, meeting minutes and arrangements for managing complaints. We also looked at the latest quality assurance checks which were completed which were used to monitor and assess the quality of the service provided.

Inadequate

Is the service safe?

Our findings

People gave us mixed views about whether they felt safe. One person told us it made them feel unsettled and worried when other people who lived at the home shouted and used inappropriate language. Although staff spoken with were aware of how to identify and report incidents of potential abuse we saw the systems and practice in place did not reduce risks to people, meaning they were not fully protected from harm. We found a incident affecting one person who lived at the home had not been followed through and reported by a senior staff member at the time to ensure immediate action was taken to reduce the risks of potential harm to people. The senior staff member had not reported the incident as required under the local safeguarding procedures. The local authority were required to be informed about potential concerns and incidents of abuse. This is because they are then able to consider if any action is required to manage or minimise further incidents from happening to assure people's safety is maintained from the potential risk of abuse. This was a breach of Regulation 13 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider had failed to safeguard people from the risk of abuse.

In addition to this the provider's own management systems in reviewing care records along with the senior staff member's practice of not reporting this incident did not provide assurances about how incidents and accidents were managed to reduce reoccurrence. When we showed the manager the record of the incident they acknowledged it should have been recorded and reported following the provider's own accident and incident procedures to the local authority and the Care Quality Commission.

We found other examples where risks were not closely managed to make sure people received safe and effective care. For example, one person with dementia unsteadily climbed onto the rung of another person's walking frame which was positioned in front of them. The person managed to climb down but there was potential for this incident to have compromised both people's safety. We spoke with the manager about this incident. They said the person possibly thought the walking frame was a ladder as they were practically minded. Although the manager understood the potential risks to both people, we were concerned about the possibility of this incident happening again without risk assessments in place and staff being aware of this.

We found concerns about some staff practices when using equipment which could put people's safety at risk. For example, we saw a staff member failed to discard needles safely. We observed them carrying used needles around the home. When asked about this practice they told us they were looking for a safe container. This practice is unsafe and places not only people but the staff member at risk of injury or potential cross infection.

There were aspects of people's safety around their home environment which had not been consistently considered so people were at increased risk of injury or harm which could have been avoided. For example, there was a room just off one of the corridors where chemical products were stored. We checked and found this area was unsecured which posed significant risk of harm to people, as these products were accessible. This was particularly concerning as there were some people who lived at the home who could place themselves at risk unintentionally if they were to obtain these products. Although risk assessments for these people identified they needed supervision, which was also confirmed by staff and the manager, there were

times when they were left unsupervised. When we pointed out the risks to people's welfare of access to chemical products action was immediately taken to secure the products in a locked container. In addition to this there were potential trip hazards. For example, there was tape across parts of the ground floor carpet in the corridor areas and a thick mat which was placed directly in front of a television. The manager recognised these were potential trip hazards and immediately removed the thick mat.

People we spoke with told us they felt the cleaning offered to them was acceptable but we saw the infection control practices in place did not consistently promote people's safety from the risks of infection. This was because we saw examples where areas of the home environment and furniture were unclean. For example, chair seats in the conservatory area were visibly stained and soiled. On removal of the cushions on armchairs we saw food debris and dust on chairs which were designed to be easily cleanable. Another example was the serving cabinet where crockery and cutlery was kept was dirty which included the container used to store cutlery which had debris at the bottom of the compartments. The food trolleys were also seen to be dirty.

We looked at some of the equipment people used and found this was not clean, such as, toilet frames and seats soiled with brown matter and urine. In the ground floor sluice there was a yellow bucket and mop, which was covered in brown matter causing an extremely offensive odour into the corridor every time the door opened. The sluice hoppers and surrounding areas were dirty and there was an offensive odour and there was no hand hygiene soap available.

Our findings did not show the areas of concern identified by the provider's quality assurance manager and the clinical commissioning group had been acted upon to address the risks of cross infection due to inadequate measures in place. We asked the manager about the management of the cleaning duties. The manager advised us they had recruited staff to do the cleaning duties and they were due to start work at the home the week following our inspection. However in the interim staff had covered some of the cleaning duties together with staff from the provider's other home. We saw this happened on the second day of our inspection.

There had been an infectious outbreak at the home which caused some people to become unwell. As part of the procedures to prevent and control infections the carpets had been deep cleaned. However, we saw some staff practices which did not consistently show lessons had been learnt either from the infectious outbreak and their training. This was because we saw staff did not always wash their hands with soap before and between tasks. In addition to this we did not see people being offered assistance to wash their hands prior to lunch. We also saw hand towels were stored on top of the dispensers because the towels did not fit into these. There were new dispensers but these had not been installed as yet and one of the reasons provided to us was there was no permanent maintenance staff member.

We found the provider had failed to mitigate the risks to people's safety, health and welfare. This was a breach of Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We identified there were issues with the water supply at the home where risks of scalding had not been mitigated for both people who lived at the home and staff. We saw and staff we spoke with told us they recorded the water temperatures for each person whenever they assisted people with their personal care needs. However, staff told us they were filling and carrying bowls of water in corridor areas due to the inconsistency of the water temperatures in some people's rooms. We heard different responses from staff about which people were affected and how they tested water temperatures which did not provide assurances the risks of people scalding were reduced. For example, some staff told us they used a thermometer and other staff said this was done by hand which is not an accurate method of ensuring water

is of a safe temperature. The manager was unaware of the inconsistency in the water supply and staff practices in filling and carrying bowls of water around the corridor areas of the home until we identified this.

We found the provider had failed to ensure the facilities are maintained for the delivery of care in order to meet people's needs safely and effectively. This was a breach of Regulation 15 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We received mixed views from people about how available staff were to meet their needs. One person told us, "There seems to be enough staff as they answer the bell quite quickly most times." Another person said, "They are doing what they can. There are so many of us." One relative told us, "There seems to be the right staffing levels." Another relative said, "Personally I would like to see a few more staff."

Staff spoken with told us although they were busy in the mornings people were assisted with their personal care needs in an unrushed way and their safety was not compromised. We spoke with the manager about how staffing numbers were determined and they told us this was done by the provider. However, the manager showed us they were knowledgeable about their staff team's availability to meet people's individual needs and had taken action to ensure people were safe with their needs met. For example, they had increased the hours of the staff member who arranged and supported people with fun and interesting things to do in the mornings. This was because the manager had seen how busy staff were in the mornings assisting people with their personal care. They were also considering the layout of the home which was set out over two floors to ensure people were supported in the different areas of the home.

People were supported to self-administer their medicines independently when they were able and wished to do so. We spoke to one person who looked after their own medicines and they told us staff always ordered their medicines when they needed them which allowed them to maintain their independence. They had been provided with a secure area in their room to store them which kept other people safe.

We observed people being given their medicines by the nursing staff. We saw that the nurse asked each person whether they wished to take their medicine prior to giving it to them. Where the medicine was a 'when required' variable dose, pain relief tablet people were asked if they were in pain and asked if they wanted one or two tablets.

People received their daily and regular medicines as prescribed by their GP. We looked in detail at the medicines and records for nine people living at the home. Records were kept of medicines received into the home and given to people. When a dose of medicine was not given, any reasons for people not having their medicines were not consistently recorded. When a variable dose of a medicine was prescribed the records did not consistently show what dose people had received

When additional handwritten entries were made to the medicine administration records these were accurately made although the entries were not double signed in line with best practice. People were protected against being given medicines that they were allergic to. Their allergies were recorded in their care plans, on their identification sheets in the medicines file and on their administration records.

When people were prescribed medicines on a when required basis there was insufficient information to allow nurses to know when these were needed. For example, the protocols governing 'as required' medicines for pain and those for agitation did not contain enough detail to show the nursing staff how and when to administer these medicines which may result in people not getting their medicines when they were needed.

When people had their medicines through a slow release skin patch, records were kept to identify the rotation of skin sites to be used. However these records did not always demonstrate sufficient rotation to avoid skin irritation associated with this medicine.

Medicines were being stored securely, and at the correct temperatures, for the protection of people. Controlled drugs were stored and recorded correctly, and regular checks had been carried out.

Care plans described how people liked to receive their medicines and we saw a care plan detailing how to approach someone whose cognitive impairment may make them reluctant to take their medicines. This care plan was individualised and detailed and gave the nurses information to support this person to take their medicines safely.

Staff told us that they had started a medicines training programme but had not completed this.

Requires Improvement

Is the service effective?

Our findings

We looked at the procedures in place to make sure staff had the training they required to care and support the people who lived at the home. The manager was able to provide us with a training planner which showed staff had received training in a range of subjects which would provide staff with the knowledge about basic care principles and safe ways of supporting people. However, staff we spoke with consistently told us they did not believe they had the skills and knowledge to meet the needs of some people who lived at the home. One staff member said that although they had attended training around the awareness of learning disabilities and mental health this had not prepared them for their caring role. We saw examples where staff struggled to meet the needs of some people who needed support at times with their behaviour. This impacted upon people who lived at the home as they were wary of some people and did not like how some people expressed their feelings of distress and anxiety by shouting and using inappropriate language.

The manager also confirmed what staff had told us and was concerned some people's needs were not being met well and not in line with good practice guidelines. Throughout our inspection the manager spent time checking and supporting staff in their roles because of their concerns around staff practices being ineffective.

This was a breach of Regulation 18 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We spoke with staff about the support they received in order to do their roles. Staff told us they had had one to one meetings to discuss their roles However, all staff felt the changes in management was unsettling and impacted upon how supported they felt on a day to day basis. One staff member said they loved their work but they did not feel valued by the provider. Another staff member told us the day to day support they received was, "Better now [manager's name]. She makes sure it all runs smoothly."

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA.

We saw staff asked people for their consent before they assisted people with their care needs. However, when we spoke with staff about how the MCA and DoL affected their caring roles they lacked knowledge in this subject. Staff told us they had not as yet received training around MCA and this was also confirmed by the manager. Staff were also unsure where people may have possible restrictions in place to keep them safe and to meet their care needs but staff were able to tell us all the current people were too unsafe to go out alone.

The manager was knowledgeable about the principles of the MCA and DoLS. They were able to tell us about one person where an application under DoL had been sent to the local authority for authorisation purposes. However, at the time of our inspection they were unsure how many applications had been made and who these were for. We specifically spoke with the manager about one person whose mental health needs meant their behaviour could be unpredictable and how they would manage these if the person wanted to leave the home alone. The manager acknowledged they needed to take action to establish which people had restrictions in place, if these were still current and follow the procedures as set out by the MCA and DoLS. Without the manager having this level of insight they would not be able to lead the staff team in making sure people received personalised care to meet their needs.

People told us they liked the meals offered but thought their choice was not always considered. One person told us, "I don't know what I'm having until it comes." Another person said, "I don't get to choose what I want, they just bring my lunch to me, they know what I don't like." A further person told us, "The chef is very good, the food is excellent." This was echoed by a relative who said they had found the kitchen staff to be "Really delightful."

The manager told us before our inspection people were not always provided with the assistance and support they needed in order to eat their meals which resulted in people losing weight. However, the manager told us people had now gained some weight but what the manager could not show us was how this improvement in staff practices had been effectively sustained over a period of time. We saw when necessary staff had given people individual assistance when eating and drinking to meet the nutritional needs in safety and comfort. The manager also checked staff practices over the lunchtime period to make sure people were supported to eat their meals. We noted although there were menus on the tables in the dining room for people to look at some people would need more support to enable them to choose their meals. This was an area the manager was looking to improve.

People spoken with said that they received all the help they needed to see their doctor and other healthcare professionals. One person said, "The doctor has been here today." One relative said their family member had been unwell but with the medical treatment and the care from staff they were feeling better. They told us, "[Family member] looks better than they have ever looked."

Requires Improvement

Is the service caring?

Our findings

People we spoke with were happy with the care they had received from staff. This was also echoed by relatives we spoke with. We saw some individual care provided by staff which brought people happiness and a sense of comfort. One example of this was when the person who was supporting people with fun things to do spontaneously danced with a person. We saw how for that moment the person seemed more reassured than earlier when they had been walking around with their head down with no real sense of what to do. However, there were elements of the routines staff followed which did not always show a caring approach to people's needs. For example, we saw when a person raised the tone of their voice and was using inappropriate language other people looked nervous. We saw staff did not spend time speaking with the person who was expressing their feelings to support them but continued with their daily routines. One staff member told us, "They are always swearing as they don't want to be here but sometimes they are quiet. We just carry on with what we have to do." What we saw during our inspection was staff continuing with their approaches which were task led and had not considered how people's behaviour may be impacting on other people.

Staff were seen to know some people really well and used effective communication skills, such as, sitting down to speak with people at their eye level and using touch appropriately. There were other examples where staff's communication was centred around the task in hand and did not take into account of people's individual feelings. For example, we saw one person wanted a particular food item. However, staff were unable to provide this but did not take the time the person needed to help them understand why which did not show a caring attitude as staff continued with their task. Another person told us, "I have no choice of when I wake up; they just come and get me up."

We saw the manager showed they cared as they spoke with people about their day and found out what mattered to people. One person's glasses were in need of some repair and the manager showed they interested in what the person had to say about their glasses. The person happily chatted with the manager and from their facial expressions we saw they had enjoyed this shared experience.

The manager had shared with staff positive caring practices. For instance, staff were asked to share lunchtime with people as before staff had their lunch at a different time. This showed the manager was trying to lead by example so staff would be able to see some positive caring practices which made a difference to people for them to learn from and copy. However, the manager would need to spend a lot of time doing this on a consistent basis. We were concerned about how the manager would be supported to sustain positive practices. This is because these were in their infancy at the time of our inspection so we were unable to review how effective they had been.

Relatives and friends were able to visit when they wished and welcomed into the home. We saw some caring conversations with some relatives whose family member had died which provided comfort and support. We also heard from another relative who was complimentary about how they were happy to find their family members nails had been manicured and painted. They told us, "Wonderful lady (staff member who organised activities), really caring. Goes round to see people and talks with people."

We saw staff knew to knock on the doors to private areas before entering and were discreet when supporting people with their personal care needs. One member of staff told us, "I keep people covered and dignified at all times."

Requires Improvement

Is the service responsive?

Our findings

Before people came to live at the home their individual needs were assessed to make sure their needs were appropriately met and responded to. Despite this process the provider did not make sure staff had the specialist knowledge and skills to meet people's specific needs. We saw staff did not respond effectively to people's individual needs which impacted upon people's wellbeing at the time of our inspection. For example, one person expressed verbally how they did not like living at the home and how they wanted to move. We looked at the person's care records and saw they had mental health needs and their behaviour could be unpredictable. We shared our concerns with the manager as they had made requests to move from the home as soon as possible. We concerns that any changes could have impacted on the person but also other people who lived there. The manager told us that they would approach the relevant professionals to ensure that this move happened as quickly as possible. We saw how at times the person expressed their anger by raising their tone of voice. This made other people become unsettled and one person's facial expressions showed they were unhappy. Another person told us they did not like the shouting and swearing they heard from other people who lived at the home. The manager acknowledged some people had come to live at the home but their specific needs were not able to be met and responded to in an effective and safe way.

We saw staff lacked the skills needed to provide effective personalised care for all people who lived at the home. For example, one person's mental health needs meant they needed staff to support them with their behaviour. On the second day of our inspection we saw and heard the person was loudly expressing their unhappiness. One staff member who was trying to support the person was finding this difficult to achieve. This was worsened by the fact there were no other staff around at the time to assist with other people who were in the area who could be worried about the levels of noise. We asked the staff member how they supported the person with their specific mental health needs. They told us they just needed to help them to walk around, "To quieten down."

Another example of staff lacking knowledge was the support they tried to offer to a person living with dementia who was walking around the home. We saw and heard the staff member hold the front of the person's walking frame at times and repeatedly saying, "do you want to sit down now". The person became more unsettled as a result of the staff interactions. We shared our concerns with the manager as this could be seen as restrictive practices. The staff member told us the person could be at risk if they walked on their own as they liked to open doors. The staff member thought they had the person's best interests at heart but their practices reflected their lack of skills and knowledge they had in trying to support the person's needs effectively. In addition to this we saw a further example where staff had difficulty in responding to this person's needs. On this occasion three staff crowded around the person trying to encourage the person to go with them. However, the person was not reassured or comforted by this approach as we saw they became more unsettled and agitated.

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

In the care plans we looked at we saw many of these had recently been updated and the manager was

undertaking work with staff around making sure these were accurate. People had plans of care with details about their individual needs for staff to follow. For example, in one person's plan we saw there was a detailed description of their mental health needs alongside how staff should assist the person with these. Staff spoken with had an awareness of how to support the person with their needs which was in line with their plan of care.

We saw information which confirmed people's health needs were being responded with in line with their plans of care. For example, people requiring blood glucose monitoring were having this done in accordance with their care plans. However, there was no information available to guide the nurses as to what a normal range might be and how to address abnormally high or low readings.

People we spoke with had mixed views about how they were supported to follow their interests. One person said the staff member responsible for arranging social events always, "Gives us things to do, I like to do the word games and exercises." Another person said, "We don't have a lot of activities, I've never been out (apart from in the garden) since I moved here last year." A further person told us, "I read a lot, play chess and I like going out but haven't been out for a long time, last year I once went to the park to watch a brass band and I went to a big store for shopping, I like [staff member's name] who runs the activity centre."

The provider employed a staff member whose role and responsibilities was to lead on planning, arranging and supporting people with fun and interesting things to do. We spoke with this staff member and they showed us they tried different approaches to respond to people's wellbeing needs. We saw the things they supported people to do such as, painting and listening to music. One person was supported to fold linen which had a positive impact upon people's wellbeing. Another person was supported by the use of touch which we saw provided them with interest and comfort. The person looked relaxed and enjoyed the attention they were provided with.

People we spoke with told us they felt comfortable raising concerns if they were unhappy about any aspect of their care. One person told us, "I would see the girls (staff)." Another person said, "I would see the manager but I asked [relative's name] to complain about the food for me but no changes have happened." A further person told us, "The lift has broken three times recently, it's not fair on residents or staff to be wheeled around the side of the building to reach the top floor, it's dangerous for staff. With a little expenditure they could get a second hand stair lift but the managers are based in Surrey and they don't see the disruption the lift breaking causes." The manager had completed a risk assessment of the lift. This captured the potential risks posed by the pathway which was the only exit from the home for people who lived on the first floor when the lift was not working.

Inadequate

Is the service well-led?

Our findings

We found the provider had not notified us before they decided to accept the admissions of people with learning disabilities and specific mental health conditions. The provider is registered with the CQC to provide accommodation to older people with nursing and or dementia care needs and this was also confirmed within the provider's statement of purpose. We spoke with the person nominated by the provider for liaison with us. We gave feedback about our findings generally but also specifically raised concerns about the decisions taken to accept people into the home whose needs could not be met by the staff team. They told us at the time the former manager agreed to accept admissions of people whose needs were not covered by the provider's own statement of purpose. They said they were unaware people had come to live at the home with learning disabilities or specific mental health conditions until recently as they had not been advised by the former manager. There had been no consideration in how the staff team would be enabled to meet people's needs before people came to live at the home. We also noted that this person and other senior staff from the company had visited to undertake their quality assurance checks but these issues had not been identified.

The former registered manager left the provider's employment in February 2016 but had been away from work for some months up until they left. This had resulted in changes in the management of the home but these were not sustained. A new manager was recently appointed by the provider and had been in post for three weeks. When we spoke with the manager they acknowledged the shortfalls in care but said they were committed to improving the safety and the effectiveness of the care provided. However they were unable to show us the plans they had in place to make this happen and to sustain the improvements. The manager showed us they were honest and accountable as they described the care and overall performance of the home as "poor". They acknowledged the organisation of effective cleaning needed attention so people could be assured they were protected from the risks of infections and had a pleasant environment to live in. They also recognised people had come to live at the home and their needs were not being effectively met which concerned them.

We found the provider's systems for monitoring and reviewing the effectiveness of the care provided had failed to identify the issues we identified during our inspection. For example, the methods staff were using to test the water temperatures and the failure of some taps to produce consistent hot water to enable staff to respond to people's needs in a safe way. We considered this to be a significant safety risk to people which the provider had failed to learn lessons from as we had highlighted the same issues in 2013 when at the time we took enforcement action. In addition to this there was no evidence of checks to ensure staff were competent to handle medicines. The provider's own quality audits had failed to identify the numerous findings regarding poor infection control practices raised by both visits from the local Clinical Commissioning Group (CCG) and our inspection. At the time of our inspection the provider was following an action plan of areas which needed to be improved upon and this was being monitored by the clinical commissioning group. The action plan was only put in place in response to visits made by the clinical commissioning group. The CCG found significant improvements were needed which the provider's quality checking measures should have identified. For example, the water seeping through in places in the laundry room which the provider had clearly not been identified and action taken. On reviewing this plan, we found

action had still not been taken at the time of our inspection to make sure the health and safety of people living at the home was promoted.

At our last inspection in 2015 we found that although a number of audits and checks to ensure the services offered to people were safe and well led these were not consistently effective. This was because the provider had not identified the issues we had during our inspection. They did undertake work to rectify the issues but this was reactive to requirements placed upon them rather than developing a programme of work arising from a commitment to improvement. During this inspection the manager had difficulty in finding the audits which had been undertaken. This did not provide assurances that the quality checking systems in place were clearly organised to assist in making effective changes.

Professionals we spoke with described how staff seemed to lack consistent leadership and direction to be supported to provide safe and effective care. We also found the findings of our inspection supported this was the case.

The manager said the staff team had adopted a culture where staff considered the home was being run for their convenience. The manager felt this needed to change to enable care to be centred on each person as this was lacking at the time of our inspection. We saw staff met people's care needs but this was mainly through basic tasks such as personal care. However, there had been a lack of leadership and 'leading by example to enable staff practices to be changed and promoting good practice. The lack of this leadership has had a negative impact upon people who lived at the home. For example, we saw staff struggled with the basic care needs of a person with dementia at the time of our inspection. The manager had to support staff in responding to this persons needs by instructing them not to crowd the person which can be frightening for a person with dementia. The manager recognised planning improvements and sustaining them would be a challenge for the future.

These issues were a breach of Regulation 17 HSCA of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People had mixed views about how well led the home was. One person told us, "This is the best care home in Britain." Another person said, "It's managed well, there are new staff working here, they do their best, the manager doesn't come round, I've seen her once or twice." A further person voiced their displeasure about having to live at the home which we saw and heard was distressing for other people. One relative told us, "Quite confident (manager) is putting in place processes that need correcting. Giving her time to do this."

The manager showed they valued people's views and a meeting had been arranged to provide people with the opportunity of sharing their opinions and views of the services provided.

We found there were inconsistencies in communication between the management team. For example, the manager did not feel their induction to the home provided them with a good basis to start from as the manager of the home. This had also been noted in the recent quality monitoring visit undertaken on behalf of the provider where there was a discussion noted about the manager not receiving an induction. However, the nominated individual for the provider showed us a copy of the manager's induction which was over a five day period. These discrepancies between the management team did not provide assurances the improvements required would be consistently communicated, acted upon and sustained for the benefit of people who lived at the home.

Staff we spoke with told us there had been changes with each new manager and this had not helped them to feel supported and or confident in their roles. However, staff acknowledged they did feel supported by the

new manager who they believed was making improvements. One staff member told us, "The service is getting better." Staff said the manager had taken a 'hands on' approach to assisting them in their roles. We saw this was the case during our inspection as the manager led by example as they had put into place some procedures for staff to follow and also used their own practice when working alongside staff. For example, we saw they checked people were provided with support to eat their meals where this was needed at lunchtime during our inspection. We saw they had set up some procedures to enable people's care to be monitored, such as, the monitoring charts where staff recorded what people had eaten. At the time of our inspection the manager told us people were gaining weight. However, we were unable to test how effective this was as the practices were still in their infancy and needed to be sustained over a period of time.

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 9 HSCA RA Regulations 2014 Person-centred care People could not be confident they would receive person centred care which appropriately responded to their needs. The registered provider had agreed to meet the particular needs of some people without ensuring they were able to provide the care required.

The enforcement action we took:

Notice of Proposal to restrict admissions to the service and to impose conditions on the provider's resgistration.

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 did not do all that was possible to mitigate risks to people's safety and welfare due to potential hazards. People were at risk from infections as the practices and procedures in place were not effective in assessing and taking action did not assess and mitigate the prevention and control of infections.

The enforcement action we took:

Notice of Proposal to restrict admissions to the service and to impose conditions on the provider's resgistration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment People could not be confident they would be protected from abuse due to the ineffectiveness of the systems and practices in place.

The enforcement action we took:

Notice of Proposal to restrict admissions to the service and to impose conditions on the provider's resgistration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment People had not been protected against the risks associated with unsafe or unsuitable facilities because of the inadequate practices and procedures which were in place to ensure the water supply was properly and consistently maintained.

The enforcement action we took:

Notice of Proposal to restrict admissions to the service and to impose conditions on the provider's resgistration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance There were inadequate systems and processes in place to ensure people would consistently receive good care and improvements would be made to sustain good care.

The enforcement action we took:

Notice of Proposal to restrict admissions to the service and to impose conditions on the provider's resgistration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing People had not always had access to staff who were skilled and knowledgeable to effectively meet their particular needs. The registered provider did not ensure staff were suitably qualified, competent and skilled.

The enforcement action we took:

Notice of Proposal to restrict admissions to the service and to impose conditions on the provider's resgistration.