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Epsom Lodge

Inspection report

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Date of inspection visit:
03 October 2017

Date of publication:
10 November 2017

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection was carried out on the 3 October 2017 to follow up on breaches found on the inspection in March 2017. We found that sufficient improvements had not been made.

Epsom Lodge is a residential care home without nursing for up to 13 people, some of whom may have dementia. On the day of our inspection seven people lived at the service.

There was no registered manager at the service. 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. There was a manager that had just started working at the service who supported us on the day of the inspection.

There were aspects to care delivery that remain unsafe and people remain at risk. Where a risk had been identified no assessment had taken place to plan how people could be protected from risks. People at risk of malnutrition and dehydration did not have systems in place to monitor their health or to ensure they had adequate food and fluids. Accidents and incidents were not always investigated or analysed. Staff were not always following best practice in relation to infection control and medicines were not always managed in a safe way. There were aspects to people's medicines that were being managed in a safe way.

People were not always protected from the risk of abuse as staff were not always reporting incidents to the Local Authority. Staff did not always have the skills and competencies they needed to meet people's needs and ensure their safety. Although training was being provided staff were not always providing the most effective care. Nutritional assessments were not always updated to reflect a changing need and guidance was not always available.

We have recommended that there are always the appropriate numbers of staff available as at times they were lacking. People's rights were not always protected because the staff did not always act in accordance with the MCA or DoLs. MCA assessments were not taking place particularly when specific decisions needed to be made. For example in relation to people being given medicines covertly and people being kept in their room.

There were some people at the service that were at risk of social isolation and staff did not have sufficient meaningful interactions with them. There were times where people were not always treated with dignity.

Care plans lacked detail around the specific needs of people. Where a need had been identified there was not always detailed guidance for staff. Improvements were still needed around the activities provided when external entertainment was not being provided.

The provider continued to breach regulations from previous inspections. Audits and surveys were not being

used as an opportunity to make improvements. Not all staff were attending meetings to discuss best practice. Notifications that were required to be sent to the CQC were not being done. Complaints were not being investigated, recorded and responded to.

Robust recruitment checks were in place that ensured that only suitable staff worked at the service. There were appropriate plans in place in the event of an emergency at the service.

People enjoyed the food at the service and were offered choices of meals. Where health care professionals needed to be contacted this was being done, with the exception of two people who had lost weight.

Staff at the service were observed to be kind, caring and respectful towards people. People that were able could access all areas of the service when they wanted.

We found a number of continued breaches and new breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The overall rating for this service is 'Inadequate' and the service therefore remains in 'Special measures'.

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

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. There were aspects to people's medicines that were being managed in a safe way.

We have made a recommendation that the appropriate numbers of staff are always available for people.

Staff were not always raising concerns where alleged abuse may have taken place.

Robust recruitment checks were in place that ensured only suitable staff worked at the service. There were appropriate plans in place in the event of an emergency at the service.

Is the service effective?

Inadequate

The service was not effective.

Staff were not acting in accordance with the MCA 2005 and DoLS. People's capacity had not been assessed before specific decisions were being made on their behalf.

Staff were not always competent to carry out their role and training was not always effective.

People that were at risk of malnutrition did not always have measures in place to address this.

People enjoyed the food at the service.

People had access to health care professionals when they needed.

Is the service caring?

Requires Improvement

The service was not always caring.

There were some people at the service that were at risk of social isolation and staff did not have sufficient meaningful interactions with them. There were times where people were not always treated with dignity.

We did see staff treat people in a caring and respectful way.

Relatives and visitors were welcomed at the service when they visited.

Is the service responsive?

Inadequate

The service was not responsive.

Care plans lacked detail around the specific needs of people.

Where a need had been identified there was not always detailed guidance for staff.

Improvements were still needed around the activities provided when external entertainment was not being provided.

Complaints were not being investigated, recorded and responded to.

Is the service well-led?

Inadequate

The service was not well- led.

The provider continued to breach regulations from previous inspections.

Audits and surveys were not being used as an opportunity to make improvements.

Not all staff were attending meetings to discuss best practice.

Notifications that were required to be sent to the CQC were not being done.

Staff did feedback that they thought the service was well managed.

Epsom Lodge

Detailed findings

Background to this inspection

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

This was an unannounced inspection which took place on the 3 October 2017. The inspection team consisted of two inspectors.

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 also reviewed information from the Local Authority Quality Assurance team. On this occasion we did not require the service to complete a Provider Information Return (PIR) to review prior to the inspection as we were following up to see if improvements had been made from the previous inspections. This 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. We also 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.

During the visit we spoke with two people, the provider, the manager and three members of staff. We looked at a sample of four care records of people who used the service, medicine administration records and training records for staff. We looked at records that related to the management of the service. This included surveys and audits of the service.

The last inspection was on the 8 March 2017 where breaches were identified. We undertook this inspection to ensure that they were making improvements.

Inadequate

Is the service safe?

Our findings

On the previous inspections in April 2016, September 2016 and March 2017 we had identified a breach in safe care and treatment. On this inspection these concerns were still ongoing.

On person we spoke to told us that they felt safe at the service. They told us, "I feel safe here. They have put things on the windows to stop me falling out." Despite this there were aspects to people's care that was not safe. The care plans did not contain detailed information about actions required in order to provide safe care. For example one person was at high risk of falls and there were 'dangers of them walking into hazards'. There was no detailed guidance for staff on how to reduce these risks. The risk assessment had not been reviewed since May 2017. We saw from the incidents reports that this person in April 2017 and September 2017 had injuries to their body that staff had not witnessed. The risk assessment had not been updated to reflect these incidents. Another person's risk assessment stated, 'When I go out…..remind me of my fluid limitations.' There was no further information of what the risk was or what the person's limitations were. The care plan also stated that the person 'should support (the person) to walk if required'. There was no information about how staff should support them. A third person's care plan stated that they went out independently. There was no risk assessment specific to this which was particularly important as the person had a diagnosis of dementia and was at risk of falls.

People at risk of becoming dehydrated and developing a UTI (Urinary tract infection) did not always have appropriate plans in place to reduce these risks. According to the service communication book, from August 2017 to September 2017 staff were reminded on three separate occasions to encourage one person to drink more fluids during the day as their urine was concentrated. Although staff were recording how much this person was drinking there were no target amounts to identify when they had sufficient hydration. We asked one member of staff how much this person should be drinking and they were unsure. On 22 September 2017 it was identified that this person had developed a UTI. The communication book also stated that staff were reminded to increase daily fluid intake for another person on four separate occasions due to their dark urine which can indicate dehydration. There were no fluid charts in place for this person. This person also had a catheter and staff were not recording how much urine was in their catheter when it was emptied. Recording this could indicate if the person has drunk sufficiently and also indicate there may be a blockage.

The manager told us that after the inspection that a fluid input and output chart had been introduced for the person with the catheter.

People at risk of malnutrition were not always being monitored sufficiently to ensure that safe care was being delivered. People at the service were required to be weighed monthly or more frequently if required. However the records showed that between June 2017 and September 2017 no one at the service had been weighed. We reviewed the records in relation to people's weights and found that one person had lost four kilograms of weight between June 2017 and September 2017. Another person had lost 11 kilograms of weight in the same time period. In the communication book staff were reminded to ensure that this person was given higher calorific foods. We did not see this happening on the day. There had been no action by staff to record how much food both people were eating. There was also no updated risk assessment in their care

plan in relation to this or actions recorded around weighing them more frequently.

Accidents and incidents were not always analysed or followed up to reduce the risk of them occurring. Since the inspection in March 2017 six incidents had been recorded. There was no information recorded on how they believe the incident occurred. For example for one person there were two incidents of unexplained bruising and for another person one incident of a cut on their hand. There was no evidence that these had been investigated for the probable cause. There was also no information recorded on what actions should be taken to reduce the risks of these incidents re-occurring. Another person had 'slid' to the floor when going to the toilet. Other than to state the person was assisted back to their room there was no other information around how to reduce the risk of this happening again. Other incidents were not always recorded. For example we saw from the staff communication book that one person had locked themselves in their bedroom. There was another instance of medicines being dropped on the floor and being unusable. Neither of these had been recorded as incidents.

Staff were not always following good infection control practices which put people at risk. The laundry room was not set up to ensure that there was a designated area for the clean and dirty laundry to be handled. The manager told us that they had identified this as a concern but no action had been taken. We saw a member of staff enter a bedroom without gloves and place the person's dirty laundry into the laundry bin. They then carried the laundry bin through the lounge where people were sitting to place it into the laundry room. There was no sink in the laundry room for staff to wash their hands so in order to do this staff need to walk back through the lounge to access a bathroom. There was a risk of cross contamination. The provider told us after the inspection that they are seeking to make improvements to the laundry room.

There were aspects to the management of medicines that were not safe. One person had been prescribed an 'as and when' medicine however there were no medicines for this person in stock. There were medicines that had not been dated on opening that had a limited 'shelf life' so there was a risk that people would receive medicines that were out of date. Daily audits completed had been conducted in February 2017 and September 2017. An audit that took place in September 2017 had identified that daily audits were not taking place but there was no action recorded to rectify this. The medicines policy had not been reviewed since 2015 and records showed that only three members of staff had signed in 2015 to say that they had read and understood this policy. The provider notified us after the inspection that the paper version of the medicine policy has now been removed and staff now access the electronic version. Of the seven staff that had been trained to administer medicines only one of them had been competency assessed.

As care and treatment was not always being provided in a safe way this is a continued breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were aspects to people's medicines that were being managed in a safe way. We noted medicines administration record (MAR) charts contained relevant information about the administration of certain drugs. Each MAR had a photo of the person and details of any allergies. Medicine cabinet and fridges had temperature checks undertaken twice a day to ensure that medicines were kept safely. There were 'as and when' protocols in place so that staff had guidance on when people needed these medicines. Body maps were in place for prescribed creams so that staff knew where they needed to be administered.

People were not always protected against the risk of abuse. There had been instances of unexplained bruising and injuries to two people. These had not been reported to the Local Authority or the CQC as possible instances of abuse. One member of staff told us, "We would have to report unexplained bruising. Bruising could be a punch or someone holding someone tightly." Despite having this knowledge no steps had been taken to report or investigate the possible reasons for the unexplained bruising. Another member

of staff said, "I have had training in safeguarding. We asked them what indicators they could look for in relation to abuse. They said, "Bruising, sometimes they will tell you. Everything has to be reported to social services and to CQC. I would re-assure the resident." Staff had received safeguarding training. Although staff understood safeguarding adults procedures and what to do if they suspected any type of abuse they were not always putting this into practice.

The provider ensured that this notifications were sent to the Local Authority and the CQC after the inspection.

As people were not always protected against the risk of alleged abuse this is a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

On the previous inspections in September 2016 and March 2017 we had identified a breach in the recruitment checks for staff. On this inspection that had improved. People were protected against the risk of being cared for by unsuitable staff. We checked files for new members of staff that had started at the service since the last inspection. We noted criminal records checks had been undertaken with the Disclosure and Barring Service (DBS). There were also copies of other relevant documentation including full employment histories and references.

On the previous inspection in March 2017 we identified a breach around the safety of the environment. On this inspection we found that this had been met. It had been identified that to prevent the spread of fire plasterboard needed to be fitted to the wall faces of the lift. This had now been addressed and checked by Surrey Fire and Rescue Service as appropriate. Window restrictors had now been placed on people's windows and PAT (Portable appliance testing is the term used to describe the examination of electrical appliances and equipment to ensure they are safe to use) had taken place.

One person we spoke with told us that they were enough staff to support them. They told us, "I can ring the buzzer. They (staff) come straight away." Despite this we found at times that there were not always appropriate numbers of staff available. When we arrived there were two members of staff at the service. One member of staff had been assisting in the kitchen preparing breakfast as there was no cook at the service whilst the other member of staff was supporting people on all three floors. One member of staff said, "We would normally have three carers but (name of carer) is late. Three is better." Another member of staff said, "I feel there should be more staff. We can cope but having someone to cook would be better." Later on in the morning an additional member of staff did arrive at the service to support people. The manager told us that on the day of the inspection a member of staff had called in sick. They told us that they intended to recruit a cook so that care staff were not taken away from care duties to make meals for people. They also said that ordinarily a manager would also be present to provide support. They had arranged on the day of the inspection for the Provider to cover the management role in the morning so that they could catch up with paperwork at home. However the Provider was absent from the service for part of the morning. Another member of staff said, "We have enough staff. Sometimes someone goes sick. You have to call the agency. We have a lot of self-caring residents."

We recommend that appropriate numbers of staff are always available to support the needs of people at the service.

There were appropriate plans in place in the event of an emergency. In the event of an emergency such as a fire each person had a personal evacuation plan (PEEP) which was reviewed regularly by staff. These were left in the reception area and could be accessed quickly and easily if needed. We noted PEEPS also contained information on how people needed to be supported to be safely evacuated, either during the day

or at night. There was a business continuity plan in the event the building needed to be evacuated.

Inadequate

Is the service effective?

Our findings

On our inspections in April 2016, September 2016 and March 2017 we found that staff did not always follow the principles of the Mental Capacity Act (MCA) and Deprivation of Liberty (DoLS). The requirements were still not always being followed and people were not always being protected.

People's rights were not always protected because the staff did not always act in accordance with the MCA. MCA is a legal framework about how decisions should be taken where people may lack capacity to do so for themselves. It applies to decisions such as medical treatment as well as day to day matters. Mental capacity assessments were not undertaken to ensure people's rights were protected. There were people at the service where decisions were being made for them without an appropriate MCA taking place to assess their capacity. The manager made us aware of one person where they had made a decision that they should stay in their room four days a week. They told us that this was because the person was quite vocal and that this 'irritated' other people. The manager told us that the person lacked capacity to make decisions however there had not been a MCA assessment to establish this or a best interest meeting held in relation to the decision that they should stay in their room four days a week.

The manager advised us that another person had been refusing medicines. We saw from the audits of MAR sheets that the person had been given medicine covertly (disguised in food or drinks). There was no MCA assessment around the person's capacity to refuse medicines or any evidence of best interest meetings. We also noted from a MAR audit in June that 'Night medication for one or two residents have been discreetly administered covertly.' There had been no MCA assessments for anyone at the service in relation to refusing medicines. This meant that the person's right had not been protected and decisions were being made for them without due process.

The provider has since confirmed that no one at the service is receiving medicines covertly and that MCA assessments will be taking place. This will be checked at our next inspection.

No mental capacity assessments had been carried out to determine whether people had the capacity to consent to their care. The manager told us no best interests meetings had been held to ensure that decisions were made in the best interests of people who lacked capacity. The staff we spoke to on the day were unable to tell us what MCA was or the principles behind it. The manager also lacked an understanding of the principles of MCA and incorrectly said that the GP needed to undertake any assessments.

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. We noted that DoLS applications had not been made to the local authority in line with current legislation for people living at the service. Appropriate MCA assessments had not taken place to review people's capacity in relation to the DoLs. For example they were not being completed for people unable to leave the service without staff.

As care and treatment was not always provided with the appropriate consent this is a continued breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Staff did not always have the competencies they needed to meet people's needs and ensure their safety. One person had been referred to the GP in relation to their reduced mobility. The person was unable to stand from a sitting position without assistance. A member of staff said (in relation to this person), "We shouldn't lift because there is a risk of injury to them (the person) and to us." They said however that because there was no equipment in the service to help this person stand they, "Sometimes lift them under their arms (known as a drag lift that can tear and bruise skin)." The manager confirmed that they were aware that staff had been lifting the person under their arms. On another occasion we saw from an incident report that a person had fallen to the floor. Staff told us that they are not allowed to lift people from the floor and would call an ambulance. However on this occasion a member of staff said, "(The Provider) lifted her as he is strong so he can lift." There was no acknowledgement that this was an inappropriate way of getting a person up from the floor.

Although staff had received mandatory training in most areas this was not effective in relation to their practices. We observed shortfalls around moving and handling, Safeguarding procedures, the management of medicines, the management of those people that were nutritionally at risk and infection control practices. We identified that staff had not received training in MCA. Staff had not had their competencies checked and had not received regular supervision of the work they carried out to ensure best practice. Of the ten members of staff at the service five had not received a formal one to one supervision this year with their manager.

As staff were not always receiving the appropriate training and supervision to undertake their role and staff were not always effective in their role this is a continued breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

One person told us that they liked the food at the service. They told us, "It's got better lately. We have a bit more selection now. We had gammon and egg yesterday. You can suggest things. I asked for gammon and eggs and got it. Staff always ask what I want." We saw that people were given choices of a meal prior to the lunch being served.

Nutritional assessments had not been updated where a risk had been identified. There were two people at the service that had recently lost weight. Their care plans did not contain an updated Malnutrition Universal Screening Tool (MUST). At the previous inspection it was noted that the staff did not have a record of people dietary needs. At this inspection this had not improved. We asked staff whether there were people at the service that had particular dietary needs. They told us that there was only one person whose diet was restricted and referred to the person who was on a soft diet. The guidance on the wall in the kitchen stated that the person was on a normal diet. A member of staff said, "We don't follow that guidance." There was also no information about the person who was on a fortified diet. This meant that there was a risk that people may not be supported appropriately by staff who may not know their needs. The guidance on the wall was removed on the day of the inspection.

We recommend that the provider ensures that all staff are provided information and guidance on people's dietary needs and that nutritional assessments are updated regularly.

We did observe a meal being served in the dining room. The food looked appetising and people ate all of the meal and were offered desserts. We noted that one person who was diabetic was given a low sugar dessert. People were offered hot drinks and biscuits throughout the inspection and there was fruit available for

people to eat. People were able to feedback on the menu. We saw that a residents meeting took place where people said what they liked and did not like on the menu and we saw that staff acted on this.

We looked at care plans in order to ascertain whether people's health care needs were being met. We noted the provider involved a wide range of external health professionals in the care of people. These included community nurses, Speech and Language Therapist (SALT) and the GP. We saw that the manager had recently referred people to the GP where they felt their health required reviewing including concerns around their mobility.

Requires Improvement

Is the service caring?

Our findings

On our inspection in September 2016 and March 2017 we found that people did not always have the opportunity to make choices in their day to day lives. We found on this inspection that this had improved although we still identified concerns in relation to how people were cared for.

Social interactions between staff and people should be seen as important as supporting people with their personal care needs. We found that there were people who remained in their rooms with little interaction from staff. During the inspection we noted that one person on the top floor just sat in their chair in their room. Other than staff going to the room to provide personal care, drinks and meals there was no meaningful interaction. The manager told us that they were aware of this.

People were not always treated in a dignified way. On the previous inspection we found that people were given coloured plastic cups to drink out of at lunchtime. On this inspection this had not changed. The manager told us that they did not know why people were drinking out of coloured plastic cups. We noted that when people were offered hot drinks they were given a cup and saucer which was more dignified. There was no reason why people could not have been offered a glass to drink out of instead of a plastic cup.

The provider has informed us that since the inspection people have been offered more appropriate cups to drink out of.

We recommend that people are treated with dignity and respect at all times and that people are protected from the risk of social isolation.

We did observe times where staff were kind and caring towards people. One member of staff approached a person and gently rubbed their arm. They said, "Are you ok?" The person responded to this with a smile. They then chatted together for a while which you could see the person appreciated. On another occasion a person walked into the lounge and approached a member of staff and kissed them on the cheek. It was clear that the person felt comfortable with the member of staff. We heard another member of staff say to a person, "Good morning (person's name). How are you? Oh good, nice to hear that." One person mentioned that they were cold and a member of staff responded to this immediately and fetched them a jumper.

There were times where people were given choices and were treated with respect. One person was asked if they wanted to take part in an activity and the person chose not to. The member of staff told them that they could change their mind in their wanted. Another person was asked discreetly if they needed to use the toilet and was supported to the bathroom. Another person required some personal care. We observed staff gently encouraging the person despite their initial refusals. The member of staff talked about making the person handsome. The person responded to this and staff supported them to have their personal care.

There were people that were independent and were able to access all areas of the service. We saw people walk into the garden when they wanted and access their rooms. One person liked to tear tissue and we saw staff gently and kindly encourage the person to place the pieces of tissue in the bin. The person responded

positively to this. Relatives and visitors were able to visit the service when they wanted.

Inadequate

Is the service responsive?

Our findings

At the previous inspection in April, and September 2016 and March 2017 we identified a breach in regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Detailed guidance for staff was not always available around people's needs and activities were lacking. This had not improved sufficiently on this inspection.

At the previous inspection there was a lack of pre-admission assessments for two people. Since this inspection no one has been admitted into the service. Care plans were not detailed enough for staff to understand the specific and personalised care people needed in order for them to provide responsive care. One person had diabetes; there was no care plan for staff with guidance around the signs to look out for should they become unwell. Staff were unaware that the person had a heart condition that needed to be monitored carefully and there was no care plan for this. We had identified this at the last inspection in March 2017 but no changes had been made. One person had a particular behaviour on the day of the inspection. Staff told us that the person often displayed this particular behaviour however there was no mention of this in their care plan. Where behaviour had been identified for people there was no detailed guidance on how best to manage the behaviour. For example one person was awake a lot at night. There was no guidance for staff on how best to manage this other than around theirs and others safety. There was no guidance around the person's emotional and psychological needs. Another person's care plan stated that they had an 'ocular' condition. There was no additional information or guidance for staff around this.

At the previous inspection we were told that staff were in the process of updating people's care plans. The manager (who had just started at the service) told us on this inspection that this still had not been done. They said that this was their priority and that they were working on them.

At the last inspection there were long periods of time when people sat in the lounge areas without interaction with others or engagement from staff. We found on this inspection that there had been some improvements. People were offered activities outside of the planned entertainment but these were still quite basic and not specific to people's individual hobbies and interests. Some people were cared for in their rooms either through personal choice, illness or infirmity. There was no evidence that activities had been planned to ensure these people did not experience social isolation. One member of staff said, "There could be more activities. I would like to bring the atmosphere up. I think it would bring them out (of their rooms) and talk."

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.

Daily records were completed to record support provided to each person and had improved since the last inspection in March 2017. There was information about people's well-being, interactions, activities and mood, providing a picture of the person's day.

Complaints were not always investigated and responded to appropriately. We were aware of one complaint that had been made to the service prior to our inspection. The provider assured us that an investigation would take place and that the complainant would be contacted with a response. We found on the day of the inspection that the complaint had not been recorded and no investigation or response had been provided. The complainant confirmed to us that they had not had a response.

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

In April 2016 the service was found to be requiring improvement and breaches were identified in a number of areas. When we re-inspected in March 2017 improvements had not been made and further breaches had been identified. Therefore instead of improving the service and care people received the provider had allowed the service to deteriorate and had failed to take action in a timely way. The service was rated as Inadequate in the March 2017 inspection and placed into Special Measures. We found at this latest inspection that the required improvements had not been made and further concerns were identified. There is a history of non-compliance and lack of action by the provider to improve the care.

On the inspections in April 2016 and March 2017 we identified breaches in Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider did not have effective systems in place to monitor the quality of care or drive improvement. On this inspection whilst there had been improvements in relation to the environment we found continued and additional breaches in other areas. We reviewed the Providers action plan prior to the inspection which identified the gaps. However there was a lack of detail around who was required to make the improvements and by what date.

Although there were some systems to assess the quality of the service provided we found these were not always effective. These systems had not ensured people were protected against some key risks described in this report including the risks of receiving inappropriate or unsafe care and support.
There were aspects to the quality assurance that were not used to drive improvement. There was no system in place to identify and mitigate risks or to analyse accidents to learn from them which was identified on the previous inspection in March 2017. Accidents such as falls or incidents (such as unexplained bruising) were recorded by staff but they had not been investigated for possible causes or reported to the appropriate authorities.

Although surveys had been completed by relatives and people these were not used as an opportunity to make improvements. For example in one survey a relative had asked that heavier curtains be placed in their family member's room as they were cold. Although a note had been written by staff to state that this may be a possibility this still not been addressed. Another relative stated that their family member's hair was 'often dirty and smelly.' There was no action plan to state how this was resolved or whether the relative was contacted about this.

Although audits were taking place these were not effective in making improvements. We noted that several audits took place in July 2017 including, accidents and incidents, complaints, first aid and fire procedures. It was identified on one audit that the first aid boxes needed to be restocked. The manager confirmed to us that this had still not been addressed. We identified that complaints were not always being recorded. On an infection control audit in August 2017 it was identified that there were improvements needed around infection control and we found that this was still the case. The manager had undertaken a health a safety audit of the premises three weeks prior to the inspection. They identified that brighter lighting was required in the hallway, a bulb was missing from the dining area and one person's window could not be opened safely. None of these actions had been addressed on the day of the inspection. There were no action plans

in place for any of the audits that we looked at to identify who was going to address the concern and in what timescale.

There were staff meetings at the service. We saw that shortfalls of care were addressed and staff were reminded to ensure best practice. However this was not effective as we still identified shortfalls on the day. We also identified that not all staff attended the meetings. One member of staff said, "They have staff meetings. I don't attend them all. I read the minutes."

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

Staff told us that they were happier with how the service was being managed. One told us, "It is much better here (with management). Before we did not understand paperwork. We now use the communication book (we saw this was being used)." Another member of staff said, "The manager is supportive. They employed the wrong people (before)."

Services that provide health and social care to people are required to inform the Care Quality Commission (CQC) of important events that happen in the service. We found that notifications were not always being submitted to the CQC despite the requirement to do so. This is so CQC can take follow up action where needed. There had been instances of alleged safeguarding concerns that had not been notified to the CQC. After the inspection the manager informed us of these incidents.

As notification were not always been sent in to the CQC this is a breach of regulation 18 of the (Registration) Regulations 2009.