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Surrey Heights

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection of Surrey Heights took place on 27 April 2017 and was unannounced. This inspection was to follow up on actions we had asked the provider to take to improve the service people received.

Surrey Heights is registered to provide accommodation with nursing care for up to 39 people. At the time of our visit, there were 26 older people living at the home. The majority of the people who lived at the home were living with dementia and a mental health diagnosis. The accommodation is provided over three floors that are accessible by stairs and a lift. The service is a detached house with communal lounges, dining room, kitchen and bathroom facilities.

There was a registered manager in post however they were not present on the day of the inspection. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. On the day of the inspection we were supported by the deputy manager. Since the inspection changes to the management arrangements have taken place and a new manager is in post who will apply to register with the commission.

At our previous inspection on 18 May 2016 we found a breach in relation to ineffective recruitment systems. We also made two recommendations to the provider in regard to infection control, to improve care plans and improvements around the supervision of staff. The provider sent us an action plan and provided timescales by which time the regulations would be met. They stated that the actions would be completed by 1 September 2016.

During this inspection we found that although some improvements had been made in regard to our recommendations and breach of regulation we found new concerns that put people at risk of harm.

People were at risk because there were inadequate systems and arrangements to protect people from the spread of infection. Appropriate standards of cleanliness were not being maintained. Infection control policies and procedures were in place; however staff had not followed these. We raised concerns about the conditions of mattresses, furniture, commodes, and bedding in the home.

There were insufficient numbers of staff deployed to meet people's needs. This had an impact on the care and support provided and the cleanliness of the home.

People were not always safe because up to date risk assessments were not in place to identify, assess and manage risk safely and to minimise the risk of harm to people.

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

practices were not being followed. MCA assessments were not being completed specific to particular decisions.

There were inconsistencies in how staff used their training and put this into practice which put people at risk. We made a recommendation that the registered provider follow their policy in relation to supervision to ensure staff received appropriate support and supervision for their role.

The home could be improved because it was not easy for people living with dementia or who had impaired sight to find their rooms or their way around the service as all areas looked the same. We made a recommendation that the provider researches and implements relevant guidance on how to make environments used by people who live with dementia more 'dementia friendly'.

People were not always treated with dignity and respect. There was a strong smell of urine in people's rooms and in the corridor outside rooms that people had to endure. Staff were not always listening to what people wanted.

Some peoples' rooms were bare and lacked personalisation. Other rooms did have people's own furniture and personal items so that they are surrounded by things that were familiar to them.

Pre-assessments of people needs were undertaken before they moved in however; these were not always used effectively in determining whether their needs could be met.

Care plans did not always reflect up to date information regarding people's care and support needs, therefore they did not provide staff with guidance they needed to deliver responsive care. There was a risk that new staff would not have this knowledge or access to up to date information to enable them to provide appropriate and safe care to people. Staff who had been at the home for some time had got to know people well and they were providing care that meet peoples individual needs and preferences.

Activities took place, however they were not person-centred. During the inspection we observed activities taking place but this did not include the majority of the people and there were only a few one to one activities taking place. We found there was no physical stimulation around the home for people that would provide them with something to do during the day when organised activities were not happening.

The quality assurance systems were ineffective in reviewing the quality of the service provided. Audits did not identify poor practices and therefore action was not taken to improve the care people received.

People told us they were safe at the home. Staff had a good understanding about the signs of abuse and were aware of what to do if they suspected abuse was taking place. The home had a business contingency plan that identified how the home would function in the event of an emergency such as fire, adverse weather conditions, flooding and power cuts.

People were not always offered choices of the meal they wanted. However people had enough to eat and drink throughout the day. Where people needed support with eating; they were supported by a member of staff, apart from in one instance we observed.

People were supported to have access to healthcare services and healthcare professionals were involved in the regular monitoring of their well-being. The provider worked effectively with healthcare professionals and was pro-active in referring people for assessment or treatment.

Staff treated people with compassion and kindness when providing care. People's relatives and friends were able to visit when they wanted.

People knew how to make a complaint. People told us if they had any issues they would speak to the manager. People told us the staff were friendly, supportive and management were always approachable.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

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

There were not always enough staff effectively deployed to meet people's needs which had an impact on the care provided.

There were aspects of the environment that were unsafe and put people at risk.

Effective procedures to prevent and control the spread of infection were not in place and best practices were not being followed.

Medicines were administered, stored and disposed of safely.

Recruitment practices were safe and relevant checks had been completed before staff commenced work.

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

Is the service effective?

Requires Improvement

The service was not always effective.

People's human rights could be affected because the requirements of the MCA and Deprivation of Liberty Safeguards (DoLS) were not always followed.

Staff did not always receive appropriate support that promoted their professional development or reviewed their performance.

People were usually but not always given choices of meals. However people had enough to eat and drink and there were arrangements in place to identify and support people who were nutritionally at risk.

The environment was not set up appropriately so that people

living with dementia could find their rooms or their way around the service as all areas looked the same.

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

Is the service caring?

Requires Improvement

The service was not always caring.

People were not always treated with dignity and respect.

Individual staff cared about the people living at the home, but the care provided was task orientated. There were inconsistencies in the care that people received.

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

Is the service responsive?

Requires Improvement

The service was not always responsive.

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

People were not always supported to participate in a range of activities; and there was a lack of individualised stimulation.

People were given information about how to make a complaint.
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Is the service well-led?

Requires Improvement

The service was not always well- led.

The provider did not have effective systems in place to regularly assess and monitor the quality of the service the home provided. Records were not always up to date and accurate.

Although the provider had made some improvements, new concerns were identified putting people at risk. Although, since the inspection we have received an action plan stating what will be done to improve the service, which includes new management and arrangements for monitoring quality.

The provider sought, encouraged and supported people's involvement in the improvement of the home.

People said that staff and management were always there to speak with when they needed to.

Surrey Heights

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 27 April 2017. The inspection team consisted of three inspectors, and a mental health specialist.

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

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

We spoke to six people living at the home, four staff, the senior management team and the operations director. We observed care and support in communal areas; looked in six bedrooms with the agreement of the relevant person. We looked at six care records, risk assessments, medicines administration records, accident and incident records, minutes of meetings, three staff records, complaints records, policies and procedures and external and internal audits.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

Following the inspection the provider sent us a detailed action plan of areas that were going to address around the immediate concerns we found.

The last inspection of this service was carried out on 18 May 2016 where we found one breach of the regulations in relation to ineffective recruitment systems in place.

Requires Improvement

Is the service safe?

Our findings

When we asked if people felt safe at the home, one person told us, "I do, because the staff are here." Another person told us, "I walk around with staff and I feel safe." People told us that if they felt unsafe they would speak to the staff on duty. Despite these comments we found that people were not always cared for safely and were put at risk.

People were not always protected from the risks of unsafe care. There were people at the home that had behaviour that challenged the service. In one person's care plan guidance for staff was that the person required one to one support from staff at all times. This was because their behaviour put themselves and others at risk. However during the inspection we saw on two occasions where the person was not with the member of staff and the person was displaying these particular behaviours towards others. We looked at behavioural care plans for other people and found that they lacked specific guidance that staff needed to manage and provide the most appropriate support.

Staff did not have all the information they required to guide the care they provided to ensure it was appropriate and to protect people from risks. There were people who were at risk of falling. The guidance in one of the care plans stated that the person needed to be kept safe whilst walking however there was no information for staff on how this needed to be done. We asked the provider for any analysis of the accidents and incidents to show how they identified trends and patterns regarding falls to enable them to take action to prevent further incidents. They were unable to provide any evidence that they had done an analysis or taken action to prevent further falls. Another example of where risks were not being managed included skin integrity. There were people at risk of developing pressure sores but there was no detailed guidance to staff on how to manage or reduce the risk of them developing pressure sores.

At our last inspection on 18 May 2016, we identified concerns relating to infection control and we had made a recommendation to the provider to ensure that people were protected from cross contamination and the risk of harm. During this inspection, although we found that some improvements had been made, we found new risks to people, this demonstrated that the systems in place were not robust enough to protect people from harm.

There were aspects of the environment that were unsafe and put people at risk. One person's room, furniture and bedding smelt strongly of urine and remained that way throughout the day. There were other areas of the home that smelt strongly of urine throughout the day. There were bed bugs at the home which is caused by the lack of appropriate cleaning. These had remained at the service on and off since 2015, and appropriate action had not been taken to get rid of them. There were other areas of the home that were not clean. In another person's room the commode was stained with urine and dried faeces. This demonstrated that the systems in place were not robust to prevent and control infection satisfactorily.

There was a cleaning schedule for domestic staff to follow in regard to daily cleaning tasks. Although the cleaning schedule detailed the different tasks that needed to be carried out and checked, this did not include cleaning and disinfecting commodes and mattress which was having an effect on the standard of

cleanliness throughout the service.

People were not always protected against the risk of harm in the event of an emergency. There was no personal evacuation plan for one person. There was a risk that staff did not have the most appropriate information to evacuate the person safely. One person had oxygen in their room which is a known fire hazard. There was no risk assessment in place or signage on the person's door to indicate the presence of oxygen in the room.

As safe care and treatment was not always provided this was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The environment and equipment had not been well maintained. In one person's room there was no hot water or heating. One person told us, "I have no heating or hot water. I haven't had any since I have been here. " On the top floor of the home there was no hot water in people's rooms or in the communal bathrooms and toilets. One member of staff who was aware of this told us, "We have to open the valve on the boiler." However when we checked later on in the day there was still no hot water. The compliance manager told us that they had called the external company out to address this on the day. Mattresses on people's beds that were too long for the bed frame and there was a risk that people whilst sitting on the bed would fall off.

We noted that the fish tank was coated in a green film that demonstrated that the tank had not been cleaned appropriately.

Failing to ensure that the premises were well maintained was a breach in Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People we spoke to felt there were enough staff at Surrey Heights. One person told us, "If I need help I just ask." Despite this comments, we found that the number of staff did not always meet people's needs and this had an impact on the care people received.

There were not enough staff to meet people's needs consistently and safely. We saw that people were supported by staff with personal care and support during mealtimes. However staff did not have time to have any meaningful interaction with people. Staff were busy and tasked focussed on the day. There were two people who required one to one support from a member of staff at all times. During the inspection we found that this one to one support was not always provided as one member of staff was busy providing support to other people. The management team told us that there needed be a minimum of seven members of staff to support 26 people during the day. They said there needed to be one cleaner and one laundry assistant on duty each day. They told us they used a dependency tool to calculate how many staff were required to meet the needs of people. We reviewed the staffing rotas over a four week period and found that on 13 occasions there were two care staff less than required and 13 occasions there was one less than were required. On a further eight occasions there was no laundry assistant on duty and on six occasions there was no cleaner on duty. This meant that the care staff were having to undertake these duties and so spend less time caring for people or interacting with them.

Failure to ensure there were sufficient numbers of staff deployed to meet people's needs safely was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection on 18 May 2016, we identified a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People were not always protected from being cared for by

unsuitable staff because although recruitment processes were in place, they were not always followed. During our visit we found they had reached the required standard set out in the regulations.

People were protected from being cared for by unsuitable staff because there were robust recruitment processes in place which had been followed. Staff confirmed that they were asked to complete an application form which recorded their employment and training history, provided proof of identification and contact details for references. Staff recruitment records contained the necessary information to help ensure the provider employed staff who were suitable to work with adults at risk. They included a recent photograph, written references and a Disclosure and Barring System (DBS) check. DBS checks identify if prospective staff had a criminal record or were barred from working with adults at risk. Staff confirmed they were not allowed to commence employment until satisfactory criminal record checks and references had been obtained.

People's medicines were managed safely and people understood the medicines that they received. One person told us, "There never seems to be a problem with my medicines." There was a clear policy and procedure in place and the staff had training in medication management and had been passed competent to administer medicines. Staff demonstrated good knowledge of medicine being administered. All prescriptions were appropriately signed and regularly reviewed by the GP. Medicine was ordered in a timely manner and were checked well in advance of the person receiving their medication. Medicine was appropriately stored in cupboards and medicine trolley.

Each person had their own Medicine Administration Record (MAR). The MARs contained a photograph to enable identification, which medicines people received and any allergies to medicines were recorded. We observed medicines being given and the member of staff making the person comfortable before the administration of medicines. They checked the identity of the person and asked which medicine they would like to take first. Staff said to one person, "I have your medicines here, how would you like to take them? With water or orange juice?" The member of staff asked each person whether they were in pain and whether they required any additional pain killers. Another person she knelt beside and said, "This will help the pain." Staff checked that the person was okay and waited patiently until the person had taken their medicines before signing the recording sheet. There was a PRN (as and when) protocol in place and this was reviewed regularly.

Staff had the knowledge and confidence to identify safeguarding concerns and acted on these to keep people safe. Staff had access to a safeguarding policy which gave information about how to raise concerns to the local authority if necessary. Staff were knowledgeable about the types of abuse and the procedures to follow if they suspected or witnessed abuse. A member of staff told us, "If I suspected abuse I would inform the manager." Records confirmed that staff had received safeguarding training within the last year.

There were some arrangements in place to keep people safe in an emergency and staff understood these and knew where to access the information. Alternative accommodation arrangements were in place in the event of the building being unusable following an emergency. Communal areas, stairs and hall ways were free from obstacles which may present an environmental risk.

Requires Improvement

Is the service effective?

Our findings

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's human rights could be affected because the requirements of the MCA and Deprivation of Liberty Safeguards (DoLS) were not always followed. People were at risk of having decisions made for them without their consent, as appropriate assessments of their mental capacity were not completed. There was evidence that some MCA assessment had taken place however they were not specific to the decision that needed to be made. For example where people could not leave the home unaccompanied. There was no evidence that MCA had .been undertaken or best interest meeting had taken place to support this particular decision and there was no detail on whether the least restrictive options had been discussed.

We found instances where decision making had been taken away from the person that had capacity. One person was told by the provider and their next of kin (NOK) that it was in their best interest of their health not to have all of their cigarettes when they wanted but instead had to ask staff when their daily 'allowance' ran out. Another person, who had capacity had asked if they could have kettle in their room to make hot drinks. A decision had been made by the provider and the next of kin that this was not safe for them and no alternative options had been considered. This meant people's rights had been affected as the MCA process was not being followed in accordance with current legislation. Staff told us, "Everybody is deemed to have capacity before they are deemed otherwise." Although staff and the provider had a basic understanding of their responsibilities under the MCA and DoLS, they did not always put this knowledge into practice.

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, and whether any conditions on authorisations to deprive a person of their liberty were being met. The provider had submitted DoLS applications for everyone regardless of their capacity and where MCAs were completed they were not specific to the decision.

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

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

There were inconsistencies in the support that staff received through supervision and appraisals. The provider's policy stated that staff should have supervision at least six times a year. From the records we reviewed, only four members of staff had received supervisions this year. One member of staff had not had received any supervision, another one had not had supervision since December, a third since July 2016, and a fourth since September 2016. When reviewing the records we noted the discussions taken place outlined what staff weren't doing or what they were required to do. These were not positive discussions about performance and standards or about what support might be required to attain the expected standard of care.

We recommend that the registered provider follow their policy in relation to supervision to ensure staff received appropriate support and supervision for their role.

It was not easy for people living with dementia or who had impaired sight to find their rooms or their way around the service as all areas looked the same. Sections of the service were not easily identifiable; walls and doors were painted the same colour. Although there were signs on the doors describing rooms there were no visual aids to help people. People who were living with dementia may need help with finding and recognising their bedrooms. Some people had memory boxes that contained items that were familiar so they could recognise their rooms, whilst others did not. An environment decorated in contrasting colours may help people's orientation and support their independence.

We recommend that the provider researches and implements relevant guidance on how to make environments used by people who live with dementia more 'dementia friendly'.

The registered provider ensured staff had the skills and experience which were necessary to carry out their responsibilities. The provider developed the knowledge and skills of new staff by supporting them to complete the Care Certificate. The Care Certificate is an identified set of standards that health and social care workers adhere to in their daily working life. Training was delivered in different formats such as online learning, DVDs, training courses and certificated learning workbooks. All new staff attended induction training and shadowed an experienced member of staff until they were competent to carry out their role.

Staff confirmed they had received training and that they had sufficient knowledge to enable them to carry out their role. Staff told us, "I couldn't start doing the job until I had completed all my e-learning. I have also had moving and handling training, infection control and safeguarding to name a few. I am waiting for training on dementia and death and dying." Staff provided us with information about people's care and support needs and how they met these. We observed staff when they were helping people to move around the home or assisting them when transferring from a wheelchair to a chair and this was done effectively and according to best practice. This showed staff were using their training and knowledge to carry out this task.

The provider's records confirmed that all staff had received mandatory training including safeguarding adults; moving and handling, dementia, mental health awareness, positive behaviour, administration of medicines, health and safety, infection prevention and control, the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS).

We asked people whether they liked the food at the service. One person told us, "The food is ok." Another person told us, "You never go hungry here." We observed lunch being served. People were able to choose where they would like to sit. However the menus on display and on the table did not reflect what was being offered to people. We observed staff showing people two plated-up meals in order that they could visually see what was on offer and make their own choice. However some people were offered these whilst others were given the meal that the previous person did not want. There was one occasion where staff placed food

in front of the person but they were unable to reach the food to eat independently. The person managed to take a spoonful of food, however gave up and had to wait for a member of staff to assist them further. We raised this with the provider who told us that this would be addressed.

People were supported to have their nutrition and hydration needs met. Care records contained information about people's food likes and dislikes and preferences. We saw information displayed in the kitchen about people who had special dietary requirements such as diabetes, and health conditions that required pureed or softened food. Staff confirmed that drinks and snacks were available at any time.

We saw staff assisting people to get ready for lunch, at a slow and steady pace, they were not rushed. People who were able to eat independently were prompted and encouraged to do so. People who were unable to eat independently were supported by a member of staff, except in the case above where someone was unable to reach their food. There was one occasion where one person was sat with her meal in front of her and appeared not to know quite what to do with it. A staff member helped them and talked to them throughout the time they were supporting this person. Throughout the day people were encouraged to take regular drinks, to ensure that people were kept hydrated.

Nutritional assessments were carried out as part of the initial assessments when people moved into the service. These showed if people had specialist dietary needs. People's weights were recorded and where needed advice was sought from the relevant health care professional.

People had access to health and social care professionals. One person told us, "If I am not feeling well I can see the doctor." All people living at the home had access to the GP, chiropodist, dentist and district nurse. Appointments were made with other healthcare professionals as and when required. Any visits made by healthcare professionals were documented and any guidance was acted upon. We did raise a concern with one person's who dental needs were not being met. The provider informed us that they would address this.

Requires Improvement

Is the service caring?

Our findings

People were not consistently treated with dignity and respect. There was a strong smell of urine in people's rooms and in the corridor outside rooms that people had to endure. No consideration had been given to people having to smell this. Staff were not always listening to what people wanted. One person was offered lunch by staff on 10 occasions. On each occasion the person told staff that they did not want the lunch however staff ignored this and the person ended up shouting at staff to be heard. One person's personal care was provided in their room however there were no curtains in their room to protect their dignity. Some rooms at the service were bare to the point that you would not know a person lived in them. Since the inspection we were told that changes were being made and families were being contacted to try to offer people more pleasant and personalised rooms.

Where people needed to wear dentures, they did not always receive person centred care. One person told us how it made them feel not have their dentures. We reviewed this person's care plan and noted that the dentist had visited in January 2017 but nothing had had been done since. We raised this issue with the provider who informed us that the matter was an ongoing issue which they would review. The person informed us that whilst they are without dentures they are restricted to the type of food they could eat, at present they have to eat pureed food.

The lack of dignity and respect shown towards people was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were aspects of dignity and privacy that were maintained with people. People did tell us that staff treated them with respect. One person told us, "They are very good; they help me get washed and dressed in the morning." We observed that staff knocked on doors and announced themselves before entering people's rooms. One staff member was very discreet with one person who wished to go to the toilet. They asked if they would like to be accompanied, which the person agreed to.

People had the opportunity to make choices around other aspects of care including what to wear and activities they would like to participate in. One person told us, "I tell them what I want to do and they will listen to that, like I tell them what I want to wear in the mornings and they get it out for me." In one person's care plan it stated, 'Do nails once a week and I like to wear makeup'. We saw that both of these had been done. Some people's rooms were personalised with their own furniture and personal items so that they are surrounded by things that were familiar to them.

We observed that individual staff cared about the people living at the home, but the care provided was task orientated. People were well groomed, clean, they had access to sufficient food and drink and staff supported them with their personal care. However as reported in the key area of 'safe' staff did not always have time beyond these tasks to spend time interacting with people. The staff did know people's care and support needs.

Staff approached people with kindness and compassion. One person told us, "They take good care of me

here." Another person told us, "They are very good to me." Staff called people by their preferred names or by terms of endearment such as, "Sweetie." A member of staff said to one person, "Hello lovely, how are you." A staff member commented on the person saying, "You look wonderful" which clearly pleased the person.

When staff did support people at the home at each stage they checked that the person was happy with what was being done. Staff spoke to people in a respectful and friendly manner. On one occasion a staff member was walking with a person down the corridor and they gently tucked the person's hair back so they could see properly.

The atmosphere in the home was calm and relaxed during our inspection. Staff talked to people in a calm, patient way, using eye contact and repeating information where people needed it. People were happy and laughing whilst enjoying being in the company of staff. We observed staff dancing in front of people to the music in a cheerful way. Staff were seen gently waking people who were dozing to offer them a cup of tea.

People were supported by staff that knew them. Staff were able to talk with ease about people, their likes, dislikes, past lives and interests as well as the care and support they needed. Information was recorded in people's plans about the way they would like to be spoken to and how they would react to questions or situations. Staff knew people's personal and social needs and preferences from reading their care records and getting to know them.

Relatives and friends were encouraged to visit and maintain relationships with people. Staff supported people to visit their relative's homes. Each person had detailed information about people who were important in their lives.

Requires Improvement

Is the service responsive?

Our findings

Pre-assessments of people needs were undertaken before they moved in however; these were not always used effectively in determining whether their needs could be met. There were a number of people living at the home with mental health issues and challenging behaviour and therefore required a higher level of care and support. As a consequence one person has been given notice to leave as the staff were unable to continue to meet their needs.

There was a risk that staff were not providing the most appropriate care to people. Where a particular behaviour had been identified there was not always detailed guidance for staff on how best to support the person. One person had displayed aggression at times, there were no behaviour plans in place or information on what interventions had been tried to support the person. Where one to one support was provided, the only distraction technique we observed being used was to ask the person if they wanted a cup of tea. There was no information about how to manage different situation or their behaviour. Care records did not reflect up to date information regarding people's care or support needs which meant new or agency staff who did not know people might not be working to the most up to date information.

We found there was no physical stimulation around the home for people that would provide them with something to do during the day when organised activities were not happening. There were no areas in the home that could create sensations to assist people living with dementia, sensory impairment or complex needs with relaxation.

An activity programme was in place, but this was not person-centred. It consisted of bingo, exercise, board games, arts and crafts. It did not take into account people's interests. We also noted that some people's capabilities were limited due to living with dementia and this also had not been taken into account when organising activities. We observed an activity taking place and the majority of the people who took part appeared to be enjoying it. We did not see any one to one activities taking place, which would provide social interaction and reduced isolation to people who remained in their rooms or who did not wish to participate in group activities.

We recommend that the provider finds out about people's preferred activities, hobbies and interests and ensures that enough activity is provided to meet people's individual wishes and needs to reduce social isolation.

There were some aspects to the care plans that were detailed. People's care had a description of their medical history, moving and handling, sleep routine and how people needed and wanted to be supported. There were examples where the person's needs had been identified and care was provided that met their needs.

People were aware of the complaints system and told us that they knew what to do if they needed to make a complaint. One person told us, "I would tell staff if I was unhappy." People could voice their opinion about the home. For example, discussing issues with staff, or the registered manager. We looked at the provider's

complaints policy and procedure which was displayed at key points around the home. We reviewed the complaints log and noted there were six complaints about the home in the last twelve months and were dealt with in a timely and appropriate manner.

Requires Improvement

Is the service well-led?

Our findings

People spoke positively about management at the home. One person told us, "Both the staff and the manager are very good." Despite people's positive comments we found that the provider and registered manager had failed to take timely action to assess the quality of the service and make necessary improvements.

Since this inspection we have been informed that management and provider oversight arrangements have been changed and a new manager has started to improve this service and they will apply to register with the commission.

At our last inspection on 18 May 2016, we identified concerns relating to care plan records and practices followed by staff. We had made a recommendation to the provider to improve the care records and continue to monitor staff to ensure procedures were followed. During this inspection, although we found that some improvements had been made, we found new risks to people, this demonstrated that the systems in place were not robust enough to protect people from harm. We have also identified a number of breaches some of which were similar to the breaches identified during our previous inspection in 2015. This demonstrated that the provider and registered manager had not made improvements in a timely way, sustained improvements that were made or monitored that people were consistently receiving a safe and personalised service at all times.

Although policies and procedures were in place it was clear that they were not always put into practice. Staff and management did not have a clear working knowledge of the current changes in legislation to protect people's rights and freedom. Mental capacity assessments had not been fully completed in accordance with current legislation. Staff did not always follow best practices which put people at risk of harm.

The provider did not have effective systems in place to monitor the quality of care and support that people received. There were a number of systems in place to monitor and review the delivery of care. We saw there were various audits carried out such as care plans, medicine administration records, health and safety, room maintenance and housekeeping. However we noted that these audits were not effective in identifying shortfalls or poor practices including the lack of MCAs specific to the decisions and the environment not being maintained appropriately.

Staff were not given the opportunity to be involved in the decisions about the home or discuss areas for improvement. There were no staff meetings held where staff could discuss a variety of topics or good practice or contribute ideas. The compliance manager told us that no staff meetings had taken place, only the daily handover which all (or certainly the majority of) staff were meant to attend. These meetings discussed residents only; no other topics. In an internal audit, this was identified as a concern so the action taken was for only the seniors to have handover and the information written on a handover sheet and shared with staff. Staff would have a separate staff meeting on a monthly basis. We noted that this meeting had not taken place.

Staff told us that they completed a handover sheet after each shift which relayed changes to people's needs. We looked at these sheets and saw, for example, information related to a change in medication, healthcare appointments and messages to staff. Daily records were completed to record support provided to each person; however these were written in a task orientated way. There was no information about people's well-being, interactions, activities or mood, providing a picture of the person's day and highlighting any issues. This showed that although there was up to date information about the support provided, the information was not person- centred which would enable staff to monitor any issues that might arise.

On occasions derogatory words had been recorded when describing people or what care staff should provide. In one person's care plan, whose behaviour was challenging to the service, staff had been given instructions to tell the person 'God is watching you'. This meant that staff had been instructed to talk to somebody in a way that reflected their religious beliefs. Their religious views were used inappropriately to develop their care plan, used as a means to control their behaviour with the possible effect of instilling fear in them. In another person's care plan, to assist staff when providing personal care, it stated 'may benefit from a firm hand'. This meant that inappropriate methods may be used by staff to control and manage the person's behaviour because inaccurate recording of their care was included in their care plan. We raised this immediately with the provider and before we left the service this had been removed.

Failure to assess, monitor and improve the quality and safety of the service, not identifying and mitigating risks and failing to maintain accurate , contemporaneous records is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Since the inspection the provider has sent in a detailed action plan which describes what action they have taken and continue to take to address the concerns identified. We have also met with the provider's representative who informed us of changes to the management at the home and what action had been taken.

People were involved in how the service was run in a number of ways. There were 'residents' meetings for people to provide feedback about the service. We saw minutes of the meeting where people discussed issues regarding, food, meal times and care provided. A questionnaire had been sent out to people to obtain their views about the service provided. The analysis of the results had not yet been completed.

People and staff told us that the management team were approachable. There was an open door policy as we saw people come into the office to share information, asks questions or if they required assistance. One person spent quite a long time with staff.

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. The registered manager had informed the CQC of significant events including significant incidents and safeguarding concerns. Records were accurate and kept securely.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The provider had not ensured that dignity and respect was shown towards people.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider was failing to meet the requirements of the Mental Capacity Act 2005.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not ensured that safe care and treatment was always provided

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The provider had failed to ensure that the premises were well maintained.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to assess, monitor and improve the quality and safety of the service. They had failed to identify and mitigate risks

	and failed to maintain accurate , contemporaneous records.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to ensure there were sufficient numbers of staff deployed to meet people's needs safely.