Bupa Care Homes (CFChomes) Limited

Tadworth Grove Residential and Nursing Home

Inspection report

The Avenue
Tadworth
Nr Epsom
Surrey
KT20 5AT

Tel: 01737813695

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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 unannounced inspection was carried out on 29 January 2016. Tadworth Grove Residential and Nursing Home provides residential care for people living with dementia in Pine unit and nursing care in Willow unit. It is registered to accommodate up to 71 people. On the day of our inspection 48 people lived at the service. The accommodation is arranged over three floors that included people with nursing needs on Willow and people who lived with dementia on Pine unit.

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

The last inspection of this service was on the 15 July 2015 where we found breaches around the safety of people who lived at the service. People's call bells were not being answered quickly and we were able to access the building without staff being aware that we were there. We found on this inspection that there were still concerns around people's safety. We found on the inspection on the 15 July 2015 that people were not always treated with dignity and respect. This was still a concern on this inspection.

There were not always enough staff deployed in the service to consistently meet people's needs. People were left on their own for long periods of time without the support of staff. There were times where there were less than the required staff needed to care for people safely. Risk assessments for people were not always followed by staff. Incidents and accidents were not always recorded and there was not always evidence of any learning from that had occurred to reduce the risk of falls and incidents in the service.

Medicines were not always being safely stored and there was a risk that people did not receive their medicines when they needed them. Medicines Administration Records (MARs) for people were signed for appropriately and all medicines were disposed of safely by staff.

Staff had good knowledge of safeguarding adults procedures and what to do if they suspected any type of abuse. There were clear policies in place to guide staff should they have any concerns.

Before staff started work appropriate recruitment checks had been undertaken.

Staff at the service were not always caring and did not always treat people with dignity. There were times where people were ignored for periods of time throughout the day and people's dignity was not always maintained. We did see times when staff were caring and considerate to people. People were not always consulted about the care they wanted.

People's rights were not always met under the Mental Capacity Act 2005 (MCA), and the Deprivation of

Liberty Safeguards (DoLS). 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 them from harm. Assessments had not always been completed specific to the decision that needed to be made around people's capacity. DoLS applications had been submitted to the local authority but we were unable to see what this related to.

People were not always receiving care from staff who had received appropriate training. There was a risk that people were receiving care from staff who were not up to date with their clinical training, including wound care and end of life care.

Staff competencies were not always assessed with staff as they did not always have regular supervision with their manager. However some staff did have regular supervisions and found these useful.

The environment did not always meet the needs of the people, particularly those who were living with dementia.

People's preferences were not consistently being sought by staff. The service was not always responsive to people's needs. There was information missing in people's care plans around the support they needed. There was a lack of detail around care for people living with dementia, care for people with diabetes and wound care.

Communication was not always shared with staff about changes in people's needs which put people at risk.

There were not enough meaningful activities on offer specific to the needs of people living at the service. There were long periods of time where people had no meaningful engagement with staff, particularly people who lived with dementia. Other people told us that they enjoyed the activities in the service.

Relatives felt that the management was ineffective. There was not always consistent and obvious leadership in the service. Not all staff received annual appraisals to discuss their performance or training and development needs and some staff told us they didn't feel valued. However some staff told us that the registered manager was approachable and supportive.

There were not effective systems in place to assess and monitor the quality of the service. Audits and surveys had been undertaken with people but had not always been used to improve the quality of care for people. Records were not always completed accurately and were not always complete. 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 not informed the CQC of significant events in a timely way.

In the event of an emergency, such as the building being flooded or a fire, there was a service contingency plan which detailed what staff needed to do to protect people and make them safe.

Although people had access to a range of health care professionals guidance provided was not always followed by staff.

There was a complaints procedure in place for people to access however complaints were not appropriately responded to.

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

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

There were not always enough staff deployed at the service to meet people's needs.

People were not always safe because risks of harm had not always been managed.

There was a risk that people were not receiving their medicines on time and as prescribed. Medicines were not always stored safely. .

People told us they felt safe and staff understood what abuse was and knew how to report it appropriately if they needed to.

Safe recruitment practice was followed.

Is the service effective?

Inadequate

The service was not effective.

People's human rights were at risk because the provider had not followed the requirements of the Mental Capacity Act 2005 and people's capacity assessments were not always completed appropriately.

Staff did not always have the most up to date training to be able to meet people's needs.

Adaptations to the environment were not always effective at meeting the needs of people living with dementia.

People were not always provided with nutritious food and drink and people's weight and nutrition was not always monitored.

People did not always have access to healthcare services to maintain good health.

Is the service caring?

Requires Improvement

The service was not always caring.

People were not always treated with kindness and compassion and their dignity was not always respected. We did see occasions where staff were kind and considerate to people.

People and relatives were not always consulted around preferences of care.

People did tell us that staff were kind and caring towards them.

Is the service responsive?

Inadequate

The service was not responsive to people's needs.

There was not always the most up to date information available to staff about people's care needs. Changes in people's support needs were not always met.

There were not enough activities that suited everybody's individual needs however some people told us they enjoyed activities in the service.

Complaints were not always dealt with appropriately and to people's satisfaction.

Is the service well-led?

Inadequate

The service was not well-led.

There were not appropriate systems in place to monitor the safety
and quality of the service. Records were not always complete and accurate.

Where people's views were gained these were not used to improve the quality of the service.

Staff told us they did not always feel valued. Some staff did say that the manager was approachable.

Notifications of significant events in the service had not been made appropriately to CQC.

Tadworth Grove Residential and Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned in response to concerns raised with us, and 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 29 January 2016. The inspection team consisted of three inspectors and a specialist nursing advisor. The nurse specialised in care for people living with dementia.

Prior to the inspection we reviewed all 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. As we undertook this inspection due to concerns we had we did not ask the provider to complete a Provider Information Return (PIR). 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 looked through notifications that had been sent to us by the registered manager. A notification is information about important events which the provider is required to tell us about by law.

During our inspection we spoke with the registered manager, the regional manager, nine people that used the service, six visitors, 16 members of staff and one health care professional. We looked at eight care plans, six recruitment files for staff, medicine administration records, supervision records for staff, and mental capacity assessments for people who used the service. We looked at records that related to the management of the service. This included minutes of staff meetings and audits of the service. We observed care being provided throughout the day including during a meal time.

Inadequate

Is the service safe?

Our findings

There were mixed responses from people and relatives around whether there were enough staff to meet their needs. Comments included "Staff are around if you need them (but I don't have to call on them too often)", "As far as I can see there are plenty of staff" and "As far as I can see there are plenty of staff." However comments from relatives included "I come here twice a day and I think they are understaffed, you can ring the call bell and wait for ages" and "After meals I often see (people) left just outside the lift waiting for someone to take them to their rooms."

People's needs were not always met because there were not enough staff deployed at the service. People were left without support from staff when they needed it. At 9.25 we brought to the registered manager's attention that one person on the top floor of Pine unit had been calling out for a period of 30 minutes We found a member of staff to assist them. There were no staff on duty on this floor, as all staff were. on the ground floor. At 11.30 we found that there was only one member of staff covering two floors on Pine. One person was in bed on the first floor and there was no member of staff on the floor to supervise or support this person. The member of staff downstairs told us that the second carer was on their break and that the third member of staff was helping out at Willow. We brought this to the registered manager's attention again however they did not feed back to us how this had been addressed.

The number of staff on duty did not reflect the staffing rota . On the first floor on Willow we were told by the registered manager that there should have been four members of care staff and one nurse. We later found out that there had only been three carers on duty as one member of staff had called in sick. During the day it was difficult to find staff on the first floor and we observed that people had to wait for support from staff. One person called out several times over a period of 10 minutes, during this time the person was attempting to try and stand despite needing support from staff to do so. We found a member of staff and asked them to support the person to prevent an incident from occurring. In the afternoon we overheard one member of staff say after not being able to find a colleague "Everyone has gone on a break at the same time." This left 16 people with high support needs being supported by one member of staff.

We looked at the rotas over a four week period and found that there were times that there were less than the required numbers of staff deployed. On the Pine unit we were told by the registered manager that three members of staff were needed in the morning. According to the rotas there were only two staff working. On the Willow unit we were told that nine carers and two nurses were required during the day. According to the rotas on most days there was one less care staff needed in the afternoon. There were always two nurses on duty where needed.

We asked staff whether they were enough staff to meet people's needs. One told us "I can't say if we have enough staff or not. We have been really busy today so some people have had to wait, other times it can be really quiet. I'm happy with the staffing levels, but sometimes staff phone in sick very late so the home cannot cover quickly." Another member of staff told us "Sometimes we are short of staff. Sometimes we can't meet everyone's needs at once and people have to wait for support. Sometimes staff call in sick so it is hard to get cover – this is the main reason I feel we are short of staff. We should have three carers plus the

nurse on this floor in the afternoon, but the third carer phoned in sick today."

There were not always sufficient numbers of staff deployed around the service to ensure that people's care and treatment needs were being met. This is a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's safety could not be assured because not all identified risks of harm were appropriately managed. There were people at the service who smoked, although there were risk assessments around this staff were not always ensuring that people were wearing the appropriate protective fire aprons when smoking which put people at risk of their clothes setting alight. We found that accidents and incidents were not always recorded and there was no evidence to show what action had been taken to reduce the risk of falls and incidents for individuals. Relatives and a visiting health care professional informed us of significant falls that people had that had not been recorded as an incident. One person (who was found by staff) was taken to hospital as a result of an injury that occurred at the service. The person was found to have broken their leg however there was no accident/incident report completed. We saw from notes of a staff meeting that another person was found on the floor with an injury to their head. This had not been recorded on the accident and injury file. There was no evidence to show what action had been taken to try and reduce the risks of these accidents from occurring.

People were not always protected from the risk of harm. This is a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Other risks had been assessed and managed appropriately to keep people safe. This included the management of bed rails, skin care and personal care. Risk assessments were also in place for identified risks such as malnutrition and choking with clear guidelines on the action that should be followed by staff.

People's medicines were not always administered safely. On the day of the inspection there was an agency nurse was administering morning medicines to people. At 11.30 the morning medication round had still not finished even though it had started at 9.00am. It was the agency nurse's first time working at the service and they were aware they were taking a long time but were fearful of making a mistake as they did not know the people living at the service and were not familiar with the drugs trolley. For people who required their medicines spaced evenly throughout the day for example people who had Parkinsons medicine there was no way of knowing what time the medicines had been given as they did not write the exact time on the MAR sheet. This could have impacted on the health and wellbeing of people if the next dose was given too soon after the first. The start and finish times of medicines rounds were not always recorded therefore making it difficult to know when the person last had their medicines.

There was a risk that people were not receiving their medicines when they needed. There were no PRN (as required) guidelines for staff for people that lived on Willow unit. There were people who lived on Willow who had difficulty communicating when they were in pain and there was no guidance for staff around this. Topical cream medicine charts had not consistently been completed since 5th January 2016 so there was no way of knowing if people were having the cream that they had been prescribed. There was not always detail around where the cream needed to be applied and the frequency needed.

There was times when medicines were not being kept safely and there was a risk that people could access the medicines. During our inspection the clinical room on the second floor was left open for most of the day. Staff did not have assurances that the medicines were being kept at the correct temperature to maintain its effectiveness. The last recording of the fridge temperature was on the 15 January 2016.

People were not always being administered medicines in a safe way. This is a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were areas where medicine was being administered safely. There were no gaps in the Medication Administration Records (MAR) reviewed and there was guidance for staff around PRN medicines on Pine unit. All of the MAR charts had up to date photographs of people and there was detail around allergies that people had.

People told us they felt safe with the staff. One person said "I feel safe everywhere here," Another person said "The carers are fine both day and night" whilst another person said "Staff are very good, they are not rough with me and are very nice." One relative said "It has made a difference to my (family member's) life since being here. We were worried about how staff would treat (the family member) the staff have been fantastic here." Staff had knowledge of safeguarding adults procedures and what to do if they suspected any type of abuse. One member of staff said "Straight away I would tell the nurse in charge then the manager, if they didn't do anything then I would tell head office, the social services or CQC." There was a Safeguarding Adults policy and staff had received training regarding this. There were flowcharts in the offices to guide staff and people about what they needed to do if they suspected abuse.

People would be safe in the event of an emergency because appropriate plans were in place. In the event of an emergency, such as the building being flooded or a fire, there was a service contingency plan which detailed what staff needed to do to protect people and keep them safe. There were personal evacuation plans for each person that were updated regularly and a copy was kept in the reception area so that it was easily accessible.

In other areas people's safety was maintained as appropriate checks were carried out on staff to ensure they were suitable to support the people that lived at the service. Staff recruitment files contained a check list of documents that had been obtained before each person started work. Documents included records of any cautions or convictions, evidence of their conduct in their previous employment, evidence of the person's identity and full employment history. This gave assurances to the registered manager that only suitable staff were recruited.

Inadequate

Is the service effective?

Our findings

People's human rights could be affected because the requirements of the Mental Capacity Act (MCA) and Deprivation of Liberty (DoLS) were not always followed. 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. Staff didn't always understand their responsibilities under the MCA. Staff were not able to describe what MCA meant. One member of staff told us that it was about "People's choices" and another member of staff said "We always tell (people) what we are doing and wait for a response." There was a lack understanding from staff around knowing the person's state of mind rather then it being about people making choices. Staff did not have an understanding of how people had the capacity to make decisions about their care.

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 not enough evidence of mental capacity assessments specific to particular decisions that needed to be made. |For example, one person had a bed rail however there was no assessment around whether they had the capacity to agree to having a bed rail. Where a best interest decision had been recorded there was not always an appropriate assessment in relation to this decision or a signature from the lasting power of attorney. For example one person was on covert medication and there was no evidence around why it was in their best interest to have this. There were key pads on the Pine unit but there were a lack of mental capacity assessments for people around this on why people were not able to leave. There was not always enough detail about why it was in someone's best interest to restrict them of their liberty where necessary.

We were told by the registered manager that several applications had been submitted to the local authority however they were unable to tell us what this related to or provide us with evidence of the applications. We were unable to establish if requirements of DoLS were being applied for where necessary and in people's best interests. This is a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People did not always receive care from staff that had the training and experience to meet their needs. We found several examples of wounds not being managed in an effective way. There was little evidence of staff checking and recording people's wounds on a regular basis. One person was on a pressure mattress to reduce the risk of their wound deteriorating, there was no evidence that the mattress was set at the correct level and staff were unable to confirm whether it was or not. Another person had a catheter and there was no information in the care plan on what size had been used, when it had been inserted and when it was due to be changed. Staff were unable to confirm this which put a risk that the person's catheter may not be changed when needed. Where people were being moved with hoists there was no information for staff on what size sling was needed. There was risk that people were being moved with the wrong sized sling. Another relative had identified that their family member had thrush in their mouth which had not been identified by staff. This had been confirmed by a visiting health care professional who provided advice to staff on how best to deal with this.

Staff consulted health care professionals however they did not always adhere to the advice that had been given, which put people at risk. One health care professional told us that they had reminded staff about the need to elevate a persons leg to reduce the risk of swelling for a period of a week and this still was not being done. We saw on the day of the inspection that the person's leg was still not elevated and was very swollen. We asked a member of staff to address this. Staff could not be sure that they were acting on the correct guidance. We asked them why one person's medication had changed and they were unable to tell us. They could not locate the information from the GP as to why the person's prescription had changed. One health care professional told us that one person had not had access to a chiropodist. They said that their feet needed urgent attention and that they had been reminding staff about this for over a week. One senior clinical member of staff said that they needed to find another chiropodist as the one they used had left the service. On the day of the inspection this still had not been done.

There was a risk that people received care from staff that had not had the most up to date guidance and training. We found that the clinical training was not always up to date with nursing staff. There was no evidence of when nurses had wound care or end life care training which reflected the practices around wound care and end of life care we saw on the day. Staff were not always kept up to date with the service mandatory training. Only 50% of staff had received dementia training, 49% were up to date with safeguarding training and 56% were up to date with moving and handling. None of the staff had received training around behaviours that may be challenging or falls training.

People were not always cared for by staff that were competency assessed in relation to the work that they carried out. At the time of our inspection there was no clinical lead at the service who was undertaking assessments of the nurses' skills. We asked for evidence of when the nursing team last had one to one or group supervisions. We were told by the registered manager that these had not taken place. Other staff had not undergone one to one supervisions which included housekeeping staff and administration staff. However the care staff had started having one to one supervisions with the registered manager. One member of staff told us "I have supervisions every three months; we talk about training and what I want to do."

Not all staff received annual appraisals to discuss their performance over the year and further training and development needs. The registered manager told us that appraisals had not taken place. They were not able to provide us with a schedule of planned appraisals.

Staff were not always suitably supported, competent and skilled in their role. This is a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The environment did not always meet the individual needs of people living at the service. The provider undertook an assessment of the dementia unit to ensure that the environment met the needs of people who lived there. The report indicated that there was need for improvements to the building including the widening of doors. The registered manager told us that they were no longer taking in people whose primary needs were dementia. They told us "I don't feel the needs of people there (on Pine) are being met, the lighting isn't good and the layout of the building needs improvement." There were some memory boxes outside people's rooms to help orientate them but these were not always filled with items about the person so they were not always helpful to people. There were no particular areas of interest or sensory items for people around the service to keep them occupied or engaged.

The service was not always suitable for purpose of assisting people living with dementia. This is a breach of regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People at risk of dehydration or malnutrition did not always have effective systems in place to support them. One person had lost 4.8kg since December 2015. Although their weight loss was noted in their care plan there was no investigation into why this person may have lost weight other than to recommend to staff that they gave them additional snacks between meals. There was no evidence of advice being sought from the GP or dietician. Another person was on a pureed diet. They had lost a significant amount of weight and told us they did not enjoy eating pureed food. They told us (and the staff confirmed) that no one had talked to them about what other options of food were available or what could be done to help them find something they liked to eat. They said "They have just gone with what the SALT (Speech and Lanuguage Therapist) team have said." Another person had been losing weight and this had not been addressed by staff by contacting any health care professionals to seek advice. There was no guidance to staff on how best to help the person. Where people's weight had been taken staff were not always completing the nutritional tools to assess whether people's weight was at a healthy range. One relative told us "(Their family member) is on a soft diet with thickener in their water. (The family member) was also put on fortisip, but wasn't always encouraged to drink it by staff."

The service was not always meeting people's nutritional and hydration needs. This is a breach of regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us that they liked the food that was provided. Comments included "I do get to have curries here which brings back memories (of their childhood); they (staff) always ask if I am happy with the food" and "The food is very nice."

The chef had records of some of the people's individual requirements in relation to their allergies, likes and dislikes and if people required softer food that was easier to swallow. For those people that needed it equipment was provided to help them eat and drink independently, such as plate guards and adapted drinking cups. The chef was aware of people's dietary needs and told us that 'night bites' were available for people if they were hungry through the night. We saw that people were offered a full breakfast if they wanted it and people told us that they enjoyed their lunch on the day.

People did have access to a range of other health care professionals, such as the GP, dietician, SALT team and tissue viability nurses. The GP visited regularly and people had been referred when there were other concerns with their health. On the day of the inspection the GP visited people at the service to assess any needs that they had.

Requires Improvement

Is the service caring?

Our findings

Staff at the service were not always caring. There were times during the inspection where staff were not as supportive to people as they could have been. One person living with dementia kept being told by a member of staff to "Sit down". People living with dementia may not always be able to express their needs to staff and the member of staff did not ask them what they wanted. The person kept getting up, this continued for an hour and it was not until after lunch the person was asked if they needed the toilet. On another occasion one person was calling out for assistance and the registered manager who was on the same floor did not respond to the person or ask a member of staff to assist them. We asked a member of staff if they could assist the person which they did.

We had mixed responses from people and relatives about how caring staff were. One relative told us that the trousers their family member was wearing were still wet around the waist from being washed. They told us that it was the little things that were not done that showed they were not always caring. Another relative told us "The attention to detail is poor here, they'll (staff) change a pad and leave the room without ensuring they (their family member) can reach everything like their call bell and drink."

We observed staff did not always treat people with dignity and respect. One person became unwell whilst they were in the lounge. Staff crowded around the person in full view of everyone but did not consider protecting their dignity by use of a screen or a blanket. We saw from a staff meeting in early Janaury that they had discussed the use of a screen but we didn't see this being used on the day. Another person's dignity was not protected. One person was being assisted to the toilet and the member of staff did not close their door. Another person was receiving their oral hygiene whilst the door to their room was wide open. One relative told us that they found their family member had been left exposed to people in the corridor as staff had not ensured that they had been covered by the bed sheet.

Staff did not always treat people in a caring and dignified way. This is a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Other people at the service told us that staff were caring. Comments included "I have always found (staff) very helpful, I can talk to them, they are friendly and they do try and sit and talk with me", "It's very good here, staff are nice and friendly and kind, they have taken the time to know me" and "Staff treat me as if they know me, they know my support needs and how I like to be cared for." We did observe occasions were staff acted in a caring way. We heard staff and people laugh and chat together and it was clear that staff knew people well. One newer member of staff asked someone what they preferred to be called. Another member of staff looked after a person's pet at home and brought the pet in each day to be with them. Another member of staff told us that they loved working at the service.

We asked staff how they would treat people with respect and dignity. One told us "I don't wash or shower people with the door open; I ensure they are covered when hoisting them in case their clothing moves and I give people choices." Another member of staff said "I always cover people up when giving people personal care."

People's and relatives views around their care were not always sought or recorded by staff. There was little information about people's choices, likes and dislikes. One care plan stated that additional information around the person needed to be sought from the relative. The relative told us that they had not been asked for any additional information about their family member. In one care plan there was no information around how best to communicate with the person. Instead the care record stated that the person was unable to communicate. There was no information in the care plans that we reviewed around what time people preferred to get up or whether they preferred a male of female carer. During lunch the people living on the dementia unit were not offered a visual choice of their meal to help them to make the decision.

People were not always supported at the end of their life to make decisions about what they wanted. Staff did work with the local hospice team around how to support the person to be pain free however the care plan for the person was generic and not detailed around the person's wishes. Other care plans we looked at did not have any information around the care people wanted then they were nearing the end of life. Concerns had been raised to the Local Authority from health care professionals around the end of life care for people at the service.

Inadequate

Is the service responsive?

Our findings

People did not always receive care and support that met their needs. Where a need had been identified there was not always guidance or a detailed care plan for staff to follow. For those people who were prescribed warfarin there was no care plan for staff about moving and handling to minimise the risk of skin damage and bruising, which is important to people who are receiving this type of medicine. There were people at the service who had diabetes however there was no guidance in their care plans around what the safe blood sugar levels were. There was no detail around the signs to look out for should they become unwell. For people who were living with dementia there was not always guidance for staff on how to help reduce people's anxieties or how best to communicate with them. Another person was being fed through a PEG (a medical procedure in which a tube is passed into a patient's stomach through the abdominal wall) and although there was guidance from the dietician on the regime needed there was no guidance for staff on how to look after the site where the feeding tube was inserted.

Care plans were not always up date and therefore did not accurately reflect people's needs. One member of staff told us "The care plans need working on." They told us that they were not as up to date as they would have liked. One person had developed respiratory problems however their care plan stated that there was no problem in this area despite the person being prescribed medicines for this. Another care plan stated that the person had 'no issues with eating and drinking' however this person was on a pureed diet.

Information about people's care was not always shared between staff which put people at risk. Recommendations had been given by a health care professional that one person needed specific mouth care. Although nurses were aware of this guidance, this had not been discussed with the care staff. One person should have been given liquid medicines however three staff gave conflicting information about this. None of them were clear on what the correct procedures were. Meetings between senior staff took place each week that discussed people's needs however there was no evidence that matters discussed were followed up. For example one person fell from their chair and the care plan needed to be updated to reflect that they were no longer able to use that specific chair. We found that there was no reference to this on the care plan.

Activities that were available did not always meet the needs of people. On the day of the inspection there were nine people who lived on the Pine unit. There was no evidence of meaningful activities on offer specific to the needs of people who lived with dementia. There were long periods of time where people had no meaningful engagement with staff. There were no resources to hand to enable spontaneous engagement with people such as objects of interest, books or games. One person told us "We do get bored here, there's nothing much I can do."

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

There was an activities coordinator employed at the service who undertook activities with people who lived on the Willow unit. We saw that people participated in a range of activities that included games, quizzes,

singing, seasonal events and entertainers. On the day of the inspection people participated in a sherry morning which they told us they enjoyed. One person told us "We have lots of entertainment, I've never been bored, there are plenty of things going on."

There was a complaints procedure in place however the registered manager was unable to demonstrate how people's complaints were responded to. Relatives told us that when they had raised a concern they never felt they were listened to by the registered manager. One relative told us "I've made several complaints about (their family members) general care." These complaints were not recorded and the registered manager was unable to tell us how this had been addressed. We saw reference to other complaints in the minutes of staff meetings but these had not been recorded in the complaints folder and there was no evidence that these had been addressed or any learning from them. The registered manager told us that they had not recorded the complaints or how they had been addressed.

As complaints were not always responded to in an appropriate way 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

There was not always consistent and visible leadership around the service. We were told by people's relatives that they did not feel confident in raising their concerns with the registered manager and that they were not always visible. They told us "There is a communication issue with the manager; we feel that if we raise things there would be recriminations for (their family member.) Another relative told us that they asked the registered manager to organise a meeting with relatives and they said this request was refused. One person told us "I'm not sure we have had any meetings." Another relative told us "The manager has never met me; I've tried to make an appointment." We asked the registered manager when they last had a relatives meeting. They told us that since being at the service in April 2015 they had not had any residents or relatives meetings. During the inspection we did not see evidence of the registered manager talking to people and making themselves visible to people or visitors. Staff told us that they did not always feel valued. One member of staff said "I do more than I should do and I never get thanked, I don't feel valued but I love my job."

There were positive comments from relatives about the management of the service. One relative told us "They (management) are listening and making some changes." Another relative told us "The manager is alright, he has an open door policy." Staff told us that they had seen an improvement since our last inspection in July 2015. One told us "Things have improved a lot; (the manager) is a lot better." Another member of staff told us "I feel the manager listens to me" whilst another said "I think the home is well run, if we work as a team it goes smoothly."

Effective management systems were not in place to assess, monitor and improve the quality of service people received. On the day of the inspection we asked the registered manager to provide us with evidence of quality assurance that was undertaken. They told us that they would have to provide this after the inspection as this could not be located on the day. At the end of the inspection we fed back all our concerns to the registered manager who told us that they were not surprised and that a lot of what we had found had been identified by them. However there was no evidence provided to us on the day that work was being undertaken to address the shortfalls. For example in the review of care plans or updated nurses clinical training.

After the inspection we were provided with evidence of audits that took place in October 2015 and December 2015 by the regional team however we were not provided with an action plan to show how shortfalls identified where being addressed. The audits identified the lack of care planning, lack of care notes, the lack of dementia care, the lack of medicine fridge temperature checks and the lack of personal backgrounds in people's care plans. We found that these shortfalls had not been addressed on the day of the inspection.

People's feedback about how to improve the service was not always gained. There had been no residents meetings at the service. Surveys had been undertaken in December 2015 but there was no action plan to address things that needed improvement for example around staff needing to be available for people when needed. There were no systems in place to improve the quality of care for people.

Since the inspection we have been informed that the additional management support has been provided at Tadworth Grove and we have been provided with actions plans to show how shortfalls are being addressed.

Records were not always secure, accurate and were not always complete. We found that one member of staff had written about the care for a person before they had received it. The record stated that they had been washed and had a cup of tea and had been given topical cream. We found that the person was still in bed asleep. Health care professionals' notes were kept in a separate file for each person. We asked to look at one person's notes and it took a member of staff some time to locate the file. The information in the files was loose and not in good order and the information that we needed to find could not be located in the notes. On the second floor the room where the care plans were kept was unlocked for most of the day which gave people an opportunity to gain access to confidential records. The registered manager was unable to locate other records on the day of the inspection that we needed to review.

Appropriate systems were not in place to assess, monitor and improve the quality of the service, and the records were not always complete and accurate. This is a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We could not effectively monitor what was happening in the service. 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 not informed the CQC of significant events. The registered manager has failed to inform us that the lift had been out of service and injuries to people. This is a breach of regulation 18 of the Health and Social Care Act 2008 (Registration) Regulations 2009.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents
Treatment of disease, disorder or injury	The provider had not ensured that all statutory notifications were submitted to the CQC.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect
Treatment of disease, disorder or injury	The provider had not ensured that people were always treated with care and dignity.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs
Treatment of disease, disorder or injury	The provider had not ensured that people's nutritional and hydrations needs were always being met.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment
Treatment of disease, disorder or injury	The provider had not ensured that the environment was suitable for people living at the service.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care
Treatment of disease, disorder or injury	The provider had not ensured that care and treatment was provided that met people's individual and most current needs.

The enforcement action we took:

As this is a breach we issued a warning notice to the registered provider on the 23 February 2016 in relation to Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We have set a timescale of 15 March 2016 by which the registered provider must address this breach.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent
Treatment of disease, disorder or injury	The provider had not ensured that people's consent had been gained and their capacity had been assessed.

The enforcement action we took:

As this is a breach we issued a warning notice to the registered provider on the 23 February 2016 in relation to Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We have set a timescale of 15 March 2016 by which the registered provider must address this breach.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	The provider had not ensured that people were protected from the risk of harm.

The enforcement action we took:

As this is a breach we issued a warning notice to the registered provider on the 23 February 2016 in relation to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We have set a timescale of 2 March 2016 by which the registered provider must address this breach.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints
	The provider had not ensured that people's

Treatment of disease, disorder or injury	complaints were acted on appropriately.

The enforcement action we took:

As this is a breach we issued a warning notice to the registered provider on the 23 February 2016 in relation to Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We have set a timescale of 2 March 2016 by which the registered provider must address this breach.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	The provider had not ensured that there were effective systems to assess and quality assure the service.

The enforcement action we took:

As this is a breach we issued a warning notice to the registered provider on the 23 February 2016 in relation to Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We have set a timescale of 23 March 2016 by which the registered provider must address this breach.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing
Treatment of disease, disorder or injury	The provider had not ensured that there were enough staff deployed to meet people's needs. People who used services were not always cared for by qualified, competent and experienced staff.

The enforcement action we took:

As this is a breach we issued a warning notice to the registered provider on the 23 February 2016 in relation to Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We have set a timescale of 8 March 2016 by which the registered provider must address this breach.