Landmark Care Homes Limited

Crann Mor Nursing Home

Inspection report

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Date of inspection visit:
12 April 2016

Date of publication:
07 June 2016

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

This inspection took place on the 12 April 2016 and was unannounced.

Crann Mor Nursing Home is registered to provide accommodation for persons who require nursing or personal care and who may be living with dementia for a maximum of 24 people. At the time of our inspection there were 21 people living at the service.

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

The premises and equipment used at the service had not been appropriately maintained. We found parts of the environment required repair and cleaning.

The environment did not support the independence of people living with dementia as there was a lack of signage in the key areas of the building including people's bedroom doors.

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 home's safeguarding procedures had not been reviewed since 2013 and had not been updated to include the latest national guidelines.

We recommend that the provider reviews their arrangements to keep people safe in line with current legislation and best practice.

People living at the home may have had their freedom of movement unnecessarily restricted. This was because the provider had not followed the Mental Capacity Act 2005 as decisions made were not specific to individual people.

The provider had failed to ensure people had their assessed needs met by staff. People had not received appropriate support, which included encouragement as well as physical support, when they needed it.

Formal processes for actively involving people in making decisions about their care and treatment were not in place.

We recommend that the processes for the involvement of people in the planning of their care and support in line with good practice are implemented at the home.

The registered provider had not maintained effective systems that were robust to assess, monitor and improve the quality and safety of the home.

People's medicines were managed safely. Records and documentation were in place to ensure that people received their medicines as prescribed by their GP.

There were enough staff deployed to meet people's needs. The provider carried out appropriate checks to help ensure they employed suitable people to work at the home.

Staff received training and regular supervisions that helped them to perform their duties. New staff received induction to the home which included training. However, staff had not always put their learning into practice that would ensure they delivered effective and responsive care to people.

Care records provided information to staff about people's food and nutrition that also included people's food preferences. However, People's meal choices were limited and their preferences and dietary needs were not always taken into account.

People were supported by staff who were kind and friendly. There was a stable staff group employed at the home and this helped build positive relationships with people.

People were supported to attend to their appearance, many ladies were wearing jewellery that complemented their co-ordinated outfits and some gentlemen were freshly shaved.

People told us that they were treated with kindness and that positive, caring relationships had been developed between them and staff.

People told us there were activities at the home that they could choose to join in if they wanted to, although this was an area for improvement. We have made a recommendation about the provision of activities and occupation for people living at the service.

People and their relatives knew how to raise a concern or make a complaint. Compliments had been received from people's relatives.

People expressed satisfaction with the management of the home. One person told us of the registered manager, "I see him every day". A member of staff said of management, "It's very good. The home runs very well". We found, despite people's positive views, this was an area that required improvement.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the 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 consistently safe.

The premises and equipment used at the service had not been appropriately maintained.

The service's safeguarding policy requires review to ensure it is in line with current legislation and best practice.

People's medicines were managed safely.

The provider employed staff to work at the home that had been appropriately vetted.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff had not acted in accordance with the Mental Capacity Act 2005 Deprivation of Liberty Safeguards for people living at the service.

People had not received appropriate support, which may include encouragement as well as physical support, when they needed it.

The environment was not fully suited for people with dementia.

Staff received training and were given the opportunity to meet with their line manager regularly, however, not all learning had been put into practice.

People had involvement from external healthcare professionals as well as staff to support them to remain healthy.

Is the service caring?

Requires Improvement

The service was not consistently caring.

There were no processes for the involvement of people in the planning of their care, support or treatment.

People that were able told us that staff treated them with respect.

Staff were knowledgeable about the people they cared for and were aware of people's individual needs, however, not all staff attended to people's assessed needs as stated in their care plans.

People told us they felt they were looked after by caring staff.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People had not received person centred care and treatment that was appropriate to meet their individual needs.

Information about how to make a complaint was available for people and their relatives.

Relatives told us they knew how to make a complaint should the need ever arise.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

Quality assurance not effective to help to ensure that people were receiving safe care, treatment and support that met their needs.

Staff and relatives felt that this was a well-run service and there was an open culture.

Staff felt they were supported by the registered manager.

Crann Mor Nursing Home

Detailed findings

Background to this inspection

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

This inspection took place on 12 April 2016 and was unannounced. The inspection was undertaken by two inspectors and one specialist advisor who is a specialist in nursing care.

Before the inspection we gathered information about the home by contacting the local and placing authorities. In addition, we reviewed records held by the Care Quality Commission (CQC) which included notifications, complaints and safeguarding concerns. A notification is information about important events which the service is required to send us by law. We also asked 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 used this to inform our planning and inspection.

During our inspection we had discussions with six people who used the service, one relative, five staff and the registered manager. We observed how staff cared for people and worked together. We read care plans for four people, medicine administration records, mental capacity assessments for people, four staff recruitment files, supervision and training records, audits undertaken by the provider and a selection of policies and procedures.

The service was previously operated by the same provider. This was the first inspection since there had been a change in their legal entity in October 2014.

Requires Improvement

Is the service safe?

Our findings

People told us that they thought that the home was clean. One person said, "It's very nice here, lovely view." Another person said, "It's nice and clean". However, we observed some areas that were not clean or well maintained. Some carpets in communal areas had ripples, arms on lounge chairs and pressure relieving cushions were stained and/or covered in food debris and crumbs. Walls in communal areas and some people's bedrooms were marked as were some radiator covers. One of the sluice rooms had stained flooring and the flooring in a toilet was not sealed. This was in contrast to the second sluice room that was clean and well organised. The curtain tracking was coming away from the wall in one person's bedroom and the curtains in another person's room did not fit when closed. The vanity unit around a sink in another person's room was damaged and the carpet was raised in areas.

Some people's bedrooms located on the first floor did not have window restrictors in place. When entering a room that was signed as a bathroom we found that this was a storage room for cleaning materials and staff items. The room was not locked and posed a risk to people as cleaning items were not stored securely.

Checks were undertaken on aspects of the building and equipment to ensure it was safe. These included servicing of the fire alarm, emergency lighting and moving and handling equipment. There was a clear procedure informing staff what to do in the case of a fire and fire practices had taken place. However, we asked to see the fire risk assessment for the home but this was not provided to us. Individual personal evacuation emergency plans (PEEP) had been produced but these lacked information in relation to how people would be evacuated. For example, for one person the PEEP stated they were bedbound with no other information about how to safely evacuate the person from the building. We had a telephone conversation with the local fire and rescue team who informed us that they had seen the fire risk assessment during their previous visit to the service. We were advised by the fire and rescue team that they would revisit the service to check the fire safety at the service.

Water sampling had been conducted and analysed to ensure Legionella was not present. However, the registered manager confirmed that a risk assessment had not been completed or other checks such as running of water in unoccupied rooms. There would be a risk to people contracting Legionella disease if appropriate risk assessments and testing of water were not regularly conducted.

The premises and equipment used at the service had not been appropriately cleaned or maintained and this was in breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Other areas of the home were clean. For example, the first floor shower room. Domestic staff were deployed at the home seven days per week from 8 am until 2pm.

The majority of people who lived at the home lived with dementia. Some people were unable to communicate with us verbally, but others told us they felt safe. We observed that people looked at ease with the staff that were caring for them. Staff confirmed that they had received safeguarding training and

were provided with annual refresher training. Staff were able to describe the various types of abuse. They told us what they would do if they suspected abuse was taking place and that they would speak to the registered manager or nurse on duty. For example, one member of staff said, "I would report to the manager or nurse. If no action was taken I would call the police." Another member of staff told us, "I would report concerns to the local authority if I felt nothing had been done."

A relative told us they believed their family member was safe at the service and that staff treated her well.

The home had a safeguarding policy in place that was available to staff. This policy was last reviewed in January 2013. Therefore it had not incorporated the information and guidance of The Care Act 2014. For example, not all the different types of abuse were included. There was not a copy of the local safeguarding procedures in place at the home. The registered manager told us staff could download this from the website.

We recommend that the provider reviews their arrangements to keep people safe in line with current legislation and best practice.

A relative informed us that there was plenty of staff around the service when they visited. They stated that staff were, "Very welcoming."

We observed that staff were available when people needed assistance with personal care. For people who were being cared for or chose to stay in their rooms we saw that they could call for assistance, as the home had a call bell system in place. However, we observed a number of rooms where people could not reach their call bells as these were beyond their reach. This meant that people may not be able to summon assistance quickly if they needed help.

Hoists were used where needed to ensure that people were moved safely and these had been recently serviced. We observed two staff supporting one person to move safely from a wheelchair to an armchair in the lounge using a hoist. People had moving and handling assessments that described the equipment required to assist them to move safely. We noted that information about the correct sling sizes to be used was not included in the assessments and when we looked at the slings in place at the home we saw that these were not allocated to individual people to use. This meant staff could use the wrong size sling that would pose a risk to people's safety. We discussed this with the senior nurse and registered manager who informed us that this would be rectified.

People that were able told us that they were happy with the numbers of staff on duty. Staff also said that staff levels were sufficient. One staff told us, "We work in pairs and all help each other." We observed that staff were available when people needed assistance with personal care. The registered manager informed us that staffing levels consisted of one nurse and four care staff of a morning and afternoon. During the night we were informed there was one nurse and two care staff. In addition to this dedicated kitchen, domestic and activity staff were employed. We observed these staffing levels during our visit. The registered manager told us that the staffing levels were assessed against the needs of people living at the service. One member of staff told us that the staff team cover staff absences, where this was not possible then agency staff would be used. We saw this information recorded in the business continuity plan provided to us by the registered manager.

The provider carried out appropriate recruitment checks which helped to ensure they employed suitable staff to work at the service. The provider had obtained appropriate records as required to check prospective staff were of good character. These included two written references, proof of the person's identification,

employment history and a check with the Disclosure and Barring Service (DBS). The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services.

People we spoke with told us they always received their medicines when they needed them. One person told us, "The nurse gives me my medicines; I know what they are for because they tell me." One relative told us there had never been any issues in relation to their family member not receiving their medicines.

People's medicines were managed safely. Records and documentation were in place to ensure that the right person received the right medicine at the right time. We observed the medicine round. We saw that the correct procedures was followed when administering medicines and signing the Medication Administration Records (MARs). The MARS sheets were up to date and had been properly completed. Homely remedies are available as required. PRN medicine protocols were in place for those people who required them. This is medicines that were to be given only 'when required.' This showed us that people could be assured they received their medicines as prescribed by their doctor.

Accidents and incidents were looked at on an individual basis and action taken to reduce, where possible, reoccurrence. For example, following an unwitnessed fall one person had moved bedrooms to a room where staff were nearer at hand. The registered manager told us that an overall analysis was not completed. This meant that trends and themes were not identified and information then used to influence the service as a whole.

The interruption to people's care would be minimised in the event of an emergency. The provider had a business continuity plan that detailed the action to be taken to minimise the effects on people and the business in the event of an emergency. For example, fire, flooding and the loss of electricity and gas.

Requires Improvement

Is the service effective?

Our findings

People told us they made choices every day. One person told us, "I make choices about the time I want to go bed and get. I also join in with the activities I want to do." Another person told us, "Staff always ask me if it ok for them to help me with things I cannot manage." A relative told us that their family member made choices. For example, "My X likes to be always in the lounge watching and listening to what is going on. Staff always oblige with X requests."

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

The registered manager told us that a number of people who currently lived at the home were subject to a DoLS application. We looked at a selection of these and found that applications were not specific to the individual. When walking around the home we saw that the doors to the garden and windows in the lounge had locks located at the top of them. A member of staff told us these were in place to stop one person who lived at the home from going outside. This person had a DoLS authorisation in place that allowed for these restrictions to be in place. However, the home had not formally considered how the use of locks impacted on everyone else who lived at the home.

We observed that some people who had a formal diagnosis of dementia had bedrails in place that had the potential to restrict their movements. Bed rail assessments were in place but these did not evidence that less restrictive options had been considered first. Some people had mental capacity assessments completed that stated they lacked capacity to make decisions regarding the use of bedrails. DoLS applications had not been submitted to the local authority in these instances. We also noted that another person's mental capacity assessment had not been completed despite other records stating they lacked capacity to make decisions about their care. This meant that people may have had their freedom of movement unnecessarily restricted. This was not in line with the MCA Code of Conduct.

The registered provider had not ensured staff had acted in accordance with the requirements of the Mental Capacity Act 2005 Deprivation of Liberty Safeguards for people living at the service and this was in breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Despite formal consent processes not being followed in full, we did observe instances when staff checked that people were happy with the support being provided and attempted to gain their consent. For example, before undertaking personal care and when offering drinks. For example, staff offered a person a drink

which they declined. Staff then took this away and offered an alternative. Staff had an understanding of Mental Capacity Act. Staff confirmed that they had received training in this area as part of the dementia training they had completed.

When visiting people who were in their bedrooms one person told us, "I'm very thirsty, mouth awful dry". We noted that the person's lips appeared very dry. The person agreed that we could call staff to request a drink. The person also told us that they had not yet had breakfast (10.30am) and that "Some porridge would be lovely". A member of staff came and they confirmed that the person had not yet had breakfast .A drink was brought to the person and arrangement made for them to have breakfast. This was discussed with the registered manager who advised this should not happen and would be monitored.

We observed during lunchtime in the lounge/dining room. The atmosphere was calm. There was one small dining table with seating for up to four people however no one chose to use this table. People sat in the lounge chairs with small, individual tables by them. Staff brought people their meals, which were individually plated along with a drink. Staff sat next to people and encouraged and supported them to eat. Comments included "Well done" and "That's it, how about trying another mouthful". The mood throughout lunch was relaxed and friendly and people were seen to enjoy the food and each other's company. The meal served was meatballs, potatoes, sprouts and carrots with cheesecake for dessert. People were not offered a choice. The cook informed us that she would make alternative meals if people did not want the meal provided. This limited the choice for people living with dementia who may be unable to ask for an alternative that they would prefer.

We did observe two people who did not receive effective support at lunchtime. One person had their main meal placed in front of them at 12.40 and a fork placed in their hand before staff continued to bring others their meals. At 1.05pm the person had not started to eat their meal and no assistance was offered. At 1.10pm a member of staff placed dessert in front of the person and then left them with the untouched meal still in place to assist another person. The person did not attempt to eat the dessert and picked up a drink. At 1.20pm staff started to remove plates from the room. A member of staff approached the person and asked if they were going to eat their lunch and placed food on the person's fork but left them before assisting the person to eat. At 1.30pm a member of staff removed the person's plate and dessert. This meant that the person went without a meal as staff did not support them. In addition to this when we checked the records for this person staff had recorded that they had eaten all of their meal. We were informed that this was a recording error.

On the second occasion we saw a different person slowly eating their lunch using a spoon. They were given gentle encouragement by a member of staff. Halfway through lunch a member of staff came and sat with the person, took the spoon off them and mashed all the individual food items on their plate together and then proceeded to feed the person. There was no reason for the staff member to do this and further gentle encouragement would have been sufficient.

It was recorded in a care plan for one person that they were a vegetarian. However, we noted on the daily records maintained by staff that this person had been offered meat dishes on the three occasions over the last three days which they had refused. The person was having nutritional supplements, however, there was no evidence that alternative meals had been offered.

The registered provider had failed to ensure people received appropriate support, which may include encouragement as well as physical support, when needed. People's meal choices were limited and their preferences and dietary needs were not taken into account. This was in breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People expressed satisfaction with the meals at the home. Comments from people included, "Food is nice, and we have ice cream after dinner". Another person said, "I remember I enjoyed breakfast but I can't remember what I had". A third person told us, "Food varies but it is generally good." A relative told us they thought the food was ok and that staff knew how their relative liked to have their food.

We observed that drinks were available in communal areas and peoples bedrooms throughout the day. People told us that they always had drinks close by that were within reach and we observed this to be the case with the exception of one person.

Staff received support and training that helped equip them with the skills and knowledge to care for people effectively. New staff received an induction that provided them with information and knowledge relevant to the care sector they were working in. However, this training had not ensured all staff had provided effective care to people at all times. For example, appropriate support for people with their meals and people's oral care needs.

Staff confirmed that they received both individual and group supervision. We saw evidence of this in the staff files we looked at. One member of staff explained, "My induction included three shifts where I shadowed. Then I did moving and handling, fire, food hygiene, safeguarding and infection control training. Plus I have had an update since". With regard to supervision a member of staff said, "X (nurse) often talks to us, daily of a morning. She tells us who needs what, for example, a bath. I have had meetings with X (registered manager) to talk about if I am happy and my progress".

Staff also confirmed that they had received dementia training and that this helped them support people who lived at the home. One member of staff told us, "Dementia training helped me to understand their needs and to help them". We saw evidence of training staff had told us about in the staff files we looked at. We saw staff gave reassurance when they supported people. For example, a member of staff supported a person to the toilet. Discussions and praise was used by the member of staff throughout the process.

People's preferences were recorded but we found little evidence that these influenced the routines within the home. Care records provided information to staff about people's food and nutrition that also included people's food preferences. Specialist diets were catered for and the cook was able to explain which people required these and why. Although this was recorded in people's care plans it was not always used in practice. One person had been assessed by the Speech and Language Therapists (SALT) and we observed staff assisted the person to eat and drink in line with the SALT recommendations. People had been assessed for malnutrition and were being weighed on a regular basis. We saw that a number of people had gained weight since living at the home and the risk of malnutrition had reduced. This showed that for these people, they had received effective support to meet their dietary needs.

Records evidenced that people had access to chiropody, optician, the GP, dieticians and speech and language therapists.

A relative told us that their family member could access all the healthcare professionals when they needed to. We noted that one person had a severe cough. Discussions with the staff and examination of records confirmed that the person had been seen by a GP and medication was prescribed.

We observed that a number of people spent time in the lounge. The chairs in the lounge were positioned all around the edge of the room and did not help promote a sociable atmosphere. Pictorial signs were displayed on toilets and bathrooms to help people orientate independently. However, we saw that the

signage was inconsistent and of poor quality. There was no signage on people's bedroom doors apart from their name to help them find their rooms. People's bedrooms were personalised with possessions such as pictures, bedding and furniture. However, we saw no evidence of anyone's individual or personal interests integrated into the home outside of their rooms. There was little colour contrasting on walls and doors to help aid orientation for people who lived with dementia.

The registered manager informed us that the toilet seats had recently been replaced so that a colour contrast was apparent to help people who lived with dementia. There was also a noticeboard with large print information about the day, month and year that helped people.

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'.

Requires Improvement

Is the service caring?

Our findings

People told us that they were treated with kindness and that positive, caring relationships had been developed. This was confirmed during discussions with a relative. They told us that the staff were very friendly and they knew what they were doing. One person said, "She (pointing to staff) is a lovely person, so kind." and another told us, "We all get on". We observed staff treated people with warmth and affection. For example, a member of staff was heard to say to a person, "You look pretty today". We saw that hugs were comfortably offered if someone asked for one and reassurance given by holding hands or putting an arm around the shoulders too.

People were supported by staff who we observed to be kind and friendly when they interacted with people. There was a stable staff group employed at the home and this helped build positive relationships with people. Staff were able to explain the individual needs of people and people's personal preferences. They told us that they got to know people by spending time and talking with them more than reading care records. One member of staff told us about the previous employment of a person and their family members. As a result, the person became animated, smiling and talking about their past.

People that were able told us that staff treated them with respect and dignity when providing personal care. One person told us, "As you can see we are well looked after". Another person said, "It's quite comfortable here. I get what I need. Staff give me support. We get up when we want". When people needed assistance with personal care we observed that staff did this behind closed doors in bedrooms and bathrooms apart from one instance. A member of staff explained how they promoted privacy. They said, "We knock on doors and ask permission before doing anything, for example, would you like me to wash your face, would you like my help? Most can't say verbally but can in other ways. We make sure we cover up parts of body with towel. That's how we were taught when I did my NVQ". Another member of staff told us, "We never do anything without asking people's permission. For example, we ask if they are ready to have their curtains opened in the morning."

People were supported to attend to their appearance, many ladies were wearing jewellery that complemented their co-ordinated outfits and some gentlemen were freshly shaved.

We spoke to staff about their understanding of treating people who lived with dementia with respect. One explained, "It's knowing how to talk to them, approach them and respond to them. We talk to them about their past, what they did, family life and children. Things that they remember. Show pictures in their rooms".

Where needed, people's care plans included information about personal care that also promoted independence. For example, one person's care plan stated 'X (person) can wash her own face and brush her own teeth after full explanation of the procedure. She can put top clothing on with some assistance'. Staff told us that they promoted independence by encouraging people to do as much as they could for themselves. For example, dressing themselves and washing their bodies as much as they are able to.

Formal processes for actively involving people in making decisions about their care and treatment were not

in place. The registered manager confirmed that neither residents nor relatives meetings were held. One member of staff told us that those people who were able to made decisions about their care and support. Where this was not possible discussions would take place with their relatives or next of kin.

We recommend that the processes for the involvement of people in the planning of their care and support in line with good practice are implemented at the home.

Requires Improvement

Is the service responsive?

Our findings

People that were able to expressed satisfaction with the activities offered. One person who was sitting knitting told us, "There is always something going on". However, we found that the opportunities for people to remain meaningfully occupied during the day were limited to some set entertainments.

Some routines in the home were not responsive or personalised. People were allocated a day for bathing. A member of staff explained, "This is allocated by the office. They do this so they all have bath in the week". People's preferences were recorded but we found little evidence that these influenced the routines within the home.

People's needs were assessed prior to admission to the home and relatives confirmed this. Records showed that assessment included input from other professionals. The registered manager told us they would talk with potential residents and their families so that they had a picture of the person, their health and care needs, personal preferences and cultural needs.

Care plans were generic, rather than personalised and were not always being followed by staff. Care records were easy to access, clear and gave descriptions of people's needs and the support staff should give to meet these. However, there was a lack of information in relation to setting objectives or goals. For example, one person who was on respite care had no information in relation to how and when they would be able to return to their home or how the person would be able to manage their catheter care needs.

One person had a continence issue that this was poorly managed. For example, the person should have two hourly care provided but we noted this person was in their bedroom for four hours without any care being undertaken.

We saw one instance when staff did not respond to a person with consideration. The person was heard to shout out "I want to go home, I want to go home". A member of staff was in hearing distance of the person but did not go and offer reassurance. This was discussed with the registered manager and senior nurse who informed that this was not acceptable practice at the service and it would be addressed.

Staff completed daily records of the care and support that had been given to people. These detailed task based activities such as assistance with personal care, moving and handling and eating. None included information about the person's frame of mind or stimulation that had been provided in relation to support with dementia. There were separate activity records but these were very brief. We noted that care plans had last been reviewed in February 2016. This was not in line with the providers procedures which stated they should be reviewed monthly.

When spending time with people we did observe three people whose teeth were not clean. Their care records stated that staff were to support them with oral care. We were informed that this would be recorded in people's daily notes. We looked at the daily notes for the week prior to our inspection and found no evidence that people had been supported with their oral care. We asked a member of staff about people

who required assistance with oral care. They named four people. These did not include two of the people whose records said staff should support them. This meant that people did not receive effective oral care.

The registered provider had failed to ensure people received care and treatment that was appropriate to meet their individual needs and preferences and was in breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We noted that there was not much physical stimulation such as interactive tactile activities or textured surfaces or objects around the home for people who lived with dementia that would have provided people with something to do during the day when organised activities were not happening. Also, people could not access the garden independently due to locks being in place that were out of reach.

We recommend the provider considers improving meaningful occupation and activities, based on good practice, for people living at the service.

An activity programme was in place that included external entertainers who visited the home on a regular basis. Activities included reminiscence, pet therapy and exercise to music. The home employed activity staff who worked from 10am to 12 noon. On the morning of our inspection we observed people in the lounge sitting reading magazines and having discussions with the activity person. During the afternoon an external entertainer visited and provided gentle exercise which people appeared to enjoy. For example, one person who had earlier appeared withdrawn was seen smiling and joining in.

There were no restrictions when relatives or friends could visit the home. Relatives felt welcomed by staff when they came to visit. One relative told us," I visit every week and I can come at time during the day."

People and their relatives knew how to raise a concern or make a complaint. People who were able, said they felt able to express concerns or would complain without hesitation if they were worried about anything. One relative told us they would talk to the nurse or registered manager but they had not needed to make a complaint. Staff also demonstrated understanding of supporting people to raise concerns. One member of staff explained, "If people are unhappy we talk to them, try and understand reasons. We report concerns to the nurse in charge". Another member of staff told us they would report concerns to the registered manager and would follow the whistle blowing policy if they had concerns about bad practice.

At the entrance of the home, we saw that there was information displayed about how to make comments, complaints or suggestions. It also included the timescale for responding to complaints and the contact details for the local ombudsman and the CQC so that people could make contact if they wished to share information about the service they received.

There was a record of complaints received maintained at the home. Complaints received were clearly recorded and had been addressed with the outcomes recorded.

The home had also received many letters and cards of compliments. For example, relatives thanking staff for "The excellent care" they had provided to their family members.

Requires Improvement

Is the service well-led?

Our findings

Everyone expressed satisfaction with the management of the home. One person said of the registered manager, "I see him every day". A member of staff said of management, "It's very good. The home runs very well". The registered manager was supported by a lead nurse. Both were viewed as supportive. One member of staff said, "It is a very happy atmosphere here. X (lead nurse) is very good". Despite people's positive views of the management of the service we found areas that required improvement.

Systems to assess the quality of the service provided in the home were not effective at driving improvements. The registered manager completed audits of the service but these had not identified areas of the home and equipment that were not clean, required repairs or the lack of signage and stimulation to help people who lived with dementia. The registered manager confirmed that the findings from individual audits were not incorporated into a development plan for the home. As a result, people received an inconsistent service. We noted that issues identified with the water supplied to one bedroom had not been addressed.

A survey to ascertain the views of people, staff and associated professionals had been completed in 2015; however, only one response was received.

The registered provider's quality assurance systems were not effective or robust to assess, monitor and improve the quality and safety of the service and this was a breach of Regulation 17 of the Health and Social Care Act 2008 (regulated Activities) Regulations 2014.

There was a stable staff group at the home, with many of the staff having worked there for a number of years. People who lived at the home, their relatives and staff all told us that they felt this helped people receive a consistent and good service. The registered manager told us that they had undertaken a number of courses in the last 12 months that included fire safety, moving and handling and food safety. All of the training that the registered manager had undertaken was relevant to their role. The registered manager had not undertaken further training to ensure his management skills and knowledge were current and that would ensure the home was consistently well led. When discussing this, the registered manager informed us that he was a member of the Surrey Care Homes Association and that he attended a three monthly meeting where information and ideas were shared.

The registered manager demonstrated some understanding of promoting a positive culture that was person centred, open, inclusive and empowering. He explained, "It's important to talk to staff with dignity. They are the ones doing the important work with residents". Staff confirmed that regular staff meetings were held where they were given the opportunity to share their views on any improvements they felt would benefit people and the smooth running of the home. Records confirmed that staff meetings were held both during the day and of an evening. This enabled all staff to participate in the sharing of information. A member of staff said that the aim of the home was, "To work together to help and do our best for the residents". The registered manager confirmed that there were no formal staff recognition schemes in place but that they were often praised for their good work and that take away meals were sometimes provided as a thank you.

The provider had a set of visions and values for the service and staff we spoke with were aware of these. They told us that the values included "Supporting people to meet their assessed needs and to promote their privacy, dignity and safety at all times." A 'Residents' Charter' was on display at the entrance to the home that informed people that they were entitled to care that was based on the principles of dignity, privacy, choice and consultation. However, we found that despite these very positive aims they were not always being translated into the practices of the home or the care of people.

Staff appeared motivated and told us that the training provided helped them to do their jobs. Staff were aware of the whistleblowing policy and the action that they would take if they had any concerns. The registered manager told us that staff were encouraged to raise their concerns and complaints without fear of recrimination. One member of staff told us they would not hesitate to raise any concerns with the registered manager. At the time of our visit no concerns or complaints had been raised by staff.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care The registered provider had failed to ensure people received care and treatment that was appropriate to meet their needs and preferences.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent The registered provider had not ensured staff had acted in accordance with the requirements of the Mental Capacity Act 2005 Deprivation of Liberty Safeguards for people living at the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs The registered provider had failed to ensure people received appropriate support, which may include encouragement as well as physical support, when needed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The premises and equipment used at the service had not been appropriately cleaned or maintained.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The service had not maintained effective systems that were robust to assess, monitor and improve the quality and safety of the service provided.