Mr & Mrs J Dudhee

St Mary's Lodge Residential Care Home for the Elderly

Inspection report

81-83 Cheam Road
Sutton
Surrey
SM1 2BD

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 2 and 6 September 2016 and was unannounced. At our last inspection in March 2016, we found the provider was in breach of the legal requirements in relation to safe care and treatment and good governance. The provider wrote to us with their action plan stating these issues would be resolved by the end of June 2016.

The care home provides personal care for up to 38 people, some of whom may be living with dementia. At the time of our visit, 33 people were using the service. The home is not fully wheelchair accessible but provides support for people who are independently mobile or who use walking aids. There was a registered manager 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.

At this inspection we found a continuing breach of the regulation which related to safe care and treatment. The provider had not taken sufficient action to improve the safety of the service. Hot water from showers ran at above 44°C, which was above the temperature recommended by the Health and Safety Executive and meant people were at risk of serious injury from scalding. Dangerous chemicals, such as bleach, were not securely locked away and there was a risk of people coming to harm through coming into contact with them. There was a risk of people falling from height through windows, because some windows did not have appropriate restrictors. Some alarm pull cords were placed out of reach so people were not able to call for help in an emergency. There were no assessments or management plans for a number of risks we identified, including hazardous materials kept in the garden and staff carrying trays of hot food and drinks down a narrow communal passage with a step.

In addition, some risk assessments were still not adequate because they were out of date or did not include risks such as those associated with moving and handling and choking on food or drink. Staff told us they took action to reduce risks but these were not included in risk management plans, meaning there was a risk that some staff were not aware of what they needed to do to keep people safe.

We also found a continuing breach of the regulation in relation to good governance. The provider's quality checks were still failing to identify serious risks to people's safety and did not find any of the concerns described in this report. Some health and safety checks were not marked as complete, meaning the provider could not be sure that they had been carried out. The provider had not identified when their checks were not sufficiently thorough, such as their water temperature checks failing to find that showers were too hot, despite these issues arising at our two previous inspections. The registered manager was not always aware of their responsibilities around monitoring the quality of the service, meaning they only carried out some important actions when we told them to do so. However, their checks around medicines management and cleanliness were fit for purpose and helped to ensure people's safety in these areas.

Staff were not always clear about what support people needed to eat, because this was not always in their care plans. We observed two people left without the support they needed for 15 minutes during a meal. Staff did not always take appropriate action when people were losing or gaining significant amounts of weight, where this posed a risk to their health. We found the service was in breach of the regulation in relation to meeting nutritional needs.

Although most people said they felt safe using the service, we found there was no clear procedure in place for people, visitors and staff to report suspected abuse. Staff knew they should report safeguarding concerns to the manager but there was no written information about what to do if staff wanted to escalate their concerns outside of the home.

Staff asked people for their consent before they carried out care tasks or, where people did not have the mental capacity to make decisions for themselves, staff followed the requirements of the Mental Capacity Act (2005). However, we found some misleading or contradictory information in care plans which suggested people did not have the capacity to make decisions when they might have been able to do so.

The provider was meeting their responsibilities under the Deprivation of Liberty Safeguards (DoLS). These safeguards are there to help make sure that people in care homes are looked after in a way that does not inappropriately restrict their freedom.

Some aspects of the home environment were not adapted to fully meet the needs of people who used wheelchairs or were living with dementia.

People felt that staff were caring, although they were not always able to spend time talking to people. Staff were aware of the need to protect people's privacy when they were supporting them with personal care, but people's personal and confidential information was not always kept securely, meaning that there was a risk that people's privacy around their personal information could be compromised.

People had care plans with some detailed information about how staff should care for them, but this was often contradictory, incorrect or out of date and some information was missing. There was therefore a risk that people might not receive the care they needed.

There was equipment in place to help people move around the home and use washing facilities safely. The equipment was checked and serviced regularly to make sure it was safe to use. The home was clean and the provider took appropriate precautions to help protect people from the risks of infection through poor hygiene practices. Medicines were stored appropriately, staff recorded administration of medicines and there were regular checks of medicines stocks to help ensure people received their medicines as prescribed. There were enough staff to care for people safely and the provider carried out appropriate checks to help ensure staff they employed were suitable to work with people.

Staff received the support they needed to carry out their roles effectively, including regular supervision and training. People were able to access healthcare professionals when they needed to. Staff knew how to give people the emotional support they needed and had information about people's preferences about their care and what was important to them. Staff gave people the information they needed to make decisions about their care.

People were able to take part in a range of activities and spend time in the garden if they wanted to. People's religious needs were met. The provider responded appropriately to concerns and complaints made by people and their relatives. They acknowledged people's concerns and took action to address them. The

provider regularly sought feedback from people, their relatives and staff and used this to make improvements to the service.

During this inspection we found repeated breaches of regulations in relation safe care and treatment of people and governance. We also identified a new breach of the regulation in relation to meeting nutritional needs.

We have taken action against the provider for the breaches of regulations described above. Full information about CQC's regulatory response to any concerns found during inspections is added to the back of reports after any representations and appeals have been concluded.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe. The provider had failed to ensure hot water in showers was at a safe temperature, that chemicals and other hazardous materials were locked away securely and that other risks within the home environment were appropriately assessed and managed. People had individual risk assessments in place, but these were not always sufficiently robust or up to date.

People mostly felt safe and the provider responded appropriately to safeguarding concerns, but there was not a clear written procedure for reporting abuse.

There were enough staff to keep people safe and they were appropriately vetted. There were systems in place to help ensure the safe management of medicines and the control of infection.

Is the service effective?

Requires Improvement

The service was not always effective. People did not always receive the support they needed to eat and were at risk of malnutrition or other health problems because the provider did not take prompt action in response to significant changes to people's weight and nutritional state.

Staff obtained people's consent before providing care and the provider met the requirements of the Mental Capacity Act (2005) although care plans did not always reflect these.

Some aspects of the home environment were not adapted for people who were living with dementia.

Staff received the support they needed to perform their roles effectively. They involved healthcare professionals when people needed them.

Is the service caring?

Requires Improvement

The service was not always caring. People told us staff did not have time to sit and talk to them. Although staff understood how to ensure people's privacy when providing personal care, people's personal information was not always kept private.

People had the information they needed to make decisions about their care. Staff knew how to give people the emotional support they needed.

Is the service responsive?

Requires Improvement

The service was not always responsive. Some care plans contained contradictory, incorrect or out of date information and some information was missing. However, some care plans were detailed and up to date.

People were able to take part in activities within the home and people's religious needs were met.

The provider listened and responded to concerns that people and their relatives raised.

Is the service well-led?

Requires Improvement

The service was not always well-led. The provider failed to make improvements they were previously required to make. They did not have adequate systems in place to identify and address shortfalls in the quality and safety of the service and were often reliant on other agencies and people to inform them of improvements they needed to make.

The provider had systems to gather the views of people, relatives and staff and they used these to make some improvements to the service.

St Mary's Lodge Residential Care Home for the Elderly

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 2 and 6 September 2016 and was unannounced. It was carried out by an inspector and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. This expert-by-experience had experience as a family carer of people living with dementia and older people using regulated services.

Before the inspection, we looked at information we held about the service. This included reports from previous inspections together with the provider's action plans, information and feedback we received from commissioners about the service and notifications the provider is required by law to send to us about significant events that happen within the service.

During the inspection we observed how staff interacted with the people who used the service. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We also undertook more informal observations of people's experiences of using the service. We spoke with five people who used the service, two relatives, three members of staff plus the registered manager and a visiting healthcare professional. We looked at care records, including care plans, for seven people using the service and we checked four staff files. We also looked at other records such as staff rotas, audits and equipment checks.

Inadequate

Is the service safe?

Our findings

At our last inspection in March 2016, we found a breach of the regulation regarding safe care and treatment, which the provider was still not meeting after we originally identified the breach in October 2015. This ongoing breach was in relation to risk assessments not being reviewed when needed, hot water outlets running at hot temperatures which increased the risks of scalding to people and risk assessment and management plans for specific risks to individuals not always in place. The provider wrote to us with their action plan stating these issues would be resolved by the end of June 2016.

At this inspection, we saw that the provider was still failing to ensure that hot water was safe for people to use. We tested the maximum temperature of two shower units and found that one ran at 49 degrees Celsius and the other at 46 degrees. This is above the temperature recommended by the Health and Safety Executive in their guidance, "Managing the risks from hot water and surfaces in health and social care". If people are exposed to hot water above 44°C for either washing, showering or bathing, they are at increased risk of serious injury or fatality.

The provider was not complying with Health and Safety Executive (HSE) guidance or relevant legislation about the control of substances hazardous to health (COSHH). We found a number of hazardous substances, such as cleaning chemicals, were in unlocked rooms and cupboards where people could access them. We alerted the registered manager to this, but when we returned on the second day of our inspection we found more chemicals including an open bottle of bleach on top of a cupboard at waist height. People were therefore at risk of serious harm from coming into contact with, or ingesting, dangerous chemicals because there were not sufficient controls to protect people from this risk.

During the inspection, we noticed a number of additional safety hazards on the premises. Two fire extinguishers were standing on the floor and not secured to walls as the Fire Brigade recommends, meaning there was a risk that people could trip on them or they could be removed. We notified staff, who made sure they were returned to their wall brackets. We also noted that the garden contained a number of hazards such as mature trees with overgrown branches that could present a risk because they could fall on people as they had not been trimmed. There were bricks, rubble and large garden tools such as spades in an easily accessible part of the garden. These items could cause serious injuries if used improperly and not kept in a secure place. We found an empty first-floor bedroom with no restrictor on the window and a second-floor staff room was left open and also had no window restrictor, meaning that people were at risk of falling from height if they entered these rooms without staff support. This was despite one person having a known history of absconding or attempting to abscond through windows. Although there was an alarm system fitted with pull cords in bathrooms, we noticed that the cord in one shower room was tied up near the ceiling so any person who fell in the shower would be unable to alert staff to help them.

We observed that the structure of the home meant that staff were not able to take trolleys to some areas where people sat for lunch and had to carry loaded trays up and down a step and through narrow doorways. This increased the risk of accidents caused by staff tripping or dropping heavy or hot items that they carried. The provider had not assessed this risk and there was no management plan to reduce the likelihood of such

accidents.

People had individual risk assessments covering their risk of falling, developing pressure ulcers and some other risks specific to them. There were plans in place to manage these risks and people's relatives were aware of them. Risk management plans were in place for long-term health conditions such as diabetes. Where incidents occurred, risk management plans were updated to show actions staff were taking to prevent them from happening again.

However, some risk assessments were still not in place despite people's initial assessments indicating they were at risk. For example, one person, who was on a diet of soft food due to swallowing difficulties, did not have a choking risk assessment and people who required assistance to mobilise did not have moving and handling risk assessments in place. Another person had fallen seven times in the last year. A senior member of staff was able to describe how they managed the person's risk of falls, but because the information they gave was not present in the person's risk management plan there was a risk that not all staff were aware of these methods of helping the person avoid falls. We also saw two people's risk assessments had not been updated for over a year, meaning that staff may not have been taking into account any risks arising from their changing needs or those that had increased over time. People were therefore at risk of coming to harm because the provider had not fully considered risks and there were not adequate risk management plans in place.

These issues were a repeated breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Most people and their relatives told us they felt safe at the home. However, one person told us they were unhappy with another person who persistently came into their room without permission. They told us the person who entered their room had threatened to hit them when they asked them to leave and that they had also threatened to hit the intruder if they did not leave. We spoke with the registered manager about this, who told us they were not aware of this incident and contacted the local safeguarding team. Records showed that the provider responded appropriately to safeguarding concerns and acted promptly to put risk management plans in place. However, at the time of our visit there was no written reporting procedure for suspected abuse. Although staff knew that they should report to the manager in the first instance, there was no written information about what they should do if they wanted to escalate the safeguarding concerns to an agency outside of the home such as the local authority safeguarding team or the CQC.. This meant there was a risk that safeguarding concerns could go unreported because there was a lack of clear information about this.

There was equipment to help people to remain safe, such as adapted step-free showers with chairs and pressure relieving mattresses for people at risk of developing pressure ulcers. We saw evidence that staff carried out regular checks of equipment, including mobility aids, to make sure they were safe to use. This equipment and other items such as call bells and fire safety equipment were serviced regularly by appropriate professionals.

People, relatives and staff felt there were enough staff to keep people safe. One person said, "When I ask for something to be done it is never a problem." The home had set staffing levels, which the registered manager told us were based on current guidance from the Social Care Institute for Excellence (SCIE) for staffing levels in social care. We looked at rotas and found that, with the exception of one day, the set staffing levels were met for every shift since May 2016. We observed that staff were present during our inspection in areas where people were spending time and were able to attend to people's needs promptly. The provider carried out appropriate checks to assure themselves that staff were suitable to work with people, such as criminal

record checks, fitness to work assessments and proof of their identity and right to work in the UK.

Medicines were stored securely and at an appropriate temperature. We checked medicines records and stock levels for seven people and saw evidence that they received their medicines as prescribed or, where they did not, staff took appropriate action. For example, one person had declined to take their medicines on three occasions and staff had consulted the person's GP to discuss this and check that the person was not at risk of harm from missing their medicines. There were protocols in place for each person who was prescribed medicines to be taken only as required, containing information such as the dosage, maximum frequency, when to take the medicines and why they were prescribed. This helped ensure that people received their medicines when they needed them.

One relative said, "The cleaners are there all the time and they go straight to any mess that people leave." Toilets and bathrooms were clean and had adequate supplies of toilet paper, hand towels and soap so people could maintain their personal hygiene. There was a sanitising machine kept on the premises, which could be used to help prevent infection by killing germs in bathroom areas and on floors. The home had dedicated cleaning staff, who used cleaning checklists to ensure cleaning tasks were complete and care staff followed a health and safety policy with clear guidelines about precautions they should take to reduce the risk of infection spreading within the home. The provider carried out a quarterly infection control audit and the latest of these showed no areas of concern. Relatives told us the home was usually clean when they visited. We saw evidence that the Food Standards Agency had visited the home during the month before our visit and had awarded the service the maximum rating of five, meaning they had judged the food hygiene standards to be very good. This meant the provider was taking appropriate action to protect people from the risk of infection caused by poor hygiene.

Requires Improvement

Is the service effective?

Our findings

We received mixed feedback about the food served at the home. One person told us they liked the food, particularly the choices they were given. We saw that different choices were planned on the menu for each meal. Another person told us the quality of the food varied and a third said, "It is quite nice, not brilliant." A relative told us staff were good at following instructions about what their family member should or should not eat. At lunchtime we observed that most people ate independently. However, we observed two people who for 15 minutes did not eat anything and were not offered assistance with their meal until we mentioned it to the manager. A member of staff then came to assist the two people but did not check if the food was still warm or offer to heat up the food. Where people required assistance to eat, their care plans did not always specify what support they needed. One person's care plan specified that they required "full assistance" but there was no information about what this meant or how staff should provide it. This meant there was a risk that people did not always receive the support they needed to meet their nutritional needs.

People had nutrition and hydration care plans and staff recorded people's weight at least monthly. However, there was not always evidence that staff took appropriate action in response to significant changes in people's weight. One person's weight records showed that their BMI was in the 'obese' category and they had gained weight almost every month, but despite the person having a medical condition that could be made worse by being overweight there was no evidence the person was receiving any support or medical advice to help them manage their weight. Another person had lost over six per cent of their overall body weight over nine months and weight records showed they were continuing to lose weight, but this was not covered in their nutrition risk assessment and no actions had been recorded following an appointment with their GP to discuss the weight loss several months before our inspection. This meant the person may have been at risk from malnutrition but the risk was not identified and there was no plan in place to manage this.

This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We observed that people were provided with drinks throughout the day and relatives told us drinks were always available for people when they visited. Our inspection took place during a period of warm weather and staff took appropriate measures to ensure people stayed hydrated. Fruit was available in communal areas so people had access to healthy snacks.

As part of this inspection, we checked whether the provider was meeting the requirements of the Mental Capacity Act 2005 (MCA). The 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. We saw evidence that, if they had the capacity to do so, people had given their consent for proposed care plans before these were put in place. A relative told us, "If [my relative] doesn't want them to do something, [staff] won't do it" and gave examples of when this had happened. Staff were aware of the

importance of involving relatives, advocates, social workers, doctors and others who knew people well when making decisions on their behalf about their care. Care plans contained information about who should be involved in making decisions for each person and whether they had advocates for this. This helped to ensure that the right people were involved in decisions about people's care.

However, we saw information in three care plans about mental capacity and consent that was misleading or not in line with the MCA Code of Practice. For example, one person's care plan stated that they had "no mental capacity" to make decisions but also stated elsewhere that they were able to make minor decisions about their care. Although one care plan also stated that staff should consider least restrictive options for the person's care, the misleading or contradictory information could undermine these processes.

We recommend that the provider review their arrangements and processes around assessing and recording people's mental capacity according to the Mental Capacity Act 2005 Code of Practice.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. We saw evidence that the provider had applied for DoLS for several people using the approved processes and these had been granted.

The home had a complex layout with several levels, multiple staircases and narrow doorways. A visiting healthcare professional told us the environment was difficult for the person they were visiting to move through. We saw people using grab rails, either independently or on the advice of staff, to help them move through the home and to use stairs safely.

There were five communal rooms people could use to socialise or take part in activities. Apart from one room that contained pictures of film stars from the 1940s and 1950s, these were all decorated in the same style and colour with a small number of pictures on the walls. This could cause confusion to people, especially those who experienced problems with orientation, as all the rooms looked similar.

We recommend that the provider review the suitability of the premises and the need for adaptations according to national guidance on creating a suitable environment for people with dementia and/or a physical disability.

People and their relatives told us that staff seemed competent and knowledgeable. Staff told us they were happy with the training they received, including sufficient training to understand and meet the needs of people living with dementia. There was evidence that staff had regular training in areas relevant to their roles. Staff told us they received regular supervision and appraisals and found these useful. We saw records confirming supervision took place.

People and their relatives told us they received the support they needed to access healthcare professionals. One person said, "If I want [a GP appointment] I would get it that day or the next one." Another person's relative told us, "They are really good. As soon as they saw there was a problem they called an ambulance straight away." There was information in care plans about ongoing healthcare support people needed for long-term conditions such as diabetes or mental health problems. This included detailed care plans with information about when to contact healthcare professionals. We saw evidence that people received the support they needed and saw healthcare professionals when needed to help maintain their health.

Requires Improvement

Is the service caring?

Our findings

People told us staff were "quite caring" and we observed staff interacting with people in a friendly and respectful manner. One person's relative told us, "I want to say they look after [my relative] really, really well." Another relative told us the home was "very homely and very caring" and that staff "try their best to make everyone as happy as they can." We asked three people whether staff talked to them regularly and two said they did not. One said, "No, not often. They are too busy. They are all very friendly" and the other person told us, "No, not really. They have their work to do." However, a relative told us, "If [staff] see someone looking sad, they go over and bring them out of it. They are very caring and interactive."

Staff told us they always made sure doors were closed when they assisted people with personal care or using the toilet, to protect their privacy. We saw a cupboard containing a large amount of personal information about people, such as old care plans, was left unlocked. We told the registered manager about this but when we tried the door on the second day of our inspection we found that it was unlocked again. This meant there was a risk of unauthorised persons gaining access to personal confidential information about people.

There was a board displayed in a communal area with photographs of staff and an explanation of their roles. This was designed to help people identify who staff were and to help them remember the names of staff members. We observed the registered manager reminding one person about an appointment they were due to attend later in the day, showing that they kept people informed about what was happening.

Care plans contained information to help staff maintain positive relationships with people such as how to support them emotionally. For example, one person's care plan had a description of what might cause the person to become upset and how staff should speak with them to reassure them. Another person's file contained descriptions of how their emotional state was sometimes negatively affected by disorientation and memory loss and how staff should support them and divert them towards activities they enjoyed.

Staff told us how they supported people to understand what their choices were and to make those choices, for example by showing people pictures of different foods so they knew what was on offer. However, we noted that a pictorial board showing people the day's menu choices was only visible in one of the communal rooms, meaning that people who spent their time in the other rooms may not have been aware of what their meal choices were. We mentioned this to the registered manager, who told us this was something they were working on. We observed staff verbally offering people in the other rooms choices about their meal. The provider had developed 'choice care plans' which were accessible in people's bedrooms so staff could check them when assisting people who were not able to assert their preferences verbally. The care plans included information about people's likes and dislikes, what they enjoyed doing, what was important to them and how staff should assist them in making choices. We saw information in care plans about how people communicated and how staff should deliver information to them to help them understand it. This helped staff to enable people to make choices about their care.

Requires Improvement

Is the service responsive?

Our findings

People's needs were assessed and each person had a care plan that reflected information from their assessments. Some care plans were personalised and detailed, with information about what support people needed and what they could do for themselves, their usual routines, preferences as to how staff supported them and other relevant personalised information. For example, for one person who sometimes refused support to complete personal hygiene tasks we saw there was a list of actions staff should take to try to resolve this. However, we also found that some information was contradictory or out of date. One person's care plan stated they were unable to use stairs, they needed help to move from their bed to a chair and they used a wheelchair and walking frame, but also had a health assessment that stated they were fully mobile. There was no information about when they should use the frame and when they needed the wheelchair and no information about what equipment they used to move from their bed or chair. Another person's care plan stated that they did not eat beef or pork for religious reasons but records showed they had eaten beef or pork almost every day for the last two weeks and when we queried this staff confirmed that the note in the care plan was an error.

There was information in people's bedrooms summarising what help and support they required from staff. This helped staff ensure they were delivering care to people as planned without having to access the computerised care plans.

There was a full-time activities organiser employed by the home although this person was away during our inspection. The activities organiser worked only on weekdays and people told us this meant there were not many structured activities at weekends. At the time of our inspection there were no activities planned outside the home although people made regular use of the large garden for fresh air and exercise. The garden contained a patio with tables, chairs, sun umbrellas and barbecue equipment. During the inspection we saw people using the garden to enjoy the warm weather and speak privately with visitors. The home had recently held a barbecue party, which one relative told us was "lovely" and we saw the service had received two written compliments about this. The registered manager told us they had applied for a badge that would allow them to use disabled parking spaces and that when it arrived people would be able to go on trips in the car, including at weekends.

People told us staff responded to their individual needs with regard to activities. One person told us the home provided them with a packed lunch so they could go out to a club with a friend. Another person said, "I am an artist and they give me books to colour in." A third person said, "You get plenty of time to do what you want." We asked staff how they supported people who remained in their rooms throughout the day. They told us they visited those people regularly to talk and engage in activities such as watching films.

We saw a bingo game taking place, although some people were not engaging with the activity, and later a visiting musician led a music and singing session. We observed people participating in this, clapping and tapping their feet in time with the music. A relative told us the music session took place twice a week and "people love it." We also saw people reading current newspapers. However, we did not see evidence of activities tailored to the needs of people living with dementia, such as reminiscence work.

We recommend that the provider look into activities designed to provide meaningful engagement to people living with dementia.

During our inspection, a representative of the local parish church came to visit people and offer Holy Communion. The registered manager told us a number of people using the service were practising members of the Christian faith and that these visits occurred monthly. There were also regular visitors from different faith groups. We saw information about people's religious needs in their care plans, including whether they wished to take part in Communion.

People told us they knew how to complain and who they should speak with if they wanted to make a complaint. There were logs of concerns and complaints received including dates, the action taken to prevent the concern from arising again, plus any updates such as feedback on the action taken or further action the provider took after the issue was resolved. We saw evidence of action the provider took in response to people's concerns and complaints, such as replacing carpet with wooden flooring in people's bedrooms where relatives had raised concerns about the condition of the carpet. One relative told us, "It has been much better since the flooring was replaced." This showed that the provider was responsive to people's concerns.

Requires Improvement

Is the service well-led?

Our findings

At our last inspection in March 2016, we found a breach of the regulation regarding good governance in relation to issues that we originally identified at our previous inspection in October 2015. We found that the provider's audits were insufficient in identifying, assessing and managing risks relating to the safety of the premises and equipment and also risks to individuals. The provider wrote to us with their action plan stating these issues would be resolved by the end of June 2016.

At this inspection, we saw the provider had a range of audits and checks that they used to assess and monitor the quality of the service. However, these were still not adequate because they did not identify the serious concerns that we found at our inspection. These have also not led to significant and consistent improvements in regards to the provider meeting regulations they were previously breaching. There was a monthly check of the environment. Although this had included windows, the check in August 2016 had not identified that at least two upper floor windows were missing restrictors and therefore posed a safety risk to people. The check had not identified that chemicals were not being stored safely, hot water outlets were running at unacceptably high temperatures, the garden contained hazardous materials and the alarm pull cords were not always within reach of people. This meant that people were at risk of coming to harm because systems designed to identify risks to their safety were not doing so effectively.

We also noted that items on the monthly environmental check were not marked as complete unless problems were identified. This meant the provider could not be sure that all items on the list had been checked properly. The provider also carried out an annual audit of health and safety checks that staff carried out, but did not assess the effectiveness or accuracy of these checks so issues such as incorrectly recorded water temperatures were not identified by this audit.

A visiting healthcare professional told us the registered manager and team leader made improvements quickly if they raised concerns and felt they were knowledgeable about their work. Although the registered manager took immediate action to address some of the concerns we raised, such as installing window restrictors during our inspection and contacting a professional to address the problem with water outlets, this showed their approach to governance and quality improvement was reactive and they did not identify and address the problems themselves. The provider did not always carry out sufficient checks to make sure the action they had taken was adequate. For example, the provider had arranged for thermostatic valves to be fitted on taps after we identified at a previous inspection that water temperatures were too high, but did not check properly to make sure they were effective. This meant that risks to people's safety or other shortfalls in the quality of the service were not being addressed in a timely fashion because there were no effective systems in place to do so.

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

Some audits and checks were effective. The provider carried out a weekly medicines audit for each person who took medicines and we saw how this helped to ensure that people's medicines were handled safely.

There was a monthly housekeeping spot check that the provider used to make sure the environment was clean and tidy. We saw these were up to date and the cleanliness of the home was found to be satisfactory.

One person told us, "I have no idea who the manager is. I haven't a clue." However, a relative said they regularly spoke with the manager and "they keep us informed." There was evidence that a meeting took place the month before our inspection for relatives of people using the service. The manager informed relatives about improvements they had made to the service, some of which were in response to earlier feedback from people and relatives. They also asked relatives for any suggestions they had about improvements they would like to see at the service and recorded these. The registered manager told us they asked people who were able to communicate verbally about any improvements they would like to see made to the service.

The provider had carried out a survey gathering feedback from people's families in June 2016 and another for people who used the service, although there was no date on this. People and their relatives gave positive feedback about the care they received, saying standards of care, management, responses to their concerns, menus, activities and respect for people's privacy and dignity were all good or very good. We did not see any negative feedback, but there were some suggestions for improvements and we saw evidence that the provider had acted on these or was planning to do so. We saw feedback was used to inform the provider's development plan for the service, which included carrying out work to improve the garden.

There were monthly meetings for staff, or more often if needed. Staff told us they were encouraged to voice their opinions and that managers listened to them. We saw evidence that these meetings gave staff the opportunity to discuss their training, incidents, complaints and care planning amongst other issues pertinent to their work. There was a staff survey in June 2016 where staff fed back positively about the support they received and their involvement in developing the service.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs The nutritional needs of service users were not met. This included receipt by service users of suitable and nutritious food which is adequate to sustain life and good health and support for service users to eat and drink. Regulation 14 (1)(4)(a)(d)

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 12 HSCA RA Regulations 2014 Safe care and treatment Care and treatment was not provided in a safe way for service users. This included assessing risks to the health and safety of service users, doing all that was reasonably practicable to mitigate such risks and ensuring that the premises used by the service provider were safe to use for their intended purpose and used in a safe way. Regulation 12(1)

The enforcement action we took:

We have imposed a condition preventing the provider from admitting new service users to the home without our prior written consent.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not establish and effectively operate systems to ensure compliance with the regulations. The systems in place did not enable the registered person to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity. They did not effectively assess, monitor and mitigate risks relating to the health, safety and welfare of service users. Regulation 17 (1)(2)(a)(b)

The enforcement action we took:

We have imposed a condition preventing the provider from admitting new service users to the home without our prior written consent.