Mr & Mrs M Turner

Underhill House Residential Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on the 15 and 16 March 2016 and was unannounced. We last inspected the service on the 7 August 2014 and found the service was meeting the requirements of the regulations.

Underhill House provides residential care without nursing for up to 28 older people who may be living with dementia. Twenty eight people were living at the service when we visited.

A registered manager was employed at the service. 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 registered manager, who is also one of the providers, was on holiday when the inspection took place. The deputy manager was the person in charge in the absence of the registered manager and they were present during the inspection.

Prior to the inspection we received information of concern about people's care at Underhill House from different sources. This included concerns about care not being personalised, people receiving medicines which then made them sleepy, personal care not always completed to a high standard, food portions were described as "small" and staff were not following choking risk assessments. We were also told people's care at their end of life was not well planned and medicines to alleviate pain at this time were not readily available. We were also told the service had strict routines in place and people who could not consent to care due to their level of dementia were having routines decided for them. We were also told the water people had access to was "scalding". We checked these concerns as part of the inspection. We found concerns during the inspection which are summarised below but can be reviewed in the full report.

People's medicines were not always managed safely. For example, staff trained in the safe administration of medicines were not on duty overnight. This meant people had to wait to be administered pain relief from an on call member of staff. Gaps between the administration of some medicines were not sufficiently spaced. For example, antibiotics were given over a shorter timescale than recommended. Storage of some medicines was not in line with current guidance and temperatures of medicines were not being recorded. Staff who were administering medicines were suitably trained but were not having their competency checked.

People's medicine administration records were completed. People were happy with how their medicines were administered. There were clear systems of ordering and returning unused medicines. A medicines audit was in place to check systems were being followed.

People were not having their ability to consent to their own care and treatment assessed, as required by the Mental Capacity Act 2005 (MCA). When people could not make decisions about their care and treatment due to their living with a condition which may have affected their ability to consent this had not been assessed. Best interest decisions had not been recorded. People who were having their medicines given without their

consent had not been assessed in line with the MCA. However, staff were observed asking for consent when offering care and applications had been made to seek an assessment of people who may be deprived of their liberty to keep them safe.

Staff demonstrated they knew people well and how to meet people's needs. However, people's care was not recorded in a personalised way which reflected their needs and how they wanted their care to be given. For example, care plans showed no evidence of having been planned with people or their family or representative as required. People's preferences were not recorded. For example, what time people wanted to get up or go to bed. Staff recordings in daily records were inconsistent and often made it difficult to establish whether an identified need had been met. People's end of life care was not routinely discussed with them or their family. Family members were complimentary about staff's ability to support both the person and their family when someone was dying or had died. One of the GPs we spoke with was happy with how the staff were looking after people at their end of life.

Prior to the inspection, we were told there were strict routines in place which people had to adhere to. We found people were being supported to get up for breakfast at 8am. Some people told us they did not want to get out of bed that early. Also, staff confirmed some people were being supported to get ready for bed at 5.30-6pm. Staff said the early rising and getting ready for bed reflected people's preferences but these were not recorded. Staff had also had not ensured this was in the person's best interest when they lacked capacity to consent. Staff advised they would review this area of their practice.

Risk assessments did not always reflect people's current needs and where not always updated as required. Individual risk assessments were not always available to ensure all risks people may be exposed to while living at the service were then mitigated. For example, choking risk assessments were not completed for people cared for in bed or who could be at risk due to identified swallowing concerns.

Action had not been taken to ensure water temperatures placed people at a lower risk of accidental scalding. A plumber was called to the service during the inspection to start putting this right. Up to date Personal Emergency Evacuation Plans and evacuation equipment were not available. We have advised the fire service of our concerns.

Prior to the inspection we were made aware that complaints and concerns had been raised by relatives, or via safeguarding concerns, but these had not been reviewed in line with the complaints policy. The service had a complaints policy in place however, we found complaints that had been made had not been investigated. This meant lessons learnt or patterns had not been reviewed to see if there were positive changes which could be made to the service to improve everyone's experience.

The registered manager did not have robust systems in place to ensure the quality of the service. Audits, other than in relation to medicines, were not taking place to check practice was safe. For example, there was no audit of infection control, care plans or staff recordings. There was also no falls audit to check if amendments could be made to keep people safe. People and staff felt the registered manager and deputy manager were approachable. The registered manager had systems in place to ensure the building and equipment were safely maintained.

People were positive about staff and staff spoke fondly about the people they cared for. People confirmed staff treated them with respect and dignity. We observed positive interactions between people and staff. Relatives told us they were always welcomed and kept up to date about their loved one's care.

People and their relatives said Underhill House was a safe place to live. People were looked after by staff

who understood how to identify abuse and what action to take if they had any concern. People were supported by a sufficient number of competent, trained staff, who were recruited safely. Staff felt the management would take action on any safeguarding and staffing issues to keep the service running safely.

People had their need for an adequate diet and enough to drink met. Action was taken to address any concerns. People were complimentary about the food and felt the portions they were served were large enough. People were offered extra servings in the dining room at lunch time. People also had their health needs met. People said staff always responded quickly to ensure any health needs were met. Records showed people's GPs were contacted as required. The GPs we spoke with were positive about staff member's ability to contact them appropriately and give them current information on people's needs.

We found breaches of the regulations. 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 always safe. People's medicines were not always managed safely and did not always consider people's needs

People's risk were not fully recorded. Risk assessments did not always reflect people's current needs and where not always updated as required. Up to date Personal Emergency Evacuation Plans and evacuation equipment were not available. We have advised the fire service of our concerns.

Action had not been taken to ensure water temperatures placed people at a lower risk of accidental scalding.

Staff knew how to identify abuse and report on concerns about people's welfare. There were enough staff to meet people's needs and they were recruited safely.

Is the service effective?

Requires Improvement

The service was not always effective. People were not having their capacity to consent to their care and treatment assessed as required.

Staff received regular training to support them to meet people's needs effectively. Staff had training in understanding the needs of people living with dementia.

People's needs were met by staff who received continual on-the-job supervision from the senior staff on the floor. Formal staff supervision was being developed.

People had their need for an adequate diet and enough to drink met.

People had their health needs met and could see their GP as desired

Is the service caring?

Requires Improvement

The service was not always caring. People's care at their end of life was not routinely discussed with them or their families.

People in shared rooms did not have clear guidelines on how staff needed to ensure their dignity and privacy were protected.

Staff responded to people's needs quickly. People and staff spoke fondly of each other. People felt staff cared about and for them.

Records of people's care emphasised the need for staff to ensure people were encouraged to maintain their independence and complete tasks for themselves.

Is the service responsive?

Requires Improvement

The service was not always responsive. Care records lacked detail about people's needs and how they preferred their care delivered.

Family complaints had not been reviewed as part of the service's complaints procedure.

Activities were provided for people and their faith needs were met.

Is the service well-led?

Requires Improvement

The service was not always well-led. People's life at the service was not enhanced as there were not robust quality assurance processes were not in place to monitor the quality of the service.

People and staff felt the registered manager was approachable. Staff said they could suggest new ideas.

There were contracts in place to ensure the equipment and building was maintained so they were safe for people to use.

Underhill House Residential 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.'

The inspection took place on 15 and 16 March 2016 and was unannounced

Two inspectors from the adult social care directorate and a pharmacist inspector completed the inspection.

Prior to the inspection, we reviewed the information we have on the service including previous inspection reports, notifications and any information shared with us by the public and other professionals. Notifications are information on specific events providers are legally required to tell us about. We also removed the Provider Information Record (PIR). The PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also received feedback from a GP and the local authority.

During the inspection we spoke with 10 people and four relatives. Many people had varying levels of dementia and were unable to talk with us. We therefore observed how staff interacted with people. We reviewed the care records of five people to check they were receiving their care as planned. We also looked at how staff were keeping records in relation to people's medicines. We spoke with one GP during the inspection.

We spoke with seven staff and read four staff personnel files and all training records. We requested to read a number of documents registered managers and providers are expected to keep demonstrating they are reviewing the quality of the service. All records were not available as required. We therefore read what was available to us.

Requires Improvement

Is the service safe?

Our findings

People's medicines were not always managed safely and did not always consider people's needs. For example, none of the night staff had been trained to give medicines, so if people needed medicines at night they had to wait until a trained on-call staff member arrived. For example, if someone needed 'when required' medicines such as pain killers there would be an unnecessary delay in them receiving them. We saw recorded in the Medicines Administration Records (MARs) on at least one occasion where a staff member who had not been trained to give medicines had signed for a dose of antibiotic given at 10pm.

Staff who were administering medicines in the day and who were 'on call', had up to date medicine's training however, they were not having their competency to carry out this task completed by a suitably qualified person. We discussed this with senior staff who stated they would speak to their trainer and supplying pharmacist to arrange this.

MARs were generally well completed, however one person who was receiving a course of antibiotics had no doses signed as given for 24 hours. Staff said this was an error and the person would have had their medicines. We saw several people who had antibiotics prescribed three times a day, which were not being spread out as evenly as possible through the waking day. Other medicines which had been printed as due at 10pm, had been signed by senior staff who had finished work at 9pm. Staff told us that this was because staff had to give medicines at the times printed on the charts. Two charts had dates printed for the following week after our inspection but staff had been signing these charts for the previous week.

There was no system for recording the administration of creams or other external items, and directions for care staff as to how to apply these preparations for each person was not always available. There was no detail in people's care plans or other means to ensure staff had the information required. This meant that it was not possible to tell if these were being administered in the way prescribed for people. We found one cream labelled for a person in another resident's room which was highlighted to staff to ensure this was addressed.

There was a procedure in place for any medicines needing to be given covertly. That is, people being given their medicine without their knowledge or consent. However, this was not being followed in practice. We were told one person was having a medicine administered in this way at the request of their doctor. No mental capacity assessment or best interest decision was recorded for this person to ensure the person's right to consent or refuse treatment had been assessed.

We observed medicines being administered to people at lunchtime, however on one day of the inspection we saw medicines being handled directly by staff, which is not good practice. We saw a staff member take tablets into the palm of their hand and use their thumb to snap them in two before giving them to the person. They were not wearing gloves.

Storage facilities for some medicines were not meeting regulations, and storage temperatures for medicines requiring cold storage were not being monitored. This meant it was not possible to be sure that these

medicines were safe and effective for people.

There was an audit trail of medicines received into the home and those sent for destruction. This helped to show how medicines were managed and handled in the home. Audits were completed to help make sure medicines were managed correctly, and we saw some issues were identified, for example the lack of monitoring of the medicines refrigerator. However no action had been taken about this at the time of our inspection.

Not ensuring the proper and safe management of medicines was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Medicines were ordered at regular intervals to ensure people had them available to be administered. People were asked if they needed any medicines that were prescribed 'when required'. For example, people were asked if they wanted their pain relief which was to be given when needed. People were only given this medicine if they said they wanted it.

Staff demonstrated they knew people well. They told us how they managed the risks people faced. However, individual risk assessments were not always available to ensure all risks people may be exposed to while living at the service were mitigated. Choking risk assessments were not completed for people cared for in bed or who could be at risk due to identified swallowing concerns. For example, in February 2016 one person cared for in bed was described as having been referred for a swallowing assessment due to "urging when eating". We spoke with staff as it would appear the assessment had not taken place and there was no risk assessment to support staff to manage the situation safely. Staff stated they would follow this up. Another person, also cared for in bed, was described as having "severe osteoporosis" which affected their ability to sit comfortably but this had not been linked to a choking risk assessment and guidance for staff to support them to sit and eat comfortably to reduce the likelihood of any problems arising. No external assessment had been completed to inform a risk assessment or care plan.

There were no individual risk assessments in place for people with certain health conditions. A person with a particular health condition resulted in the ambulance being called and a GP review. There was no risk assessment and associated care plan to support staff to manage this safely in the future.

There were a range of other risk assessments recorded in people's records. These included risks to their skin, falls, when staff supported them to move, nutrition, mood and mental health and fracture risk. Staff told us people's risk assessments were reviewed "three monthly or as needed". We found where risk assessments were in place; these had not always been regularly updated or clearly linked to people's care plan to ensure staff had the information available to support people safely. For example, one person who began living at the service in November 2015 had not had any of their risk assessments reviewed. They were assessed as at a high risk of falls with a history of falls prior to living at the service. Records in March 2016 stated this person was "unsteady" on their feet but their risk assessments and care plan were not reviewed to ensure their needs were being met.

Another person's social behaviour risk assessment in October-November 2015 showed their welfare needs were becoming greater as they were noted from moving from "mixes well" to "needs encouragement" to mix with other people. Their mental health risk assessment was last reviewed in November 2015 and also noted a decline in their mental health placing them at medium risk. Their care plan stated the person's mood was "variable" and often would have low mood. Also, in November 2015 they experienced a fall but their falls risk assessment was not been updated. We spoke with staff about this person's needs as the records pointed to a number of areas where this person's needs had changed but were not reflected in the risk assessments.

Staff stated they would discuss the person with their GP to ensure they were reviewed.

Up to date Personal Emergency Evacuation Plans (PEEPs) were not in place to keep people safe in the event of a fire or other emergency. A list of people had been collated but this did not detail people's specific needs and how to meet their individual needs of evacuation. The service held no personal evacuation equipment in the event of this being required in the event of a fire or other emergency. We spoke to staff about this and they stated they were unaware they needed to provide this. They stated they would take advice in relation to people's PEEPs were in place. We have advised the fire service of our concerns.

Not ensuring the risks associated with people residing at the service are clearly recorded is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

We requested to review the risk assessments completed in respect of the internal and external environment. Staff said there was one available but it could not be located during the inspection and has not been sent to us since. The information we received before the inspection had told us the water was "scalding". Staff told us the local authority safeguarding team had informed them of this concern being raised. The Health and Safety Executive state "High water temperatures (particularly temperatures over 44°C) can create a scalding risk to vulnerable people who use care services". We were shown a record of water temperatures and were told by staff this was completed mid-2015. This record detailed water people had access to in their rooms, showers and bathrooms ranged from 42oC to 54oC with the majority reading above the recommended 44oC. Other areas that were unlocked such as the kitchen and staff room recorded temperatures of 53oC and 51oC respectively. We asked what action had been taken to address these readings. We were advised no action had been taken and no other recordings taken. No risk assessments were in place and no action to reduce temperatures to safer limits taken. We requested action be taken immediately to reassess the temperatures which again read higher than 44oC at many outlets placing people at risk of scalding.

Not ensuring the premises was safe and being used in a safe way was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During the inspection, a plumber was called to the service to set the water outlets with thermostatic controls to read no higher than 44oC and to reduce the boiler temperature to ensure all outlets were safe while other action was taken. We were told the plan was to ensure all outlets people had access to would be fitted with thermostatic controls in the week following the inspection. Staff told us they would risk-assess those areas people may access, such as the kitchen and staff room, to mitigate the risks.

People said they felt safe living at Underhill House. People said they felt comfortable speaking with staff and told us staff would address any concerns they had about their safety. Visitors also felt it was a safe place for their family member to live. One person said, "The staff are always ready to care for me. If I was worried I am sure the staff would do their best to sort it out". Another person said, "I feel safe. If I wasn't I would speak to my daughter; there's nothing to be worried about though." A relative said, "I feel there is something really good; something very good here. I have no concerns about mum or any of the others; I feel mum is safe."

People were looked after by staff who understood how to identify abuse and what action to take if they had any concerns. Staff said they would pass on concerns to the registered manager. All staff felt action would be taken in respect of their concerns. Staff said they would take their concerns to external agencies, such as CQC, if they felt concerns were not being addressed. On being asked if the home was a safe home one member of staff responded, "Yes, I think so as safe as they can be. We put things in place if they need it. I'd not like to think that they're not safe."

People were supported by a sufficient number of competent staff to meet their needs and keep them safe. Staff told us they felt there were enough staff on duty to enable them to meet people's needs. Staffing for some people was flexible so their needs could be responded to immediately when they required support from more staff. Staff told us they had enough staff on duty. One staff member explained that occasionally it got difficult, especially during school holiday periods, "but other than that I think there's enough." A second staff member told us the service never used agency staff to cover absences. Instead they would work additional hours but they went on to say, "People don't phone in sick very often to be honest." Another member of staff said, "I think there's enough staff and (the deputy) always gives a hand if needed." When there were concerns about staff practice we saw this was dealt with.

The PIR stated, "All residents at Underhill have the right to live in a safe and secure environment and we endeavour to ensure they are treated with dignity, privacy and respect at all times. If any form of abuse is witnessed or suspected it is reported to the Manager who will follow the relevant procedures for investigating the case and reporting it to the relevant outside agencies. We ensure we work and think to protect adults in our care supporting them to ensure they are free from abuse, harm or neglect, encouraging them to make informed choices where able and providing the correct information."

People were supported by staff who were recruited safely. Robust recruitment practices were in place and records showed checks were undertaken to help ensure the right staff were employed to keep people safe. Staff confirmed these checks had been applied for and obtained prior to commencing their employment with the service. Staff then followed a three month probationary period to ensure they remained suitable to work in their chosen area of work.

Requires Improvement

Is the service effective?

Our findings

We checked whether the service 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. Staff said they had training in the MCA and the linked Deprivation of Liberty Safeguards (DoLS). 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 found no record held details of assessments of people's capacity to make decisions about their care and treatment. This is despite many people being described to us as having a level of short term memory loss, dementia or other condition such as Parkinson's, which may affect their ability to consent to all aspects of their care. There was also no record that staff understood when they were acting in people's best interest. For example, the care plans did not refer to what people could or not consent to in order to ensure their right to consent was respected. Also, there was no record of discussions with relevant professionals or family where decisions had been made about people's care and treatment.

Several people had alarm mats in place which were not linked to an assessment of capacity or showed the person had consented to their use. We asked staff how the decision to use alarm mats had been decided as 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 asked if the alarm mats were being used to control people. Staff told us the mats were in use to prevent falls and because not everyone could use a call bell so the mats would alert staff to people moving. However, staff did not understand how the MCA and DoLS related to each other despite having had training in this area. We were told that DoLS applications had been made. When we asked staff who had DoLs applications pending one staff member said, "To be honest I don't know how many are on DoLS but it does not impact on my day to day work." The local authority designated officer has advised us the service has submitted 16 DoLS applications which are awaiting authorisation.

Not ensuring people's consent to their care and treatment was in line with the principles of the MCA was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We observed staff seeking people's consent when offering support in the lounges and dining room. People said staff would always ask their consent when offering personal care and waited for them to decide what they wanted to do. People added staff respected if they said they would like them to come back later.

Staff received regular training to support them to meet people's needs effectively. Staff had training in understanding caring for people living with Dementia. We were shown a "Training at a glance" file which contained a record of each individual's training. We noted some training was out of date. However, staff confirmed they did receive regular training and told us they had training in most of the provider's mandatory

areas such as moving and handling, infection control and safeguarding vulnerable adults. One member of staff told us, "I've had training in DoLS and in fire safety, dementia, verification of death – which was quite interesting – first aid, but I think that's out of date now." Senior staff stated they would review the training with the registered manager when they came back from holiday to ensure it was all in date and recorded.

We only noted supervision notes on two staff files and these both appeared to be addressing problems or concerns. When we spoke to staff they confirmed that formal 1:1 supervision was only done when there were problems. Staff told us they received continual on-the-job supervision from the senior staff on the floor. One staff member told us, "Seniors do daily checks of the beds and cream charts to make sure we're doing all the paperwork and they do check that everything's all right." Another member of staff said, "We supervise the care staff and we get supervised by the deputy and the registered manager; they're always there watching, looking to see if we can manage and deal with situations as they arise."

Senior staff told us we would find annual staff appraisals on staff files. Staff knew they were meant to have appraisals, but no one could remember when they last had one. On one file we found an appraisal dated in 2014 completed two weeks after the staff member started work as part of their probationary period. Senior staff advised they knew appraisals were needed to be completed and had plans in place to address this.

People had their need for an adequate diet and enough to drink met. People had breakfast at 8am, lunch at 12pm and tea at 4pm. A trolley then was taken around at 7pm with hot drinks, sandwiches and cakes. Snacks were also available during the morning and afternoon drinks round. People who required staff support to eat and drink were given support. People were complimentary about the food and felt the portions they were served were large enough. People were offered extra servings in the dining room at lunch time. At lunch there was a choice of two main meals and one dessert. People said they were sure they could have something else if they did not like what was on offer. However, no one had felt the need to ask for another choice. People added they all had snacks in their rooms which they could have if they felt they wanted anything else to eat.

Where there had been concerns about people's needs, action had been taken but not always recorded accurately. Assessments by other professionals were not always available to refer back to and the services own nutritional risk assessments were not updated. Kitchen staff said they knew people and received a verbal update on people's needs. However, this was not recorded and meant people's preferences, allergies or food they should not eat if it meant their medicines (such as certain blood thinning medicines) would not work properly were not available to refer to. Senior staff agreed to review these concerns and stated they were in the process of reviewing people's records to enable them to have an easier oversight and ensure the records were complete. Kitchen staff were to be given clear written records of how to provide for people's preferences and needs. We spoke with staff about the recording of people's food and fluid intake which was also often incomplete. Staff told us night staff would review these and feedback in the staff handover but again there was no recording of this. Staff started to look at ways to improve this straight away.

People had their health needs met. People said staff always responded quickly to ensure any health need was met. Records detailed people's GPs were contacted as required and both the GPs we spoke with told us they were satisfied staff contacted them as necessary and were always able to give them an up to date picture of people's health needs. People also saw a chiropodist, optician and dentist as required.

Requires Improvement

Is the service caring?

Our findings

Prior to the inspection we had received both positive and negative comments about how people's end of life was met at the service. We found people's end of life was not routinely discussed with them or their families. Of the two people highlighted to us as entering their end of life neither had care plans in place to ensure staff had the information available to them that would tell them how to look after the person. Staff described how people wanted their needs met at this time. However, people's choices were not recorded to ensure their needs were met as they would want. One person noted as being at the end of their life had recorded "Wants to die at Underhill House." There were no other details which were personalised that described how they would want this carried out.

We discussed people's end of life with staff who stated there were plans to update people's end of life records; staff had reviewed the care plans and had started to approach people and family about their end of life care needs and preferences. The PIR stated, "We aim to ensure each resident has an Advanced Care Plan in place so we can meet their individual needs and preferences surrounding End of Life Care, making sure the residents and their families are consulted and encouraged to complete the forms where able".

Prior to the inspection in a letter received, and in correspondence to the service, we read that family members were complimentary about staff member's ability when supporting both the person and families when someone was dying or had died. One of the GPs we spoke with was happy with how the staff were looking after people they were looking after at their end of life. Both GPs we spoke with told us they had only seen staff act in a caring manner.

One of the concerns raised with us prior to the inspection was that Underhill House has shared rooms and people were moved into these rooms when they required a higher level of staff time. For example, at people's end of life. We were told this did not always reflect the person's choice and individual care needs were not being met in a way which ensured people's privacy and dignity were respected. There are three shared rooms at Underhill House. There was a mobile screen provided to separate the two beds visually at times of personal care however, these would not have protected them from sounds and smells nor maintained confidentiality. We reviewed one person's care records who was living in one of the shared rooms. This person did not have the capacity to make their own choices due to their advanced dementia and end of life status. Their records did not detail how this person's needs were going to be met how they wanted them to be. For example, it did not give specific detail to staff on how to ensure the person's privacy and dignity were to be protected while sharing a room. Records did not state it was this person's choice to be in a shared room.

We spoke with staff about the shared rooms and how people's personal needs were being met. We were told people might initially be placed in a shared room but would be given a single room "if one became available". They added they would speak to families "about consent to share a room when a person was dying." Staff agreed this was not then clearly recorded. Staff told us this was planned for the forthcoming review and reorganising of peoples' records.

When we arrived at the service we identified then, and throughout the inspection, that people's records were not always kept securely and their details treated with confidentiality. People's MARs, people's medical information and recordings of certain aspect of care by staff were found in the main corridor, dining room and a bathroom. As these were located staff were made aware of them and they were taken to a place where they could be secured. We spoke with staff about the importance of ensuring people's records were kept secure and only made available to people who had the right of access to them.

People's needs were met quickly when staff were available but this was not always the case. People were in the lounge for long periods of time with no staff available to interact with. When staff were in the lounge and dining room conversation took place which was friendly and caring. When people were brought to the lounge they were asked where they wanted to sit and with whom. When people needed extra support, such as a blanket because they were feeling cold, this was provided quickly. Staff were observed then asking people if they were alright before leaving them.

People were positive about the staff and the staff spoke fondly about the people they cared for. One person said, "I think it is extremely good and I think this is one of the nicest places." They went on to comment "[The registered manager] has such good staff, cos they work hard. They know what they've got to do and they do it. I would say everyone enjoys themselves here there is an overall feeling of happiness. They're very kind to the likes of me." Another person said, "I like it here; they are wonderful carers. The staff are very kind; they're always ready to look after me."

Relatives told us they were always welcomed and kept up to date about their loved one's care. A relative said, "I find [the service] excellent; not just for myself but everyone. I am always welcomed" adding, "The staff are very easy to talk to. I can relax and not worry about anything about mum; I know she is being looked after properly." Another relative said, "What I love about this place - it is like being at home. The staff behave as if it someone's home" adding, "[The staff] are really nice; they employ a certain type of person, which is important. The atmosphere feels safe."

One staff member said, "You can't help it, some of the clients here are lovely, you do get fond of them. They've all got their own personalities and they're lovely." They went on to say, "You get to know people by talking to them. If they've got dementia I ask the senior; if new clients come in all you have to do is ask the seniors and they'll explain what you have to do, if they need help getting dressed or walk them to the dining room." Another member of staff said, "I think this is a good place, I get along with everybody well; residents are nice, you get used to them and know what they like, like sugar in their tea and that. And they are kind as well, and very polite. They generally appreciate what we do for them, they stay pleasant and they are nice and polite". A different member of staff also commented, "It's rewarding, like yesterday I was helping make Easter bonnets and this (description of the person) nudged me and said 'thank you'."

People confirmed staff encouraged them to remain as independent as they could for as long as possible. One person said, "The staff encourage me to be independent." For example, they put on their own cream and staff helped them where they could no longer reach.

The PIR stated, "We pride ourselves on being a very much family run home with a friendly and welcoming atmosphere with long standing staff members that reflects on the wellbeing of our residents" and, "We ensure each resident is treated as an individual and that others respect their dignity, irrespective of any disability or frailty. We maintain privacy by ensuring all staff knock before entering a room". Records of people's care emphasised the need for staff to ensure people were encouraged to maintain their independence and complete tasks for themselves.

Requires Improvement

Is the service responsive?

Our findings

Staff demonstrated they knew people well and how to meet people's needs. However, people's care was not recorded in a personalised way which reflected their needs or how they wanted their care to be delivered. Care plans showed no evidence of having been planned with people or their family or representative as required. Initial assessments were completed about people prior to their living at the service but sections of this were blank which would have given the detailed information about people's "Physical care needs", "Physical well-being" and "Previous medical history". The initial assessment was a tick list of items to consider such as ticks against "needs helper" and "walking frame" for mobility in one person's case. However, no further detail was then added about how the person needed or wanted this care delivered.

Peoples' full care plans were factual but lacked detail so staff knew how to deliver personalised care. Also, where people's needs were recorded these were not always respected. For example, one person living with dementia was described as "private" and preferring to stay in their room but was in the lounge each day. No amendment to their care plan or discussion with the person or best interest decision was then recorded to demonstrate their preferences were being taken into account.

People's care plans did not always include their full needs. For example, one person had a risk assessment stating they were at medium risk of experiencing low mental health, but there was no care plan in place to support staff to meet this need. People's personalised history was not always used to inform the care plan and how to keep people active.

On the first day of the inspection one person said, "We get up too early, they wake you. But then again when you've got 28 people you've got to start early." Prior to the inspection we received information that people's care was not being delivered in line with people's preferences and choice. We were told there were strict routines in place which people had to adhere to. Two concerns were around everyone being woken at 7am and had to be ready for breakfast at 8am. Another was that people were being dressed into their nightclothes at 5.30pm and 6pm to make it easier for night staff to get people ready for bed. We were told that people's night clothes would be placed in a plastic bowl and taken to the downstairs bathroom near the front door. People were then changed there one after another. We were also told this was the main toilet in use all day by people using the main lounge.

On the second day of the inspection we arrived at 7.20am and found 24 people were up and dressed in their day clothes. One person's choice was not to wake until after 11am and this was respected. For others, beds were made and many people were in the lounge heading for breakfast in the dining room for 8am. We spoke with people and asked them if it was their choice to be awake at that time. Eight people could communicate with us. One person said it was not their choice to be up at that time stating, "No not really; I would like to get out of bed when I am ready". When we asked what time that would be they said, "About 8ish". The seven other people felt 7am was appropriate for them commenting, "Half past six; that's my choice", "The staff get me up, but I was awake. I am happy to get up at 6.30am", "I am awake then" and, "I wake up at 4am and get myself up; I am happy to be up early." Another person who was still in their room, but dressed, said, "I'm ready to get up at 7am and I wait until 7.30am to call staff". Records did not record people's choice and

preference was to be up and awake at this time.

Staff told us five or six people were being changed for bed, as reported to us. They added though, that this was people's choice. This was not recorded in people's records as being their choice. We spoke with staff about people being changed in a bathroom which is just off the front door and not in their own room. Staff reflected on the evening practice and how this could be perceived as institutionalised and stopped doing this. However, they had yet to demonstrate what practice would replace this.

Staff recordings in daily records varied in quality and often made it difficult to follow people's care through to ensure an identified need had been met. For example, one person's records noted "Unsteady today" and then two days later the person was "Very unsteady and chesty today; requested a home visit from GP. See treatment file." However, the treatment file did not state the GP had attended and what then happened. The record the next day encouraged staff to monitor the person due to the ongoing cough which happened on the following day. Then there was no record for the following two days.

Not recording people's care accurately was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff we spoke with said they felt they respected peoples' choices. They told us they would knock on people's door at 7am and if people were asleep they would leave them and come back later.

We found people's care records were split and held in different locations which made ensuring continuity of information and ensuring people's needs were met, difficult. We spoke with staff about this who advised it had already been identified it would be ideal if all people's records were held in one file. We were advised the work on this was due to commence soon.

Activities were provided by staff in the afternoon and people spoke about enjoying attending these. Visiting entertainers and other activities were provided. People told us they enjoyed the musicians in particular. Local religious leaders came and provided services and one to one time for people.

The service had a complaints policy in place. The PIR stated there had been no complaints but 20 compliments had been received. We were also told on inspection there were no complaints for us to review. Prior to the inspection we were advised that complaints had been made on two occasions which had raised concerns with the registered manager about people's care. We asked staff if they were aware of the issues raised and they said they were. We asked if these concerns had been investigated in line with the provider's complaint policy as described in the PIR. The PIR stated, "In the event of complaint or concern with the care offered the concern or complaint should be discussed with the Registered Manager, alternatively it can be discussed with a Senior Carer on duty who will do their utmost to rectify the situation. The manager will respond to a complaint within 28 days with the aim to rectify the situation following an investigation." Staff confirmed there was no record of the concerns having been recorded and responded to in line with complaints policy. Staff were also aware that the water had been described as "scalding" as part of the safeguarding concerns but confirmed no investigation had taken place to review this.

Not acting on complaints was a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service well-led?

Our findings

Underhill House is owned and run by Mr and Mrs M. Turner. Mrs Turner is also the registered manager. They were supported by a deputy manager and senior carers to run the service. Mr & Mrs Turner were involved in the home on a daily basis and lived close by.

Systems were not in place to routinely assess the quality of the service. The last thorough recorded quality assurance review was completed in 2013 by an external company. There was an audit of medicines in place but no other. This meant other key areas such as reviewing care plans, infection control, falls and the environment were recorded as taking place to ensure practice was good and people's needs were being met. People and their families were not routinely being asked for feedback on the quality of the service they received. In 2015 three questionnaires had been completed by two family members and one person. On two staff files we saw they had completed a quality assurance questionnaire in 2014. We could not see what had happened with their responses or how they had been used to improve the service.

We spoke with staff about the lack of auditing and quality assurance processes in place. Staff confirmed there was no regular programme of quality assurance such as the use of questionnaires and audits.

Not having systems in place to assess, monitor and improve the quality of the service was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager has contacted us following the inspection to state they are seeking to employ an external company to complete their quality assurance process. The PIR stated, "As a measure to test the quality of the services we provide we continually ask ourselves: "Is it good enough for my Mother, Father" etc. if not, it is not good enough for our residents, we always ensure the management are kept up to date with best practice by providing training and taking recommendations from outside agencies to provide the best care possible".

Staff did not understand the Duty of Candour (DoC) when asked. There was also no policy to support them to understand what this meant. The DoC places a legal obligation on registered people to act in an open and transparent way in relation to care and treatment and to apologise when things go wrong. Staff said they would look to address this and the registered manager has advised us a policy is now in place and all staff are aware of the DoC. There was a whistleblowing procedure in place and staff understood their responsibilities to raise concerns about poor conduct. Staff told us they felt confident concerns raised with the registered manager would be addressed appropriately.

People could identify who was in charge at Underhill House and said they saw the providers often. One person said, "I don't know much about the lady in charge, but she's always nice to me. You wouldn't blind her with any rubbish."

The PIR stated, "We provide an open door policy for staff and residents and their families and representatives acting on any concerns and complaints promptly to ensure we can provide a good quality of

care taking into consideration any suggestions that will enable us to provide a better service. The staff are encouraged to consult management with any concerns as we feel if the staff are happy within their job role this will reflect on the care they provide".

Staff spoke positively of the registered manager and deputy manager and felt supported by them to carry out their various roles. Staff told us the registered manager and deputy worked well together and felt everyone knew what their roles and responsibilities were. Comments we received from staff included, "The registered manager is easy to work for; I think she's really good, easy to talk to", "I've always liked (the deputy) we get on really well. She's doing a good job; she's really approachable, and yes she will take action", "(The deputy)'s always fine, obviously she sorts out all the courses and updates our training, and it's just like working all together really. She'll help out, she's very hands on", "(The registered manager) looks after you; she takes good care of her staff, and people as well" and, "The management are good, if you ask for a day off they'll try to give it you and holidays, they're organised." Staff felt they could suggest new ways of working and both the registered manager and deputy manager would listen to them.

The registered manager knew how to notify the Care Quality Commission (CQC) of any significant events which occurred in line with their legal obligations. The registered manager had systems in place to ensure the building and equipment were safely maintained. The utilities were checked regularly to ensure they were safe. Essential checks such as that for legionella and of fire safety equipment took place.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Regulation 11(1) and (2)(3) The registered person was not acting in accordance with the Mental Capacity Act 2005 to ensure those who lacked capacity were being assessed as required.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Regulation 12(1) and (2)(a)(b)(d) Care and Treatment was not provided in a safe way for people as risks to people's health and safety were not always completed or updated. Medicines were not always managed safely. Action had not been taken to protect people from the possibility of scalding.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints Regulation 16(1)(2) Complaints were not investigated and necessary and proportionate action taken in relation to the failure identified by the complaint or investigation. The registered person had not developed systems to effectively receive, record, handle and respond to complaints.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Regulation17 (1) and (2)(a)(c) Systems were not established and operated effectively to assess, monitor and improve the quality of the service and maintain securely an accurate, complete and contemporaneous record for each person.