Caring Homes Healthcare Group Limited

Home of Compassion

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

About the service
Home of Compassion is a 'care home'. It delivers care for up to 78 people living in one large building split in to five wings. At the time of our inspection there were 63 people living at the service who had a range of needs including living with dementia and a mental health diagnosis.

People's experience of using this service
People told us they did not always feel safe or that they mattered. People and their relatives gave us examples of times were staff had not treated them with privacy and respect. We were also told that any issues or complaints raised with the management team were met with defensiveness, which we also experienced during our inspection. There were members of staff that found the management team were not approachable. We received mixed feedback from people and their relatives around being involved in decisions around their day to day care, with some saying staff did not listen to their wishes or choices.

Documentation was not contemporaneous or up to date. Risk were not always appropriately recorded and managed and did not reflect people's current needs. The registered manager had not informed us and the local authority of all reportable incidents and safeguarding concerns. End of life care was not responsive to people's needs, and there was limited information on end of life wishes in people's care plans. People were not always supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible; the policies and systems in the service did not always support this practice. Internal audits and quality governance processes did not identify the issues we found during our inspection.

Although the environment was clean and tidy, it was not set up to meet the needs of people with cognitive impairments such as dementia, and there was a lack of meaningful activities. People were not supported to access the healthcare required at times. There were a sufficient number of staff to meet people's needs. However, some had not received recent appraisal meetings to discuss their performance and development.

People's needs were assessed before they moved into the service to ensure their needs could be met. We received positive feedback about the food at the service, and the kitchen staff were knowledgeable about people's dietary needs and preferences. People felt staff knew them well due to a stable workforce with no agency use. There were plans in place to improve care plan records, and the management team ensured they attended local forums and meetings in order to network with other services in the area.

We have made recommendations around risk assessments and mitigation, effective training, the environment, notifying CQC of certain events and the care and dignity provided at the service.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
The last rating for this service was Good (published 6 April 2017).

Why we inspected
This was a planned fully comprehensive inspection in line with our inspection scheduling based on the service's registration with CQC.

Enforcement
We have identified breaches in relation to personalised care, need for consent, good governance, dealing with complaints and safeguarding concerns at this inspection. We also identified notifiable incidents that CQC had not been made aware of.

Please see the action we have told the provider to take at the end of this report. Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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.

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service caring?

Requires Improvement

The service was not always caring.

Details are in our caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Details are in our responsive findings below.

Is the service well-led?

Requires Improvement

The service was not always well led.

Details are in our well led findings below.

Home of Compassion

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
The inspection team consisted of three inspectors, a specialist nurse advisor, 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.

Service and service type
Home of Compassion is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

During the inspection
We spoke with 13 people, seven relatives and 11 staff members including the registered manager, deputy

manager and chef. We reviewed a range of documents including 12 care plans, three staff recruitment files, medication administration records, accident and incidents records, policies and procedures and internal audits that had been completed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records. We spoke with two healthcare professionals who regularly visit the service.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Requires Improvement.

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This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Systems and processes to safeguard people from the risk of abuse

● Systems to identify abuse were not always operating effectively. People gave us mixed feedback when we asked if they felt safe at Home of Compassion. One person told us, "I feel unsafe at times. A man turned up at midnight outside and was dealing with pigeons on the roof. I rang the bell because I had no idea what was happening at that time of night. It made me worried." However, another person told us, "Someone walks with me round the garden twice every day. I like to walk and feel safe."

● Staff were not always aware of their responsibility to safeguard people from abuse. One staff member told us, "That's our main job to ensure people are safe and free from the risk of any abuse. I treat them like my family, and I would report anything for them as quickly as I would for my own family." However, we found incident reports of unexplained bruising and significant skin tears. Injuries like these must be reported to the local authority as a safeguarding concern. However, the deputy manager confirmed the local authority had not been made aware of these injuries, leaving people at risk of abuse. We raised this with the registered manager who told us they would inform the local authority of all the notifiable injuries within the service. This has not yet been completed.

People were not always protected from the risk of improper treatment or abuse as systems to identify potential concerns were not always operating effectively. This was a breach of Regulation 13 (Safeguarding service users from abuse and improper treatment) of The Health and Social Care Act 2008 (Regulated Activities) 2014.

● Where the local authority had been made aware of safeguarding concerns, internal investigations had been completed where required by the registered manager. This included obtaining witness statements and answering questions raised by the local authority's safeguarding team.

Assessing risk, safety monitoring and management

● Risks were not always appropriately managed. One person had lost a significant amount of weight within six months. Staff had been completing weekly weight records for the person, but these had recently stopped despite the person's weight still not being stable. Therefore, staff were not adequately monitoring people's weight which left them at risk of further weight loss.

● Another person was not receiving support to reposition in bed, despite the deputy manager confirming in a later safeguarding concern referral that the person 'requires repositioning'. This resulted in the person sustaining bruising on their arm where they had been laying on it for the morning. We raised this with the

registered manager and asked them to complete a referral to the local hospice for support and start a repositioning chart. They sent us confirmation by email that this had been done and that a safeguarding concern had also been raised with the local authority.

● Emergency pull cords in bathrooms were not always accessible to people. We observed one had been tucked in to the top draw of a cabinet. Other emergency cords were over a metre off the floor, making them inaccessible if someone were to fall. We informed the registered manager who has now addressed this and ensured pull cords are at an accessible length in the case of an emergency.

● Some risks to people were correctly recorded and managed. One person at risk of skin tears had clear guidance for staff to follow in their care plan. This included photos taken of any tears that had occurred and action plans put in place to aid their healing.

● People's care plans included personal emergency evacuation plans (PEEPS) to advise staff how to support people to evacuate the building in an emergency.

● A recent fire service inspection had identified actions the provider needed to take to ensure the service was safe. The actions required had been addressed.

We recommend the provider ensures all risks to people are appropriately identified, managed and recorded in order to mitigate their occurrence.

Learning lessons when things go wrong

● Accidents and incidents were recorded, but information around what action taken to prevent reoccurrence was not always documented. For example, one person had caused a skin tear to their hand when moving furniture in their room. This had been recorded, but there was no information around what action was taken to try to prevent this from happening again.

● A monthly tracker of accidents and incidents was in place. However, there has been no analysis of the information to identify trends. For example, one person had fallen six times in a short period. Some accident and incidents forms around this did not confirm what actions were taken to mitigate further reoccurrence, and others repeated the same "constant monitoring". There had been no further investigation into why the person was repeatedly falling and what further action could be taken, such as referrals to healthcare professionals. We raised this with the registered manager who informed us they would identify ways to mitigate the risk of falls for the person, and that recording of accidents and incidents and the actions taken would be more thorough in future. They were not able to explain why detailed recording had not been occurring.

We recommend the provider ensures staff document the steps that have been taken to mitigate the risk of any reoccurrence of an accident or incident.

Using medicines safely

● On the whole, medicine administration was safe. People who required their medicine to be given at specific times of the day were given so. However, one relative informed us staff did not administer a new prescription until two days after it had arrived at the service. This meant the person was late receiving the medicine they required, and staff were not proactive in chasing this up. We fed this back to the registered manager to look in to and identify lessons to be learnt.

● Medicine recording and storage. Medicines was safely stored in locked cabinets and the medicine room and fridge temperatures were monitored and recorded daily. Protocols were in place for as and when medicine (PRN) which informed staff how much of a medicine a person could have within a 24-hour period. Medicine administration records (MAR) charts were completed in full.

● Staff received medicine competency checks on a regular basis. These checks are to ensure that staff are safe and knowledgeable to administer medicines to people.

Staffing and recruitment

● There were a sufficient number of staff to meet people's needs, with staff covering any sickness or holidays. A staff member told us, "We don't have agency here. I will work five to six days a week to ensure that we don't have agency staff here." Another staff member said, "I think there is more than enough staff. Sometimes if someone calls in sick then management will find a replacement for that shift." We observed staff were not rushed during our inspection and had ample time to sit and talk to people.

● People were cared for by staff members who had been recruited safely. Recruitment files included written references, a full employment history and a Disclosure and Barring Service (DBS) check. A DBS checks ensures that potential staff members are safe to work with vulnerable people. Checks had also been completed with the Nursing and Midwifery Council to ensure nurses were registered to practice nursing.

Preventing and controlling infection

● People were protected from the risk of infection. We observed staff wearing personal protective equipment (PPE) such as gloves and aprons when supporting people with their personal care. A nurse informed a person when administering their medicine, "I am going to wash my hands before giving you your eye drop." There were clear guidelines in place for staff informing them how to prevent an outbreak of infections such as norovirus.

● Hand hygiene sessions were carried out with staff to ensure they were washing their hands thoroughly and therefore preventing the spread of infection. The registered manager then completed random spot checks on staff to confirm they were still practicing safe hand hygiene.

● The service was clean and tidy with no malodours. The sluice room was locked and clinical waste was stored in appropriate areas. One person told us. "Everywhere is very clean and if something is dropped on the floor it is quickly swept up."

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Requires Improvement.

This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Ensuring consent to care and treatment in line with law and guidance

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA.

In care homes, and some hospitals, this is usually through MCA application procedures 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 had the appropriate legal authority and were being met.

- People's legal rights were not always protected as the correct legal documentation had not always been completed. Decision specific mental capacity assessments had not been completed for restrictions that had been placed on people such as coded key pads on doors and sensor mats. One person was dressed in a nightwear jumpsuit to prevent them from pulling their catheter out at night. There was no mental capacity assessment or best interest decision for this restriction.
- Staff had not identified where people required mental capacity assessments to ensure they were making unwise decisions. One person had repeated entries in their care notes stating they were 'grimacing'. Staff had not administered pain relief as the person had denied being in pain. However, a mental capacity assessment around this had not been completed to ensure that the person still had capacity despite their deteriorating physical health. A staff member told us, "Personally I feel that she is in pain."
- Correct legal documentation was not in place for people who were given their medicine covertly (hidden medicine within food or drinks). Mental capacity assessments and best interest decisions had not been completed or recorded, and there was no evidence to show that families had been consulted in the

decision-making process.
● DoLS applications that had been submitted did not include the restrictions that were in place for people. This included constant supervision, bed rails, sensor mats and key pads throughout the building.

People's rights were not being protected and staff were not working within the principles of the MCA 2005. This was a breach of Regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Staff support: induction, training, skills and experience
● Staff were not always receiving an annual appraisal. 33 out of 63 members of staff had not received an appraisal in 2019. This included all care assistances, senior care assistants, activities coordinators and the maintenance officer. Therefore, the provider and registered manager could not ensure that staff were given the opportunity to discuss their performance and personal development as raising any concerns they may have.
● Most staff were up to date with their training. This included areas such as infection control, fire safety and moving and handling. One staff member told us, "The training here is good. I always feel like I'm prepared for my job." This in turn made people feel that staff were competent. One person told us, "Some staff seem to have the training to help me and I am well looked after most of the time."
● However, despite training being provided staff were not always following good practice as evidenced in other areas of this report, such as safeguarding and working within the principles of MCA.

We recommend the provider ensures training is effective to address the shortfalls found in other areas of the service, and staff receive an annual appraisal of their performance.

Adapting service, design, decoration to meet people's needs
● The environment was not always set up to meet the needs of people with dementia. Floors for people living with dementia did not include dementia friendly signage to direct people, or sensory items for people to engage with or be stimulated by.
● However, people did have memory boxes outside their rooms, which contained personal items and pictures to make their room identifiable to them. People had been able to personalise their rooms to make them more homely.
● The building had been adapted to ensure people were safe. Key coded external doors were in place, and ramps and lifts made the building accessible to people with mobility needs.

We recommend the provider reviews the environment to ensure it meets the needs of people living at the service.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● People were not always supported to access the healthcare they required. A visiting healthcare professional had noticed one person's health had started to deteriorate in relation to their specific condition. They notified staff of their concerns however no action had been taken to refer the person to their GP. Instead staff waited until the next GP visit which was six days after the concerns had been raised. This meant the person did not receive appropriate healthcare support in a timely way.
● However, healthcare professionals had been involved in other people's care. Records in people's care plans showed that people had been seen the GP, podiatrist, and optician amongst others. A staff member told us, "We are very grateful for their (health care professional's) support". We observed the deputy manager update a person's relative following a GP consultation on the morning of our inspection.

● Despite the issues we identified around staff not always communicating effectively with healthcare professionals, staff felt communication and teamwork within the service was effective. One staff member told us. "We have flash meetings every day at 11am. It provides an opportunity to discuss and update management on any clinical issues you may have. Allocations are done on mornings, daily tasks are allocated among the team, and you prioritise workload. I will help the carers with personal care if I finish with medication rounds." We observed effective communication taking place within a flash meeting on the day of our inspection.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

● Pre-assessments were completed prior to people moving into the service to ensure they could meet their needs. Pre-assessments included gathering information around people's mobility, personal care and social needs which was then used to formulate their care plan. The registered manager told us, "We accept anybody as they are. We take people that are declined everywhere else. We like to take a risk and improve their quality of life."

● Nationally recognised standards and guidance were used within the service. For example, Waterlow assessments were completed to determine how at risk a person was from pressure sores.

● The registered manager had signed up to receive best practice guidance from a range of organisations including CQC. She told us, "Our regional office send us things, so do CQC. We check the website and stay up to date. We're not afraid to ask if we don't know."

Supporting people to eat and drink enough to maintain a balanced diet

● The lunchtime experience for people was enjoyable. People who required assistance to eat were given support, and people living with dementia were presented with two visual choices to choose from. One person was unable to verbally communicate what they wanted. A staff member sat down with them and went through the options available. They were patient with the person, giving them the time they needed to make and communicate their decision.

● People were offered food and drinks throughout the day to keep them hydrated. People were regularly offered tea, coffee and a variety of juices with biscuits in between meals. Food and drink was made to be appetising. One person was heard to say at lunch, "They must have a wonderful cookbook as they come up with wonderful ideas for our meals don't they?"

● The chef and kitchen assistants were aware of people's dietary preferences and needs. Each person had a food fact sheet which the kitchen staff could refer to if needed. One person preferred to have a vegan diet. The chef told us. "Every day we go and talk to him about what he wants. He has asked for us to go and talk to him about the food choices. He asks for a particular choice like a five bean salad and if there is anything he needs then we have bought it in. As we get to know his likes and dislikes then we can better prepare with the food we order."

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Requires Improvement.

This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity

● People and relatives gave us mixed feedback when we asked them if staff were kind and caring towards them. One person said, "When I go to hospital, no-one has ever asks how I got on or what was said." Another person said, "I can tell if someone doesn't care; that's when they talk over me when they're washing or dressing me. It's not that they rush me but some don't talk to me or listen. I don't know but they seem as they have a lot to do and make me feel a nuisance." Two people indicated that it depended who was on duty, with one saying, "They are very cold and don't listen." A relative told us, "I heard the two (staff) talking in their own language while bending over my mother and carrying out their tasks. I was outside the door but they were speaking loudly so I could hear them. I have heard them stop during tasks to answer their phones. They don't see or treat my mother as a person."

● Staff did not always speak about people in a respectful manner. One staff member told us, "Dementia care is like treating babies." Another staff member spoke to another staff member, calling the person they were supporting "inpatient" when they had requested their lunch to be served.

Respecting and promoting people's privacy, dignity and independence

● Staff did not always respect people's privacy dignity. One person told us. "They don't always knock on my door." A relative told us, "Sometimes the carers come into the mother's bedroom with no concerns for her privacy and dignity. They enter the room where my mother is lying quietly and peacefully, abruptly switch the light on in her face, speak in a loud voice in such a manner that is very unprofessional and not nice."

Supporting people to express their views and be involved in making decisions about their care

● People were not always involved in decisions around their care. One person told us, "Staff don't ask things like, 'Do you want the curtains closed or the light switched on.' They just do it and I feel cross but I don't say anything in case they don't help me." Another person told us, "Staff are busy and don't have time to stop and listen. If I need help they've often disappeared before I can decide or ask." Care plans were reviewed monthly. However, over half the people we spoke to informed us they had not been involved in this process.

We recommend the provider ensures staff treat people with kindness and respect their privacy and dignity through training and staff observations.

● However, we also received positive feedback in this domain and observed caring interactions between people and staff. One person told us, "Staff work hard. They've looked after me when I've needed them. You

can't buy that." Another person said, "The majority of staff are lovely, kind and helpful." When one person became upset, a member of staff sat with them and held their hand. The person's mood improved and they leaned their head in towards the staff member.

● Visiting relatives were welcomed into the home. Relatives were offered a hot drink and were able to bring in their dog to visit their loved one. A relative said, "I live many miles away from the home, but whenever I have visited it seems wonderful. only a visitor but love the way staff chat to me." A staff member told us, "The big thing for me is to build relationships with the relatives – always communicate. It gets the best results for the people we're supporting."

● We observed some positive examples of privacy and dignity being respected. People were discreetly supported to go to the toilet when they requested assistance. Another person was taken to the privacy of their room for their appointment with the GP.

● People were encouraged to maintain their independence. People were encouraged to cut up their own food and feed themselves at lunch where they were safe to do so. Another person asked to go for a walk and was supported to stand. Once stood up, they were able to use their walker and were able to go for a walk independently.

● Some people also felt they were involved in making decisions around their care. One person told us, "They're always asking me for my choices relating to everything, they're very good at that." Staff felt people were heavily involved in decisions around their care. One staff member said, "This is their home, they should be in complete control of everything that happens with them. They should always be involved with making decisions about how they live here." Another staff member said, "It's so important you make sure that you're not making decisions for them."

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Requires Improvement.

This meant people's needs were not always met.

End of life care and support

● People were not supported to be pain free during the end of their lives. One person told us, "I'm not always well-looked after. Staff don't understand the pain."

● The registered manager and staff informed us people and relatives were provided with support during this stage of a person's life. One staff member said, "The people here are supported well, we support family members after deaths." However, a relative informed of their concerns around end of life care at the service. They told us, "I feel so unsupported and alone even though surrounded by people. There is no support for relatives and there does not appear to be much input for people dying."

● We found inconsistent levels of recording of end of life wishes. In some care plans, there was limited information around their end of life wishes and in others there was none at all. The registered manager informed us they were providing end of life care to two people on the day of our inspection. However, these people did not have end of life care plans in place. The registered manager could not explain why these were not in place.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

● There was a lack of meaningful activities for people, especially those living with dementia. Activity records were limited to people watching television, read newspapers or had a cup of tea or hot chocolate. We observed staff trying to engage people with games like snakes and ladders or bingo. People did not want to take part on engage with this.

● People fed back to us about the activities on offer. One person told us, "I miss going out. I was always out and enjoying fresh air but now I sit here as staff can't help everybody." Another person said, "I stay in my room a lot as we don't have much interesting discussion. I want to go out as the days can seem long if there's nothing much that I can do." A staff member told us, "Sometimes it can be a bit tight with us doing the activities. The main activities in the main part of the house do not always suit people on this [dementia] floor."

People's personalised needs were not met and staff did not design or deliver care and treatment to ensure people were pain free at the end of their life. This was a further breach of Regulation 9 (Person centred care) of The Health and Social Care Act 2008 (Regulated Activities) 2014.

● There were people that told us they enjoyed activities at the service. One person said, "I like the yoga and

some of the singing. The children coming made me cry it was so happy." The activities and management team had arranged for a local school to perform a pantomime for people living at the service. People fed back to us that they had enjoyed watching this.

● People told us they felt staff knew them well. One person told us, "They really know me here, they know what I like and they make sure they take care of all the minor details." Another person said, "The staff know all of us separately, we are never treated the same just because we are old and live here. The staff make a real effort to find out what we actually like as individuals." Care plans included details around people's backgrounds and interests.

Improving care quality in response to complaints or concerns

● Complaints were not always appropriately dealt with or taken on board. One relative had complained there was a lack of activities. The complaint record did not confirm what action had been taken, and we also identified a lack of meaningful activities. A relative told us, "I met up with [the registered manager] and raised a complaint of care and she promised to look into it. I have seen no evidence that she has." There was no written record of this complaint.

● Other complaints were dealt with appropriately. One person had complained as their breakfast had been served late one morning. The registered manager had investigated, given the person a full explanation and apologised. One person told us, "The manager is good and listens; she is kind and does what she can."

● The service had recorded compliments that had been received. One of these read, "I have always found a friendly warm and relaxed atmosphere throughout this beautiful home. All levels of staff are always extremely caring." Another read, "We could not have found a better place."

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

● Communication care plans were in place to guide staff on how best to communicate with people. For example, people's communication care plans confirmed if they wore glasses and hearing aids, and if they were able to inform staff if their hearing aid batteries needed changing.

Requires Improvement

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Requires Improvement.

This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

- There were people and relatives that felt the management of the service were sometimes defensive and unapproachable. When we raised issues during the day the management team did not always react positively. The registered manager said, "My staff get very defensive when they get told they aren't doing something correctly. We don't get it right all the time but we try to."
- Staff did also not always feel the management team were approachable. A staff member said, "The support from management? Well expectations are extremely high." Another staff member told us they felt a member of the management team had no compassion towards their colleagues and felt they "are only nice to you if they want something."
- The registered manager had not always reported significant events to the Care Quality Commission and other outside agencies. This included significant injuries to people. We raised this with the registered manager on the day of the inspection who told us they would send the appropriate notifications to us. We have now received the notifications for these.

We recommend the registered manager ensures the CQC are made aware of any notifiable incidents, and promotes an open, approachable culture within the service.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- Records that we reviewed were not always accurate and did not always reflect the most appropriate information about people's care. For example, risk assessments were not always appropriately recorded and care plans did not reflect people's current needs. Daily notes and GP visit records did not always include information around what had been discussed during healthcare professional visits, and accidents and incident records did not record what action had been taken. A staff member told us, "I admit documentation is a huge challenge."
- The provider had received a Regulation 28 report from the coroner in July 2018. This report details improvements needed to be made to the service following a coroner's investigation. The report noted there had been a lack of contemporaneous notes, lack of health care professional involvement, and important information not being in people's daily notes that had contributed to a death. Our findings identified that

sufficient action had not been taken following the coroner's recommendations.
● Audits were not always effective. Quality audits were completed on a regular basis. However, they had not identified the shortfalls we found on our inspection. For example, the latest regional monthly management report which looked at various areas of the service such as safety, medication and documentation found there were no actions to be taken. Each person's care plan was audited monthly but this had not identified the irregularities and missing information that we did, such as complaints records.
● The registered manager did not keep up to date staff supervision records. Following the inspection, we received a supervision tracker from the registered manager which showed four staff members did not have any supervision dates recorded for 2019. We asked the registered manager for clarity around this, who then sent us an updated tracker and additional evidence which showed all staff except one had received supervision since April 2019. Therefore, the tracker was only updated after we had identified the concern around supervision records.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● People felt they were not engaged in the running of the service. Although residents meetings were occurring every three months, people did not feel they were asked for their opinion or experience of using the service. One person told us, "I don't remember anyone asking for my opinion. No, I haven't filled anything in." There was a weekly newsletter available from the provider. However, people commented that they would like the opportunity to make their own as a residents group or be involved in the current newsletter.
● Relatives were asked for their feedback on the running of the service, but their feedback was not always listened to. A questionnaire had been sent to relatives in September 2019. Some of the responses received were negative, such as the feeling there should be more activities available. The action plan created by the registered manager stated the reason for negative feedback was a lack of communication with relatives, and therefore an improvement in this would lead to an improvement in their feedback. The registered manager had not used the feedback received to improve the quality of the service and we still found that some people were not happy with the activities on offer.
● Staff meeting minutes documented who attended the meetings but did not record the feedback or any issues raised by staff. Therefore, the registered manager could not demonstrate issues raised could be reviewed in the following meeting to determine if they had been dealt with.

Quality checks and leadership was not always robust. This a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●However, staff were engaged in the running of the service. Some staff had been awarded 'champion' roles of responsibility to focus on areas of risk and care. For example, there were hydration champions, continence champions, infection control champion amongst others.
● Staff felt able to engage with staff meetings. One staff member told us, "We have regular staff meetings and we highlight areas on our floor that need attention."
● Other people and staff members found the management team to be open. One person told us, "The manager listens, she is good and will try and sort things out." A staff member said, "The manager is supportive and I see her walking around the home speaking to people and staff." Another staff member told us, "The manager and the deputy are very supportive and have put everything in place to support me developing my nursing training."
● There were wellbeing incentives available for staff in order to improve their work/life balance. This included use of the in-house hairdresser, massages and yoga classes.

Continuous learning and improving care; Working in partnership with others

● The registered manager had plans in place to improve the care plans. They told us, "We're hoping to change the care plans, there's far too much paper and its not user friendly. We're considering electronic care plans."

● There service had close links with local organisations. The deputy manager attended Surrey Skills for Care forum. Skills for Care is an independent registered charity who work with adult social care employers in England to supply staff with the skills and knowledge needed to deliver high quality care to people who use care services. The registered manager informed us, "We will network with anyone at all."

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 9 HSCA RA Regulations 2014 Person-centred care The service failed to provide meet people's personalised needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The service failed to work within the principles of the Mental Capacity Act 2005.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The service failed to ensure people were protected from improper treatment and abuse.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The service failed to ensure staff received regular performance and development review meetings.