Oakhurst Court Limited

Oakhurst Court Nursing Home

Inspection report

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Date of inspection visit:
04 July 2017

Date of publication:
05 September 2017

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

Oakhurst Court is a large nursing home that provides nursing care for up to 57 older people and people who may be living with dementia. The service can also provide respite care and palliative care. At the time of out inspection there were 45 people living in the home.

The service was run by a registered manager, who was not present on the day of the inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run. The registered manager was away on leave on the day of the inspection. The deputy manager was in charge; however she had only worked at the home for two weeks. The provider told us that the deputy manager was supported by the senior care team.

At the last inspection in March 2016 we found concerns with the support provided. Following the inspection in May 2016 we told the provider and registered manager to take action to make improvements to ensure people's care and treatment was safe. We told them to ensure staff had the right skills and knowledge to care for people safely. We also told the provider to take action to ensure that the requirements of the Mental Capacity Act 2005 (MCA) were met and that people received dignified and person centre care. We also told the provider to take action to ensure that there were robust systems in place to monitor, review and improve the quality of care. These actions and requirements had not been met.

People were not always protected from harm. Risks to people had not always been identified and assessed and therefore put them and others at risk of harm. People did not have their own individual slings. This puts people at risk of poor positioning and is an infection control risk. This put people at potential risk of serious harm. The registered manager had not informed CQC of safeguarding allegations.

People were not always safe from avoidable harm. One potentially serious safeguarding had not been reported to the local authority and staff had not recognised it as an incident of abuse.

There was enough staff on duty to ensure people were safe, however staff deployment needed to be reviewed at meal times and other busy times. We have made a recommendation in this area. There were recruitment practises in place to ensure that staff were safe to work with people.

People's medicines were administered safely. Medicines were always stored and disposed of safely.

People's human rights could have been affected because the requirements of the Mental Capacity Act were not always followed. For people who lacked capacity to make decisions about their care, mental capacity assessments and best interests decisions had not occurred. The registered manager had applied for some Deprivation of Liberty safeguards (DoLS), when people had restrictions to their care, however some were missed.

People did not always receive effective care. Staff did not always have the knowledge; skills and regular supervision to enable to them care for people safely and effectively.

People did not always receive care that met their cultural or religious needs. Staff were not always aware of people's choices and preferences. People's care provided was not always dignified.

People and their relatives said that they were involved in their care. However this was not always evident in peoples care records. People and relatives said that the staff were kind and caring.

People did not always receive personalised care. Care plans were in place; however they were not detailed or personalised. Care records were inconsistent, for some people who had health conditions they did not have the appropriate care plan in place to tell staff how to manage the health condition. People's preferences and wishes were not always recorded in their care plans.

People and their relatives knew how to make a complaint. The provider had not responded to the complaints in line with the current regulations. There was no evidence of an investigation and the provider had not advised the complainant that if they were not satisfied with their response they could contact another organisation.

The home was not well led. There was not a robust process in place to monitor and evaluate the care provided to drive improvements. Record keeping was inconsistent and records were not sufficiently detailed to guide staff. There was a lack of leadership from the provider and registered manager to drive the improvements.

Staff told us that they now felt supported by the management and were feeling positive about the changes.

People had sufficient food and fluids. People said they thought the food was 'Okay'.

There was an activities programme in place; people said they enjoyed the activities. However we have made a recommendation about activities for people who received bed based care.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

We found six continued breaches and two new breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We found one breach of the CQC (Registration) Regulations 2009. 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?

Inadequate

The service was not safe.

Risks to people were not always identified and managed to keep people safe. Care equipment was not always safe for people to use.

People were not always protected from avoidable harm. Safeguarding concerns were not always reported.

There were sufficient staff to keep people safe. However the deployment of staff at meal and busy times needed to be reviewed. Staff were recruited safely.

Medicines were stored and administered safely to people.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff did not always have the right training and knowledge to care for people effectively and safely. Staff did not receive regular supervision.

People's human rights could be affected because the requirements of the Mental Capacity Act were not always followed.

People had enough to eat and drink. People said they liked the food.

People had access to health care professionals to maintain their health needs.

Is the service caring?

Requires Improvement

The service was not always caring.

People were not always involved in their care.

People's dignity and cultural needs were not always respected.

People and their relatives said staff were caring and kind. Staff had developed caring relationships with people.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care was not always personalised. Care plans did not always contain the detail and information staff needed.

People and relatives knew how to make a complaint. Complaints were not responded to in line with the requirements

People were happy with the activities that were on offer. Improvements needed in activities offered are needed for people who receive bed based care.

Is the service well-led?

Inadequate

The service was not well led.

There were now some systems in place to monitor the quality of care provided. However, they were not robust, embedded into practise or always identify areas for improvement. The timescales for improvements was slow.

Record keeping was inconsistent. There was some information missing and inaccuracies in some records.

Staff told us that the registered manager was supportive and approachable. People and their relatives said the management was 'ok'.

Oakhurst Court Nursing Home

Detailed findings

Background to this inspection

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

The inspection took place on the 4 July 2017 and was unannounced. The inspection team consisted of two inspectors, one Specialist Advisor in nursing and an expert by experience. An expert by experience is a person who has had experience of caring for older people and people with dementia.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

Before the inspection, we reviewed all the information we held about the provider. This included information sent to us by the provider in the form of notifications and safeguarding adult referrals made to the local authority. A notification is information about important events which the provider is required to tell us about by law. We contacted the local authority, quality assurance and safeguarding team to ask them for their views on the service and if they had any concerns.

We used a number of different methods to help us understand the experiences of people who used the service. We spoke with six people, three relatives, six staff members, the chef, two activity co-ordinators, the maintenance person and the deputy manager.

We spent time observing care and support provided throughout the day of inspection, at lunch and tea time and in the communal areas. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We reviewed a variety of documents which included nine people's care and support plans, risk assessments and medicine records. We also viewed four weeks of duty rotas, maintenance records, health and safety records, recruitment and training records, menus and quality assurance records. We also looked at a range of the provider's policy documents. We asked the registered manager to send us some additional information following our visit, which they sent some but not all.

Inadequate

Is the service safe?

Our findings

At our previous inspection in March 2016 we found a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, in relation to not enough staff. We saw that improvement had been made in this area and the requirement was now met. We also found at the previous inspection a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to safe care and treatment. This was because risks to people had not always been assessed and managed. We found similar concerns at this inspection.

People and their relatives told us that they felt safe. One person said "Oh yes, I've felt safe", another said "I'm quite happy, yes, safe." A relative said "He is safe here; they are all fine with him." Despite this, risks to people were not always managed well.

Risks to people were not always identified or managed. One person had behaviours that challenge which meant they could sometimes be aggressive to others living in the home. There had been a recent incident where staff had to intervene to stop them from harming another person. Staff lacked the guidance to support this person and others from keeping safe. One person liked to smoke, however there was no guidance in place to reduce the risks of them burning themselves. Since the inspection the provider told us that the person was accompanied by a staff member when smoking to ensure they were safe. We spoke with the deputy manager about this and since the inspection a fire retardant apron was now being used. There are now guidelines in place to support the person when distressed and how to keep them and others safe.

There were inconsistencies in managing people's distress and anxieties which placed others at risk of harm. One person could become agitated and threw objects and shouted. There was a risk assessment in place for keeping people and staff safe when the person began throwing objects. However, there was no guidance for staff to follow when the person started to shout to de-escalate their behaviour. Some staff told us that they did not know how to support the person when they were shouting.

For people who needed the use of equipment to be transferred, there were slings and a hoist for staff to use. People did not have their own individual slings. People need individual slings to ensure it meets their needs and keeps them safe and in the right position. It is also important for people to have their own slings to maintain infection control. Since the inspection the deputy manager told us that new slings and a new hoist were due to be purchased and labelled accordingly.

For people that needed equipment to be moved or for staff to assist them with walking or moving, there were moving and handling risk assessments in place. However, they did not meet current guidance from the Health and Safety Executive. This states that information in a risk assessment should be specific to the person and detail which sling to use, which loops and how to fit it. Without this information there was a risk that staff will use the incorrect slings, people would be unsafe or badly positioned. This placed them at risk of harm as a result.

There were risk assessments in place for people who needed them for skin integrity and falls. However, the

information on how to manage these risks was not specific to the person. For example, where a person had been identified as being at a high risk of developing pressure areas, the plan stated, 'Report any redness or sores, and complete a body map and photo if needed'. The plan lacked personalised information to tell staff what to do to reduce the risks of pressure areas. Without detailed risk assessments the risks to people and staff cannot always be managed safely. If the information is not written down, care staff may not know how to support people safely. Despite this, no harm came to the person.

The registered manager had systems in place for reviewing incidents and accidents that happened within the home and had identified any necessary action that needed to be taken. However, they had not been alerted to the incidents of aggression and self harm by one person. These reports had been kept in the persons file and had not been bought to the attention of the management. Staff told us how they would respond to an incident or accident and understood what to do in emergency situations that included accidents and falls.

Failure to manage risk demonstrated a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not always protected from avoidable harm as the registered manager had not always informed the safeguarding team when concerns arose. We found that one person had become aggressive to another and the potential for harm was high. However this was not reported to safeguarding as the management were not aware of the incidents. Staff had not bought these concerns to the attention of the management. We mentioned this to the deputy manager who has since reported it. The registered manager had reported other concerns to the safeguarding team and had taken action when necessary. There were inconsistent views from staff about what types of abuse there were how to identify abuse and who to report it to. A staff member told us "I'd go to them and calm them. I could then go to the manager or even the police." Another said "It's about protecting someone's well being, so they can live free from abuse and neglect. I would report it to my manager, the nurse in charge or social service." Despite having a safeguarding procedure in place this was not always being followed by staff.

We asked for a copy of the safe guarding policy of the home, this was sent to us after the inspection. The policy stated "It is the responsibility of all staff to alert others to any potential or suspected abuse. It is the responsibility of the management to ensure that effective robust systems are in place to ensure the maximum protection exists for the clients who live in the home." Despite having a safeguarding procedure in place this was not always being followed by staff or the management of the home.

People were not always safe from avoidable harm this is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was guidance and information provided to staff, relatives and people about how to report concerns to outside agencies. Staff knew that there were telephone numbers of the local safeguarding team and CQC to contact if required. Safeguarding information and whistleblowing information was displayed in communal areas of the home.

People told us that they thought there were enough staff. We saw that improvements had been made in this area. A person said "I think there are enough staff." Another said "Most of the time there are regular ones (staff) but we do see agency staff, usually at night." A third person told us "They are short-staffed sometimes." The deputy manager told us that there are nine carers on in the morning with one nurse and seven carers in the afternoon with one nurse. At night there are four carers with one nurse. The home also employed a cook, kitchen staff, housekeeping and laundry staff. There were also two activity co-ordinators

and a maintenance person. The rotas and our observations on the day confirmed that the agreed staffing levels were maintained.

People told us that staff responded quickly when the call bell was pressed or when they called for help. A person told us "When I call for help, they usually come quickly." Another person told us "There always seems to be someone to hand, ready to help." Staff were available in communal areas and provided care and support when required. However at lunch time we observed that two staff were helping four people to eat their meals at the same time.

We recommend that the registered manager review the deployment of staff at meal times and other busy times such as mornings.

Staff were recruited safely. Staff recruitment records contained information to show us the provider took the necessary steps to ensure they employed people who were suitable to work at the home. Staff files included a recent photograph, written references, checks on eligibility to work in the UK and a Disclosure and Barring Service (DBS) check. The DBS checks identify if prospective staff had a criminal record or were barred from working with children or vulnerable people. The registered manager ensured that when recruiting nurses their registration was checked with the Nursing and Midwifery Council (NMC).

During the inspection in June 2015 we identified a breach in Regulation 15 as the premises and equipment were not properly maintained and was not always clean. At the last inspection in March 2016 improvements had been made to the maintenance and cleanliness of the premises and equipment. However we found that work was now needed to improve the hygiene and cleanliness of the home. Parts of the home had an unpleasant odour at times during the day. The deputy manager dealt with this immediately. The floors in the communal area were sticky. We found a cushion in a communal area that had faecal matter on it. A table in a communal area had a dried fluid stain on it. The management of the home were aware of the malodours in the home. 'Slight malodour' was noted in an audit in June 2017 and from relative's feedback in June 2017. Flooring had been replaced in communal areas to try to reduce the smell. People's bedrooms were clean and tidy. We saw staff wore personal protective equipment (PPE) when supporting people when support people with their personal care and other tasks.

We recommend that the registered manager and provider reviews there cleaning and maintenance schedules to ensure that the home is clean and free from malodours.

People received their medicines safely and when they needed them. A person told us "I get my medication regularly all day." Another said "They watch me take my tablets." There were procedures in place for the safe administration and storage. However, improvements were needed in the disposal of prescribed medicines. We observed staff administer people their medicines. Staff signed the medicine administration record (MAR) after the medicine had been taken by the person in line with good practice. We looked at people's MARs and confirmed there were no gaps in their records. Staff had knowledge of the medicines that they were administering and explained to the person what the medicine was for.

For 'as required' medicine, such as pain relief or medicine to help people who may be anxious, there were now guidelines in place which told nursing staff the dose, frequency and maximum dose over a 24 hour period.

Medicines were stored safely in locked cabinets when not in use. Medicines were labelled with directions for use and contained both the expiry date and the date of opening, so that staff would know they were safe to use. When medicines were stored in a fridge temperatures were monitored daily to ensure that the medicine

was kept at the right temperature. The registered manager had identified that the medicine room was too hot for medicine to be kept safely and had identified an alternative location; however no date had been agreed for this to change over. The storage of medicines that needed to be disposed of needed improvement as there were overflowing bags of medicines that needed to be returned to the pharmacist.

People would be kept safe in the event of an emergency and their care needs would be met. The provider had a contingency plan in place should events stop the running of the service. We saw a copy of this plan which detailed what staff should do and where people could stay if an emergency occurred. People had personal evacuation and emergency plans (PEEPs) which told staff how to support people in an emergency or in the event of fire. Staff confirmed to us what they were to do in an emergency.

Requires Improvement

Is the service effective?

Our findings

At our previous inspection we found a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the requirements of the Mental Capacity Act 2005 were not always met. We also found a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as staff did not always have the skills to provide effective care to people. Similar concerns were identified during this inspection.

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. There were inconsistencies with the application of the MCA. The mental capacity assessment forms that were used by the home were not decision specific and did not follow current guidance. One stated, 'X lacks capacity on every aspect of his life on the grounds of (disease)'. Another mental capacity assessment form stated, 'I lack full capacity.' However, for the same person on another form it stated, 'I have some capacity' and, 'I need a best interest decision made for me.' This information could be confusing to staff and could mean that decisions are made on the persons behalf when they could have capacity to decide for themselves. For these two people, mental capacity assessments had not been completed and DoLS applications had not been made despite some restrictions placed on their care.

Where people lacked capacity to make decisions about their care, for example where someone needed covert medicines (where medicine is hidden in food or drink), there were mental capacity assessments and best interest decisions involving the appropriate professionals. However, there was not always a record that people's consent to care and treatment had been obtained. Where people lacked capacity to consent to their care, mental capacity assessments had not been completed.

Staff's knowledge and understanding of MCA and DoLS had improved and training records confirmed that staff had received training in this area. However a staff member told us they were not sure if they had training in mental MCA. One staff member told us "We need to decide if someone can make decisions for themselves. Act in their best interests." Further improvements were required about staffs' knowledge of DoLS, as a staff member told us that they were not sure and to check in a person's care plan. We saw staff ask for people's consent before providing their care.

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 are called the Deprivation of Liberty Safeguards (DoLS). Some people's freedom had been restricted to keep them safe. For example, some people were unable to consent to their care and required staff support and supervision in the home. The home also had a locked door and used stair gates to restrict people from using the stairs. Where people lacked capacity to understand why they needed to be kept safe the registered manager had made some DoLS applications to the relevant authorities to ensure that their liberty was being deprived in the least restrictive way.

The requirements of the Mental Capacity Act were not being met; this is a continued breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our previous inspection we found a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as staff did not always have sufficient skills and training to support people effectively. At this inspection we found that this requirement had not been met.

People told us that they thought the staff were well trained. One person said, "The staff are well trained, they get training" and another person said, "All the staff seem well trained."

There were mixed views from staff about the training. One staff member told us, "We have health and safety training and dementia training. It showed us how to deal with people with dementia." Another said, "We all need more training, especially in dementia so we can understand it. We also need training in dealing with someone who shouts and has aggressive behaviour." According to the provider information return, only a quarter of staff had received training in dementia. We saw care staff attempting to support a person who was shouting, however the person continued to shout and finally settled on their own. If staff had improved knowledge about people's histories and training in supporting people when they were distressed, this could have been managed more positively.

The deputy manager told us that training was to be provided over the summer months, in dementia and moving and handling. We saw improvements with staff using the correct techniques to move people safely. However, people's safety were at risk as some incidents were not always reported (as identified in Safe). Staff did not have a good understanding of the MCA and DoLS, which meant that some people were being deprived of their liberty unlawfully. We asked to see the training records of nursing and care staff, the deputy manager was unable to locate the training records on the day of inspection. After the inspection, we asked the registered manager for them, and they have been provided.

There was an induction for new care staff. One staff member said, "I did courses and then I followed a senior carer until I was confident." The provider information return (PIR) stated that all new care staff would be expected to complete the Care Certificate in the first 12 weeks of employment. This is a certificate that sets out standards and competencies for care workers.

Staff told us that they felt supported and that they received supervision regularly. A staff member told us, "We have one to ones often. We have a yearly appraisal too – I had mine last Tuesday." Another said, "We have regular supervision, It's helpful." Despite this, some records showed that staff received supervisions irregularly. We asked for further records regarding supervision after the inspection. They have not been received. The registered manager had commented in the PIR that regular supervision for staff was an area for improvement. Supervision is an opportunity for staff and their line manager to discuss any training needs, to discuss performance matters or peoples support needs. The nurses received clinical supervision from the registered manager.

The registered manager had not ensured that staff had the right skills and knowledge to provide effective and safe care to people. This is a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People had mixed views about the food; some people told us the food was just "Okay"' whilst other people said that it was good. Four people told us that the food was "Okay" or "All right", whilst another person said, "The food is very nice." We observed a meal time. People could choose where they wanted to sit, either in

the dining areas or in the lounges on their own tables. People had a choice of main meals, and a dessert. People waited 15 minutes before their meals were brought out by staff. Some people were getting up and walking away and staff had to stop supporting people to eat to re-direct them back into the dining area.

The deputy manager told us that they were aware that they needed to improve in this area and had very recently put guidance in place for staff. However, this was early days and good practice had not been embedded.

People had sufficient food and fluid through the day and staff served hot and cold drinks and snacks throughout the day.

People were not always protected from poor nutrition as people's food and fluid intake was not always monitored. One person's care records stated 'Staff to record any intake of food/drink diary'; however there were no food and fluid charts in place. For other people who had food or fluid charts in place, the records were not always completed. People's weights were monitored regularly and weight for people remained stable. Where weight loss had been identified, the GP was made aware and the appropriate fortified diets had been put into place. No harm came to people, this was a records issue.

People were supported to maintain their health by having access to external health care support. When there was an identified need, people had access to a range of health professionals such a GP, community psychiatric nurse, optician and podiatrists. We saw evidence of these visits in people's care plans. A person told us "They organise a chiropodist, as well as a dentist and an optician." A relative said "The doctor checked his medication when he (resident) came in."

Requires Improvement

Is the service caring?

Our findings

At our previous inspections in June 2015 and March 2016 we found a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as people's dignity was not always respected. Although we saw some improvement at this inspection there was still work needed to be done to meet the requirements.

People and their relatives said that staff were kind and caring. One person said, "Most of the staff are very nice." A second person said, "Staff are friendly towards me. A third person said, "Staff are very nice, cheerful, courteous and chatty, they are all lovely people."

Despite this staff did not always know and understand people's cultural needs and wishes. Two people were of a particular religion that meant following a certain diet. The deputy manager told us that for those two people they had a vegetarian diet and they did not prepare any specific cultural foods. The provider's website states 'We cater for all dietary needs, be they medical or cultural'. However this wasn't being followed in this instance. Staff confirmed that this diet was not being followed.

There was a religious holiday that had occurred recently for the two people; however staff confirmed that this had not been celebrated by either. One staff member told us that they did not know about the two people's culture or religion. They went on to say, "We need more background on the residents." As staff were not able to demonstrate that they were aware of two people cultural or religious needs, this meant that views and choices were not always followed or respected.

The two people did not speak English as their first language. A staff member told us it was difficult to communicate with them. Key words were printed in the person's bedroom to help staff communicate; however, staff told us they were of little use. The home had not done anything else to support this person with their communication needs. The staff member said, "We use hand gestures and point to things." This meant that some people were not always able to communicate their needs or wishes to staff.

People dignity was not always respected. We saw people being hoisted in communal areas in full view of other people, their relatives or other visitors. This practice did not maintain the person's dignity. We spoke to the deputy manager about this and they told us that they were in the process of ordering dignity screens.

This is a continued breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff were caring and had developed positive relationships with people. Staff interacted with people when they were in the communal areas. Staff were warm and showed kindness to people. One person was asked if they wanted a drink. The person did not understand what the staff was saying so the staff showed the person a choice of the two drinks available. We observed staff sat down in the lounges chatting to people and holding their hands, engaging people in conversations. One staff member crouched down to a person's level and said, "Hello my friend, how are you?"

We completed a short observational framework for inspection (SOFI). This is a tool to capture the experiences of people who use services who may not be able to express this for themselves. We observed staff interact with people at lunch time, there were 11 people at three staff present in the dining room. Staff interacted with people whilst they were eating in a positive and kind manner.

Some people and their relatives told us that they felt involved in making decisions about their care. One person said, "I do feel involved; they talk to me about things." And another person said, "I am aware of my care plan and I think they involve me in decisions about my care." A relative said, "They have discussed his care needs." However, peoples input was not always documented in people's care records.

People's privacy was respected. One person said, "Staff are always respectful when dealing with me." Another said, "I feel they [the staff] do give me respect." We saw staff knock on people's bedroom doors and waited for an answer before going in. Staff spoke to people using their preferred names. People's bedrooms were individually decorated and contained pictures and photographs of things that people were interested in and had chosen themselves.

There were no restrictions on when people could visit their relatives. Relatives told us that they were free to visit at any time. A person told us, "I do have visitors, no restrictions on them." A relative said, "My brother visits Dad, its okay for him to come anytime". We saw relatives stay with their loved ones for a meal time. One relative told us that they enjoyed the meal.

Requires Improvement

Is the service responsive?

Our findings

At our previous inspection in March 2016 we found a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as people did not always receive care that fully met their needs. Although we saw some improvement at this inspection there was still work needed to be done to meet the requirements.

People had care plans in place; however the information in the plans was inconsistent. The PIR submitted recorded that 'Our care plans are person centred and updated as necessary' however this was not what we found. For people who had specific health conditions that needed monitoring regularly, there were no specific care plans in place. One person who had a health condition that was affected by their food intake, staff told us that weekly monitoring should have occurred, but there were no records to state that this had happened. There was no care plan in place to tell staff what the normal reading should be, what to do it the reading was outside of those ranges and what they should do if their health deteriorated. We discussed this with the deputy manager and this was put into place on the day of the inspection. However, for another person with a similar condition there was an improved care plan with more details for staff.

Information in some care plans was generic and lacked detail to inform staff on how to support people, or how to manage a certain aspect of a person's health or well being. This lack of information on people's life histories and choices meant that some people would not always be getting the care that they need. Most of the care plans were tick box format which did not enable staff to enter detailed information about their care. Information in people's care plans was also generic. One person's care plan stated in the 'routine' section, the person had 'no specific pattern.' Under the heading of social and life pattern the support a person needed was to 'uphold culture' and to 'remain content'. Some staff knew people well. However, the lack of detail in peoples care records was a missed opportunity to tell staff how to support a person with their cultural needs or how the person's morning routine was and their preferences.

People did not always receive person centred care. We asked a staff member what person centred care meant, they said, "Treat people as an individual, tailor care to them." They went on to say, "Some of us are trying to do it; we need more training so we can understand it." Staff did not always know people well. Personal histories and peoples likes and preferences were not always recorded in care plans. Some people's life histories had been left blank, whilst others had minimal information. This meant that people may not always have their choices and preferences respected as carers would not always know what they were, this is particularly vital for people who may have difficulty in communicating. As information was not always recorded about peoples previous lives, there was a risk that staff may not always have the information they need to care and support people in the way they wish.

Staff told us that they were too busy to read care plans and did not always have time to compile them. A staff member said, "The carers are too busy to read care plans, but they listen and understand what is important in the handover." Another staff member said. "They give me lists on who is who. When things change they (people) tell me or the staff tell me." We asked staff how they got up to date information about people's needs. A staff member told us that the best way to get information over to staff was at handovers.

They said, "I give them any important and new information during the handover, and tell them to let me know of any concerns they have about any of the residents during their shift." Using a hand over to pass on important pieces of information and preferences is not robust to ensure that staff understand people's needs, preferences or life histories.

People's care plans contained a pre-assessment. This gave staff some information about the persons needs prior to them moving into the home. It covered areas such communication, moving and handling, medication and medical history. Pre-admission assessments contained some detail about people's needs.

Activities had improved for some people. People and their relatives told us that they were happy with the activities on offer. A person said, "There's enough entertainment to keep me occupied." Another said, "They do provide entertainment, but I don't go too much". A relative told us, "They do have things to do like singers coming in and cookery sessions." Staff were playing 1960's music in the lounges, some staff were encouraging people to get up and dance. Another person was playing a board game with a staff member. The activities co-ordinator had one to one time with people, either chatting or passing a ball to one another. Later in the afternoon an activity co-ordinator ran an arts and crafts group where people made lollipops and discussions occurred around memories of this and their childhood. However we saw there were little opportunities or activities for people who were cared for in bed or for those people who chose to stay in their rooms

People did not always receive person centred care; this is a continued breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and their relatives told us that they felt listened too. One person said, "No, I've never complained, but I would." A relative said, "I've never complained and not needed to, but when I did ring for help, they sorted the problem out."

There had been three complaints since the last inspection. Two relatives had complained about poor care of their loved one and these were responded to by the provider. The complainant was not provided with information of other organisations about who they could complain to if they were not satisfied with the provider's response. There was also no evidence of an investigation into the complaints.

In one of the complaint responses there had been no acknowledgement of the impact on the relatives concerns for their loved one. The response did not set out how the conclusions had been reached and offered limited reassurance that the concerns would be addressed.

The homes complaints policy states "An independent person will undertake the necessary investigation into events…." There was also no evidence of an investigation into the complaints. After the inspection we asked for evidence of the investigations but this was not provided. The complaints policy was sent to use after the inspection. Since the inspection the provider has told us that they had investigated the complaints. The PIR stated that the registered manager has received 32 compliments in the past 12 months.

As the provider had not followed the requirements set out in Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, this is a breach.

Inadequate

Is the service well-led?

Our findings

At our previous inspection in March 2016 we found a breach of Regulation17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the registered manager had not ensured there were robust systems in place to monitor and review the quality and safety of care. Similar concerns were identified at this inspection.

People and their relatives thought that the home was adequately led. One person said, "The organisation here is perfectly okay," others made similar comments.

At the inspection in March 2016 there were seven breaches of the Health and Social Care Act 2008 (Regulated Activities) 2014. From this inspection we identified nine breaches of regulations, three of these were new. Although people and relatives remarked that they thought the service was well-led the additional breach of regulations, lack of risk management, inconsistent approach to people's care and response to complaints highlighted concerns about how the home was run.

The deputy manager who had been in the home for two weeks had identified many areas that needed improvement and had begun to discuss and implement some changes. However, these changes should have been made and embedded after the last inspection. The registered manager had implemented some quality assurance process to monitor and improve care. However, they were not robust and did not identify any areas from the previous report or the concerns from this inspection.

The registered manager and provider had an action plan in place. The plan did not include any of the requirements that were identified in the previous inspection. Actions to be taken included, 'Increase the monitoring of the dining room and improve the 'dining experience' to include more choice, quicker service and satisfaction.' Action to be completed was 'on going'. The plan was reviewed in June 2017 but did not detail what needed to be done and how it should be done.

The registered manager and provider undertook care plan audits monthly. However this was monitoring what documents were in place rather than the content of the care records. This was a missed opportunity to evaluate what information was available to staff in knowing how to support people. An audit in May 2017 noted that fluid charts were not all completed for one person and incorrect information written on a risk assessment and, 'any changes need to be recorded in the care plan and not wait for the review…' We found that this was still an issue at this inspection.

A 'home audit' completed in April 2017 identified that, '11 points raised in CQC report – no evidence these have been addressed in an action plan.' This was not addressed in the homes action plan. There was no name on the audit to advise who had completed it. There is no evidence to state that action had been taken to meet the requirements of the previous inspection.

A Surrey County Council Quality Assurance visit from May 2017 identified that supervisions needed completing more than every six months, that work needed to be done on personal histories and to review

staffing levels at meal times. The registered manager had not completed any of the recommendations suggested. We have made a recommendation in relation to staffing levels at busy times, such as mealtimes.

The registered manager had not always ensured that complete and contemporaneous records were kept for people. Care records needed improving as information in care plans was inconsistent. One persons' care plan stated that they were 'fully independently mobile', however, the person had two falls and was had decreased mobility due to a health condition. They were now unsteady on their feet. The care plan had not been updated to reflect the change in need.

Although care plans were reviewed, the change in need was often documented there and a new care plan was not developed to tell staff how to care for the person. This person had recently undergone significant health changes and required different care; however no new care plans were implemented. Staff told us that they had not got the time to re-assess the person despite their change in need. For people who had food and fluid charts in place, the amounts were not always totalled which meant that staff would not be able to monitor the fluid intake of people that were at risk of de-hydration. For some people who had re-positioning charts in place, there were some gaps, staff told us that the person had been turned, but the information had not been recorded.

Feedback from people and their relatives had been obtained in June 2017. Some of the issues raised were that people were not always wearing their own clothes and some people had no opportunity to engage in activities. The action that had been taken to resolve both concerns were to 'Invite to care review to determine needs'. These actions did not detail how and when these issues would be resolved.

The registered manager had completed the provider information return (PIR) on time. The PIR did not always reflect what we saw on the day. The PIR stated that, 'Wherever possible we aim to deliver a service which meets those preferences including equality and diversity.' However, this was not always the case as staff were not aware of the two people who had cultural and religious needs. Their preferences and needs were not always met.

Although the registered manager and provider had put some systems in place to monitor and review the quality of care, they were not effective as they did not always identify areas that needed further improvement. Limited improvement had been made in relation to staffing levels but other areas continued to be below what was needed and some people continued to receive care that did not meet their needs.

This is a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager did not always understand her responsibilities and the requirements to notify CQC of specific incidents that had occurred. Notifications had been sent in for some incidents; however, the registered manager had not notified us of any allegations of abuse. We found three allegations of abuse from January 2017 that the registered manager had notified the local authority, however had failed to notify CQC. This meant we would not be able to effectively monitor significant events in the home.

This is a breach of Regulation 18 of the CQC (Registration) Regulations 2009.

Staff told us that they were very positive and motivated about the new changes that the deputy manager was trying to implement. One staff member said, "If it makes life better for the residents, we are of course happy." Another staff member said, "Finally we are moving forward. Carers are listened to more now."

Staff told us that they felt supported by the registered manager. A staff member said, "They are supportive. It's got better over the years." Another said, "We love her, she listens to us and supports us. If we need extra staff we get them."

Staff meetings occurred regularly. A staff member said, "We have staff meetings every month. The deputy comes in for handover and passes messages." We requested to see copies of the minutes from staff meetings; however the deputy manager could not locate them. Since the inspection we asked the registered manager to send us copies and they have been received.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 Registration Regulations 2009 Notifications of other incidents The registered manager had not always notified CQC of safe guarding concerns.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care People were not always receiving person centred care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People did not always receive dignified care. People's cultural or religious needs were not met.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent The requirements of the Mental Capacity act (2005) were not always being met.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks to people's health and wellbeing were not always identified and managed. People were at

Treatment of disease, disorder or injury	risk from unsafe care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The registered manager had not always identified and reported safe guarding concerns to the local authority.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The provider had not always investigated or responded to complaints appropriately.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The registered manager and provider had not always ensured that staff had the appropriate training and skills to care for people safe and effectively.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider and registered manager did not have robust systems in place to monitor, review and improve the care of people. The timescales for improvement were too slow.

The enforcement action we took:

To be decided at MRM. Do not publish