Golden Manor Healthcare (Ealing) Limited

Charlton Grange Care Home

Inspection report

Charlton Lane
Upper Halliford Village
Near Shepperton
Middlesex
TW17 8QN

Tel: 01932732600
Website: www.upperhallifordnursinghome.co.uk

Date of inspection visit:
04 July 2017
10 July 2017

Date of publication:
09 October 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?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

Charlton Grange Care Home provides accommodation, nursing and personal care for up to 62 older people, some of whom are living with dementia. There were 53 people living at the service at the time of our inspection.

The inspection took place on 4 and 10 July 2017. Both visits were unannounced.

There was no registered manager in post at the time of our inspection. The registered manager had recently resigned from their post and a peripatetic manager was managing the service. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run.

At the last inspection on 4 February 2016, we found the provider was in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. There were not enough staff to keep people safe in all areas of the home.

Following this inspection, the provider submitted an action plan telling us how they would make improvements in order to meet the relevant legal requirements.

At this inspection, we found staff worked hard to meet people's care needs but did not have time to engage with them, which meant some people were left without the care and support they needed for significant periods of time. Some people had complex needs and required two staff to provide their care. As a result staff spent most of their time providing care in people's bedrooms, which meant they were not able to spend sufficient time engaging with people. Comments from relatives and staff indicated that staff worked hard to provide the care people needed but were too busy to spend time with them. Some relatives were concerned that they could not locate staff when they visited the home.

Suitable steps were not always taken to minimise risks to people. Two people were at risk when trying to feed themselves whilst in bed from an almost horizontal position, which put them at risk of choking. Staff had not followed the guidance in people's care plans to ensure these risks were minimised. In one case, a person was eating their meal alone although their care plan stated they should not be left unsupervised when eating as they would be at risk of choking.

People were not always supported by staff who had received all the training they needed to provide their care. For example, two staff who cared for a person who had epilepsy had not had training in this area and told us they would not feel confident in providing the person's care if they had a seizure. Two other members of staff who supported a person who had mental health needs said they did not feel sufficiently skilled to meet the person's needs as they had not had training in this area. Some people living at the home had dysphagia (difficulty in swallowing). A lack of training in dysphagia had previously been identified as a

concern but records indicated that no staff had attended this training since October 2015.

Some people had needs that were not reflected in their care plans, which meant staff did not have guidance to follow about how to meet these needs. Some care plans did not contain information about people's lives before they moved into the home, which meant staff did not know their personal histories or interests. Some people were at risk of social isolation because they were not encouraged or supported to engage with others. There were few opportunities for people to take part in meaningful activities or to go out into their local community.

The provider's quality monitoring systems were not effective in addressing concerns where these were identified. Action was not always taken where shortfalls were identified and issues raised by relatives were not always addressed. For example quality audits had recorded that parts of the home needed refurbishment but this had not taken place. Relatives had raised concerns about staffing levels at relatives but these had not been addressed.

The views of staff about the management support they received were mixed. Some staff said the peripatetic manager had made efforts to listen to them and to recognise their efforts. Some other staff said they did not feel adequately supported or listened to, which they said had affected morale.

People were protected by the provider's recruitment procedures. The provider made appropriate pre-employment checks to ensure that only suitable staff were employed. Staff understood their responsibilities in terms of safeguarding and knew how to report concerns if they suspected abuse. They had attended safeguarding training and were able to describe the different types of abuse people may be subjected to.

People's medicines were managed safely. Medicines were stored securely and there were appropriate arrangements for the ordering and disposal of medicines. Accidents and incidents were recorded and reviewed by the peripatetic manager. The provider maintained appropriate standards of fire safety. There were plans in to ensure people would continue to receive care in the event of an emergency.

Staff had an induction when they started work, which included mandatory training and shadowing experienced colleagues. Staff told us they received one-to-one supervision and this was demonstrated by the records we checked.

People's care was provided in accordance with the Mental Capacity Act 2005 (MCA). Staff sought people's consent before providing their care and respected their choices. Applications for Deprivation of Liberty Safeguards (DoLS) authorisations had been submitted where people were subject to restrictions in their care.

Most people enjoyed the food provided at the home and were satisfied with the choice of meals. Relatives said staff tried their best to meet their family member's dietary preferences. They told us staff encouraged their family members to eat and drink to ensure they maintained adequate nutrition and hydration. Information was provided to catering staff about people's individual dietary needs and preferences.

Staff monitored people's healthcare needs and supported them to access medical treatment if they needed it. People told us they were able to see a doctor if they felt unwell and relatives said their family members' health was monitored effectively. Care plans demonstrated that healthcare professionals were involved in people's care where necessary.

People were supported by kind and caring staff. They said they had good relationships with the staff who

cared for them and enjoyed their company. Relatives told us their family members were supported by staff who worked hard to provide compassionate care. They said staff knew and respected people's preferences about their care. People told us they could have privacy when they wanted it. They said staff treated them as individuals and supported them to maintain their independence.

Any complaints received had been investigated and responded to appropriately. People told us the peripatetic manager had made efforts to get to know them and they knew the deputy manager well. Relatives said the peripatetic manager had re-introduced relatives' meetings and made themselves available to speak with them. The peripatetic manager had worked co-operatively with other agencies when necessary and had informed CQC of any notifiable events as required.

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.

Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded. .

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

There were not enough staff deployed to meet people's needs, which meant some people were left without support or interaction for significant periods of time.

Suitable steps were not always taken to minimise risks to people.

People were protected by the provider's recruitment procedures.

Staff understood safeguarding procedures and knew how to report any concerns they had about abuse.

There were plans in place to ensure people would continue to receive care in the event of an emergency.

Medicines were managed safely.

Is the service effective?

Requires Improvement

The service was not always effective.

People were not always supported by staff who had received all the training they needed to provide their care.

Staff had an induction when they started work and access to one-to-one supervision.

People's care was provided in accordance with the Mental Capacity Act 2005.

Most people enjoyed the food provided at the home and were satisfied with the choice of meals.

Staff monitored people's healthcare needs and supported them to access medical treatment if they needed it.

Is the service caring?

Requires Improvement

The service was not always caring.

Staff were kind but the lack of opportunities for engagement with staff affected people's experience of care at the home.

People had positive relationships with the staff who supported them.

Staff treated people with dignity and respect.

Staff supported people in a way that promoted their independence.

Is the service responsive?

Inadequate

The service was not responsive to people's needs.

Some people had needs that were not reflected in their care plans, which meant staff did not have guidance to follow about how to meet these needs.

Some care plans did not contain information about people's lives before they moved into the home, which meant staff did not know their personal histories or interests.

There were few opportunities for people to take part in meaningful activities or to go out into their local community.

Some people were at risk of social isolation because they were not encouraged or supported to engage with others.

Complaints were managed and investigated appropriately.

Is the service well-led?

Inadequate

The service was not well led.

The views of staff about the management support they received were mixed.

The provider's quality monitoring systems were not effective in addressing concerns where these were identified. Issues raised by relatives were not always addressed.

People told us the peripatetic manager had made efforts to get to know them and relatives said the peripatetic manager made themselves available to speak with them.

The peripatetic manager had worked co-operatively with other agencies when required and had notified CQC of any significant events.

Staff maintained daily records of the care people received.

Charlton Grange Care 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 was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 4 and 10 July 2017. Both days of the inspection were unannounced. Three inspectors carried out the first day of the inspection and two inspectors carried out the second day.

Before the inspection we reviewed the evidence we had about the service. This included any notifications of significant events, such as serious injuries or safeguarding referrals. Notifications are information about important events which the provider is required to send us by law. We reviewed information submitted by relatives and healthcare professionals. We had not asked the provider to complete a Provider Information Return (PIR) on this occasion as we were following up a breach of regulation identified at the previous inspection. The PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection we spoke with 12 people who lived at the service, five relatives and a healthcare professional. If people were unable to express themselves verbally, we observed the care they received and the interactions they had with staff. We spoke with 12 staff, including the peripatetic manager, regional manager, care, nursing and catering staff. We looked at the care records of five people, including their assessments, care plans and risk assessments. We looked at how medicines were managed and the records relating to this. We looked at five staff recruitment files and other records relating to staff support and training. We also looked at records used to monitor the quality of the service, such as the provider's audits of different aspects of the service.

Inadequate

Is the service safe?

Our findings

At our last inspection, we found there were not enough staff available in some parts of the home to meet people's needs and keep them safe. On the first floor people sometimes had to wait for care when they needed it and people at risk of falls were not always appropriately supervised.

At this inspection, we found staff worked hard to meet people's care needs but did not have time to engage with them, which meant some people were left without interaction for long periods of time. Some of the people living at the home had complex needs and many were being nursed in bed and required two staff to provide their care. As a result staff spent the majority of their time engaged in providing personal care in people's bedrooms, which meant they were not available to spend time engaging with people and getting to know them.

We spent time observing people's experience in communal areas such as the lounge and dining room. These observations confirmed that staff did not have time to spend speaking with people, which left them without any form of social interaction for significant periods of time. For example we spent 30 minutes in a lounge on the ground floor. Staff brought four people into the lounge, where the television was on. Once the staff had brought people to the lounge, they returned to providing people's care in their rooms. The four people in the lounge sat in silence for the duration of our observation with no apparent interest in the programme on the television. Two people closed their eyes and appeared to go to sleep. Staff entered the lounge approximately every five minutes to check whether people required support then left again to return to care duties. We observed similar scenarios during further observations in other areas of the home.

Relatives told us staff worked hard to meet people's care needs but did not have time to engage with them socially. One relative told us, "I don't think they've got enough staff. They need time to spend with the complicated residents so don't have time to spend with the others. They don't get enough time to be with the residents, to get to know them." A healthcare professional told us it was sometimes difficult to find an available member of staff as they were occupied in people's rooms providing their care. The healthcare professional said, "I sometimes find it hard to find staff. This morning I had to find a member of staff to get someone a drink."

A relative contacted CQC in June 2017 to express their concern that there were not enough staff deployed to support their family member to get out of bed every day or to ensure they had sufficient to drink to maintain hydration. The relative said they often had difficulty finding staff when they visited the home. The relative reported that, on one visit, "I never saw a member of staff at all. This to me is of great concern as my mother cannot talk or use a buzzer. How do they therefore know she is okay?" The relative said that, on another visit during a hot day, "There was no drink at all in her room and [relative] had to walk all round the home to find a member of staff to get her some."

A friend of a person living at the home contacted CQC in July 2017 to express their concern about staffing levels. The friend told us the person had become incontinent and they asked a care worker to support the person to change their clothing. The friend said, "I asked a carer and they said they would help as soon as

they could. It took 30 minutes to get my friend changed during which he was laying in wet clothes and a wet bed. When the carer came she was very helpful but explained there was only two of them on that morning looking after over 20 people. A bit later I asked a carer if my friend could please have a drink and was again told politely that they would get one as soon as they could, but was running late due to staff shortages and would get one as soon as possible, it never came." In a satisfaction survey carried out by the provider in November 2016, 26% of those who responded said staff were not always available. The minutes of the most recent relatives meeting recorded that one relative had commented the staff were "Run ragged."

The staff we spoke with were clear that they did not have time to spend interacting with the people they cared for and getting to know them. They understood that people needed social interaction for their continued well-being and were frustrated they did not have enough time to fulfil this aspect of their role. One member of staff told us, "There are not enough staff here and we are all under pressure. You haven't got time to sit with people, to have a chat with them." Another member of staff said, "There are not enough staff on either floor. We can't sit with people or talk with them as we are constantly on the go. We are not interacting with them." A third member of staff told us, "There are not enough staff at all. The number of nurses has improved but there are shortages with care staff as well as in the laundry and kitchen. There is not enough time to spend with the residents."

The peripatetic manager told us there were 11 care workers and two registered nurses deployed during the day, with six care workers and a registered nurse on the ground floor and five care workers and a registered nurse on the first floor. The peripatetic manager said that there were two care workers and a registered nurse on each floor, plus a member of 'floating' staff, on duty each night. The peripatetic manager told us that staffing levels were calculated using a dependency tool, which assessed people's needs on a regular basis to ensure staffing levels were appropriate to meet their needs. However quality checks carried out by the provider's regional manager identified that the staffing dependency tool had not been completed in March, April or May 2017, which meant the provider could not be sure the number of staff deployed was sufficient to meet people's needs.

Failure to deploy sufficient numbers of staff was a continuing breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff did not always take suitable steps to minimise risks to people. We observed that two people were at risk when trying to feed themselves whilst in bed. Staff had left their meal on a table next to their bed, which was above the level of their head. The people were trying to feed themselves from an almost horizontal position in bed, which put them at risk of choking. One of these people's eating and drinking care plan stated, "When in bed, needs to be sat upright to reduce risk of choking." The person's admission assessment recorded, "Needs food cutting up but able to feed self." Staff had not cut up the person's food before leaving the meal on their table, which potentially put them at risk of choking.

The second person's eating and drinking care plan stated, "She has mild dysphagia and is at risk of choking" and "Staff must ensure she is in an upright position when giving food." When we asked staff about the support this person needed to eat, they told us the person liked to feed themselves but should be sitting upright when they did so and supervised by staff. One member of staff said of the person, "I have never seen her choke but she should not be left on her own." We observed a third person eating their meal alone in their bedroom. The person's eating and drinking care plan stated they should not be left unsupervised when eating as they would be at risk of choking.

Some people had needs that were not reflected in their care plans, which meant staff did not have guidance to follow about how to meet these needs. For example one person had been diagnosed with epilepsy and

had experienced a seizure within the last 12 months. There was no care plan in place to inform staff how they should manage and monitor this condition. A member of staff told us that another person had "Very dry skin for no underlying reason." The member of staff said this was a long standing condition. When we checked the person's records, we found there was no care plan in place detailing the care the person needed to manage this condition.

Action had not been taken to monitor people who had been identified as at risk of failing to maintain an adequate weight. We saw from care records that a number of people were losing significant amounts of weight. Staff told us these people should be weighed weekly to monitor any weight loss and referrals made to healthcare professionals if necessary. Staff confirmed that these people's weights were not being recorded weekly. They told us that the scales used to weigh people had not been working for some time, which meant they had not been able to monitor this aspect of people's care. We saw a note dated 13 June 2017 stating "Hoist scale isn't working." We also found that referrals to healthcare professionals had not always been made when concerns about people's weight loss were identified. The quality monitoring check carried out by the provider's regional manager in April 2017 assessed standards of care in nutrition recording, "Not all weight loss has an action plan in place." The peripatetic manager contacted us after the first day of the inspection to advise that the scales had been recalibrated on 6 July 2017.

Failure to provide care in a safe way was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were protected by the provider's recruitment procedures. Prospective staff were required to submit an application form with details of employment history and qualifications achieved. The provider carried out appropriate checks before staff began work, including obtaining references, proof of identity, proof of address and a Disclosure and Barring Service (DBS) certificate. The DBS helps providers ensure only suitable people are employed in health and social care services. All staff were required to provide proof of their right to work in the UK and nursing staff were also required to provide evidence of current professional registration.

Staff understood their responsibilities in terms of safeguarding. They were able to describe the different types of abuse people may be subjected to and knew how to report concerns if they suspected abuse. One member of staff told us, "I would let the manager know if another staff member was not treating someone right." Another member of staff said, "I would let the safeguarding team know if I had to." Staff confirmed they would feel confident in sharing any concerns they had with the manager or senior staff. Where allegations had been made about people's care, these had been referred to the local authority safeguarding team appropriately. The provider had worked co-operatively with the local authority in investigating allegations where necessary. One relative who had made allegations about their family member's care had been dissatisfied with the outcome of the local authority investigation into their concerns. The peripatetic manager was meeting regularly with the relative to address their concerns about their family member's care.

The provider maintained appropriate standards of fire safety. A fire risk assessment had been carried out and a personal emergency evacuation plan had been developed for each person, which detailed the action to be taken to keep them safe in the event of a fire. Staff carried out weekly checks on the fire detection system, including emergency lighting and door closure mechanisms. Fire drills were carried out regularly and recorded. The fire detection system and firefighting equipment had been serviced by an engineer within the last 12 months. Accidents and incidents were recorded and reviewed by the peripatetic manager to ensure appropriate action had been taken to prevent a recurrence. There were plans in to ensure people would continue to receive care in the event of an emergency.

People's medicines were managed safely. Medicines were stored securely and there were appropriate arrangements for the ordering and disposal of medicines. Medicines requiring refrigeration were stored in an appropriate environment. Staff authorised to administer medicines had completed training in the safe management of medicines and had undertaken a competency assessment where their knowledge was checked. The member of staff who administered medicines during our inspection was confident with the systems in place and competent in their practice. The medicines administration records we checked were clear and accurate. Staff carried out medicines audits to ensure that people were receiving their medicines correctly.

Each person had a medicines profile that contained information about the medicines they took, any medicines to which they were allergic and personalised guidelines about how they received their medicines. Individual protocols were in place for medicines used 'as required' (PRN). These detailed how, when and why the medicines should be administered and included the maximum dose over a 24 hour period. Where people received their medicines covertly, the provider had followed appropriate procedures to ensure the decision to administer medicines was made in their best interests. One person chose to manage their own medicines and staff supported them to do this safely.

Requires Improvement

Is the service effective?

Our findings

People were not always supported by staff who had received all the training they needed to provide their care. Some staff expressed concern that a lack of relevant training meant they did not feel equipped to provide the care and support people needed.

We spoke with two members of staff who supported a person who had epilepsy. The staff members told us they had not had training in epilepsy and would not feel confident in providing the person's care if they had a seizure. We spoke with two other members of staff who supported a person who had mental health needs. One member of staff said they did not feel sufficiently skilled to meet the person's needs as they had not had training in this area. The member of staff told us, "We haven't had mental health training and I feel we should have. I wouldn't know how to handle him." The other member of staff said of this person's care, "Staff don't have enough knowledge [of mental health]. I have asked for training in this."

Some people living at the home had dysphagia (difficulty in swallowing). A healthcare professional contacted CQC in September 2016 to express their concern about staff knowledge of dysphagia. The healthcare professional reported, "Staff have poor knowledge around managing residents' dysphagia and do not appear keen to develop their knowledge. Manager offered training for staff but did not appear interested." We contacted the home to raise this with the registered manager at the time and received assurances that training in dysphagia would be provided to staff. At this inspection we saw that training in dysphagia was included in the provider's training programme but records indicated that no staff had attended this training since October 2015.

Although staff attended some face-to-face training, the majority of training was provided online. Staff told us they found it difficult to complete online training during their working hours as they were needed to provide people's care. One member of staff said, "The training is online and there is no support when we do it. We are expected to do it in our own time as there is not enough time to do it at work." We saw from supervision records that other members of staff had raised this issue in their supervision sessions. The provider's own training audit recorded that there was a 61% completion rate of staff training.

Failure to ensure that staff received appropriate training to enable them to carry out the duties they are employed to perform was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us they had received an induction when they started work, which had included shadowing experienced members of staff. They said they had received training in their induction in health and safety, fire safety, food hygiene, infection control, moving and handling and first aid. Staff told us they received one-to-one supervision and this was confirmed by the records we checked.

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 told us that staff asked for their consent before providing care and support. They said staff respected their choices and preferences about their care. Staff understood the rights of people to make decisions about their support for themselves. They said they had attended training in the MCA and this was confirmed by the records we checked. One member of staff told us, "We don't stop people making decisions for themselves if they can."

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

Some people were subject to restrictions as the provider judged their safety to be at risk. For example applications for DoLS authorisations had been submitted where people were subject to constant supervision by staff or unable to leave the home unaccompanied. Some people had bedrails fitted to their beds to prevent them from falling. In the majority of cases, the provider had followed an appropriate process when supporting people to make their own decisions or judging that a decision should be made in people's best interests. However in some cases, there was no evidence that a mental capacity assessment had been carried out to determine if the person had the capacity to make the decision themselves or whether it should be made in their best interests. For example applications for DoLS authorisations had been submitted for two people and staff had fitted bedrails to their beds without assessing or recording their capacity. We advised the provider of this during feedback at the end of the inspection. The provider contacted us following the inspection to confirm they would review all mental capacity assessments relating to people's care.

Most people enjoyed the food provided at the home. They said they had plenty to eat and a reasonable choice of meals. One person told us, "The food is pretty good on the whole." Another person described the food as, "Lovely." A third person told us they were vegetarian and that staff knew and respected their dietary preferences. Relatives said staff tried their best to meet their family member's dietary preferences. One relative told us, "They give him a choice of food." Another relative said their family member preferred food similar to what they had eaten in their country of origin and that staff provided this as often as possible. The relative told us, "They try and meet his food needs. They try and give him pasta every day as he prefers this now." We observed that the person was given pasta for lunch during our inspection although this was not on the menu. Another relative said staff encouraged their family member to eat well, which was important as they were at risk of inadequate nutrition. The relative told us, "They do try and encourage her to eat. She's putting on weight, which is a good sign as she is often reluctant to eat." Any specific dietary needs people had, such as texture-modified diets were recorded. Care staff shared information about people's dietary needs and preferences with catering staff.

People told us staff supported them to see a doctor if they felt unwell. Relatives said staff monitored their family member's healthcare needs and ensured they had access to any treatment they needed. One relative told us, "They monitor his healthcare." Another relatives said, "They'll ask the doctor to see him if I ask them to." A third relative told us staff had arranged an appointment with the GP the previous week when their family member felt unwell. People's care plans demonstrated that healthcare professionals had been consulted about their care where necessary, including GPs, dieticians, speech and language therapists and hospital consultants.

Requires Improvement

Is the service caring?

Our findings

People were supported by caring staff. However the ability of staff to spend time engaging with people was restricted because they were fully occupied with the provision of people's care. Relatives told us that this affected their family member's experience of care at the home. One relative said people were often left unaccompanied in the lounge because staff were too busy providing care to spend time with them. The relative told us, "There's often eight or ten residents in the lounge without any staff. Even when [staff] go in the lounge, they do it to write their notes." When we greeted a person who passed while we talking to the relative, the relative said, "What you just did there, spoke to that man, that has lapsed; they [staff] just don't have the time."

Other aspects of the service that did not function effectively also affected people's experience of care at the home. For example some relatives told us the home's laundry system did not work well. Two relatives said they took their family member's laundry home to wash as there had been problems when using the home's laundry service. One relative told us, "It either doesn't come back or you get someone else's or it's pink or it's shrunk." Another relative said they took their family member's laundry home to wash as their clothes "Used to go missing." A member of staff told us, "The laundry is in a mess."

People told us that the staff who supported them were kind and caring. They said they had good relationships with the staff and enjoyed their company. One person told us, "I get on well with them, we have a laugh and a joke." Another person described staff as "Kind." A third person said staff were "Super."

People told us staff tried hard to make them comfortable and at home. One person said, "I am quite happy here, I feel comfortable. The staff are nice, they are really good." Another person told us, "Staff are caring. A young lady brings me coffee at eleven o'clock. I can have meals in my room if I want. [Member of staff] comes into my room every morning and says 'Hello' and 'How are you?' They bring my newspaper up to me."

Relatives told us their family members were supported by caring staff. They said staff did their best to provide compassionate care in challenging circumstances. One relative said of the staff, "They are caring, there's just not enough of them. I respect each and every one of them." Another relative told us, "The carers are very good but they are under so much pressure."

Relatives told us staff worked hard to support their family members in a caring way. One relative said of their family member, "He is happy here. They do take care of him. They make a fuss of him." Another relative said of staff, "They do a sterling job." One relative told us staff had provided good support when their family member moved into the home. The relative said, "They made sure he settled in well. They made him feel welcome." People told us their friends and families could visit whenever they wished. Relatives said they were made welcome when they visited. One relative told us, "They'll always make me a cup of tea, even when they're really busy."

People told us they could have privacy when they wanted it and that staff respected their right to privacy.

They said staff treated them as individuals and respected their choices. One person told us, "They acknowledge that I'm different from everyone else." Relatives said staff maintained their family member's dignity when communicating with them and providing their care. One relative told us their family member found it difficult to accept personal care from staff. The relative said staff were careful to provide personal care in a respectful way that ensured their family member did not feel their dignity was compromised.

People told us their views about their care were listened to. Relatives said they had been consulted about the care their family members received. They told us any comments they made about their family member's care were considered. One relative said, "They do consider my suggestions." One relative told us their family member had expressed a preference for their care to be provided only by female staff. The relative said this preference was recorded in their family member's care plan and respected by staff. The relative also told us their family member needed to be hoisted for all their transfers. The relative said staff took care to ensure their family member's dignity was maintained during hoisting and that they remained comfortable throughout the process.

We observed examples of positive interactions between people and the staff who supported them. Staff engaged with people in a friendly yet respectful manner, sharing jokes and conversations. They provided care in a way that maintained people's privacy and dignity. For example they discussed people's personal care needs discreetly and ensured that any personal care required was provided in private.

People told us staff supported them to be as independent as they wished to be. They said staff respected their wishes if they chose to do things for themselves. One person told us it was "Very important" to them that they maintained their independence and said staff supported them to do this. The person told us, "When I first came in they didn't know I could do so much for myself." The person said staff had adjusted the support they provided to enable the person to manage some aspects of their care themselves.

Inadequate

Is the service responsive?

Our findings

The service was not responsive to people's needs. Care plans did not always reflect people's individual needs and wishes. Some people were at risk of social isolation because they were not encouraged or supported to engage with others. There were few opportunities to take part in meaningful activities.

Some people had needs that were not being met. The service had admitted one person who was significantly younger than the other people living at the home. We observed on both days of our inspection that the person sat at a desk in their room for long periods without any significant interaction with other people. Staff told us they checked on the person periodically but did not have time to spend speaking with them or engaging them in activities. The person's care plan contained information about their enjoyment of music and their favourite bands but the staff we spoke with were unaware of these interests.

Staff did not feel the person was receiving a service that met their needs. One member of staff told us, "[Person] shouldn't be here. There is not enough stimulation for him here." Another member of staff said, "I don't think [person] should be here. He loves a one to one but he just sits there staring at the wall." A third member of staff told us, "[Person] sits doing nothing. He could go to a day centre." A fourth member of staff told us the person had "gone downhill" since moving into the home. The member of staff said, "I don't think this is the right place for him." The person's care records also indicated that they suffered from depression but there was no care plan in place to address this.

People's needs had been assessed before they moved into the home. However some assessments failed to record important information about people's lives before they moved into the home, such as their employment, interests and important life events. This meant staff did not have access to the information they needed to fully understand people's personal histories or provide opportunities for them to pursue their interests. One person's social and leisure needs assessment recorded 'None' in the 'Important life events' section. The 'Particular achievements and skills' section of the assessment was blank and the 'Current skills or knowledge' section simply stated, "Retired." Another person's 'Past occupations/Life choices' assessment recorded simply, 'HGV.' Where people's assessments did identify interests or activities they enjoyed, they did not have opportunities to pursue these interests. For example one person's assessment recorded that they enjoyed word games, company and singing. The person was not offered the opportunity to engage in any of these activities during our inspection and their daily care notes indicated they did not have opportunities to do so.

People did not have sufficient opportunities to take part in meaningful activities. There was an activities programme for the home but this was not effective in meeting the needs of all those who lived at the home. On the first day of our inspection we observed that a craft activity took place, which was attended by five people. Other than this, we did not see people encouraged to join in group activities or offered one-to-one activities. One person told us, "I feel that there could be more things for people to do. There are people who have dementia and they are in their rooms but there isn't much for them to do." Another person said, "I haven't been to any activities yet. I haven't been asked. I used to like doing knitting."

Relatives told us there were not enough activities for their family members to enjoy or opportunities for people to engage with others. One relative said, "There are not a lot of activities. They just have the TV on a lot of the time. The residents have different needs and they don't cater for all their needs." The relative told us they had seen drawing and flower arranging sessions taking place but their family member did not enjoy these activities. The lack of activities had been identified in the provider's own quality monitoring reports for March and April 2017, both of which recorded, "There appeared to be a lack of meaningful activities taking place." There was no evidence that action had been taken to address this issue. In the most recent satisfaction survey of people and their relatives, 50% of respondents said there were not enough activities available at the home.

Staff acknowledged that people did not have sufficient access to activities to occupy or engage them. One member of staff told us, "There are not enough activities. There is no atmosphere. It's Wimbledon [tennis championships] and nothing is being done. It's American independence day today and no-one would know. There are no themed events. I don't think people have enough on each day. I feel there should be an activity co-ordinator on each floor." Another member of staff said, "There are not enough activities here." Some staff told us they were aware people had expressed an interest in going out in the local area but had not been supported to do so. The staff said they would have liked to support people to go out but there were insufficient care staff available to enable this. One member of staff told us, "There are people who would like to go to the garden centre or the pub. We would love to take them but we do not have the time."

Failure to provide care that met people's needs and reflected their preferences was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had a written complaints procedure, which detailed how complaints would be managed and listed agencies people could contact if they were not satisfied with the provider's response. People knew how to raise concerns and all the people we spoke with said they would feel comfortable making a complaint if they were dissatisfied. One relative told us, "If I've ever complained, they have done something about it."

We checked the complaints record and found that four complaints had been received in 2017. These had been had been investigated and responded to appropriately. Where complaints were complex or people had been dissatisfied with the provider's initial response, the manager met with the complainants to discuss their concerns further and to work towards a resolution. If necessary the manager had followed up complaints with other organisations, for example the manager had contacted the provider's caterers to investigate a complaint about the food.

Inadequate

Is the service well-led?

Our findings

There was no registered manager in post at the time of our inspection. The registered manager had been absent from the home since March 2017 and had recently resigned from their position. The home was being managed by a peripatetic manager employed by the provider, who had been in post since April 2017. The provider's regional manager told us the provider was actively recruiting a manager for the home, who would apply for registration with CQC once appointed.

People told us the peripatetic manager had made efforts to get to know them. They said they knew the deputy manager well as they had worked at the home for a long time. One person told us, "I have met the manager and she is very nice. [Deputy manager] asks if I am happy, which I appreciate."

Relatives said the peripatetic manager had aimed to improve communication with people's families by re-introducing relatives' meetings and being available to speak with them. They told us the peripatetic manager listened to what they had to say about their family member's care. However some relatives said the changes in the management of the home had affected the support staff received. One relative told us, "[Peripatetic manager] is trying her best but the turnover of managers has been a problem." The relative said, "There are some really good carers here and they need to listen to them. I do talk to the girls and sometimes they are so stressed and worn out. I don't think they feel they are being listened to."

The views of staff about the management support they received were mixed. Some staff said the peripatetic manager had made efforts to listen to them and to recognise their efforts. One member of staff said of the peripatetic manager, "She is good actually. She is always thanking us. She appreciates what we do." Another member of staff described the deputy manager as "Lovely" and "Helpful" and said of the management team, "They do listen." Some other staff said they did not feel adequately supported or listened to, which they said had affected morale. One member of staff told us, "Staff morale is really low and staff do not feel valued." Another member of staff said, "Staff are so low." A third member of staff told us, "We don't feel valued or supported."

The provider's quality monitoring systems were not effective in addressing concerns where these were identified. Action was not always taken where shortfalls were identified and issues raised by relatives were not always addressed.

The provider's regional manager carried out quality monitoring checks at the home each month and produced reports of their findings. The regional manager's reports for March, April and May 2017 all noted that the "Monthly dependency staffing tool was not completed." This meant the provider could not be certain that the number of staff deployed was appropriate to people's needs. The report for April 2017 identified that action plans had not been put in place where people were losing significant amounts of weight. The reports for March and April 2017 both identified a "lack of meaningful activities." The reports for March and April 2017 also recorded "The home requires refurbishment to ground floor corridors. Areas of the home require attention to detail." The refurbishment identified as necessary had not been carried out at the time of our inspection.

The peripatetic manager carried out weekly quality monitoring audits and produced reports of their findings. The peripatetic manager's weekly audit for May 2017 recorded an 80% compliance score. The compliance score identified by the provider as required to 'pass' the audit was 95%. The weekly audit for May 2017 identified a number of concerns related to the fabric of the building. In the audit section, 'Corridors and stairways: walls and doorways are without damage', the peripatetic manager had recorded, "No - requires full redecoration." In the audit section, 'Bathrooms, toilets and shower rooms: tiling, flooring and paintwork is in good repair', the peripatetic manager had recorded, "No. Ground floor – full refurbishment of paintwork. Upstairs requires a touch up." None of the remedial work identified as necessary had been completed at the time of our inspection.

The minutes of a staff meeting on 26 October 2016 noted, "CQC concern raised that staff do not know how to look after residents with dysphagia." The minutes recorded an action that the manager should arrange further training in this area. We found during our inspection that staff had not received effective training in dysphagia to meet the needs of people who had this condition. The minutes of a relatives' meeting on 14 June 2017 recorded that the relatives attending "Agreed the owners need to support the workers more" and that relatives said staff were "run ragged." The minutes of this meeting also stated, "General comment - owners not spending on the home for general upkeep and refurbishments." These issues had not been addressed as they remained areas of concern at our inspection.

Failure to effectively assess, monitor and improve the quality and safety of the services provided was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff maintained daily records of the care people received. Relatives told us they checked these records when they visited. They said daily records enabled them to keep up to date about the care their family member received, including what they ate and drank and any appointments with healthcare professionals.

The peripatetic manager had worked co-operatively with other agencies when necessary. For example the peripatetic manager had liaised with the local authority safeguarding team when concerns about people's care were raised by relatives. The peripatetic manager was aware of their responsibilities in terms of informing CQC when notifiable events occurred and had submitted statutory notifications as required.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care
Treatment of disease, disorder or injury	The registered person had failed to ensure that the care provided met people's needs and reflect their preferences.

The enforcement action we took:

We served a warning notice that required the provider to become compliant by 30 September 2017.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	The registered person had failed to provide care in a safe way for service users.

The enforcement action we took:

We served a warning notice that required the provider to become compliant by 30 September 2017.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	The registered person had failed to assess, monitor and improve the quality and safety of the services provided.

The enforcement action we took:

We served a warning notice that required the provider to become compliant by 30 September 2017.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing
Treatment of disease, disorder or injury	The registered person had failed to deploy sufficient numbers of staff. The registered person had failed to ensure that staff received appropriate training to enable them to carry out the duties they are employed to perform.

The enforcement action we took:

We served a warning notice that required the provider to become compliant by 30 September 2017.