Care Quality Commission

Northfields Care Homes Limited

West House Care Home

Inspection report

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Ratings

Overall rating for this service	**Inadequate**
Is the service safe?	**Inadequate**
Is the service effective?	**Inadequate**
Is the service caring?	**Inadequate**
Is the service responsive?	**Inadequate**
Is the service well-led?	**Inadequate**

Overall summary

The inspection of West House Care Home took place on 9 June 2015 and was unannounced. We previously inspected the service on 15 April 2014. The service was in breach of the Health and Social Care Act 2008 regulations at that time.

West House Care Home is registered to provide accommodation and personal care for up to 37 older people. On the day of our inspection there were 27 people, many of who were living with dementia, resident at West House Care Home. The home provides accommodation on the ground and first floor.

The service did not have a registered manager in place. 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 a legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Staffing levels were insufficient to meet people's needs and staff did not all have the necessary skills to support people properly.

Staff lacked knowledge and understanding of the Deprivation of Liberty Safeguards (DoLS) and the Mental

Summary of findings

Capacity Act 2005 (MCA). We saw evidence that people's freedom of movement within the home was restricted by the use of locked doors. We were told that no DoLS applications had been made to the local authority in regard to the restrictions placed on people's freedom. These examples evidenced a failure to comply with the requirements of the Mental Capacity Act 2005.

The premises had not been adapted to enable people who were living with dementia to live well. The home had bare décor, there was insufficient seating and the environment was not homely for people. Infection control measures were not sufficiently in place to ensure the home was clean.

There was a significant lack of sensory stimulation for people and people's movement within the home was restricted by locked doors and lack of support to mobilise. There was limited evidence that people who lived at the home were purposefully engaged and people were bored.

Care records did not accurately reflect the care and support people required and there was a lack of dignity, respect and person-centred care, particularly in relation to people living with dementia.

There was no evidence that the registered provider had a system in place to evaluate and monitor the quality of the service provided to people or to respond to complaints.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014.

The overall rating for this provider is 'Inadequate'. This means that it has been placed into 'Special measures' by CQC. The purpose of special measures is to:

Ensure that providers found to be providing inadequate care significantly improve.

Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.

Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.

You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was not safe.

People were not adequately protected from harm.

People were at risk of infection due to a failure to ensure the premises and equipment were safe, clean, suitable and well maintained.

Staffing levels did not meet people's needs.

Inadequate

Is the service effective?
The service was not effective.

There was no evidence that staff received appropriate or adequate induction, training or supervision.

Staff lacked knowledge about the Mental Capacity Act 2005. No DoLS application had been submitted to the local authority for people whose freedom was being restricted.

The home had not been adapted to provide appropriate support to people who were living with dementia.

Inadequate

Is the service caring?
The service was not caring.

People's dignity was not respected by staff.

People and their relatives, where appropriate, were not actively involved in the care planning process.

Inadequate

Is the service responsive?
The service was not responsive.

People were not engaged in any meaningful activities, with many people sitting for long periods of time with no stimulation.

People living with dementia were unsupported and staff did not respond effectively when they felt upset or confused.

There was no record of complaints.

Inadequate

Is the service well-led?
The service was not well led.

There was no registered manager in post.

Peoples care records were not accurate or fully reflective of their care and support needs.

There were no effective systems in place to monitor the quality of the service.

Inadequate

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

This inspection took place on 9 June 2015 and was unannounced.

The inspection team consisted of four adult social care inspectors and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for a person who uses this type of care service. The expert by experience on this occasion had experience in providing care and support to older people.

Before the inspection we reviewed all the information we held about the service including notifications. We had also received information of concern from the local authority regarding care of people who lived the home, safety and suitability of the premises and record keeping in relation to people's care. We received information of concern form a visitor to the home, who told us people were not being cared for properly in an unpleasant environment.

We used a number of different methods to help us understand the experiences of people who lived in the home. Not all the people who used the service were able to communicate verbally, and as we were not familiar with everyone's way of communicating we were unable to gain their views. 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.

During the inspection we spoke with 12 people who lived at the home and three visiting relatives. We also spoke with the acting manager, the team leader, and two staff.

We spent time looking at six people's care records and a variety of documents which related to the management of the home, including, personnel files, staff training records and maintenance of the home.

Inadequate

Is the service safe?

Our findings

We asked people whether they felt safe in the home. Some people told us they felt safe but others did not. One person told us they felt the home offered them a safer living environment than they had previously had and their relative said "I can't fault them". However, one person said: "I don't feel safe. They lock the doors at certain times and other times your door is open. I don't like it. I haven't got any money but still…". Another person said: "Nobody told us what the fire drill was. I don't know what the fire alarm sounds like and I don't know what we do if there was a fire. There are various alarms that go off and I don't know what they're for". One person told us: "I have to look out for myself and I have to keep myself safe, I can't rely on them [the staff]".

We spoke with two staff. They told us they knew there was a safeguarding policy and would know the signs of abuse and would alert the team leader if they had any concerns. However, staff did not know whether there was whistleblowing policy in place; they said they would speak with the person first and then report to the team leader if poor practice continued. Whistleblowing is when a member of staff reports suspected wrongdoing at work, particularly where someone's health or safety is in danger.

We observed people in situations that compromised their safety. For example, we saw there were frequently long periods of time where there were no staff in lounge areas and people became irritated with one another. This gave us concerns that with no staff intervention to help calm the situation, there was potential for escalation. During lunch time we saw one person shouted very loudly which made other people agitated and they shouted 'shut up' in return. Although there were staff in the room, they made no response to this situation to support people to feel safe.

This demonstrates the registered provider failured to ensure that people living at the home were protected against the risks of abuse. This is a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at the accident records for the service and saw although accidents and incidents were recorded, no analysis of these had been completed since the registered manager left in March 2015. This meant there was no opportunity to identify patterns, learn from events and consider measures to prevent a reocurrence.

We saw one person's care records showed they had been assessed in January 2015 as being at high risk of choking and was advised by the hospital to be given a soft diet and supervised when eating. We saw this person was given a salad at lunchtime, with component parts that potentially could have caused a choke hazard, such as cucumber, tomato and spring onions.This person was not closely supervised to eat. We asked the team leader about this as we were concerned the person may not have a meal that was safe for them to eat. The team leader expressed surprise that this information was in the person's records and told us the person had a normal diet, yet there were no records to show this to be the case. It was difficult to determine whether the practice or the records were incorrect for this person and staff were unable to provide evidence to substantiate the person received an appropriate diet in line with health advice.

This meant there were ineffective processes in place to identify, assess and manage risks relating to the health, safety and welfare of service users. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During our visit we made an inspection of the premises. This included looking in some people's bedrooms, communal bathrooms and toilets, lounge and dining areas. We found a number of call bells in ensuites and in bathroom and toilets had been tied up making them difficult to reach even when standing. This meant that people sitting on the toilet or fallen on the floor would not be able to access them to summon staff help.

We found a number of concerns around the home which evidenced a lack of effective management of infection prevention and control procedures. Of the fifteen bedrooms we looked in, we found six beds had been made with dirty and, in three rooms, heavily soiled linen. In two bedrooms we found the mattresses to smell strongly of urine. We also found faecal smearing on the floor in a communal toilet and on the wall in one of the bedrooms we visited. We saw two walking frames in one person's bedroom, both heavily soiled.

Inadequate

Is the service safe?

In one person's bedroom we found an unnamed pot of cream in use. The pot of cream was not pump action and therefore if used by more than one person could present a risk of cross infection.

Staff told us there was enough personal protective equipment (PPE) and said they always wore this when appropriate, for example, when assisting people with their personal care. However, facilities for staff hand washing were not available in most of the bedrooms we looked in. We also found a lack of appropriate hand washing facilities in communal toilets and bathrooms.

These examples showed a failure of the registered provider to maintain appropriate standards of cleanliness and hygiene. This demonstrated a breach of Regulation 12 (2) (h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at the systems in place for the receipt, storage and administration of medicines. We found that medicines were stored securely and daily temperature checks were recorded of the medicine fridge. However, we felt the temperature of the room in which they were stored may have been too warm for the recommended safe storage. We saw that room temperatures were not recorded and when we asked for a thermometer to check the room temperature the acting manager confirmed there was not one available. This meant there was no system in place to ensure medicines were stored safely in line with NICE guidelines.

We saw that most medicines were supplied to the home in an MDS (Monitored dose system) with other supplies in bottles and boxes. We checked a sample of boxed medicines against the amounts recorded as received and administered and found the amounts tallied.

We saw that the Medication Administration Record (MAR) sheets supplied by the pharmacist included pictures of the tablets supplied in the MDS system. This is to help staff identify the tablets and therefore reduce the risk of error. However we found that the pictures, in most cases, did not resemble the tablets supplied and so the system would not help staff identify the tablets. For example, tablets appearing as coloured blue in the picture were actually white. These anomalies had not been noted by staff who had signed for the receipt of these medicines. We shared our findings with the acting manager who agreed with our concerns.

We noticed that one person should have been administered a tablet, taken only once each month, at 7am on the day of our visit. This meant the tablet needed to be administered by the night staff. However this tablet had not been administered. The MAR sheet clearly showed what day and time the tablet was to be administered and also that one of the other tablets the person took must not be given on that day. We saw a note on the MAR sheet which said the monthly tablet had not been given because the tablet that should have been omitted had been administered. This note had been made by a member of the day staff. We raised this issue with the acting manager who agreed that the tablet should have been administered by the night staff in accordance with the prescribed time of administration and the specific instructions around the circumstances of administration. This meant the person did not receive their medication as prescribed.

We also noted that a person who had been prescribed an anti-biotic had not received their medicine on two consecutive days. The acting manager said that agency staff had been on duty to administer medicines on both of those occasions. However we saw that the issue had not been highlighted by the homes own staff and there were no clear procedures to pick up on such errors.

This meant that people did not always receive their medication as prescribed. This demonstrated a breach of Regulation 12 (2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at the recruitment file for two members of staff. We saw that references had been sought and checks made with the Disclosure and Barring Service (DBS) before staff started work at the home. The DBS has replaced the Criminal Records Bureau (CRB) and Independent Safeguarding Authority (ISA) checks. The DBS helps employers make safer recruitment decisions and prevents unsuitable people from working with vulnerable groups. However, the acting manager told us there were no staff files available for the staff that had transferred from one of the provider's other homes. The acting manager was not confident checks had been completed.

We saw from the occupancy list that 16 out of the 27 people were assessed by the provider as being 'high dependency', nine people were assessed as being 'medium dependency' and two people as 'low dependency' . High levels of dependency mean there needs to be high staffing levels to meet people's needs. Staff we spoke with did not

Inadequate

Is the service safe?

demonstrate a clear about people's dependency needs. The acting manager told us that one team leader and three care assistants during the day was sufficient to meet the needs of the people. However, we found there were five people in the home who needed two members of staff to help them with their physical needs. Furthermore we found that some staff were new to the home and did not understand people's individual needs, therefore were not able to promptly meet people's needs without consulting other staff first.

We looked at the staff rota and saw this was incorrect; not all the staff on duty were named on the rota and there were missing names of new staff who had transferred from one of the provider's other homes. This meant the acting manager was unable to identify which staff were on duty with the right mix of skills to be able to support people's needs.

Throughout our inspection we saw periods when there were no staff available to support people. For example, there were long periods of time in the lounge areas where people called out or gestured for staff attention, but there were no staff in these areas. We saw one person repeatedly called out: "Where are you, where are you" and became quite distressed. We spoke with this person who said they were waiting for staff to come back. A member of staff came with a cup of tea for this person and apologised for their wait.

We saw people had to wait a considerable length of time for their lunch. For example, we saw three people in the lounge area that had been told it was lunchtime at 12.00, yet they were still waiting at 12.45 to be served.

One person told us: "The staff are very nice but sometimes they're very busy, especially at night". Another person said: "When I need someone I can't always find them to help me".

These examples show that there were not always sufficient numbers of suitably qualified, skilled and experienced staff available to meet people's needs. This demonstrated a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service effective?

Our findings

People we spoke with told us they did not know if staff had the skills they needed to do their work. One person said: "I don't know the staff by name. They don't stop and chat. I don't really see them much so it's hard to tell if they're well trained".

One relative we spoke with told us: "The staff are nice but some of the new ones have come from a place that was closed down. Some are very young and not sure if they have the experience of working with people with dementia. You need to know what you're doing".

We saw the staff training matrix but this did not correctly list the staff employed at the home, due to other staff being transferred and so this was not up to date or accurate. Staff we spoke with told us they received training in how to use equipment. One member of staff said they were 'always learning'. The acting manager told us additional training was being planned for staff around supporting people's choices, following their recent contract monitoring visit.

We saw the team leader during the day of our visit gave clear instruction to care staff for ensuring people who needed pressure relief were repositioned frequently. However, we saw people were sometimes left for very long periods without being assisted to move. We noticed the activities co-ordinator assisted a member of care staff with a moving and handling manoeuvre. When we asked the acting manager if this member of staff had received training in this area they were unable to confirm. This meant staff may not have had the competencies required to move and handle people safely.

We looked at the personnel file for two members of staff. We did not see any record of induction other that a photocopy of an induction certificate. The certificate did not give any information about the length or content of the induction and no confirmation that the employee had understood their induction. There was no evidence of staff having received any formal supervision or appraisal. It is through regular structured meetings with a supervisor that care staff can develop their understanding and improve their practice. Staff meetings were held and minuted, although not frequently; the most recent one was held in June 2015 and the one previously was February 2015. Staff meetings provide opportunities for staff to learn from events and share ideas and good practice so it is important these are held regularly.

We asked the acting manager what induction these staff had received to work in this home. The acting manager showed us an induction checklist which did not show their competencies, but merely stated the staff had transferred from the provider's other home. The acting manager told us there was an assumption these staff were already deemed to be competent, without any further checks having been made. We asked the acting manager if there was any knowledge of whether staff had received appropriate training, such as moving and handling. The acting manager confirmed this information was not known.

These examples demonstrated the registered provider failured to have suitable arrangements in place to ensure that staff were appropriately supported. This also demonstrated the registered provider failured to ensure staff received effective induction and training in relation to their responsibilities, to enable them to deliver effective care and support to people. This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We did not find any environmental adaptations within the home which would support people living with dementia. Corridors were very bland in colour and although there were a few pictures on the walls there was no signage to assist people with orientation around the home. There were no areas for people who were walking with purpose to enjoy as they moved around the home and no items for people to engage with such as items of interest, magazines or craft equipment.

We found in one person's ensuite that there was no hot water available in the hand wash basin and when the member of staff checked the shower, they told us the water did not run warm.

One person who lived at the home told us their cold water tap ran with hot water and their shower ran cold. They said they had brought up this problem to staff several weeks ago. This was confirmed by a member of staff.

We could not find a plug for the only assisted bath we saw in the home and found that the water for this bath was only tepid.

Inadequate

Is the service effective?

Some of the bedrooms we went in felt uncomfortably warm. The member of staff accompanying us warned us about this before we entered. Some of these rooms were not occupied but others were, which meant people were sleeping in rooms with uncomfortable temperatures.

We saw a very pleasant lounge and dining area on the first floor of the home. Although we could see the rooms through the glass panes in the doors we could not go in as the doors were locked. The member of staff accompanying us said they were not used and were kept locked. This meant that people who lived at the home were denied use of these rooms which would have provided a very pleasant, peaceful environment with lovely views from the windows. We also found doors to toilets were locked and inaccessible to people.

In the downstairs lounges we saw people arguing with other over the availability of chairs to sit on. This showed there was not sufficient seating for people in these areas. We also noted that people with less complex needs were irritated and disturbed by people who presented with complex needs and disturbed behaviours.

We saw that one person, due to complex care needs, dismantled the furniture in their room and moved it around. This could have presented a safety issue for this person. We looked in the person's care records to see if any consideration had been given, through risk assessment to obtain specialist furniture. We did not see any evidence of this.

These examples demonstrated a failure of the registered provider to ensure that premises and equipment were suitable for the purpose for which they were being used. This was a breach of regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. The Deprivation of Liberty Safeguards (DoLS) are part of the Mental Capacity Act 2005. They aim to make sure that people in care homes, hospitals and supported living are looked after in a way that does not inappropriately restrict their freedom.

We asked staff about their understanding of the MCA and DoLS in relation to their work. Staff were able to explain that if a person lacks capacity, a decision may need to be made in their best interests.However, they were not able to explain the process and involvement of the person in reaching a decision, without prompting. There was no understanding of DoLS and staff were not able to explain the significance of this legislation on their role.

We looked at the care file for one person who staff had told us was subject to a section of mental health act. We saw the person's notes confirmed they were subject to a section, however when we asked staff about this they were unable to demonstrate any knowledge of the terms of the section. The acting manager later informed us that the person was no longer subject to a section of the mental health act.

We saw in practice staff lacked skills in supporting people living with dementia to make choices, in line with the MCA. For example, people were asked whether they wanted a biscuit or fruit and instead of being shown their choices they were given a plate instead. There was no pictorial information or any attempt to help people to understand what was being asked. Staff told people they would 'let them think about it' and returned a few minutes later. We saw this was not helpful to some people who had difficulty with short term memory and processing information.

We saw one person who became upset and confused because they thought they needed money to pay for lunch. A member of staff gestured towards the inspectors and told the person the inspectors were paying for lunch today. Another person who was clearly upset and in need of some reassurance was told 'don't worry about it' by staff who walked past, which did little to reassure them.

We looked at mental capacity assessments in relation to five people. We saw these were written to reflect the two stage test but there was no opportunity to evidence the answers. There was a ticklist which stated 'mental impairment'. The four areas around understanding information, weighing up the information, retaining the information and communicating the decision were all listed but only for the day of the assessment and not time or decision specific. It was also noted on one file that because someone did not have the ability to retain information they did not have capacity; there was no further exploration around this.

In a checklist for DoLS there was a series of questions as to how people's liberty may be being restricted. There was reference to locked internal and external doors but no conclusions or evidence of decisions taken or referral to the

Is the service effective?

local authority. We saw in one person's file there were restrictions placed upon the person's liberty. For example, their DoLS assessment stated they had locked doors and covert medication, yet there was no evidence of a DoLS referral having been made.

There was no evidence of any best interests meetings held in respect of any of the people deemed to lack capacity. We saw a record on the 'Doctors Log, in this person's care file that said 'We have permission from the GP to crush the tablets.' There was no evidence of any best interests' decisions having taken place for this person although a mental capacity assessment in the file concluded the person did not have capacity regarding this matter.

We asked the acting manager about DoLS referrals. They confirmed they had little understanding of the legislation but said the 'previous manager had taken them all out as they were not needed.'

These examples evidenced the failure of the registered provider to comply with the requirements of the Mental Capacity Act 2005. This was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some people told us they liked the food. However, others were less satisfied. One person told us: "The food is the only thing about this place that I don't like". We saw this person had fish pie and they remarked to staff: "Fish pie, for a change there's quite a lot of fish in – they must have known you lot [inspectors] were coming". One person told another they would like fish pie but they were presented with sausage and mash and looked disappointed. One person commented about there being three sausages, that this was unusual.

We saw the menu for the day was displayed in the dining room. We saw menus were laminated but the four weeks menus we saw had no resemblance to what was offered on the day of our visit. Staff told us people who needed help to eat their meal were assisted before anyone else at 11.30am. We saw these people were assisted with their meals on a one to one basis in their lounge chairs. Staff engaged appropriately with people as they offered support. We saw the meals offered looked appetising and were served in good portions, with second helpings where required.

We observed one member of staff interacted positively with one person they were assisting, with plenty of conversation about the food they had eaten and what they might like. The member of staff offered the person a choice of desserts and the person looked really happy at staff's suggestion of chocolate cake; staff said they would return in a minute with the person's cake, but they did not return. We saw the person was still waiting 30 minutes later for their dessert.

One person told us they were vegetarian and did not eat fish. They said this was very important to them and the kitchen staff provided meat substitutes. However, we saw this person was given fish pie for lunch. We spoke with the cook who told us this person, although vegetarian, could have fish and that meat alternatives, such as quorn, were available. The cook had a list of people's likes and dislikes in the kitchen and had a good knowledge of people's preferences and dietary needs.

We saw there were not enough seats in the dining room for all people to eat their meals together. As a result, people waited a long time after others to eat their meal and the dining experience for people was functional rather than a pleasurable occasion.

When we spoke with staff about which people had eaten lunch, they said they could not be sure and said they would need to consult with other care staff. We saw food and fluid records for people had not been completed for the day of our visit. This meant there was no accurate monitoring of people's dietary intake for staff to be able to identify if someone was at risk of malnutrition or dehydration.

Inadequate

Is the service caring?

Our findings

People told us staff were 'kind' and had 'friendly faces'. One person said:" It's alright. You can't complain". We saw some people were smartly dressed but others had uncombed hair and seemed dishevelled in appearance, although one person who we saw was going out to lunch looked very smart.

We saw inconsistencies in the quality of staff interaction with people. Some interactions were kind and caring and staff spoke with people patiently when assisting them. For example, we heard one member of staff reassured a person they could take their time when walking to the dining room. We saw one person supported patiently to get their balance with their walking frame.

However, at times we saw staff engaged with people in an impatient manner. For example, we saw one person who appeared confused and said they were looking for their room. We heard a member of staff say: Where's your stick? You've left your stick. Oh! You and your stick". On another occasion we heard staff say "Oh, just wait a minute" in an irritable voice when one person asked for a cup of tea.

Staff used people's names when addressing them. However, much of the time we saw staff were task focused and walked briskly past people without engaging with them. This meant people were often ignored.

As many people who used the service were not able to communicate verbally, and as we were not familiar with everyone's way of communicating we were unable to gain their views. During our SOFI observation we observed lunch for 40 minutes and saw the event was very task focused. Where staff engaged with people it was mostly to give or clear away food and drinks. There is a strong statistically significant correlation between high levels of neutral interactions and low levels of positive mood. For most of the time we observed people to be in a neutral mood state and for some of the time we saw people in a negative mood state.

Throughout our inspection we saw one person was particularly distressed. This person communicated with the inspector by holding their hand very tightly and gesturing with eye contact towards the care staff and pulling their hand away sharply, indicating they were unhappy. We saw this person continued to be distressed throughout the day and was not supported by staff. We looked at this person's care plan which stated staff were to distract the person in a quiet place with calm words if they became upset. However, we did not see this happened in practice.

Another person we saw, due to their health condition, walked round in circles vocalising loudly. At times this person indicated they were unhappy with facial expressions and becoming very agitated. We saw staff made little attempt to engage with this person, although their care plan stated staff were 'to give reassurance'. We saw this person remained agitated throughout the day with little input from staff.

These examples illustrate that people did not receive person centred care. The provider was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found a number of issues which suggested that staff working at the home did not always demonstrate respect for people living at the home. For example, in one bedroom we saw a large plastic tub on top of the person's wardrobe. We asked a member of staff what was in the tub and they said they didn't know. We asked to look in it and found screwed up clothing along with a number of personal items including a decorative cushion embroidered with the words 'Best Mum.' On another person's door we saw a large sign which read "All staff stop – you are only allowed to enter this room in pairs". We were told that this was in response to an allegation of theft in the room, but a sign such as this was not indicative of homely, person-centred care and was not respectful of the person whose room this was.

In another room we saw photograph collages of the person's family pushed behind the person's bedside cabinet. One person had a large bouquet of flowers in their room which the member of staff told us had been bought for their birthday the previous week. The flowers had not been removed from their cellophane wrap or arranged in the vase.

We noted that much of the bed linen was threadbare or damaged, pillows were lumpy or flat and most people only had one pillow available to them. One person told us they would like more pillows but they didn't think there were any more. We saw that new pillows had been received at the home but these were yet to be made available.

Inadequate

Is the service caring?

In one person's room we saw clothing belonging to another person. We also noted that net pants used to support incontinence pads were not named. This meant that they could be used for different people. Relatives of one person told us their family member's personal items, such as dentures and clothing had gone missing, even though clothing was named. They said when they visited they sometimes saw other people wearing their family member's clothes.

In the lounges we saw other evidence of a lack of respect for people living at the home. People who were unable to mobilise independently were seated in chairs underneath, or to the side of, the televisions which were on throughout our visit. This meant that those people could not see the televisions but the sound was above them all the time. We noticed that when people were asked to go to the dining room for a cup of tea in the afternoon, nobody was asked if they were watching a programme and would prefer to stay in the lounge. We did not see anybody given a choice of what television programme, if any, they would like to watch. We also noted that only people who were independently mobile were asked to go to the dining room.

The registered provider had failed to ensure people were treated with dignity and respect.

These examples demonstrate a breach of Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service responsive?

Our findings

One person told us: "The food's good and my room is nice. There's not much to do. I usually just watch telly. If it's nice we can go outside in the garden. I like that, but otherwise there's nowt to do". We saw there was a significant lack of stimulation for people and people had little to do and very few opportunities for social interaction, other than when being assisted with care. Throughout the day we saw people sitting inanimate, or asleep in lounge chairs or walking the corridors looking for their rooms or trying to get out of the front door. Staff did not approach or engage with these people and we found the atmosphere in the home was dismal.

In one lounge there were eight people sitting passively. There was a controversial daytime television programme on but nobody was watching this. One person told us: "I don't like this programme, but what can you do? It's always on and it's always about someone who's got pregnant by someone else's husband and then they all start shouting". Another person said: "This programme makes me feel all [clenched fists and shook head] and I don't like it one bit". We heard a radio playing in another lounge where three people were asleep. Chairs were arranged all around the walls of the lounges which prevented conversation between people. Lounges resembled waiting rooms rather than living spaces and there was nowhere for staff to engage effectively or set up activities.

We could see very little evidence people were encouraged to be involved in activities meaningful to them. We saw in one person's care records it stated they would like to go to a theatre show, yet we saw this person spent their time alone in their chair, not even with staff conversation to interest them. One person told us that they were 'strong in the church' but they did not know if there was any church involvement in the home. In the afternoon we saw a member of staff playing dominoes with two people in the dining room, although elsewhere in the home there was nothing going on to occupy or interest people.

The activities file was sparse and showed people 'walked round the garden' 'had a chat' and 'looked at a magazine'. There was no evidence activities were meaningful to people.

We saw at certain times staff attempted to give people choices, such as when the drinks trolley came. Some staff gave people choices about what they would like to drink, but this was not consistently done by all staff for all people. We knew from the contract monitoring visit this had been a concern, that people were served drinks without them first being asked what they would like. However, we saw people had limited choice as to how to spend their day and to be involved in any aspect of their care.

We saw some people who could not move without support from staff were not helped to mobilise or assisted with personal care, such as to the toilet for very long periods of time. We saw in some areas call bells were put out of people's reach. One person we spoke with in their room sounded their call bell. A member of staff came within two minutes. The person told us the staff response was quicker than usual: "That was quick compared to usual. Usually takes a hell of a lot longer. They're pulling out all the stops cos you're here".

Relatives we spoke with told us there was little stimulation or activities for people who lived at the home. One relative said: "My [family member] was in a place in…That was like a five star hotel compared to this place".

The registered provider had failed to ensure people's care was personalised for their needs and preferences. These examples demonstrate a breach of Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2014

We saw where people had concerns, these were not dealt with. For example, one person said they had reported several times that hot water came out of the cold tap and their shower was scalding hot, but that this had not been rectified. The person said they were 'fed up of telling them about it'. This was not recorded in the 'complaints and niggles' file 2014/2015 which we saw contained nothing.

Relatives told us they would complain to the staff if they were unhappy, but did not know whether their concerns would be taken seriously.

The provider did not respond appropriately to complaints and was in breach of Regulation 16 of HSCA 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

The home had been without a registered manager since March 2015. There was a temporary manager in post who had been seconded from a team leader position in one of the provider's other homes. This temporary manager told us they were managing the home until the appointment of a new manager in July 2015.

We found there was a significant lack of leadership in West House. The acting manager had been tasked with the day to day running of the home but had needed to respond to immediate concerns highlighted by the recent inspections of the local authority commissioners and the infection control audit.

We saw the team leader on duty was clear in their communications with staff. For example they discussed with staff when it would be appropriate to take their breaks and where staff should focus their attention, such as on people's pressure care. Staff we spoke with said they enjoyed working at the home and felt morale was good. However, we saw a member of ancillary staff who did not acknowledge inspectors or people who lived in the home.

The acting manager confirmed that since the previous manager left, there were no current audits or quality monitoring systems in place.We saw there were some checklists in place, such as for cleaning and for equipment and premises maintenance. However, the acting manager did not know who was responsible for carrying these out and could not identify which staff signatures were shown against the checks.Not all documentation was in place to evidence up to date checks had been carried out for gas and electricity in the home.

We saw accidents and incidents were recorded but there had been no analysis of this since the previous manager left in March 2015.

There were no robust audits done to ensure care records were accurate and reflected the care people needed. For example, information contained in care plans was conflicting. One person's care plan stated 'needs some help with continence' and another part of the care plan stated the person was 'doubly incontinent'. Another person's care plan stated 'weigh weekly' and in a different section ' weigh every month' with no indication why this would have changed. One person's care plan stated they did not have skin integrity concerns, yet in another part of the plan it stated 'skin is weak'.

Records of people's bath / shower care showed people were not being assisted with this personal hygiene frequently. For example, two people appeared as though they had not had a bath or shower for almost three weeks. When we asked staff about this, staff could not be sure whether this was a problem with people's care or with the recording of such and there were no audits in place to pick up on such matters.

Records of people's food and fluid intake had not been completed for the day of our inspection. Staff we spoke with were not sure whose responsibility this was.

This meant the registered provider had failed to establish or effectively operate systems and processes to assess and monitor the quality and safety of the service. The registered provider had further failed to make sure accurate records relating to the care of the people living at the home and the management of the service. This is a breach of regulation 17of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Enforcement actions

The table below shows where legal requirements 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 **The registered provider had failed to ensure people's care was personalised for their needs and preferences.** Regulation 9 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect **The registered provider had failed to ensure people were treated with dignity and respect.** Regulation 10 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **The registered provider had failed to maintain appropriate standards of cleanliness and hygiene.** Regulation 12 (2) (h)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **The registered provider had failed to ensure people who were living at the home were protected against the risks of abuse.** **The registered provider had failed to act with the requirements of the Mental Capacity Act 2005.** Regulation 13 (1) (2) (3) (5)

This section is primarily information for the provider

Enforcement actions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment People who use services and others were not protected against the risks associated with unsafe or unsuitable premises. Regulation (1) (c) (d) (e)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints The registered provider had failed to act upon complaints received Regulation 16

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance The registered provider had failed to establish or effectively operate systems and processes to assess and monitor the quality and safety of the service. The registered provider had further failed to make sure accurate records relating to the care of the people living at the home were maintained. Regulation 17 (1) (2) (a) (b) (c) (e) (f)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing The registered provider failed to ensure sufficient numbers of suitably qualified, competent, skilled and experienced persons were deployed.

This section is primarily information for the provider

Enforcement actions

The registered provider had failed to have suitable arrangements in place to ensure that staff were appropriately supported.

The registered provider had also failed to ensure staff received effective training in relation to their responsibilities, to enable them to deliver effective care and support to people.

Regulation 18 (2) (a) (b)