Dr Pepper's Care Corporation Limited

Western Rise

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**

Summary of findings

Overall summary

Western Rise is registered to provide accommodation with personal care for up to 37 people. People living at Western Rise had a range of needs. Some people were older, some younger, some were living with dementia and some needed help with their physical needs. The majority had mental health needs, some of which were complex. On the day of the inspection there were 28 people living there.

This inspection took place on 4 February 2016. We brought a planned inspection forward because we had received concerns about people's health and welfare.

The service was last inspected on 9 January 2015, when it was rated as 'Good'. Prior to this, the home had a history of not being able to maintain the standard of care provided to people.

This inspection took place as a result of concerns CQC received relating to the staff attitude, cleanliness and the care and welfare of people living at the service.

The registered manager for Western Rise had recently left. As a consequence there was no manager registered for the service. It is a condition of the registration for the service that a manager is registered. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Alternative management arrangements had been made. These arrangements were not robust and risks and quality issues identified during this inspection had not been identified by the management team. Action had not been taken to ensure people received a safe, effective, responsive and caring service. Although staff were well intentioned, they were working without clear leadership, direction or co-ordination. Staff talked about tasks that needed to be done and kept records relating to these. However, no one staff member had overarching responsibility for ensuring that people's needs were met, and met in a personalised way.

The majority of staff were not trained in safeguarding people and did not understand whistleblowing procedures. Staff had not escalated concerns to the registered provider when action had not been taken to ensure people were safe. Recruitment of staff was not robust enough to ensure people of good character were employed.

Risks to people's physical and mental health were not assessed or understood. As a consequence people were at risk of developing pressure sores, of becoming unwell because staff did not know about risks associated with their fluid intake, and at risk of not getting their medicines. Some people had mental health issues which were distressing to the person, and this distress was not managed. This was also distressing for others around them, and this was not managed.

There were sufficient staff on duty during the day, although we have asked the registered provider to review the staffing between 0630 and 0800am. However, staff did not receive the training or support they needed to meet their responsibilities, and to support people effectively.

The home was not clean and not well maintained. There was a strong smell of urine throughout the home and some toilets were dirty. Carpets were stained and many had significant burn marks. Parts of the home smelt of smoke. Some people were smoking in their room. One of these people had been assessed as not being safe to smoke without supervision. However, this person was smoking on their own. Fire checks had not been carried out since October 2015 and some fire doors did not close. We have shared this information with the local fire authority.

People did not always have their choice promoted. Many people were deprived of their liberty but staff did not know who had legal authorisations in place, and who didn't. The front door, porch door, door to the kitchen and door to the lower floor had key pad locks on them. Only staff knew the numbers to these doors. All staff carried a master key which they could use to go into all the bedrooms. Staff had a poor understanding of the Mental Capacity Act (2005) and when making decisions for people, were not doing this in accordance with this law.

Staff made referrals to health care professionals. However, they did not always follow the recommendations provided. For example, one person had been prescribed nutritional supplements and staff were not monitoring to ensure this person took these. This person was losing weight.

People did not always have their privacy and dignity promoted. We sat that one person was calling out whilst being hoisted in the middle of a busy lounge. Staff did not respond to this person's distress, or make attempts to protect their dignity. Distressed people, or people making requests, were sometimes ignored. People were not supported to maintain their independence or to develop new skills, and were not involved in planning their care. They spent much of their time sitting in the home. Many people said they would like to go out or do something, but there were no opportunities for this. There was a card making activity during our inspection, but people living at Western Rise said this type of activity was unusual.

Care plans did not contain information for staff on how to prevent behaviours which might challenge, or any specific information on what might help a person to be reassured or engaged. Some people told us about the small things that made them happy, but that these weren't available to them. These included going for a walk .

People's monies were well managed and kept safely.

We found ten breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, and one breach of the Care Quality Commission (Registration) Regulations 2009 (Part 4). We have also recommended the registered provider keep the staffing levels under review.

We have shared our concerns with commissioners, with the safeguarding team and with the local fire authority. People's care needs are currently being reviewed by the local authority commissioners.

We are taking further action in relation to this provider and will report on this when it is completed. 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.
• Services placed in special measures will be inspected again within six months.
• The service will be kept under review and if needed could be escalated to urgent enforcement action.

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.

Robust recruitment procedures were not in place.

People were not protected from the risks of abuse as staff were unsure of how to raise concerns outside the service.

People were not safe because risks to their health, safety and welfare were not well managed.

People were not always supported to receive medicines as prescribed.

There were sufficient staff on duty to meet people's physical care needs during the day. We have asked the registered provider to review staffing levels in the early morning.

Is the service effective?

Inadequate

The service was not effective.

People's needs were not being met because staff did not receive training and supervision to support them.

People were not supported by staff who had a good understanding of the principles of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards. As a consequence people's human rights were not upheld.

People had enough to eat and drink, although choice was somewhat limited.

Is the service caring?

Inadequate

The service was not caring.

People were not supported to be involved in making decisions about their care.

People's privacy, dignity, autonomy and independence were not respected or promoted.

Is the service responsive?

Inadequate

The service was not responsive.

Staff did not have the information they needed to provide person centred care. Where this was available, staff were not using it to good effect.

People did not receive care and support that was responsive to their needs or which helped them to have their social needs met.

People's care plans did not contain details of how their needs were to be met and were not reviewed regularly.

Is the service well-led?

Inadequate

The service was not well led.

People were at increased risk because the management systems in place were not effective.

Staff were working without direction or leadership and the quality of care provided was poor.

Western Rise

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. The planned inspection was bought forward because we had received concerns.

This inspection took place on 4 February 2016 and was unannounced. Two inspectors arrived at the home at 6.30am and were joined by another two inspectors at 9am. The inspectors were in the home until approximately 6.30pm.

Before the inspection we had received concerns relating to the health and welfare of people using the service. We reviewed information we held about the registered provider. This included information from previous inspections and notifications (about events and incidents in the home) sent to us by the provider.

We went into all rooms and areas in the home. We spoke, met with or saw everyone living at Western Rise. We spoke with the registered provider, the deputy manager, acting manager, all care and ancillary staff on duty, and with two visiting health care professionals.

We observed the interactions between staff and people living at the home and reviewed a number of records. The records we looked at included seven people's care records, the provider's quality assurance system, training, accident and incident reports, four staff recruitment records, records relating to medicine administration and staffing rotas.

Inadequate

Is the service safe?

Our findings

People living at Western Rise had a range of needs. Some people were older, some younger, some were living with dementia, some needed help with their physical needs. The majority had mental health needs, some of which were complex. People were not receiving safe care because risks to their mental and physical health were not being managed. Recruitment was not robust. People did not always get their medicines when they needed them and staff did not know how, and had not, escalated concerns about people's safety.

Records showed that only three members of staff had received training related to safeguarding vulnerable people and staff had a poor understanding of whistleblowing. One member of staff who had worked at the home for two years said they did not know how to escalate concerns to outside organisations. Another member of staff, who had worked at the home for four years, said they had raised concerns with the registered manager. This member of staff said they had not raised concerns with the registered provider when the registered manager did not take action. This meant that people were not safe from abuse because staff did not always ensure they raised their concerns beyond immediate management.

This was a breach of Regulation 13 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

People with mental health needs said they felt safe at the home. Staff told us they understood abuse and gave some examples of the types of abuse. They said they had no concerns about people's safety, but if they did would raise them with the person in charge. One member of staff told us they had raised concerns recently about another staff member and action had been taken to remove this staff member from the home. The registered manager (who has now left Western Rise) had raised safeguarding alerts with the local authority and with CQC.

Some people needed support with managing their money. Some people's money was managed through the Court of Protection procedure which required the service to request monies from them. Good records were kept of all requests for monies and all expenditure.

Risks to people and the service were not well managed. Some people were smoking in their bedrooms. This had not been risk assessed. Records relating to one person said they should not be allowed to smoke alone. However, we saw them smoking in their bedroom whilst alone. Nine bedroom doors, fitted with devices to close them in a fire, were not closing properly. We contacted the fire service about our concerns with the bedroom door closers. They have since visited Western Rise and have written to the registered provider outlining items that required attention.

Risks to people's mental health, or the risks they posed to others, were not always assessed appropriately. There was a standard set of pre-populated risk assessments in all the care files. The risks assessments did not reflect the individual risks to people. For example, one person had been considered to be a risk to others as they had been violent in their previous placement. There were no risk assessments for this person in relation to possible violence. The only comment on their care file was the person could become verbally and

physically aggressive if their mental health deteriorated. There was no information for staff on how to recognise when this may happen or what steps should be taken to minimise any risks. This placed both staff and other people living at Western Rise at risk of harm.

A note in one person's care file indicated their relative had contacted the service to raise concerns about their relative. They were concerned about the person's low mood and said they thought the person may be suicidal. There were no risk assessments in relation to this concern and no evidence that the service had responded to the relative. We have shared this information with the local safeguarding authority.

Before the inspection, we had received a concern that one person had set fire to curtains in the home. Staff had no knowledge of this, and we could not find evidence to support this. The deputy manager of the home told us no one living at the home was at risk from starting fires. However, we saw one person's records stated they had "previously broken into a shed and started a fire, also tried to set alight to his mattress in his room". There was no risk assessment in relation to the risks of the person starting fires.

Another person had fixed delusional beliefs and was anxious and in permanent distress. They constantly spoke about their beliefs to other people at the service and this could be distressing for them. There were no risk assessments in relation to this and no directions for staff on how the person's behaviours should be managed.

Each person who had risks associated with their physical health had risk assessments relating to falls, mobility and nutrition. We looked at three which were all identical. None had a management plan relating to the risk assessment or the risk identified. This meant the risks to people's physical health were not being properly assessed and managed.

There was variable practice in relation to the risk of people developing pressure sores. One person who was at risk had pressure relieving equipment in place to manage this risk. They had a safe handling plan which gave guidance to staff on how to use a hoist in order to safely move the person. This person's risk assessment indicated their risk was high. However, there was no management plan in place to reduce this risk and staff said the person was not at risk of developing pressure sores. This person's care plan (cream chart) recorded they had a "really sore bottom". This person was incontinent but could not have a bath or shower because there was no equipment suitable to facilitate this.

One person had a specific medical condition, but there was no mention of this in the care file. This meant staff had no instructions on how to monitor and manage the person's health and well-being. Another person's nutrition plan stated they needed a 'diabetic diet', but their risk assessment said there was no restriction on their diet. This meant people were at risk of receiving unsafe care and treatment as staff did not have the correct information to meet people's needs.

One person's records showed they were at risk of drinking so much fluid that they could become very unwell and had required hospitalisation in the past. Staff told us this person could get very anxious about their drinks, and not having enough to drink. Staff had restricted the amount of caffeine the person had, although they were not clear why. Staff described how they made sure this person always had a full jug of fluid and a large cup. They did not restrict how much this person drank because "they like to drink a lot". This person's care plan stated "offer plenty of fluids". The same care plan identified the risk of this person drinking too much.

One person was very thin and because of their fixed beliefs rarely ate at the home. There were no risks assessments or management plan relating to this. The person had lost almost 3 kilos since moving into

Western Rise a year ago. Staff did not appear to have acted on this weight loss. Care plans did not contain any record that this had been discussed with the GP or dietician. Care plans did not contain reference to staff having explored how they could support this person with their eating. Although the person had sachets of a nutritional supplement in their room, there was no evidence the service was monitoring the person's intake. Another person had lost a total of 4.7 kilos over a five month period. Their care plan did not contain a risk assessment or management plan about this.

Most people living at Western Rise needed support with taking their medicines. One person did not always receive their medicines when they wished and as prescribed by their doctor. Shortly after we arrived at the service, at around 7.00am one person started requesting their medicine. They were told they had to wait until the day staff came on as neither of the night staff were able to give them their medicines. The person became very agitated and distressed as they wanted their medicines. The person's records indicated they should have been given their medicines at 7.00am. The deputy manager told us that normally at least one person able to administer medicines would have been on night duty. However, due to an emergency the night rota had to be changed which led to the situation of neither staff member being able to administer medicines.

One person was prescribed a cream for a skin condition. Records showed this was not being applied as prescribed by the GP. We checked these records because the person repeatedly scratched their shoulder and chest during the inspection. Staff did not appear to notice. Medicated creams must be disposed of after 28 days. Staff were unable to do this because none of the creams that had been opened had opening dates on them.

This was a breach of Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Medicines were stored in two separate secure rooms on different floors. Medicine Administration Records (MARs) were correctly completed with no gaps on the records. There were clear records to show quantities received at the service and when any had been returned. Records relating to the administration of 'when required' medicines were not always clear as those given outside of the normal round times were not clearly recorded. There were clear instructions for staff about the dose, maximum safe dose and the reasons for administration for all 'when required' medicines.

Recruitment of suitable staff was not robust. The risk assessment relating to one member of staff's criminal record contained very little information about how the risks were to be managed or how they had been assessed. It was not clear who was responsible for completing this risk assessment as it was not signed. Although the risk assessment was not dated, it would appear it was completed after they had started to work at the home, as it contained reference to their interactions with people at the home. This meant people were at risk of receiving care from unsuitable staff during this time.

This was a breach of Regulation 19 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

We looked at the recruitment files for four staff and saw all contained proof of staff identity, references and details relating to experience in care settings. Following the inspection the registered provider supplied details of the disclosure and barring (police) checks for all staff working at the service. These indicated staff started to work at the home after the checks had been completed.

There was a strong smell of urine throughout the home. This had been reported to us as a concern by relatives and two visitors. Some areas, especially the toilet areas were not clean. One toilet wouldn't flush.

There was, what appeared to be, faeces on one bedroom floor. We were told there had been only one cleaner at the service for eight months, although a new cleaner had started the day we inspected. The cleaner told us there was no cleaning schedule and they did as much cleaning as they could. Only three members of staff had received any training in infection control and we saw a member of staff who was handling soiled linen was wearing gloves, but not an apron.

This was a breach of Regulation 15 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

There were stocks of disposable gloves and aprons kept around the home. Soap and paper towels were in all toilets and hand sanitising gel was available around the service. A member of staff was employed to manage the laundry at the home for four hours a day, Monday to Friday. Care staff managed laundry outside of these times. The laundry was clean and tidy and there were systems for managing soiled laundry which was kept and washed separately from other items.

People were cared for by five care staff in the morning, four care staff in the afternoon and two care staff at night. In addition there was a person in charge until around 5pm, a maintenance person, two kitchen staff and a laundress (between 10 am and 2pm). The registered provider visited approximately three times weekly.

When we arrived at 6.30am there were two members of care staff on duty. There were six people sitting in the lounge, three of whom were asleep, one person was walking around the home. In the following 40 minutes another four people got up. The two members of staff on duty appeared very busy and could not provide support to people, or be available to those already up, as they were busy caring for people in their bedrooms. One person was particularly distressed. Some people living at Western Rise could become upset and would need support. Staff told us one person hits and punches and that another person had a tendency to grab people. Other people living at Western Rise would find it difficult to move, or to move quickly to protect themselves, if this were needed. We have asked the registered provider to review staffing levels during the early morning period.

At other times of the day staff were available throughout the home. Call bells were responded to quickly and we saw staff spending time with people. The registered provider worked out their staffing levels using a ratio of one member of staff to eight residents, except from 8pm to 8am.

We recommend the service reviews staffing levels using a recognised tool particularly around the early morning time.

Inadequate

Is the service effective?

Our findings

People living at Western Rise had a variety of needs which staff had not had the training or support to meet effectively. Staff did not demonstrate an understanding of the importance of knowing what people's specific needs were, in order to be able to support them. Referrals were made to healthcare professionals, but the recommendations were not always followed. People did not always have enough choice, and did not always have their rights protected. The home did not provide a homely environment.

Staff did not have all the support, skills or knowledge to care for people effectively. One person was described by a member of care staff as having a personality disorder, although there was no reference to this in any of their records. This person who, before coming to live at Western Rise, was described as making progress because they were becoming more sociable, told us they spent all day in their bedroom. Another person who was very distressed by their thoughts and beliefs was ignored by staff. We were told they said things, but they weren't true. Staff did not demonstrate any understanding of the distress these thoughts caused this person. No one attended to this distress, which was clearly caused by these thoughts. One person who did not believe they were receiving an effective service said "this is a dead end, if I had a choice, I wouldn't choose this place".

Staff told us they had received training in moving and transferring, health and safety, fire, first aid and end of life care. However, they said the training had been some time ago and had not been very good. Records showed little staff training was available. Only three members of staff had received training in infection control and three had received safeguarding training. The only training available that related to the specific needs of people living at Western Rise had been completed by just four staff members. This related to managing challenging behaviour. The acting manager told us they had put a new training programme in place to address these issues.

Staff told us they only occasionally received supervision. Records confirmed this. Some supervision records identified areas for improvement. However, it was not clear how these issues would be followed up as the supervision records did not record the name of the person receiving supervision or the supervisor. There were no records relating to annual appraisals being carried out.

This was a breach of Regulation 18 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Most staff were undertaking the care certificate. The care certificate is an identified set of standards used by the care industry to support staff to meet people's needs.

We received conflicting information about whether people had a choice of foods. Some people said they had choices about what to eat, and one person told us "The food is very good" and plentiful and they never went hungry. It was not clear however, that choices were offered to everyone. For example, there was a list in the kitchen of what people living at the service had chosen to have for breakfast. This did not vary, unless the person asked for it to be varied. Some people could not make this request. Some people told us they were given their food and would ask for more if they wanted it. We heard one person ask for some porridge,

late in the morning, and they were given this. We also heard one person ask for a sandwich. Staff told us they always had a sandwich at that time and went off to prepare this.

People told us there was no choice for lunch and they just had what was given to them. One person told us there was a choice of three cereals for breakfast, but nothing else. They said "It makes me constipated, but beggars can't be choosers". Another person said the food was "OK, you have whatever you get". The chef told us there was a choice of foods at lunch time and staff asked people each day what they wanted. However, when we arrived there was only one main meal displayed on the menu. The menu sheet showed a baked potato was an alternative to the main meal. When we looked back over the previous menu sheets there was no choice recorded.

This was a breach of Regulation 14 (4) (c) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Some people living at Western Rise might not have capacity to make decisions. 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.

Records showed that staff had not received training in MCA or Deprivation of Liberty Safeguards (DoLS). Two staff had never heard of either. Staff were unclear who had capacity to make decisions and who didn't. There was conflicting information on one person's assessment of capacity. One assessment stated they had capacity, while another stated they were not able to answer questions. The person's care notes also referred to agreement from a GP that their medicines could be given without their knowledge. There was no record of other significant people being in this decision in a way that demonstrated the decision was made in the person's best interest.

Another person's file contained two mental capacity assessments in relation to administration of medicines and receiving personal care. However, neither was fully completed and there was no evidence of who had completed or had been involved in the assessment. The assessment indicated this person didn't have capacity, but there was no record of the decision made. This meant any decisions made on behalf of the person may not have been made in their best interests.

This was a breach of Regulation 11 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

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.

One person had an authorised DoLS in place. A best interest decision had been taken by the supervisory authority to agree this. This person also had a signed letter in the front of their file. This appeared to say because they lacked capacity to agree to their care plan, all activities and support would be provided in their best interests. However, there was no best interest assessment in relation to this.

People were restricted in their movements within the service and no-one could leave the home without staff opening the key-pad locked door for them. We saw one person was unable to rise from the settee they were

sitting on as the seating was not at a height from which they could rise unaided. People's movement around the home was restricted by key pads, meaning they could not go downstairs independently, where there was another lounge and conservatory. In addition, only staff had a keypad numbers to the exit doors, meaning no one could leave this home without first asking permission. Although some people had restrictions to their movements authorised by the supervising authority not everyone had such authorisations in place. This meant that some people were being unlawfully deprived of their liberty.

Staff told us they did not allow one person to leave the home although they had not carried out an assessment of their capacity and did not have lawful authorisation to deprive this person of their liberty.

This was a breach of Regulation 13 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

We looked at the majority of areas of the home with the acting manager. The only areas we did not go into were some people's bedrooms, where people told us they did not want us to go in. The home was not well maintained and there was an overpowering smell of urine throughout the service, including eight of the bedrooms. Some areas, particularly toilets were dirty and there was a general air of neglect of the environment. Four bedrooms had no curtains and one person told us they had been asking for over a month for the curtain pole to be put back up so they could have their curtains back up. Four rooms had severe burns in the carpets. We were told people smoked in their rooms and this was why there were so many burns. However, one person, whose carpet had significant burns, did not smoke. Four rooms had flooring that was either rucked or frayed and presented a trip hazard. In every room we looked in, including bathrooms and corridors, at least one light bulb was not working. Some bedrooms were tidy and contained people's personal items, whilst others were untidy, dirty and had offensive odours.

We asked the registered provider about the arrangements for maintaining the environment. They told us they had spent a large amount of money on the environment over the past year and records showed this has been spent on essential maintenance and repairs. They also told us a maintenance person was employed at the service. However, there was no effective system for staff to raise issues with the maintenance person, to ensure maintenance was carried out in a timely and systematic way. The registered provider said staff made a record of maintenance issues, but not all staff were aware of this system.

The home was not adapted for people living with dementia. The décor was tired in places, although staff reported they had carried out some wallpapering in the lounge. The TV lounge only had nine chairs meaning not everyone could choose to sit in the lounge if they wanted to. Some chairs were placed so that people would not be able to watch the TV. There was a conservatory which had both high and low seating. There was also a lounge and conservatory downstairs. However, people could not access this area independently due to a key-pad lock on the door. The décor in this area was also tired, with stained floors and carpets. One person seemed to sum it up when they said "It's alright, but if I had a choice, I wouldn't choose this. I've lived in some rough places, but this is probably the worst".

This was a breach of Regulation 15 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

One person told us they saw their GP when needed and could make appointments directly with the GP if they wanted to. They also said the service made optician appointments for them. Records showed staff made referrals to healthcare professionals such as the district nurse, GP, community psychiatric nurse, chiropodist and psychiatrist when needed.

Inadequate

Is the service caring?

Our findings

People were not cared in a personalised way that paid respect to their dignity, feelings and comfort.

We saw some friendly interactions between staff and people living at the home. For example, one staff member asked a person if they were alright and said "You look lovely in pink". However, we also saw people in distress being ignored. One person asked to see some pictures repeatedly. Staff said they would get them, but never did. We saw several people with an unkempt appearance. They were wearing dirty clothes and their hair looked untidy and unwashed. Their fingernails were long and dirty.

Where people needed support with their personal care and hygiene needs staff attended to this discreetly. However, we also saw one person being hoisted from their chair in the lounge in the presence of at least 10 men and women. Three staff were assisting this person who was calling out repeatedly, and they did not respond to this. Staff did not attempt to protect this person's dignity whilst supporting them to move.

People told us staff were "OK" and "Alright" and "Very nice" and that they had everything they needed at the service. Another person told us the staff were "Nice. I like them all. They help me, I get on well with them". One person said they had no complaints about the service but "Preferred being in hospital".

One person described staff as abusive. The registered provider told us this person's thoughts could become distorted when this person became distressed, which could be bought on by strangers. This person was visibly distressed by these thoughts, throughout the day of our inspection. Staff did not respond to them in a way that showed compassion or caring. This person had no family or supporters locally. However, although there was a poster about advocacy services displayed in the hall, this person did not have an independent advocate to support them. We have shared this information with the local safeguarding authority.

We had been told prior to the inspection that one member of staff had spoken to a person living at the home in a disrespectful manner. The person had been told in a very sharp manner, not to interrupt the staff member while they were speaking. The person in day to day charge (deputy manager) told us they had never heard any member of staff speak in a disrespectful way. They also said nothing of that nature had been reported to them. Since our inspection we have been informed by the safeguarding authority, that the person who said this had admitted it, but denies being rude.

There was no evidence people were involved in planning their care. People were unaware of their care plans. Staff did not have easy access to the care plans. The care plans were kept in the locked office. Daily records were kept locked in the dining room. Staff had to request this key from the member of staff holding it.

One care plan recorded that staff could contact their relative at any time. Despite this person experiencing periods of extreme distress, there was no evidence that staff had contacted this relative.

One person's care plan stated "I enjoy walks in the community, watching films at the cinema but please be

aware I can behave inappropriately at time. Please prompt/encourage me to plan trips, days out". There is not mention of how this person was supported with going out or where they like to go. There was no timetabling of events for this person.

There was a record relating to one person and how their dignity had not been maintained. This recorded that whilst out, the person became distressed when they had been incontinent during an outing and their pad had been so wet they had removed it. Their distress had been aggravated because staff had not planned the outing and taken extra clothing or equipment with them in case such an incident occurred. This incident was predictable and could have been prevented.

All bedroom doors were fitted with locks. However, all staff members carried 'master' keys with them at all times. This meant they could enter people's rooms at any time. We discussed this with the registered provider who told us staff may need to get into rooms in an emergency. They had not considered other ways to approach the issue of an emergency while still protecting people's privacy.

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

Inadequate

Is the service responsive?

Our findings

People living at Western Rise had many different needs. However, these needs were not met in a personalised way. People were not supported to be meaningfully engaged. Care plans did not provide staff with the information they needed to support personalised care. Care plans that did have important information, were not used by staff in a way that supported the delivery of person centred care. Feedback about people's experience was not sought or used to improve the service offered. Staff were not allocated people to support. Instead the team leader allocated tasks and checked these had been carried out. Staff completed records to show these tasks were completed. However, no one person was responsible for ensuring that each person's needs were met safely, and in a way that was person centred.

Throughout the inspection we saw many people standing around in the hallway. There was little interaction with staff other than an occasional comment when they were passing. Although there were plenty of staff around there was little attempt by staff to engage people in any kind of meaningful activity or interaction. One person told us they had enjoyed chatting to us as they never usually spoke to anyone.

One person told us that they had been asking to be taken on a shopping trip since they were admitted to the home. They told us staff were too busy to do this. They told us they spent all their time in their room and did no activities at all. We asked if anything would make their stay more comfortable and they said "I would like to go out more". Another person told us they did nothing all day "I just get up, sit in my chair and do nothing. I'd like to play cards or go into the garden but staff don't come and play cards with me". They said no trips out were organised.

One person was much younger than the other people living at Western Rise and had been living at the home for over a year. They were being supported to move out of Western Rise. They told us "It doesn't feel right living with all these old people".

We saw one person sat in the conservatory area all the time we were there. The person spent most of their time sleeping and there was little interaction with staff.

People's daily records showed little evidence of stimulation or activity. The only activity we saw on offer was Easter card making. One staff member was keen to increase the level of activities available as they recognised there was little for people to do if they could not leave the home independently. One person told us that people had been told to be on their best behaviour as CQC were inspecting. They told us that usually no activities were provided and that the card making session was only taking place because CQC was there. We saw no evidence of items such as games, books or magazines.

One person who was living with dementia had no detailed care plan in relation to their dementia. This meant staff had no instructions to follow to be able to meet the person's dementia care needs. Although there was some information regarding the emotional support they may need, this lacked the detail that staff needed to this in a person centred way, that would be more likely to be successful. For example staff were instructed to "Please support me with kindness and divert me. Prompt and encourage me to engage in

social activities".

One staff member told us about people who could display behaviour that challenged staff and other people at the home. They told us how they could prevent their behaviour becoming challenging by distracting them and talking about a subject they were interested in. However, we saw one person's care plan that just stated "Inappropriate behaviours but can easily be distracted from such behaviours". There was no description of what the behaviours may be or how to distract them.

One person had an activity plan that stated they declined to go into the community and didn't have any hobbies. However, other information suggested the person liked to play darts and liked to chat and had great stories to tell. There was no evidence that staff either played darts or chatted with the person. Their daily records referred only to matters such as how well they had eaten.

One person told us that "Having chocolate" would make their life more comfortable as they never had any. The registered provider later told us they bought sweets from the wholesaler so people could benefit from cheaper items. However, it appeared that not everyone living at the home knew this, so could not take advantage of this offer to have their preferences met.

This was a breach of Regulation 9 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

People were not routinely asked for their feedback about their care or the service provided. Where people had complaints, these were recorded weekly. Records were only available dated back to 2 December 2015. One weekly entry showed there had been an 'unpleasant telephone conversation' with a relative, but no detail of how this had been managed. The entries relating to complaints showed 'Nil' or 'nil of significance' for each week up until the day of inspection.

People were often admitted in an emergency without a pre-admission assessment. Care plans did not always contain in depth assessments recording what the person's needs were, or how they were to be met.

One person with mental health needs had been quite independent when they had been admitted to Western Rise. There was no plan to encourage the person to maintain or increase their independence, despite this having been stressed in the information given to Western Rise on their discharge from hospital. They had been stopped from making their own snacks in the main kitchen and no other provision had been made for them.

People with mental health needs had not been asked what they hoped to achieve by living at Western Rise. They had not been involved in a way that helped them to maintain their current level of mental health, or improve it. There was no reference to how each person would be supported to develop and connections outside Western Rise, and no reference to how people would be supported to improve their quality of life.

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

When we arrived at the home at 6.30am there were six people up and dressed in the lounge. Staff told us people got up when they wanted to and would not get people up unless they wished to. People we spoke with confirmed they had wanted to get up. We heard staff ask people if they wanted a shower. It appeared most people got up independently and staff asked them later if they wanted a shower.

Inadequate

Is the service well-led?

Our findings

Western Rise had not maintained compliance in meeting regulations over time. Prior to this inspection, the home had been inspected six times. Only one of these six inspections resulted in the home being judged as being fully compliant with all regulations. In June 2014 CQC issued five Warning Notices. Some people were moved out of the home and the local authority quality monitoring team worked with the home and staff to support them to bring about improvements. In March 2015 the home was rated as "good" after improvements were made. Evidence gathered during this inspection in February 2016 showed the home had not been able to maintain these improvements as eleven breaches of regulations were found.

In January 2016 we were told the registered manager was leaving, and we received concerns about people's care. During this inspection we have found people were not receiving a safe, effective, responsive or caring service.

Since the registered manager had left, the provider had appointed a member of staff to be in day to day charge of the home. They, together with a manager from another home, had been visiting Western Rise in order to assess and address the improvements needed. However, we found that the risks to people and quality issues had not been identified or managed. This meant the quality assurance and risk management systems in place were ineffective.

The provider said they were responsible for checking the previous registered manager was carrying out their role and responsibilities effectively. However, the evidence they provided showed they had not done this in a way that exposed the concerns found during this inspection. There were no audits of medicines, care plans or accidents and incidents to ensure the records were correctly completed and any issues identified were acted upon. The maintenance person told us the registered provider carried out the fire checks, but the registered provider told us this had been delegated to the maintenance person. As a result, no fire checks had been carried out. We shared these concerns with the local fire authority.

There was no system for checking the needs of people living in the home could be met by staff at the home. People were often admitted in an emergency without a pre-admission assessment. Care plans did not always contain in depth assessments recording what the person's needs were, or how they were to be met. No one person was responsible for taking an over-arching view of all the people living at Western Rise, of their needs and behaviours, and how that might affect the dynamics of the whole home.

The system for ensuring that people's needs were met on a daily basis was not robust. Staff were not allocated people to support. Instead the team leader allocated tasks and checked these had been carried out. Staff made records to show these tasks were completed. However, no one person was responsible for ensuring that each person's needs were met safely, and in a way that was person centred.

Systems for ensuring that staff had the right skills, competencies and attitudes were not effective. There was no system to ensure staff received appropriate supervisions to enable them to carry out their duties. There was no system for identifying individual staff's learning and support needs. The system for recruiting people

was not robust and this had not been identified through the audit system. Records sent to us by the registered provider showed a series of weekly and monthly meetings with staff were held. At some of these meetings concerns about staff attitudes had been raised. For example, for several weeks it was recorded a member of staff was 'lazy on nights'. There was no record that anything had been done about this.

Records relating to people were well organised. However, they were incomplete or inaccurate. There was no system in place to identify this, or to ensure that measures to reduce the risks this posed to people's care and welfare were carried out in a timely way.

Systems for checking that decisions made on behalf of people were carried out lawfully were not in place. Some people were therefore being deprived of their liberty unlawfully, and this had not been recognised.

Staff told us about the ideas they had to improve the home. They said the provider was receptive and supportive of these. One staff member told us they wanted new furniture in the conservatory as one person could not get up off the sofas independently. In the absence of any formal process for managing and prioritising suggestions and changes, these appeared to happen in an ad-hoc and uncoordinated way. Staff appeared to be acting with good intentions, but with a lack of co-ordination, managerial direction and oversight. The system for ensuring that the home was clean and well maintained was not robust.

One person told us they did not know who was in charge of the service. They knew the registered provider's name, but had met them only once.

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

The information sent to us by the registered provider contained details of two accidents to people living at the home, one incident reported by the safeguarding team and an incident involving the police. These incidents had not been reported to CQC but the registered provider or manager, as they were required to do.

This was a breach of Regulation 18 of the Health and Social Care Act (Registration) Regulations 2009.

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 18 Registration Regulations 2009 Notifications of other incidents The registered provider had not notified the Care Quality Commission of incidents that had occurred at the service. Regulation 18

The enforcement action we took:

Notice of proposal to remove location

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People did not receive personalised care that was responsive to their needs. Regulation 9 (1) (a) (b) (c) (2) (3) (a) (b)

The enforcement action we took:

Notice of proposal to remove a location

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People were not treated with dignity and respect and their privacy was not ensured. Regulation 10 (1) (2) (a) People were not supported to remain independent, or access the local community. Regulation 10 (1) (2) (b)

The enforcement action we took:

Notice of proposal to remove location

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent People's consent was not obtained before care and treatment was provided or was not obtained

lawfully. Regulation 11 (1) (2) (3)

The enforcement action we took:

Notice of proposal to remove a location

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People did not receive safe care and treatment. 12 1) (2) (a) (b) (f) (g)

The enforcement action we took:

Notice of proposal to remove a location

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 People were not fully protected from the risks of abuse. Regulation 13 (1) (2) People's movements were unlawfully restricted. Regulation 13 (1) (7) (b)

The enforcement action we took:

Notice of proposal to remove a location

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs People were not able to make choices about their diet. Regulation 14 (4) (c)

The enforcement action we took:

Notive of proposal to remove a location

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The service was not clean, secure or properly maintained. Regulation 15 (1) (a) (c) (e)

The enforcement action we took:

Notice of proposal to remove a location

Regulated activity	Regulation
Accommodation for persons who require nursing or	Regulation 17 HSCA RA Regulations 2014 Good

personal care	governance Systems to monitor and improve the service were not effective. Systems to assess monitor and mitigate risks were not effective. Contemporaneous notes for each person were not maintained or were not accurate or complete. Regulation 17 (1) (2) (a) (b) (c) (f)

The enforcement action we took:

Notice of proposal to remove location

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed People were not protected from the risks associated with unsuitable staff being employed. Regulation 19 (1) (a) (2) (a) (b)

The enforcement action we took:

Notice of proposal to remove a location

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing People were not cared for by staff who had sufficient skills, experience and training. Regulation 18 (1) (2) (a)

The enforcement action we took:

Notice of proposal to remove a location