Essex County Care Limited

Well House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We inspected Well House on 06 July 2017. This was an unannounced inspection. At the last inspection completed on 30 September 2015, we found the service was meeting all of the legal requirements we looked at. We provided an overall rating for this service of 'good'.

Well House provides accommodation and personal care for up to 43 older people who may also be living with dementia. The service does not provide nursing care. At the time of our inspection there were 32 people using the service.

At this inspection, we found four breaches of the Health and Social Care Act 2008. You can see what action we asked the provider to take at the end of this report.

The service had a registered manager in post who was also the provider. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run.

The registered provider had not ensured effective medicine management systems were in place at the service. There were no protocols in place for medicines that are prescribed as and when needed. We found discrepancies in stock levels of medicines.

The registered manager had not done all that was required to reduce risk. Moving and handling risk assessments were not being updated and bedrails were in place without an appropriate risk assessment.

The provider had not ensured that the building was well maintained. We found that windows were in a poor condition, and two bathrooms had been condemned and were not in use. Some refurbishment works had been started but other works did not have specific dates of completion.

The provider had not worked in line with the principles of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS) as mental capacity assessments and best interest information was not recorded when people's freedom of movement was restricted. There was no overview in place for deprivation of liberty safeguard authorisations, which meant the registered manager did not have oversight of authorisations in place or whether people still required them. We saw that people were supported with making decisions around their care. Staff sought people's consent before providing them with care and support.

There were gaps in staff training. We requested a revised training record which showed there were many staff who required updates in mandatory training subjects such as health and safety and fire training. Some training, such as safeguarding adults had been updated but other subjects still required updating.

Arrangements were in place for the provision of meaningful activities and stimulation. However, these arrangements were not consistent or always available for people that used the service. More opportunities are required particularly for people living with dementia. We have identified this as an area of practice that needs improvement.

People could not be assured that they would receive the support they required as care plans did not always contain accurate, up to date information.

Quality checks had not reliably identified and resolved shortfalls in some aspects of the quality and safety of the service provided.

Appropriate recruitment checks took place before staff started work. Sufficient staffing levels were being maintained.

Staff spoke positively about wanting to provide people with a high standard of care. People were supported by staff that knew them well. People were treated with kindness and compassion in their day-to-day care. People and their relatives spoke highly of the staff and the care and support they provided.

People were happy with the food and drinks provided. The chef had a good knowledge of people's likes and dislikes. People also had good access to drinks and snacks.

The above concerns in relation to the quality and safety of the service resulted in us finding breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These breaches were in relation to safe care and treatment, consent and good governance. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

Risks of harm to people were not always assessed, managed and reduced through the effective use of risk assessments.

There were sufficient numbers of staff to be able to meet people's needs safely.

Recruitment checks were carried out to ensure that staff were suitable to work with vulnerable people.

The safe management of medicines required improvement and people could be at risk of not getting medicines as prescribed

Is the service effective?

Requires Improvement

The service was not consistently effective.

The Deprivation of Liberty Safeguards (DoLS) were not monitored effectively and the correct processes were not always in place so that decisions could be made in the person's best interests.

People spoke positively about the meals and drinks provided.

People had timely access to services to support them in maintaining their health.

Is the service caring?

Good

The service was caring.

People told us that staff were caring. We saw positive interactions between people and staff.

People told us and our own observations confirmed that staff promoted people's privacy and dignity.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

The care plans we looked at had not always been updated on a regular basis, some sections were not completed appropriately or were inaccurate. This meant we could not be sure people were receiving appropriate care and support to meet their needs.

The provision of meaningful activities required strengthening. Further work was required to ensure that everybody had the opportunity to be included in activity provision.

People and their relatives were listened to and arrangements were in place to respond to complaints.

Is the service well-led?

Requires Improvement

The service was not well led.

The provider and leadership of the home had not sustained the Good which was found at the last inspection.

Quality checks had not reliably identified and resolved shortfalls in some aspects of the quality and safety of the service provided.

People and staff spoke positively about the registered manager.

Improvements were required to ensure people were receiving high quality and safe care.

Well House

Detailed findings

Background to this inspection

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

The inspection took place on the 06 July 2017 and was unannounced. The inspection team consisted of two inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

As part of the inspection we reviewed the information we held about the service. We looked to see if the provider had sent statutory notifications. A statutory notification contains information about important events which the provider is required to send to us by law. We sought information and views from the local authority. We also reviewed information that had been sent to us by the public. We used this information to help us plan our inspection.

During our inspection we spoke with ten people, six visiting relatives, the registered manager, a member of the housekeeping team and seven care staff.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk to us. We also spent time observing day to day life and the support people were offered. We reviewed a range of records about peoples' care and how the service was managed. These included the care records for seven people and medicine administration record (MAR) sheets. We also looked at records relating to the management of the service, including recruitment records, complaints and quality assurance records.

Requires Improvement

Is the service safe?

Our findings

The service used an electronic medication system, staff used a hand held device that scanned each individual medicine box, the scanner then identified the individual medicine administration record (MAR). The MAR included all relevant information staff required to administer the medicine as prescribed. The system prevented medicines from being administered too early; however, the provider's arrangements for the management of medicines required improvement.

We audited people's medicines and found discrepancies which indicated people had received medicines which had been signed for on their medicines administration record (MAR). We counted 25 boxes of tablets, out of these, six contained the incorrect balance, the senior staff were auditing medicines weekly but had not picked up the discrepancies. Where people had been prescribed 'as needed' medication (PRN) such as pain relief or medicines to aid their sleep, guidance was not available to staff to determine when to use these medicines. For example, where people were unable to communicate verbally that they were in pain, or anxious, there was no personalised guidance provided to guide staff when to use these medications. Temperatures of the room storing medicines and the medicines fridge were checked daily.

Care plans contained a range of risk assessments for such areas as mobility, falls, nutritional health and skin integrity. We found these were not always updated regularly, and sometimes contained contradictory information. For example, in one care plan we found several documents related to a person's mobility. One document was blank, one stated that the person required a hoist. In another section, the care plan stated the person paces up and down. In another care plan, the risk assessment stated the person required the use of a hoist, again in another section of the care their mobility was recorded as "walks by themselves." This meant people were at risk of not receiving safe care and treatment. We spoke with staff about their understanding of the specific risks related to these two people. They were able to discuss these and were aware of the mobility needs of both people.

On another person's care plan, we could not find a risk assessment for bedrails, this person had recently sustained a fall from bed and bed rails were put into place. However, we did not find any information related to this update in the care plan.

We completed a tour of the premises as part of our inspection. We looked at people's bedrooms, bathrooms, communal living spaces, the kitchen and the garden area. We found courtyard areas were untidy and required attention. Windows in the corridors and some bedrooms had peeling paint that required attention. Two bathrooms were out of action and the registered manager told us they had been condemned. Lighting outside of kitchen was very poor and used by people walking around the home. A refurbishment programme had begun in the service with one unit that had been completely refurbished and another unit emptied ready to start. Some of these issues had been identified on a recent health and safety audit and the registered manager did show us a plan with additional works but no dates were included. Following the inspection the registered manager did send some proposed dates for bathroom refurbishment but these dates were not confirmed.

Risk assessments were also in place for risks associated with behaviours that might cause harm to other people or staff. One care plan stated, "[Person] may cause other residents or staff harm." We noted that the control measures said, "Staff are to report accidents to the senior on duty." This did not provide adequate advice for staff. However, we observed staff supporting this person and noted that they were able to meet their needs safely.

These failings are a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We did see some examples where risk assessments did contain more information and guidance for staff to follow. For example, one person had a risk assessment in place as they were at high risk of developing a UTI, there was information on the signs and symptoms which staff needed to look out for. Another person had a good risk assessment in place for a chest infection. There was a list of symptoms to look for and then advice to staff as to what to do if they spotted any of these.

There were systems in place to ensure the environment and equipment was fit for purpose and equipment serviced regularly. The service employed a maintenance person who had clear oversight of this. A recent inspection by the fire service had taken place and personal evacuation plans were in place. We saw regular checks of water temperatures and action taken. Some portable electrical equipment testing had taken place but not completed. When we asked the registered manager why this was, they told us that there tester had been taken to another home in the provider group and the testing would be completed on its return. Staff observed good infection control procedures and we did note that the service was visibly clean.

People were protected from the risks of harm and abuse. Staff had received training in safeguarding vulnerable adults and were able to describe to us how they would recognise abuse. Staff were aware of the correct processes to follow in order to report abuse, including how to report concerns about poor practice. As a result of concerns raised with the manager, from outside professionals, prior to our inspection all staff had completed workbooks to increase their knowledge about the safeguarding of adults.

One staff member told us, "I know about the whistleblowing policy but I have never had to do this in all the time I have been here. I would just tell the manager. I have worked elsewhere and left because I was unhappy. Here I know things will be dealt with properly."

Staff knew people very well and people felt safe and their relatives confirmed this. Comments from people included, " Very good here, I have no complaints ", " It is a complete family home ", " Staff make me feel safe, I find them very nice, they are all different ages and I can say that there is not a bad one here." Relatives told us, " They never know what time I am coming and I know she is absolutely safe, there are always people about who know the needs of the residents and they know the danger points "," I cannot fault it, they treat [family member] so well, was not an easy person to start with and used to hit them but they were amazing and once they had settled [family member] they would come and give them a cuddle."

People and their relatives thought there were enough staff on duty and our observations confirmed this was the case. Comments included, ""They are reliable caring staff most of them and I am never rushed and we have a couple of male carers", " Majority of times there are staff about and if I buzz it is not over long before they come, same day and night and weekends the same ", " Staff are very good, polite and see to things straight away – always staff around ", " Staff make it, I feel safe, staff are always about and we have got a bell if we need it and two bells in our rooms."

The provider had a recruitment process in place to help ensure that staff they recruited were suitable to

work with the people they supported. All of the appropriate checks, such as references and Disclosure and Barring Service (DBS) checks were completed for all of the staff. A DBS check will identify if prospective staff had a criminal record or were barred from working with children or vulnerable people. Although the information was all within the files we found these were not clearly ordered which meant finding the information difficult. We recommended this be addressed to enable the manager to more easily check for gaps within the recruitment process.

Requires Improvement

Is the service effective?

Our findings

Staff had received an induction into their role, which enabled them to meet the needs of the people they were supporting. This included a period of shadowing a more experienced member of staff who assessed their suitability to work on their own. Staff were also required to complete a workbook, following the principles of the care certificate, which needed to be signed off by a senior member of staff. The Care Certificate is a set of standards that health and social care workers adhere to in their daily working life. Staff were provided with training as part of their induction and attended classroom based training for most subjects.

The provider's trainer had recently left and the registered manager told us that they were unsure of the plans for training going forward and had plans to meet with the trainer's replacement. However, training records identified that there were staff that did not have up to date training in several areas for example, fire safety, food hygiene, infection control, manual handling and COSHH. The registered manager agreed to send an up to date training plan to us following the inspection and had updated some training since the inspection. They also informed us that they had registered with a new training provider.

A member of staff told us that the training had improved recently. They told us about a training on dementia which they had attended. They said, "It was about the thoughts of a person with dementia and was a real eye opener." Another staff member told us, "In dementia training we had seminars, but the book I find really good as you complete the activities and go onto the links to find out more about the things I was not sure of." A third member of staff told us that training on what to write in the care plans could be better. They added, "Everyone knows the residents and we do it but sometimes on paper it doesn't look like we do."

There were a number of observations of staff practice in staff files, for example staff were observed supporting a person to use a hoist. The records did not reflect a challenging process but the manager told us they preferred to offer advice informally. There were some good observations in staff files, particularly around practical tasks, for example a member of staff was told not to put dirty washing on the bathroom floor was this was an infection control issue.

Our observation of staff practice demonstrated that staff knew people really well. One person's care plan stated, "Likes to drink excessively." We observed the person asking for another drink as soon as they had finished one. Although there was no detailed advice for staff in the care plan, staff demonstrated a high level of skill and knowledge in diverting the person, whilst not actually refusing to give them drinks. A member of staff told us how they supported the person. "It all depends how you approach them. You could ask them to sing a song. They love noise so you could do a car noise."

We spoke with staff about their monitoring documents and why people were checked so intensely. Their answer demonstrated a really good understanding of people needs in relation to skin care. The member of staff felt that with the hot weather and people's skin care, sores can develop really quickly, and these frequent checks meant they could pick concerns up quickly. We observed this member of staff throughout the day and they were very knowledgeable and skilled in practice as well as in being able to explain the care

they provided.

Following concerns raised by stakeholders for example, about whether staff were aware of the whistleblowing policy, the manager had proactively implemented improvements in staff skills and knowledge. For example, they had used group supervision sessions and additional training to offer practical advice and guidance to staff. Our discussions with staff demonstrated that this had been effective. This process was on going, for example, staff had been booked onto a refresher manual handling course.

Staff confirmed they received supervision with a senior member of staff. One member of staff told us they found this a useful meeting and they had been supported to consider what skills they needed to develop to progress to a senior level. They told us they attended team meetings which were held regularly.

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

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

We saw one person was being cared for in bed and had bed rails in place, the person did not have capacity to consent to these rails being used. We looked at the person's care plan and could not see why the person had these in place and that it had not been agreed following the principles of the MCA as being in the person's best interests. Staff we spoke with told us that the person had recently fallen from their bed and that was why bedrails were in place. We also spoke to the person's family member who told us that they had been consulted about the bedrails. However, the persons care plan did not contain any information related to the bedrails. We also saw another person that had a potential restrictive practice in place. There was no information on their care plan to explain why this practice was in place. The registered manager told us the person's family member had purchased and requested this but the care plan did not contain any information to support best interest decision making. This meant people's rights were not protected because staff did not follow the guidance of the MCA. Decision specific mental capacity assessments were not carried out before decisions were made to deprive people of their liberty.

Some people had applications or authorisations in place in relation to deprivation of liberty but the registered manager told us that they did not have an overview in place so was unsure if these were still in date. They also confirmed that other people still required these applications. This meant that some people living at the service were being deprived of their liberty without authorisation.

This meant people's rights were not protected. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager did inform us following the inspection that all deprivation of liberty applications had been sent.

Staff asked people's consent before putting their plates on the table but this appeared to be more out of courtesy than choice as people had made a decision about the meal prior to lunch. They did not offer the

alternative, which was luncheon meat. We asked the staff and they clearly knew people really well and said no one liked the alternative in this lounge, but could tell us about a person in another lounge who they knew would go for the cold meat. There were three types of vegetable and again no choice was offered. We asked staff about this and they said, "If [person] was here they would definitely not have carrots." Whilst this demonstrated staff knew people well, there was scope to offer greater choice to increase people's control over what they ate.

People told us that they liked the food they were offered. Comments included, "Food is ample, your choice, lunch is written on the board and you can have want you want, never hungry", "If you want something in the evening to eat there are sausage rolls or sandwiches. Had a glass of wine with dinner last week", "Food is nice, two choices and they would cobble something up if you did not like either, I am never thirsty, I have a catheter and have to drink" and, "Food is very good." Relatives also commented on the food, "I come every day and help with [family member] meals and I have my meal, food is very good, there are lots of foods I cannot eat and they do a meal for me and [family member] eats well" and "Food is really nice, quite a range of foods and the chef is aware of what foods are successful and what is not." During the afternoon a variety of snacks were sent out by the chef for people, these snacks included fruit, slices of quiche, flapjacks, sponge cakes and strawberry milkshakes.

The chef told us they met with all new arrivals and asked them what their favourite meal is so they can cook it for them soon after their arrival. They knew people well and told us they were hands on with the senior members of care staff. They told us they went round once a week to see people and have a chat. They helped dish up regularly which helped them understand people's needs or any issues experienced by care staff. They were able to describe people's specialist needs, such as pureed food. They were enthusiastic about birthday cakes and really made an effort to make these and other special days a pleasure for people. They told us people made the choice of meals 24 hours in advance.

We found the chef to be committed and enthusiastic. However, they had not been supported to develop their skills in terms of the best practice options available when ensuring the nutrition for people with complex needs. They were not aware of show plates or picture menus to support people with dementia to make choices at the time of the meal or how to present soft food in a more appealing way.

People were supported to maintain good health and had access to appropriate healthcare services. Their records showed they had regular appointments with health professionals, such as chiropodists, opticians, and GPs.

The manager kept a record in the main office of all the professional visits. This was done to keep a central record of visits. We met the district nurse who visited daily to administer insulin. They told us, "It's fantastic. It is one of my favourite homes. It has a lovely atmosphere. Only the physical appearance is an issue. They always come round with us when do insulin and ask us what we have done. For example, they ask us what side we have done it on. There is always enough staff, someone always comes up to you when you visit." The manager told us the GP surgery was very supportive and most if not all of the people were registered with the one surgery.

Good

Is the service caring?

Our findings

People and their visitors said that they felt staff knew them well. They understood how people wanted to be supported and interacted with them in a warm and kindly manner. One person told us, "Staff are very good more like family friends, they don't overdo it, they ask if you need help and say can they do something for you." Another person said, "It is very good, person family approach and caring." A relative told us, "They treat [family member] like an individual and they talk to [family member] about me when I am not here – they still ask [family member] things and talk to them, they ask me about [family member] and they really do know them very well. They support me, always pleased to see me and a few months ago I was upset and went to [family members] room and a carer came to comfort me." Another relative told us, "I am always welcomed, staff are always friendly, [family member] is bathed once a week and they keep them clean and tidy, clothes changed daily and I am quite happy with the care they are getting.

We observed that all of the staff across the service knew everyone and were affectionate and treated people as an individual. For example, the handyman saw that a person was anxious and stopped and chatted to them to reassure them. We also observed a member of domestic staff come over to a person and admire their newly painted nails. We spoke to person that was very anxious and needed reassurance from staff that they would not fall. They said, "The girls are very good, I am frightened of falling and I don't like being on my own." We saw staff reassure this person several times and each time with the same level of patience and kindness. We heard one staff member say, "No I am not going to leave you, and you are not going to fall, you are fine."

We saw another person in their own room visited by staff numerous times and they sat with the person and chatted to them, sometimes two staff would be in there and there would be a three way conversation full of laughter. A person when going to sit at the table asked a staff member, "Can I sit here." The staff member replied, "Yes my friend."

Staff we spoke with were confident people received good care, comments included, "It is lovely here, really friendly and we try to create a homely feel – people are cared for", "We give person centred care – they are the centre of everything we do and we adapt to them, we know their quirks, routines like knowing someone needs their meds before manual handling" and, "I really like it – it feels right – elderly people are fascinating."

One person was holding a baby (doll). We observed a member of staff asking if they could move the baby to support the person with drinking. The member of staff tried to sit the baby in front of the person on a table but when the baby did not sit up, they made sure it was comfortable on a seat. We found this to be a sensitive and caring interaction. The same member of staff supported the person during lunch. It was clear that this person was at risk from not eating and the member of staff spent ages with them, using the baby as a tool to aid with the eating. After the meal the member of staff announced proudly that the person had ate all their meal.

Staff respected people's privacy and dignity. Where people needed support with personal care, staff did this

discreetly. People were supported in their rooms with the doors closed. Staff were observed knocking on people's doors before entering, waiting for permission to enter. Staff demonstrated a good understanding of how to provide care in a way that promoted people's privacy. One person told us, "They always knock, they close the door, never intrusive and I can ask questions, they are never over baring – the care is lovely."

Staff promoted people's independence and people were able to move around the service freely. We observed that one person walked around the service from area to area, staff often gently pointed the person in the right direction or chatted with them as they walked. We saw staff from other areas also supported this person and staff all knew the person was happy walking around. Doors to the courtyard areas were open and people could go out for fresh air when they chose. One person told us, "I wash myself if I can, I get help with my leg but the majority of times I do things for myself." Another person said, "I make my own bed every day and the housekeeper gives me clean sheets and I strip off the sheets and remake my bed myself."

Requires Improvement

Is the service responsive?

Our findings

People's needs were assessed prior to their admission to the home, and these assessments were used to develop their care plans. Care plans we checked covered different aspects of people's health care needs and how they preferred to have those needs met. Not all care plans we looked at contained current information on people's care and support needs. We saw these were not always detailed, person centred or updated. One person's care plan recorded that they ate a normal diet independently but subsequent reviews since April 2017 indicated the person was now only eating cornflakes but this change had not been used to update their eating and drinking care plan. We also saw another person's mobility care plan that indicated that they required the use of the hoist but other areas of the care plan still stated that they paced up and down. In another care plan, it stated the person stands and walks independently, but subsequent reviews recorded that the person now required assistance to stand from a chair.

All the care plans we looked at showed evidence of routine monthly reviews, each section of the care plan was reviewed on a monthly basis and while reviews did identify some changes, many of the entries simply stated "No change". We could see in some care plans that when the change was significant a new care plan section was re-written, the monthly review did not record in detail any information leading up to the change. We also found another monthly review document within the care plan that recorded a paragraph related to each section of the care plan; these entries were mostly a summary of need for each section, rather than a review of care. However, staff were able to tell us the current needs of people using the service.

We observed a person said to a member of staff, "I could have a bath later" and the staff member said, "We'll see." We looked at a number of records of when people received baths. The daily record booklet had a phrase indicating that at people should have at least one bath a week, the record did not take into account people's preferences or choices in this area. When looking at bathing records we found particularly in the areas where the bathroom had been designated out of action that people were not receiving baths. Records recorded that staff had assisted people with a body wash, we looked at six people over a two week period and found that only one person had received a bath.

The care plans we looked at had not always been updated on a regular basis, some sections were not completed appropriately or were inaccurate. This meant we could not be sure people were receiving appropriate care and support to meet their needs. This was a breach of regulation 9 (3)(b) (Person-centred care); Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During this inspection, we did not observe any activities in the lounges, apart from one person having their nails done. However, the atmosphere was calm and comfortable. Many of the lounges had doors which opened out onto secure gardens. This safe environment offered the opportunity for people to walk as they wished, meeting different people and seeing different areas. People were well known by all staff and if a person ended up getting a bit lost they were treated with affection and supported to return to their room or preferred lounge.

During the day, we observed staff asking people if they wanted to go to the day centre. These tended to be

the more independent people and many people did not go. When we spoke to staff, they told us that the day centre only had capacity for 10 people, so only a limited number of people from the home could attend. One staff member said, "We have got space today as only seven came in but it depends if we have space." Another staff member told us, "They do need someone to do activities in the home as the day centre does not always have capacity." The registered manager confirmed that the activity available for the afternoon we visited was in the day centre and staff in the service provided additional activities for people that could not attend.

Some people were happy with what was available. Comments included, "I sit and chat, read, knit, paint with colours – the fan going day and night keeps it cool in here", "I choose to stay in my room, I like my TV, staff stay a few minutes and one male senior comes and we have lovely chats, there are always passing and they stop and chat, I never feel alone", "I go to the Coffee morning downstairs, I decided to give it a try and I like it, I get the newspaper delivered to my rooms 6 days a week, I go to the hair salon downstairs", "We had a Residents meeting a few weeks ago and you could ask any questions and the majority of us up here went.", "I do crosswords, read a lot, do colouring in and we chat a lot."

We found limited activities taking place in the lounges for people living with dementia. During the inspection, we found that staff did try to talk and interact with people but there was nothing available for people that staff could utilise to interact in a meaningful way. For example, things to touch, look at or interact with. We discussed with a member of staff whether they were involved in proving social activities. They said it was hard to do activities, especially in the mornings but that the afternoons were quieter so they could spend more time with people. However, if an activity was started, it would easily be interrupted if someone needed support, for example with personal care. Staff said they had not had training in providing specialist meaningful activities for people with dementia.

We discussed this issue with the registered manager who told us that they also organised various activities for people as well as they did not have an activity organiser and were reliant on staff to provide activities when the day centre was full.

We recommend the provider review their activities programme, particularly in relation to people who are living with dementia.

There were effective systems in place to manage complaints. The registered manager told us they had only received one complaint in 2016. Although we could see that the registered manager had responded more detail was required about the outcome of the complaint. People told us that they knew who to complain to if they were worried about anything. One person told us, "You can ask anything of the staff and they give you answers." Another person said, "They do listen and we can go to the manager or the deputy and some carers will take things on board you might be anxious about and pass it onto the seniors."

Requires Improvement

Is the service well-led?

Our findings

At the last inspection in September 2015, the service was rated as Good in all domains. However, the provider and the management of the home have not been able to sustain this rating of Good as the service was not consistently well led. We identified a number of shortfalls in the way the service was managed, this included concerns related to the safety of the service, the implementation of the Mental Capacity Act and person centred care.

Systems in place to monitor and improve the quality of the service were not consistently effective. Although there was an audit system in place, this had not been effective in identifying or addressing the issues we found during our inspection visit. For example, audits related to medicines had not identified concerns related to medicines management found during our inspection. Stock levels of medicines did not reconcile which meant people may not have received their medicines as prescribed. There was also a failure to identify that some people who required "as required" (PRN) medicines did not have protocols in place to guide staff about the administering of these medicines.

The provider did not have sufficient systems in place to check people's care and support was carried out safely or in a way that met their needs. For example, care plans did not always accurately reflect people's current needs and contained contradictory information. This meant the provider was not assuring themselves that people's care was being delivered safely or in line with their needs and preferences. The provider was not ensuring that people's care plans were kept up to date to ensure staff had accurate information regarding people's needs and risks.

We found that capacity assessments were not always completed where people's freedom of movement was restricted and evidence of decisions made in people's best interest recorded. We also found that deprivation of liberty authorisations were not being monitored affectively to ensure they were applied for or that existing authorisations reviewed in line with legal requirements.

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The lack of effective systems to check on the quality and consistency of the service meant there was a risk that people's care was not being delivered safely and in line with the regulations.

The service had failed to ensure the environment was maintained to an appropriate level. For example, we found that two bathrooms had been condemned, although the provider had started a programme of refurbishment some areas still required attention and plans in place were not sufficient to reassure us that works would be completed in a timely fashion. It was also noted that the registered manager was overseeing refurbishment work in the service, including identifying contractors and organising works. This was in addition to their day to day work, this additional work had impacted on their ability to oversee all systems and processes within the service.

This demonstrates a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Despite the concerns identified during our inspection visit, people we spoke with told us they were happy living at Well House and said that they felt the home provided good care. One person told us, "The manager is a treat, she came to see me today and we had a little chat and I showed her my new clock, they got me a new one as the old one did not work." A group of three people told us, "We would recommend it – it is a complete family home." Relatives commented, "The manager always knows how [family member] is, sleep day or chatty day", "A variety of staff are involved in [family members] care including the housekeepers, the laundry is spot on and their clothes are always coordinated. On special events the housekeepers will choose an outfit and hang it on the wardrobe, they have their hair done and they look good", "The manager knows what is going on, staff work together, I never hear staff moan about other staff – they are very professional" and, "I can come and go as I like and feel part of the family home."

Staff also spoke positively about their work and the support they received from management. Their comments included, "Love it here, got a nice lots of carers and any problems the manager will try and sort it out", "We all pull together here" ,"The manager and all the staff support us" and, It works not having outside help, makes it a bit harder but we know what residents needs are."

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The care plans we looked at had not always been updated on a regular basis, some sections were not completed appropriately or were inaccurate. This meant we could not be sure people were receiving appropriate care and support to meet their needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent People's rights under the MCA were not always protected as the principles of the Mental Capacity Act(2005) were not consistently adhered to.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People who used the service were not protected against the risks associated with their care and support as risk assessments were not in place or updated appropriately. People who use the service were not protected from the risks of unsafe care because medication was not always managed safely. Some areas of the home had not been maintained and required updating.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems in place to monitor and improve the quality and safety of the service were not effective. This meant there was a risk that people's care was not being delivered safely and in line with the regulations.