Richard Whitehouse

Wheathills House

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

Summary of findings

Overall summary

We inspected this service on 22, 28 March and 5 April 2018. Wheathills House is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Wheathills House accommodates up to 30 people in one building.

The service was last inspected in 7 September 2016. There were two breaches of regulation at that inspection. At this inspection the provider continued to be in breach of these regulations as they had not taken action to respond to the breaches.

On the first day of our inspection 28 people were using the service and this was reduced to 26 on the 5 April 2018. The service is required to have a registered manager. 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. The provider is the registered manager.

During this inspection we found the service was unsafe as there were no systems in place to manage the service, identify and mitigate risk and therefore ensure people's safety.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible; the policies and systems in the service do not support this practice There were no systems in place to deploy staff to ensure people were supervised at all times. The provider was unable to show the staff had trained in and understood how to protect people's rights under the Mental Capacity Act (MCA) and Deprivation of Liberty (DoLS).

Not everybody had a care plan that detailed their care needs and wishes. The care plans that existed were not inclusive and the information was inaccurate or was out of date. Some care plans consisted of data from various agencies. This information was not analysed and a plan of care written. There was no assessment process in place to re-admit people who had been in hospital. Daily notes were written in diary form. They were not referred to nor were they filed in a manner that supported the care of people.

On the first inspection visit the provider was unable to show us care plans for seven people who were using the service. Risk was not effectively assessed and put in an up to date care plan for staff to follow. Some accidents and incidents were recorded, however they were not reviewed to ensure the cause of accidents was recognised and, where appropriate, acted upon to prevent other accidents happening.

There was no process in place to identify people who were at risk of choking. People were left alone during breakfast without means of communication or calling for assistance.

There were not enough staff to meet people's needs in a timely manner. People were left unattended for long periods of time. Staff were not up to date on the training the provider considered necessary to care for

people safely and effectively.

Some medicine was stored and administered as prescribed. There were no systems in place to store medicines for people who were using the service for respite care.

There were no communication systems in place to ensure all staff were aware of the current needs and welfare of people. The provider was unaware of the number and gravity of the falls people had and was unable to supply us with accurate and up to date information when asked for.

Staff were not supported, trained or supervised. There were no systems in place to recognise and put best practice in place.

Menus were planned in advance taking in people needs wants and wishes.

There were no systems in place to recognise signs that the service may no longer be able to meet people's needs.

People were not always referred for health assistance in a timely manner.

People's dignity was not always promoted. People were not involved in the planning or delivery of their care. Staff were kind in their interactions with people. However they did not always knock before they entered a person's room. Independence was not always promoted.

Care was not person centred and reviews did not reflect the condition of people. People were not supported to pursue their hobbies and interests. They were bored. Choice was not promoted.

There was no easily assessable complaints process in place. People did not have the opportunity to join in community based activities. There was an activity co-ordinator in place but they didn't have a budget to arrange entertainment or activities.

The provider did not ensure the service was managed effectively and in the best interests of people. There were no systems in place to review the quality of the service. The provider did not ensure there was a system in place to inform CQC of incidents. Therefore there were incidents we were not informed about. Record keeping was poor and ineffective. There was no system in place to keep staff updated on people's changing needs and wishes. Some records were missing and others were not dated appropriately.

Staff were not recruited in a manner that promoted the safety of people.

There was no quality assurance process in place. No audits were completed, which meant the provider could not be assured they knew how the service was recognising and meeting people's needs and wishes. It also meant there was no process to learn from mistakes to ensure they were not repeated.

We identified the provider was in breach of eight of the Regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and one breach of the Care Quality Commission (Registration) Regulations 2009.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to

propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

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

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.
You can see what action we told the provider to take at the back of the full version of the report.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and the Care Quality Commission (Registration) Regulations 2009.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Risk assessments were not up to date and reflective of people's risk. Accidents and incidents were not monitored, reviewed or timely action taken to reduce the risk of harm.

People were not consistently kept safe from risks associated with their health conditions. People were supported to have their medicines as prescribed. Medicines were not always stored and recorded appropriately.

Is the service effective?

Inadequate

The service was not effective.

The provider could not be assured staff were trained effectively to ensure people were supported to maintain their health, welfare and personal development.

The provider and staff did not demonstrate an understanding of nor did they followed the requirements of the Mental Capacity Act 2005 (MCA) and DoLS.

People's health was not always supported in a timely manner.

People's needs and choices were not fully assessed so the provider could be sure care and support were delivered in a way that helped to prevent discrimination.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People's dignity and independence was not always promoted or respected.

People and relatives were positive about the kind and caring attitudes of the staff team.

People were not consistently supported to participate in designing or reviewing their care.

End of life care was not always considered.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

The provider did not ensure there were clear processes in place to ensure concerns or complaints raised by people or relatives were managed consistently.

People did not receive personalised care that was responsive to their needs.

People were not supported to communicate effectively by staff who understood their individual styles and methods.

Is the service well-led?

Inadequate

The service was not well led.

The provider did not provide clear effective management and leadership to the service.

The provider did not meet the requirement of the last inspection. There was no quality assurance system in place to aid improvement of the service or support staff.

There were no systems in place to inform CQC appropriately of incidents or events that affected the running of the service.

Wheathills 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, to look at concerns we received about the service and to provide

We inspected the service on 22, 28 March and 5 April 2018. The first day of the inspection was unannounced. On the first day the inspection team consisted of one inspection manager, two inspectors and one expert by experience in the care of older people. On the second and third day there were two inspectors. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Prior to our inspection we reviewed information we held about the service. This included information received from local health and social care organisations and statutory notifications. A notification is information about important events which the provider is required to send us by law, such as, such as allegations of abuse and serious injuries. We also contacted commissioners of the service and asked them for their views.

We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

During our inspection visit we spoke with eight people, five relatives, four members of care staff and the provider/registered manager.

To help us assess how people's care needs were being met we reviewed all or part of six people's care records and other information, for example their risk assessments. We also looked at the medicines records of two people, five staff recruitment files. We asked for records that showed training of staff and quality assurance audits, records pertaining to falls and incidents, training records and a range of records relating to the running of the service, for example, audits and complaints. We carried out general observations of care and support and looked at the interactions between staff and people who used the service.

We asked the provider to supply an urgent action plan setting out how they intended to address all of the concerns we identified in relation to the unsafe provision of care at the home, together with your explanation of how these actions will be sustained. We asked for this to be supplied by 9:00 am Monday 9 April 2018. This was complied with.

Inadequate

Is the service safe?

Our findings

People who live at Wheathills House told us they felt safe. One person said, "Yes it is very safe here." Another said, "Never entered my head that I could be anything but safe here. Why should it be anything else? The staff are fine. They look after you well and in my experience fellow residents all very nice people I feel very safe all the time."

This was in contrast to our findings. We found areas of concern regarding the safety of the service and the ability of the service to protect people from the risks associated with their care and support. Risks to people's health and safety were not appropriately assessed or managed. This left people exposed to the risk of harm.

For example, risks associated with people's care and support were not effectively identified, assessed or mitigated. We found seven people did not have care plans or risk assessments and a further five people did not have risk assessments, therefore staff had no direction on how to keep people safe. For example, one person had a number of factors which put them at increased risk of developing a pressure area, they also had a very recent history of skin damage. Despite this, there was no pressure area risk assessment in place and no care plan about how to maintain the person's skin integrity. We also found an absence of risk assessment and guidance in other areas such as, nutritional risk and falls. This meant we were not assured that all reasonable steps had been taken to reduce risks associated with people's care and support and placed them at risk of harm.

People were not protected from the risk of choking. Risks associated with choking had not been assessed and consequently we were not assured adequate measures were in place to reduce the risk. On the second day of our inspection we observed one person having breakfast we saw swallowing was causing them to cough. We alerted a member of staff to this and they told us this person was at risk of choking. The staff member then left the room and we observed the person continued to cough while eating. There were no staff present which meant, had the person choked, staff would not have been aware of this and consequently would not have been able to respond swiftly to provide emergency first aid.

We checked this person's care plan file and found there was not a choking risk assessment and no details, other than the provision of a 'liquidised' diet, to lessen the risk. A care plan from a previous care home stated the person was at high risk of aspiration (this means the inhalation of foreign objects, such as food, into the lungs) and consequent chest infections. This was not reflected in the person's care plan. In addition there was no evidence that external health professionals had been contacted for specialist advice. This placed the person at risk of serious harm and put their safety at risk.

There were no effective systems in place to analyse patterns of falls to try and reduce recurrence. For example, records showed that one person had sustained four falls or near misses in the past three months. Although basic details had been recorded on daily records there was no evidence of any analysis of patterns such as type of fall, location or time of day. We noted two other people who had repeated falls but again no analysis had been completed. Following our first inspection visit we asked the provider to analyse the

number of falls people had. The number given to us differed from the analysis we did of falls in January. We took the information from the day book used by staff to record incidents on a daily basis. We found there were 11 falls recorded for January 2018 the provider supplied us with details of seven which demonstrated there were inconsistences in how falls were monitored or assessed. This meant no one had a clear overview of the risk to people and opportunities to reduce the recurrence of these incidents may have been missed.

There was a risk people may not be assisted to move and transfer safely. A review of records showed that none of the staff were up to date on how to move people safely. Furthermore risk assessments had not been completed for people who required support to move and transfer using specialist equipment and we got different information from staff on who needed assistance with moving. We noted from records staff described how they were unable to assist a person to move safely while caring for them. This meant we could not be assured staff had sufficient skills, knowledge or competency to support people to move and transfer safely and this placed people at risk of harm.

Risks associated with people's behaviour had not been effectively assessed or managed. There were no behaviour management risk assessments or care plans in place for people who may be resistive to care or who may behave in ways that put them and others at risk. Records showed one person was frequently resistant to personal care and this resulted in them placing themselves and others at risk of harm. However, there was no risk assessment and their care plan did not provide any guidance for staff about how to safely support them.

In addition to the above, there were no effective systems in place to analyse patterns of behaviour, identify the triggers and support staff to come up with ways to reduce these behaviours. Daily records contained multiple entries about people being resistive to care and behaving in ways which put them and others at risk, but this information had not be reviewed. This meant opportunities to reduce the recurrence of these incidents may have been missed.

People could not be assured they would receive their medicines when they needed them. Some people were prescribed medicines to be given 'as required', for pain relief. The registered manager told us there was not a member of staff on shift, at night, who was trained to administer these medicines. The registered manager told us if people needed pain relief at night they would use shop bought pain killers. This was not a safe arrangement as night staff did not any process in place to record the amount of pain relief given and this could have a detrimental effect on people's health.
The service commissioned a review of the risk of fire within the service. They received a report in February 2018 detailing fire risks in the service. This had not been responded to and left people at risk of avoidable harm.

The provider failed to have an effective overview of the risks associated with peoples care and treatment to promote their on-going safety.

This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not protected from abuse. The management and staff team at Wheathills House did not have sufficient practical knowledge of safeguarding to ensure people were protected from abuse. The registered manager was unable to evidence that all staff had up to date safeguarding adults training. Consequently, we found evidence of incidents which had not been formally investigated and had not been referred to the local authority safeguarding adults team. A recent daily record entry for one person, documented they had alleged that staff were 'rough' with them when providing personal care. Staff had simply recorded they were

'not rough.' This meant the allegation had not been reported and consequently, no action had been taken to investigate it or to make a referral to the safeguarding adult's team.

The provider had not ensured effective systems were in place to record, communicate or investigate indicators that people may be subject to abuse or improper treatment. We reviewed daily records and found records of incidents which gave us cause for concern. For example a record for one person stated they had 'refused' to walk so 'carers took [person's] whole weight while [person] dragged their feet across the floor.' This indicated staff pulled the person against their will. There was no evidence this incident was reported or investigated. In addition to this throughout our inspection we received additional concerns from people living at the home that some staff could be "rough" with them. We took action to report these concerns to the local authority safeguarding team and this remained under investigation at the time of writing this report. .

This is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were not always sufficient numbers of staff to ensure the safety of people who lived at Wheathills House. Although staff and people living at the home told us there were enough staff we identified concerns about staffing levels at night time. Two staff were deployed on night shifts, some people required assistance from two members of staff. Records showed both night staff were sometimes required to spend periods of up to 45 minutes with one person who required a lot of assistance and reassurance. This meant there were no staff available to attend to other people's needs at these times. We spoke with a member of staff who told us, if needed, one member of staff would have to go and support the other person. This meant one member of staff would be left with a person who was known to behave in a way that placed themselves and staff at risk. Due to pressure on staff they were unable to be flexible to respond to requests such as attending to visitors and to assist CQC during the inspection process.

People who were at risk were left alone and on three occasions we had to summon staff to assist them. We found people left alone for long periods in the lounge and those who needed assistance were reliant on other people to call staff for them.

We pointed this out to the provider who said they would review the staffing levels.

This is a breach of Regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Adequate steps had not always been taken to ensure people were protected from staff that may not be fit and safe to support them. Pre-employment checks designed to help providers ensure staff were suitable to work at the service were not always completed. Two members of staff had previous convictions on their criminal record. Although the registered manager told us they had considered whether this posed any risk to people living at the home there was no written record of this which meant we were not assured the potential risks had been fully assessed.

Furthermore, application forms had not been fully completed and were missing information about the staff member's reason for leaving previous posts. This meant that the provider did not have all the relevant information to make a decision about the suitability of the staff members to work at the service.

This is a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The home was clean and fresh on during our inspection. However, there were no process in place for staff to follow for the protection of people should there be an outbreak of infection such as diarrhoea and vomiting. Staff we spoke with were not aware of process to follow. They said they would use their common sense. Staff had not had infection control training. Domestic staff were not supervised and there was no established pattern of cleaning throughout the service. Staff we spoke with said they do as much as they can on a daily basis. The staff did not have training or guidance on how to contain an outbreak of infection to ensure the safety of people.

Inadequate

Is the service effective?

Our findings

At our last inspection in 2016 we identified people's rights under the Mental Capacity Act were not promoted. No improvement had been made and the provider continued to be in breach of this regulation.

People's rights under the MCA were not protected as the Act had not been applied to ensure decisions were made in people's best interests. People's care files did not contain information about whether they had the capacity to make their own decisions. For example, staff told us they had to make day to day and complex decisions on behalf of one person as they were unable to do so themselves. Despite this, there were no assessments of the person's capacity and no documentation to demonstrate that decisions made on their behalf were in their best interests.

Staff and managers did not have the required competency to ensure the MCA was correctly applied. The majority of staff did not have training in the MCA and consequently lacked practical knowledge of the MCA. A small number of staff had training in previous posts and had sufficient theoretical knowledge but this had not been applied in practice. This had resulted in a failure to ensure the appropriate steps were taken to protect people's rights.

Some people were being deprived of their liberty without the necessary application to the local authority having been made. One person lacked the capacity to consent to their care and had significant restrictions on their freedom. They were not free to leave the home unescorted and were under continuous direct or indirect supervision. Despite this, there were no mental capacity assessments in place and no application had been made to authorise these restrictions on the person. This failure to apply the principles of the MCA did not respect the person's rights.

In addition to the above, CCTV was used throughout communal areas of the home. Although the registered manager told us he had spoken with people informally about this there was no written record of consent and no evidence that the rights of people who could not consent had been considered under the MCA.

This is an on-going breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People received care and support from staff who did not have the necessary skills and competence to support them effectively. The provider was unable to show us the staff on the rota for March 2018 had completed the annual mandatory training they considered necessary. Records we reviewed showed staff had last completed training in 2015. None of the staff on the rota for March 2018 had completed the training the provider considered necessary to care for people safely and to meet their needs. There no plans in place for staff to complete this training. Overall one staff member had competed online training in safeguarding adults and the Mental Capacity Act on 3 April 2018.

This lack of training had a negative impact on the safety and quality of the service and placed people at risk of harm. For example, we were only provided with records of hoist training for three staff. We checked

staffing rotas and found that this meant there were not always enough staff on shift with the skills and competency to safely support people to move.

Staff did not have any training in managing challenging behaviour. We saw from records staff detailed people's behaviours they found difficult. There was no evidence staff attempted to understand these behaviours or to understand what caused them or how the person could be assisted. This was of particular concern given the significant level of behaviours that posed a risk to others being managed on a day-to-day basis. This meant there was a risk staff did not have the required competency to safely manage people's behaviours.

This is a breach of Regulation 18(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People could not be assured that they would receive effective support in relation to their health. One person had been identified as being at risk of a health condition which required regular monitoring to prevent it worsening. However, we observed there were no records of this monitoring which meant there was a risk changes in the person's health may not be identified and addressed. Furthermore we found people's care records did not contain information about people's individual health conditions, the impact upon them and the support they required to manage them. One person had a serious condition which had a significant impact upon their health and wellbeing, despite this there was no information or guidance about this for staff. Medical intervention was not always done in a timely manner and not always identified by staff. Relatives were observed asking staff to ensure [their relative] saw their GP. Staff responded to the request but had not instigated the referral. On one occasion during our visit on the first day we reminded staff of one person's need to see a visiting nurse.

The needs of people living with dementia were not taken into account in the design and decoration of the home. Dementia friendly signage and colour schemes were not evident which meant we were not assured the provider had taken all reasonable steps to help people find their way around the home.

The service did not offer nursing care. There were no systems in place to identify when the provider was no longer able to meet people's needs. Because of this lack of processes we were not assured people were receiving care they needed to retain optimum health and be pain free.

Requires Improvement

Is the service caring?

Our findings

People who used the service told us the staff were caring and kind. One person said, "The staff here are really caring and always try to do their best for us however busy they are. They always have to work very hard as there does not seem to be any spare. During the cold weather they have had problems with staff getting in but they always managed and no one ever grumbled about having to work even harder than ever." A visitor said, "They always treat [relative] with respect and I have also heard how they speak to others. There is one man who gets very confused and the way they re-assure him is wonderful, so caring and appropriate."

However, a review of the day book found staff used highly subjective words and terms to describe people this included such words as 'abusive' 'very rude' and described behaviours as 'totally unacceptable'. There was no description of the actual behaviours or any consideration of why the person was behaving in that way. We also saw the use of outdated, disempowering language, such as 'toileting' to describe the assistance they gave someone with continence. The use of language was not dignified or respectful.

People said their dignity was not always promoted as some staff do not knock before entering their room. One person said, "We are certainly not treated as equals or in partnership. It's really a case of this is how we do it here. If you don't like something you can say but often the response is sorry can't do that. An example, me going to walk in the garden or round the block, they say it's not safe which could be true but I don't think so." We were told that in the main staff knocked on their door before entering. However, one person said, "They knock and then just walk in really, they don't wait to be invited in, this means I'm not always ready." Another said, "They don't knock, my door makes a lot of noise so I know they are coming anyway but a knock would be nice. "

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

Mealtimes were not a dignified experience for some people. The food served to people who required their diet to be served in a pureed consistency was not appetising and did not promote a dignified dining experience. We observed that all of their food was blended together. Care had not been taken to blend food separately nor had any consideration been given to the presentation of the food.

Staff did not have enough time to spend with people to ensure their wellbeing. During our inspection we observed one person in distress. We observed the person appear to vomit and intervened to alert staff. Staff assisted the person, offered brief reassurance and then left them. We saw the person continued to be in distress and no staff were in the area to identify this and respond.

Those people who were able to care for themselves told us they had a very pleasant lunchtime experience and really enjoyed the food.

People's care files contained variable quality information about what mattered most to people. Although we saw one person's care plan which contained information about the person's life history and interests, four other care plans did not contain any information at all about the person's history, like, dislikes or interests. We asked staff to tell us about some people's life before they lived at Wheathills House. None was able to. This is important because one person we spoke with felt staff only saw the 'shell they now were' and were unable to relate to them as a person who had lived a full life.

When asked if people felt able to express their opinions or how they were listened to, people felt they could but were unable to give examples of when they had done this or whether they had been noted and acted upon.

We were told that relatives and friends were free to visit at any time although the home does request they try to avoid mealtimes. We were told this was because staff were too busy to answer the door. We witnessed the doorbell going unanswered throughout the morning. This meant some people could miss visits that were important to them. We spoke to the provider about this and they agreed visitors were discouraged at lunch time.

Requires Improvement

Is the service responsive?

Our findings

The service was not always responsive to people's needs and wishes. One person told us, "No I don't really get up when I want to, it's the same time every day, they never asked if I want a change-they come in and make sure you are up." Another said, "I get up at 7.30 as that is when they bring my breakfast in. Sometimes I would like to have a lie in. They don't knock, just walk in. I go to bed at 8pm which suits me as I am tired by then." A third said, "I get up at 8am and they bring my breakfast which I eat in the chair. I can wash and dress myself so I sometimes get back into bed and watch TV and listen to the local radio. Usually stay in my room until time to go down for coffee at 11."

The provider did not have systems in place to ensure people were not at risk of inconsistent, unsafe support that did not meet their needs. There were insufficient processes in place to ensure that staff had access to adequately detailed care plans. This resulted in a failure to both identify and address risks and to provide staff with adequate guidance to inform support. Consequently, people were placed at risk of unsafe and inconsistent support. For example, one person was using the service for a temporary period at the time of our inspection. The prover told us they had conducted an informal assessment of their needs prior to them moving in, but this was not written down. The provider also confirmed there was no care plan or summary of the person's support needs in place in any form. They explained that as they were short term they did not think it was feasible to develop a care plan.

Another person had moved in to the home in early 2018. We reviewed their care file and found they had complex health needs, despite this there was no care plan in place for any aspect of this person's care. We looked in the day book and found a person had been admitted for respite care. There was no care plan or pre-admission assessment on their needs and wishes. There were no contact or medical details. This lack of information meant staff had no idea on how to deliver their care in a person centred manner. This included simple details, such as their dietary preferences.

Where care plans existed, the quality was poor. Some care plans did not accurately reflect people's needs and lacked individualised information. One person's care plan had not been reviewed for a period of 10 months and stated they were independent in many aspects of their care. However, we observed and other records such as the 'day book' showed the person now required significant support from staff. This failure to ensure all staff had access to clear guidance to inform safe and effective support and this placed people at risk of harm.

This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was an activities person employed from 10.00 to 12.30 Monday to Friday. They did not have a budget to plan activities or outings. We asked people about their experiences of this. One person told us "[Activities person] does quizzes most days. We play bingo and a local vicar comes in to administer Communion. There is also a film man who brings in local films and talks about them. He is very good and entertaining. It's a long time since we had any singers or other entertainers and also we don't really have many trips out- think last

one was on Poppy Day. Another said, "I do the quizzes [activities person] brings round and enjoy the film shows and bingo. Other than that I read the paper or a magazine, not books anymore and sit and chat to the others and watch TV. Not much else I can do really." We looked at the activities plan and found this was representative of the activities.

There was no evidence in the service of any other activities such as crafts and activities of daily living although. a third person said, "They don't really seem to do much in the way of crafts although they did do Easter Bonnets last year so they may do that again next week.

We were told there were regular meeting for people to express their wishes and concerns. We asked for the minutes and were given minutes dated 8 May, there was no year recorded.

The service did not have a clear complaints policy and procedure readily available to people. We were told there had been no complaints and therefore no outstanding complaints. However one visiting relative told us about some concerns they had regarding not been informed about a stumble their relative had. They said, "There was no issue as, [relative] was not hurt so perhaps this is why they did not ring but I still feel we should have been called."

There was a risk people's end of life wishes may not be respected. People had not been offered support to discuss their end of life wishes. One person was coming towards the end of their life. There was no reference to this in their care plan and no evidence the person had been offered the opportunity to discuss their end of life wishes. This placed them at risk of not having their wishes met.

It should be noted those people who were able to care for themselves had a positive experience of living at Wheathills House.

Inadequate

Is the service well-led?

Our findings

At the inspection visit carried out on 7 September 2016 we found a breach of Care Quality Commission (Registration) 2009 Regulation 18.in relation to the provider's responsibility to inform CQC about incidents that impact on the health and safety of people. At these inspection visits we found this breach had not been met as the provider did not have systems in place to ensure they appropriate people were informed of reportable incidents. We found one person who had a serious fall that resulted in an admission to hospital, the appropriate people had not been informed of this accident and were therefore unable to make a judgement on the on-going safety of the person.

This is an on-going breach of Care Quality Commission (Registration) 2009 Regulation 18.

Since the last inspection where the service was rated overall 'requires improvement' we found no improvement had been made.

We found the provider did not have an oversight on how the service was run and how people's needs were identified and met.
The service is required to have a registered manager and one was in post. 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.

The provider did not manage and lead the service in a manner that ensured the welfare of people. There were no effective systems in place to monitor the quality and safety of the service. We requested copies of all audits and quality assurance systems the provider had in place to ensure the safe and effective running of the service. However, we were informed by the provider they were in Wheathills House five or six days a week to keep check on what's going on. This was not recorded formally. This lack of governance resulted in us finding multiple risks to people's health and wellbeing which had not been identified prior to our inspection. This included the lack of care plans and risk assessment which had no oversight from the manager.

The provider did not ensure there were accurate and complete records in place for each person living at the home. Six of the people's care records we viewed were either incomplete or inaccurate. Seven people did not have any formal care plan in place on our first visit. This failure to ensure that staff had access to accurate and up to date information about the people they were supporting put people risk of receiving inconsistent and unsafe support. In addition to this we found that records of some aspects of day to day care and support were not kept. For example, one person required frequent assistance to change their position to prevent skin damage. There was no system in place to record and evidence that this person was provided with this support.

There were no processes in place to ensure staff had up to date training. The registered manager told us he did not keep a formal record of the training staff had attended and when refresher training was due. He said he used training certificates to work out when training due. We requested training certificates and found

these were not well organised and records for 10 staff were missing or out of date. This failure to implement an effective training management system meant people were at risk of receiving support from staff who were not appropriately trained.

There were no process in place to ensure the service was managed in a manner that was inclusive and responsive to people's needs and wishes. This included the provider responding to the Accessible Information Standards Act. They were clear in the information they sent to CQC prior to the inspection they did not know or understand their responsibilities to people under this Act.

There were no systems in place to ensure the service was adequately staffed. We were told staffing levels were established on room occupancy. This meant people's physical and emotional needs were not considered when establishing staffing levels. We saw care was task led and staff were very rushed.

The provider did not ensure they were up to date in their own training. Without this training they had no way of ensuing staff were working with best practice and up to date training. For example prior to an inspection visit we send ask the provider to fill out a Provider Information Request. As part of this we asked how the provider implemented the 'Assessable information Standard.' Their response showed they lacked a basic understanding of their responsibility to ensure people had access to information in a manner that met their needs.

The provider did not ensure accurate records were securely kept and up to date. There was no system of' hand over' in place for staff to know people's changing needs. Daily records were kept in an A4 diary. There was no system in place to ensure the information contained in these books (one for day time and one for night time) was extracted and used to update care plans. Some of the information was missed such as the number of falls. Without this up to date information the provider did not have an overview of people's care needs and wishes.

The provider did not have systems in place to capture and act on people's wishes and needs in relation to their care. They were not included in care planning so the provider had no way of knowing if the care plans reflected people's wishes and needs.

The provider failed to keep up to date with good practice. They did not capture enough information on people to ensure any diverse needs were recognised and met. The provider was unaware of their obligation to ensure people had access to information in a format that met their needs.

The provider when asked said their vision and strategy for the future was, "To continue to provide a high level of care for people." This showed the provider lacked the insight to understand the failings of the service they were providing.

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

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 18 Registration Regulations 2009 Notifications of other incidents The provider did not consistently inform CQC of incident in relation to the safety and welfare of peple.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider did not ensure people's care was person centred and that staff had the information and direction to achieve this.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The provider did not ensure people's dignity was promoted at all times.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider did not ensure staff were trained to recognise and to respond to abuse. Incidents we identified were not reported to the local authority for investigation.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care

Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed

The provider did not ensure all appropriate actions were taken to ensure the welfare of people.

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 11 HSCA RA Regulations 2014 Need for consent The provider did not ensure people's rights were protected under the Mental Capacity Act. This is a continued breach.

The enforcement action we took:

We imposed a condition to limit new admissions to the service

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider did not ensure people were kept safe through identifying and managing of risk.

The enforcement action we took:

We imposed a condition to limit new admissions to the service

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not ensure the service was managed in the best interests of people who used the service. There was no way to review and improve the care given to people.

The enforcement action we took:

We imposed a condition to limit new admissions to the service

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider did not ensure there was sufficient staff to ensure the safety of people. Staff were not trained in how to deliver care safely, this included assisting people to move safely. The staff training the provider considered mandatory to care for people was out of date and no new training had been planned.

The enforcement action we took:

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