Homestead Residential Care Limited

Hanwell House

Inspection report

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Hanwell
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Date of inspection visit:
07 June 2016

Date of publication:
08 July 2016

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 7 June 2016 and was unannounced.

The last inspection took place on 28 and 29 September 2015. At this inspection we found the provider was not meeting all the required Regulations. In particular we found that people were not always safe, care was not person centred, people had not consented to their care and treatment, people were not always treated with dignity and respect, staff were not always recruited in a suitable way and did not have the support and training they needed and the service was not always well led. The provider had supplied us with an action plan telling us they would make the necessary improvements. At the inspection of 7 June 2016 we found improvements had been made but further improvements were needed in some areas.

Hanwell House is a care home which provides accommodation and personal care for up to 52 older people. Nursing care is not provided. At the time of our inspection 43 people were living at the service. Some people were living with the experience of dementia. The home is run by Homestead Residential Care Limited, a private organisation. Hanwell House is the only location managed by the provider. The registered manager is also a director in the company.

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

Most risks to people's safety had been assessed and the provider had taken action to minimise the risks of harm. However, some staff practices placed people at risk because they did not follow good practice guidance and did not always ensure people were being cared for in a safe way.

There were enough staff to care for people but they were not always deployed in a way which met people's needs.

The provider had ensured that restrictions on people's liberty were lawfully obtained with the exception of one restriction which people had not consented to and had not necessarily been made in their best interests.

Some of the staff were kind and caring and people reported that they felt well looked after. However, we observed some interactions which did not always respect people's dignity or privacy.

The provider had made improvements with regards to activity provision, but some people's social, leisure and emotional needs were not being met.

Not all records were accurately maintained or complete.

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

People told us they were happy, well cared for and liked living at the home. They felt safe and told us that their needs were met.

The staff told us they felt well supported and trained. They said they had the information they needed to care for people.

The manager had an in-depth knowledge of people's individual needs and the needs of the service. He was popular and people trusted him and felt that he made improvements where needed.

There was evidence that the provider had responded to the requirements we made at the last inspection and had made improvements in all areas.

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

Some aspects of the service were not safe.

In general risks were appropriately managed and people were kept safe. However, the practices of a small number of staff on duty meant that people were put at risk.

There were enough staff employed but they were not always deployed in a way which met people's needs.

The provider had made improvements in regard to some aspects of safety and had reviewed and updated risks assessments for individuals and in relation to fire safety.

The staff were aware of safeguarding procedures and knew what to do if they felt someone was at risk of abuse.

People received their medicines as prescribed and in a safe way.

Is the service effective?

Requires Improvement

Some aspects of the service were not effective.

The provider had assessed people's capacity to make decisions and taken appropriate action where restrictions were in place, with the exception of one decision about the consumption of sugar which the provider had made without appropriate consultation or consent.

People were cared for by staff who were appropriately trained and supported.

People's nutritional needs were met.

People were supported to stay healthy and see other healthcare professionals as needed.

Is the service caring?

Requires Improvement

Some aspects of the service were not caring.

We saw examples of care where the staff did not treat people

with respect. People's privacy was not always maintained.

However, people reported that the staff were kind and caring and we also saw examples of this.

Is the service responsive?

Requires Improvement

Some aspects of the service were not responsive.

People were not always provided with meaningful activities to meet their social and emotional needs.

People's care needs had been assessed and were recorded in care plans which were regularly updated.

People knew how to make a complaint and felt confident that these would be responded to.

Is the service well-led?

Requires Improvement

Some aspects of the service were not well-led.

The provider had not always assessed, monitored and mitigated risks to people's safety and wellbeing.

Records were not always clear, accurate and up to date.

The provider undertook a range of audits to help monitor the quality of the service.

The manager had a good knowledge of individual people's needs and was committed to the service.

People liked the manager and found him approachable and supportive.

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

This inspection took place on 7 June 2016 and was unannounced.

The inspection team consisted of two inspectors, a specialist advisor dietitian 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. The expert-by-experience supporting this inspection had personal experience of caring for a relative.

Before the inspection visit we looked at all the information we held about the service. This included notifications of significant events and safeguarding concerns. We also looked at the last inspection report and the provider's action plan.

During the inspection we spoke with 12 people who used the service, three visiting relatives and friends and the staff on duty who included the registered manager, care workers, senior care workers, domestic and catering staff. We observed how people were being cared for, we looked at the environment and records relating to the care of people, the support, recruitment and training of staff and other records used to manage the service. 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 with us.

Requires Improvement

Is the service safe?

Our findings

At the inspection of 28 September 2015 we found that there was a lack of effective risk management to ensure the safety of people, staff and visitors to the home. At this inspection we found that improvements had been made. However, people were placed at risk from some of the care provided.

For example, during lunch one member of staff was supporting two people to eat at the same time. They held forkfuls of food and drinks to people's mouths before they had finished chewing the previous mouthful. At one point they stood behind a person and placed a spoonful of soup in their mouth without warning. At another point the member of staff held the person's soup bowl so that it was touching their chin and then scooped soup from the bowl into their mouth repeatedly. This practice puts people at risk of choking as the member of staff was not giving any verbal prompts and was rushing people to eat more quickly than they were able. The staff member was also not concentrating on caring for one person and did not observe how they were eating or swallowing between mouthfuls.

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

We saw evidence of dysphagia (dysphagia is the medical term for swallowing difficulties) risk assessments in the records of some people but not others. These included a management plan to help reduce the risk. The manager told us they were in the process of incorporating this risk assessment and plan into all people's records. Some of the decisions around the consistency of food texture for individuals had been made without proper assessment. For example, one person had a recorded need for a pureed diet and the staff told us this was because their relative had requested this. In another case the person had been assessed by an appropriate healthcare professional several years previously but this assessment had not been updated to reflect changes in the person's needs. We asked the manager and chef how they created the right texture of pureed food for different individuals. The manager told us puree was created with, "Just enough fluid to get the texture right, not too runny and not too thick." The National Patient Safety Agency has published guidelines on ''Dysphagia Diet Food Texture Descriptors.'' These descriptors detail the types and textures of foods needed by individuals who are at risk of choking or aspiration (food or liquid going into their airway). They state that, ''A texture modified dysphagia diet will be prescribed following assessment by a speech and language therapist or other appropriately trained healthcare professional.'' The guidelines describe different textures and consistencies of food and why these vary for each individual. In order to ensure that people receive the right consistency of food and drink to meet their needs the provider should follow these and other relevant guidance and seek the assessment of appropriate healthcare professionals.

The registered manager told us they had purchased two new hoists for the service and individual slings for each person who needed to be hoisted. However, at the time of the inspection the slings had not been unpacked from the box they arrived in and the registered manager told us they still needed to label these and distribute them to individual bedrooms.

The provider had assessed various risks to people and had recorded these. For example, they had assessed how people moved safely around the home and from chairs to beds. We saw that these risk assessments had been recently reviewed and the use of different equipment had been assessed to make sure people received the support they needed. Following discussions with a relevant professional, the manager had updated the risk assessments for some individuals to ensure that the staff used the correct equipment to support them to move, which differed from previous practice. The manager had updated the training for staff around moving people safely. Some of the senior staff were undertaking training to qualify them so they could train other staff and assess their abilities to move people safely. We saw evidence of this training. During our inspection we observed that the staff used the correct equipment to move people. However, we observed two different occasions when the staff did not take adequate measures to keep people safe. For example, one person who was able to walk with support from two members of staff was supported to walk from the dining room to a lounge. The person was wearing their trousers in a way where these were too long and kept getting caught under their heel. The staff did not check the person's clothing before they supported them or notice this was happening. In another incident a person had spilled their drink over their trousers and socks. One member of staff supported the person to walk out of the room to their bedroom to get changed. However, the person was walking in wet socks and no shoes which increased their risk of slipping.

Other risk assessments included assessments of skin condition, risks associated with people's physical and mental health and malnutrition. These included a management plan to minimise the likelihood of harm and had been regularly reviewed and updated.

There were a large number of recorded accidents and incidents which had occurred at the service. We looked at the records of these for the previous two months. The records indicated that the provider had taken appropriate action to reduce the risk of accidents and also following the accident to ensure the person was not harmed. People who lived at the service were able to move around freely and were encouraged to do so if they were able. Therefore there had been a number of slips and falls which had not been witnessed. Records indicated that the staff had checked the person's wellbeing and had sought appropriate medical assistance when needed. People who had regularly fallen had been reassessed and referred to the local health authority falls clinic in order to seek further advice and support to reduce the risk of further falls. The staff had recorded any unexplained bruises or scratches and there was evidence these had been investigated by the manager.

At the inspection of 28 September 2015 we found fire safety arrangements were not being followed and this placed people at risk in the event of a fire. At the inspection of 7 June 2016 we saw that improvements had been made.

The provider had created personal emergency evacuation plans (PEEPs) for each person. These clearly described how staff should assist them to escape in the event of a fire and any restrictions regarding their mobility or ability to respond in an emergency situation. The plans were clearly identified in people's care records as well as being clearly displayed in people's bedrooms.

The registered manager provided us with a copy of a fire risk assessment which had been carried out in October 2015. We saw that remedial work recommended in previous fire risk assessments from March 2013 and October 2015 had been carried out and recommendations had been actioned. The staff conducted daily health and safety checks and these included checks of fire safety arrangements.

The staff told us they had received fire safety training. We saw relevant training certificates in staff's personnel files.

At the inspection of 28 September 2015 we found people were not always protected from avoidable harm or potential abuse because the staff did not fully understand their responsibilities. At this inspection we found that improvements had been made.

There was a procedure for safeguarding people and the staff were aware of this. We spoke with different members of staff and they were all able to tell us what they would do if they were concerned someone was being abused. This included contacting other agencies where necessary. The provider had taken appropriate action when a safeguarding concern was raised at the service. They had recorded this, reported the incident to the local safeguarding authority and the Care Quality Commission and they had taken action to prevent harm to people using the service. They had investigated how the incident had occurred and had strategies for preventing this from occurring again.

At the inspection of 28 September 2015 we found recruitment practices were not robust. Not all of the relevant checks were carried out before staff began work to ensure people were safe. At this inspection we found that improvements had been made.

The registered manager told us that they used the support of a recruitment agency to select staff. They said that the staff were initially employed on a temporary basis while their capabilities were assessed. They told us that staff were recruited permanently after this trial.

The staff records we examined contained the required information and showed that checks on their suitability had been made. For example, the provider had requested criminal record checks, references from previous employers, checks on their identity and eligibility to work in the United Kingdom. However, one staff file did not contain a full employment history and the provider had not recorded how they had followed this up with the member of staff. In order to ensure that the staff were not hiding information about their past employment or gaps in this, the provider should ensure that discussing employment history and obtaining evidence of this is part of the recruitment procedure. We discussed this with the manager who agreed to ensure that this information would be clearly recorded in the future.

The home was clean and was mostly odour free. During the morning there was an unpleasant odour in one part of the building, however this was later cleaned away. However, the staff did not always practice good infection control. For example, we witnessed a member of staff wiping one person's face after they sneezed, the staff member then immediately continued to support a different person to eat their lunch without washing their hands. The staff supporting people to eat did not wash their hands and regularly left the table to attend to other tasks, which including supporting people to adjust their clothing, supporting people to move and moving furniture and equipment around. The staff did not offer people the opportunity to wash their own hands before eating. We noted that on one occasion a member of staff was wearing disposable protective gloves as they walked along a corridor and entered a person's bedrooms. These protective gloves should be worn for each individual task and disposed of immediately afterwards and not worn as staff move around the building.

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

Some people felt there were not enough staff at the service. Some of the comments from people included, "They could always do with more staff, particularly during the night shift", ''They need more staff because of all the people here who are aggressive'' and "I would like it if there were a garden. It's not good to be cooped up but there are not enough staff to take us out." However, other people told us they felt there were enough staff. One person said, "There are always enough staff on duty" and another person told us, "There's never a

shortage of nurses." One visitor said, "There are definitely enough staff on duty."

The manager told us that they felt sufficient numbers of staff were employed. They also told us care staff were not allocated domestic duties and were therefore designated to support people at all times. However, during lunch on the day of the inspection people's needs were not met in a timely way because the staff were not deployed effectively. The manager told us that lunch was served at 1pm and people were supported to sit in the dining room from this time. However, on the ground floor the first people to be served the starter (soup) were served at 1.20pm. Some people were not served any food until after 2pm and one person had not received any food by 2.10pm. The order of service was led by the kitchen staff directing care staff when to take food to people. Therefore, people were not always served at a time which suited them or allowed the staff to meet other people's needs. For example, one member of staff who was seated near the kitchen hatch was supporting people with their meal. The kitchen staff repeatedly asked this person to come to the hatch to collect and deliver food for other people meaning they left the people they were supporting to do this. People did not receive their food in a consistent or orderly way, so that some people seated at a dining table had been served their desserts whilst others were still waiting for their starters. Two people who required assistance to eat were served at the same time when only one member of staff was available to support them. Therefore the member of staff was attempting to support them both at the same time. The staff repeatedly left the people they were supporting in the middle of a course to attend to other tasks.

There was only one member of staff supporting the people in the second floor dining room. A number of the people required assistance to eat their food and the member of staff had to help these people and serve the food to others. The member of staff told us they had started working at the home that week. At one point the member of staff left the room for several minutes and no one was supervising people whilst they ate to make sure they were safe. People did not receive their meal for up to 20 minutes after they were seated and we were told that the delay was due to the staff returning late from a break. People waited a long time between courses because the single member of staff was not able to serve everyone when they needed.

Throughout the morning there were between nine and 12 people seated in the ground floor lounge at different times. For the majority of this time only one member of staff spent time in this room. When they requested additional support following specific incidents other staff attended to support with these incidents. However, only one person was responsible for supporting people the majority of the time. People had a variety of needs and one person in particular took a lot of the staff time and attention. This meant that other people were left without any interaction or support. We noted that one person regularly ate and drank another person's food and drinks without this being noticed by the staff. Some people became agitated and distressed but the staff did not make themselves available to comfort or spend time with them. Following one person's lunch they became agitated and attempted to touch other people and other people's food. A member of staff supported them in an appropriate way, but was left standing with the person trying to block their access to others. For a period of five minutes none of the other staff offered any additional support and the member of staff was left to reassure both the agitated person and the people they were trying to touch and prevent them from doing this. Meanwhile the people the member of staff had been supporting with lunch were left without support.

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

People told us the home was always clean. One person told us, "My room is kept thoroughly clean." One visitor said, "[My relative's] room and her clothes are spotless, her clothes are always folded and she has

clean sheets every day." Another visitor told us, ''[My relative's] room is lovely and clean.''

People living at the service and their relatives told us they felt people were safe. Some of the comments from people included, "There are no problems with safety here", "I've got a call bell in my room so I've never been in distress'' and "I'm safe here, I don't come to any harm." One relative told us, ''I can rest my head easy at night knowing [my relative] is here.''

Call bells were situated around the building. However, the cords to the call bells in some bathrooms and toilets had been tied up so they could not be reached by someone who was seated or someone who had fallen. We spoke with the manager about this who agreed to check all the cords and ensure they were left at full length. The manager told us that the majority of people living at the home did not have the capacity to understand how call bells worked and therefore regular checks were made on each person and the building. We saw that the staff did spend time walking around the building and checking on people's wellbeing.

The pipes leading into the radiators were exposed. During the inspection the heating was not on and these were cool to touch. The registered manager told us that the heating was controlled so that they did not become excessively hot. However the metal pipes were set to carry water up to a temperature of 36◦C which could cause a scald if skin was exposed to the area. People were able to move around the environment independently and they were at risk of falling. It is possible that someone could fall against or grab these pipes when they were hot. Therefore the provider should take steps to cover the pipes with a protective material to reduce the risks if scalding.

One person had been permitted to smoke within their bedroom as part of their agreement to live at the home. The provider had carried out risk assessments for this and the staff made regular checks to ensure the risk of fire from this was minimised. The manager told us that there was a ventilation system in the room to ensure smoke was extracted out of the building. However, during the morning of the inspection there was a strong smell of cigarette smoke along the corridor to this room and a foyer area between the bedrooms and lounge on the ground floor.

The building was equipped with window restricting devices throughout. The provider made checks on these to ensure they were working. The provider undertook checks on the safety of the environment and equipment. These included checks on electrical wiring and appliances, water safety and gas safety. Health and safety checks were recorded and there was evidence the provider took action where hazards had been identified. The equipment, including hoists, the lift and electronic beds were checked by external professionals.

On the day of the inspection we saw staff administering medicines. They explained what they were doing and did not rush people. They recorded the administration. Medicines were stored securely. However, there was a supply of prescribed thickening powder (for drinks) kept in the kitchen for a person who had passed away. The provider should ensure that this product is correctly disposed of.

In addition to this, a Care Quality Commission pharmacy inspector visited the service on 13 April 2016 to inspect how medicines were being managed. We saw that the provider supported people to take their medicines. People received these as prescribed and in a safe way. However, the staff had not recorded the actual dose administered where prescribed medicines had a variable dose (e.g. one or two paracetamol tablets). For entries that were handwritten on the MAR chart, we did not see evidence of two signatures to authorise this (in line with national guidance). We discussed these matters with the registered manager who said they would implement appropriate changes immediately.

We checked medicines storage, medicines administration record (MAR) charts, and medicines supplies. All prescribed medicines were available at the service and were stored securely in a locked medicines trolley (within a locked room). This gave us assurance that medicines were available at the point of need.

Current fridge temperatures were taken each day; however staff were not recording minimum and maximum temperatures.

People received their medicines as prescribed, including controlled drugs. We looked at 14 MAR charts and found no gaps in the recording of medicines administered, which provided a level of assurance that people were receiving their medicines safely, consistently and as prescribed. We spoke with one person who reported that they received their medicines in a timely and correct manner. Running balances were kept for medicines that were not dispensed in the monitored dosage system. This meant that staff were aware when a medicine was due to run out and could make arrangements to order more.

Medicines to be disposed were placed in the appropriate pharmaceutical waste bins and there were suitable arrangements in place for their collection by a contractor. Controlled drugs were appropriately stored in accordance with legal requirements, with weekly audits of quantities done by two members of staff.

We observed that people were able to obtain their 'when required' (PRN) medicines at a time that was suitable for them. People's behaviour were not controlled by excessive or inappropriate use of medicines. For example, we saw seven PRN forms for pain-relief/laxative medicines. There were appropriate, up to date protocols in place which covered the reasons for giving the medicine, what to expect and what to do in the event the medicine did not have its intended benefit.

Senior care workers who managed medicines had been trained in medicines administration.

The provider followed current and relevant professional guidance about the management and review of medicines. When asked, the provider stated that no medicines incidents/ near misses had been reported recently. However, they demonstrated the correct process verbally of what to do should an incident/near miss arise in the future (including who to contact). This was in-line with the provider's policy.

We recommend that the provider follows nationally recognised guidance regarding the provision of texture modified diets to people who are at risk of choking or aspiration.

Requires Improvement

Is the service effective?

Our findings

At the inspection of 28 September 2015 we found the service was not fully meeting the requirements of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. The majority of people at the service had their liberty unlawfully restricted. At this inspection we found the provider had made the necessary improvements to ensure that they complied with the Mental Capacity Act 2005.

However, there was one restriction in place for which the provider had not taken appropriate action. The manager told us all desserts provided in the home were "sugar free" for all people and that no sugar was used in people's tea and coffee which we observed during the inspection instead there was artificial sweetener. The manager explained that in the past people could access sugar from a dispenser and were taking large amounts. He explained in the last two months the plan (no added sugar in all desserts and no sugar with drinks) had been implemented because, "People's behaviour can change with having too much sugar, an excess sugar intake can mean they could become more verbal and aggressive to staff." We asked to see documented information about this plan but there was none. People had not consented to this restriction and there had been no application to deprive people of their liberty in this respect. People who are malnourished or at risk of malnutrition need adequate energy. Sugar in both drinks and desserts can be both an enjoyable and palatable way for people to obtain energy. The manager had implemented this policy without discussing it with appropriate health care professionals. There is no medical evidence that sugar causes people to become agitated or aggressive. Diabetes UK, the leading charity focussing on research into diabetes in the United Kingdom, has published guidance which states, ''In some cases dietary advice for the older person with diabetes may differ from general recommendations. Older people in care homes are more likely to be underweight than overweight and there is a high rate of undernutrition (a type of malnutrition). It may not always be appropriate to reduce the fat, salt and sugar for every older person with diabetes.'' Therefore the decision to remove sugar from people's diets could be detrimental to their health as well as unlawfully restricting their right to make a choice in this matter.

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

One person told us they would like more freedom to do the things they wanted to do. They said, "There are certain restrictions on freedom which gets on my nerves; I would like some breathing space and leeway to go to the park or the shops". However, another person said, "I'm free to move around and have never been stopped from doing anything I wanted to do." A third person told us, "I can move around as I want to."

We observed that people were able to move around the environment without restriction and were not asked to stay in one place if they showed a wish to leave a specific area.

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.

The law requires the Care Quality Commission (CQC) to monitor the operation of the Deprivation of Liberty Safeguards (DoLS). DoLS provides a process to make sure that providers only deprive people of their liberty in a safe and correct way, when it is in their best interests and there is no other way to look after them. The provider was aware of their responsibilities under this legislation. The manager had carried out assessments of people's capacity and these were recorded. Where people were unable to consent and their liberty had been restricted the provider had ensured this decision had been made by a group of their representatives in their best interest, with the exception of the restriction on the use of sugar. For example, the access to the front door in order to leave the home was controlled by a digital number lock. Where people had been assessed as at risk if they left the home without support, an application under DoLS had been made to the local authority. We saw copies of the requests for authorisation and the manager had kept the person's next of kin and CQC informed of these applications. The provider monitored when DoLS authorisations needed to be reviewed or updated.

The provider had assessed that a small number of people who lived at the service at the time of our inspection had the capacity to make decisions about their care. We saw that these three people had been involved in creating their care plan and had told the provider about their preferences. The manager told us that one of the people did not want to sign their care plan, and they were in the process of obtaining written consent to the care for the other two people. We spoke with these people who all confirmed that they consented to their care and to living at the service. The provider had requested DoLS authorisations for other people living at the home.

At the inspection of 28 September 2015 we found the staff had not received the appropriate training, support and appraisal in order to carry out their roles effectively and to an appropriate standard, this meant that people were at risk of receiving unsafe or inappropriate care. At this inspection we found that improvements had been made.

The staff told us they felt supported by the manager. They said that although they did not always have formal meetings they could speak with the manager or senior staff whenever they needed. The manager told us they had started to undertake annual appraisals for the staff and they confirmed this. The provider had ensured that staff received training updated in areas which they considered mandatory, such as infection control, moving people safely, food hygiene, safeguarding and the Mental Capacity Act 2005.

There was a notice board showing the date and season. There was also a notice board of activities which included pictures of different activities. However the information was not easy to understand and it was not always clear what the planned activity of the day was. There were no notices regarding staff on duty and the staff did not wear name badges to help people identify them. Although toilet and bathroom doors were sign posted and bedroom doors were identified with a photograph, name and number, there was no other signage to help orientate people around the home. The corridors with bedrooms were difficult to distinguish from each other. The corridors on the upper floors did not have windows or ventilation and were stuffy and hot. Areas of the building were in the process of being redecorated and some paint and woodwork had been left damaged and in an incomplete state. There was limited outside space and people were not able to use this at the time of the inspection because the builders had left equipment and a skip in the area.

The National Institute of Care Excellence (NICE) guidance about environments for people with dementia states, '' Good practice regarding the design of environments for people with dementia includes incorporating features that support spatial orientation and minimise confusion, frustration and anxiety.''

The guidance also refers to the use of ''tactile way finding cues.'' The government guidance on creating ''Dementia friendly health and social care environments'' recommends providers ''enhance positive stimulation to enable people living with dementia to see, touch, hear and smell things (such as sensory and tactile surfaces and walls, attractive artwork, soothing music, and planting) that give them cues about where they are and what they can do.''

People had enough to eat and drink and the provider monitored nutritional risk to make sure people's needs were met. Some of the comments people said about the food were, "I have enough to eat and I like the food"; "The food is basic but good"; "The food is okay"; "I take what comes as regards the meals but if there is something I don't like or doesn't agree with me, I can usually get an alternative. I would however like more choice of diabetic desserts because I get a banana most days"; "The food is good, there is enough variety" and "I'm satisfied with the quantity and variety of food and there is also a food hatch you can go to if you want to." One visitor said, "I think they give them too much food."

One visitor told us that they felt the provider had responded appropriately when their relative lost weight. They said, "[My relative] was losing weight so the staff have been giving her milkshakes with vitamins in.''

The manager told us that people were weighed weekly and risk of malnutrition was assessed monthly using an approved assessment tool. We saw evidence of this. People who were at risk of malnutrition were given appropriate support. For example, we saw that one person who had recently moved to the home was assessed as having very low body weight and was at risk of malnutrition. The staff were liaising with the person's doctor in order to obtain support from other appropriate healthcare professionals. The staff were monitoring the person's food intake and had placed them on a high calorie diet with homemade milkshakes. The provider had introduced regular energy dense milk-shakes for people deemed at nutritional risk and this recipe had been obtained from a local community dietitian.

People were offered hot and cold drinks throughout the day and the manager told us that food and drinks were available throughout the day and night. However, we noted that the staff did not always have a clear idea of how much people had eaten or drunk. For example, we noted that one person who was seated next to another person who was asleep drank all the drinks the sleeping person had been given and ate some of their food. The staff did not appear to notice this and the person was not offered additional drinks or food when they woke. The person was asleep again when the soup starter was brought to them at lunch time. The person did not eat any of their soup and 45 minutes later they were asleep with their food untouched in front of them. Other people who were given lunch in the lounge were not always observed by the staff and one person gave some of their food to another. The staff were attending to other tasks and did not spend time encouraging people to eat or ensuring they ate the food which was given to them.

There was no menu of planned meals available. The kitchen staff said that there was a weekly menu. However, there was no menu on display on the day of inspection –in any format, written, pictorial on a whiteboard or menu at the table.

Four people told us there was enough choice at the meals. One person said they, they did not know whether there was a choice and another person told us, "I do not know what it will be until the meal is put down." During the inspection we observed that people were not given a choice at mealtimes and the staff did not explain what the food was when they served people or supported them with their meals. The starter at lunch time was soup, however no one was able to tell us what flavour the soup was and the staff told us they did not have access to this information.

The manager showed us evidence of a questionnaire regarding people's experience of food at the service.

The results shown were positive and no changes were required.

People were given the support they needed to stay healthy. Everyone was registered with a local doctor and other health care professionals as needed. People's health needs had been assessed and there were care plans in respect of these. Changes in health need were recorded.

People told us they could see their doctor or other healthcare professionals whenever they needed. They told us the staff looked after their health and monitored their wellbeing, organising for them to see a doctor when needed. One person said, "We are weighed every week and have our blood pressure taken. We also have eye checks twice a year but there isn't a visiting dentist".

On the day of the inspection one person became unwell. The staff responded appropriately by monitoring the person's health and calling for medical assistance when they thought the person's health had declined beyond the support they could provide.

We recommend that the provider consult recognised good practice guidance for improving the environment to help orientate and support people living with the experience of dementia.

Requires Improvement

Is the service caring?

Our findings

At the inspection of 28 September 2015 we found that people were not always treated with respect and dignity by some staff. At this inspection we observed that this was still the case at times.

We saw a number of occasions when different members of staff wiped people's faces with a tissue following a sneeze, when they had a runny nose and to remove food. The majority of time the staff did not communicate with the person, often approaching them with the tissue, wiping their face and leaving again without speaking.

We witnessed one incident where a person threw their cup of water across the floor. A member of staff approached the person and said in a sarcastic tone, ''Beautiful [person's name] that was just perfect.'' The member of staff then walked away. We reported this to the manager who contacted us shortly after the inspection visit to tell us they had taken appropriate action with the member of staff. Following this incident the person was not given any further drinks until after their lunch; despite the fact other people sitting in the same room were regularly offered drinks.

During the morning in one lounge the staff removed a coffee table which one person was using without speaking with the person or asking their permission. The person became distressed and called out to different members of staff about this. None of the staff responded until another person who lived at the home said, ''[The person] wants his table back.'' A member of staff responded by saying, ''His table is busy he can't have it.'' The person was not given the table back until over two and a half hours later when they were given some lunch. Throughout this time they continued to show distress. The care staff did not interact with this person during this time apart from when we alerted a member of staff and requested that they attend to the person as they were calling out and visibly distressed. However, we noted that a member of domestic staff who entered the room, approached the person to ask what was wrong and attempted to comfort them. The person's care plan said that the person, ''Requires a lot of TLC (tender loving care).''

We observed another incident when a person was calling out to a member of staff walking past. The member of staff turned to the person and said, ''Yes.'' The member of staff did not wait for further communication and then walked away.

Throughout our visit we saw examples of how the staff were focussed on the tasks they were undertaking rather than the people who they were supporting. For example, at one point during the morning a person spilled their drink over their trousers and socks. A staff member immediately started to mop up the floor. However, they did not reassure the person or check on their wellbeing. The person was left sitting in wet clothes for ten minutes before another member of staff approached them and escorted them to their room to get changed.

The care staff regularly walked through the lounge area where people were seated. The majority of staff did not interact with people at all. At one point when there were 12 people seated in the lounge a member of

care staff walked in, looked around, spoke to one person who was asleep saying, ''How are you today [person's name]? Sleeping?'' to which the person did not respond as they were asleep. The member of staff did not speak with any of the other 11 people, nine of whom were awake.

We observed practices during mealtimes which did not show respect to the person being cared for. Before lunch the staff placed protective tabards on people without asking their permission or telling them what they were doing. Whilst one person was seated waiting for their lunch they started to pick up and play with a table mat. A staff member took the mat away from the person and said, ''No.'' They then walked away from the person without any further communication. The person waited a further half an hour seated at the table before they were offered any food.

During breakfast a person who was eating their meal independently took a long time to do this. On a number of occasions different members of staff walked up to the person and stood over them to offer them forkfuls of food. Some of the time the staff member held food up to and touching the person's lips whilst they were still chewing their previous mouthful. This support was inconsistent and the staff did stay with the person. We looked at the person's care plan for eating and drinking which stated, ''[Person's name] likes food and can eat independently.'' In another incident at breakfast a member of staff repeatedly held a drink to one person's lips whilst they were chewing food.

During the morning in one lounge a person who had been left to eat their breakfast had tipped their plate of food over their clothes. The plate remained at an angle on top of the person's chest. We saw that for over an hour the staff regularly walked past this person. During this time none of the staff helped the person to move the plate, clear the food off their clothing, offer the person fresh food or any assistance. At one point a member of staff said to the person, ''[Person's name] are you still eating?'' The person did not respond and the staff member walked away.

During lunch some people were offered a choice of drinks but the majority of people were not. One person asked for a cup of tea from several different members of staff. One member of staff responded, ''Ok, but it is juice time now.'' The member of staff did not bring the person their preferred drink and poured them a glass of squash. Another person asked for a glass of water. Neither person was served the drink they had requested for ten minutes despite a number of different staff bringing other drinks and items to the tables they were seated at. One member of staff who we noted had been attentive to others brought both people the drink they had requested.

People were supported to eat their food in a way which was disrespectful and, at times put them at risk of choking. Two people were supported by one member of staff at the same time. The member of staff moved between the two people, sometimes standing over them and sometimes sitting next to them, offering a few mouthfuls of food and then moving to support the other person. The member of staff did not explain what they were doing, tell the people when they were moving on or whether they were offering soup, other food or drinks. When one of the people attempted to eat their soup independently, the member of staff took away their spoon and bowl and said, ''No no!'' The person's care plan stated that they were able to eat independently and we saw them doing this at other times during the day. The member of staff used a spoon to scrape food off the person's chin before offering them the spoon to eat afterwards.

A different member of staff supported another person who appeared sleepy and had their eyes closed when they arrived at the dining table. The member of staff said, ''Wakey wakey'' and then started offering mouthfuls of food whilst the person sat with their eyes closed. They did not warn the person between mouthfuls so they did not know when they were about to be offered food or what this food was. The choking risk assessment for this person stated that staff should ensure the person was ''Awake and alert before she

starts eating and drinking.'' The risk assessment went on to state that the member of staff should, ''Inform her what she is eating.'' This did not happen during lunch on the day of our visit.

Both members of staff supporting people repeatedly left the table and attended to other tasks (sometimes for several minutes at a time) without telling the person what they were doing. They did not speak with the person again when they returned and started supporting them again.

We heard one member of staff addressing a person on a number of occasions by calling them the wrong name.

People's privacy was not always respected by the staff. Some of the toilets on the ground floor were designed so that there were a small number of cubicles sharing a communal sink area. During the morning of the inspection we saw that a member of staff was assisting someone to use one of these toilets. They had not locked the outer door or used a sign to show the room was occupied and they had supported the person to undress and sit on the toilet with the inner door open so there was no privacy from people entering the room.

A notice board displaying people's dietary preferences and needs was displayed on the dining room wall. Whilst it is important that staff have access to this information it should not have been displayed where other people living at the home and visitors could access this. In addition, some of the personalised information about evacuation in event of a fire was displayed on the front of bedroom doors. Therefore other people and visitors could read this, which included information about how to move the person safely and their understanding about fire safety. This information should not be accessible to others and should be coded or stored confidentially.

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

People told us the staff were kind and caring. Some of the comments people made were, "The staff are good, if you want anything they'll do their best to get it for you", "I'm happy here and the staff are caring"; "The staff are nice here, if you're nice to them they're nice to you" and "The people are friendly here." One relative told us, ''I can't fault the place; all the staff are so kind and caring.'' Another visitor said, "The staff are friendly and attentive, respectful."

We saw some interactions and support which was caring and kind. For example, we saw the staff comfort one person who became distressed by stroking their hair and face and speaking with them in a calm and gentle voice. We saw interactions where the staff knelt down to respond to people, making eye contact, listening to what the person was saying and ensuring the person understood their response. Some members of staff gave people winks and smiles as they walked past them, and asked about their wellbeing.

There was an incident where a person became agitated and tried to touch other people and other people's food. The staff supported the person and spoke with them in a calm and caring way, trying to distract them and offer them comfort until they became less distressed. The members of staff also reassured other people during this incident.

One visitor told us, ''[My relative] seems clean and tidy and is always wearing his own clothes." We saw that people were clean and well presented in their own clothes which were comfortable and appropriate for the weather. Their hair and nails were clean.

People told us their visitors were always made welcome. We saw that regular visitors had a good relationship with other people and the staff as well as the person they were visiting. One visitor told us, "When I visit I'm always offered a cup of tea." Some of the comments people who lived at the service made were, ''My visitors are always welcome, it's an open door", "My visitors can come at any time of the day", "Friends can come when they like" and "My visitors are always offered something to drink."

Requires Improvement

Is the service responsive?

Our findings

At the inspection of 28 September 2015 we found that people had limited opportunities to participate in meaningful activities or hobbies that were important to them. At this inspection we found that improvements had been made, however people were not always given meaningful activities.

During the morning in one lounge, one member of staff engaged four people in a large floor mat board game. People were asked to throw a dice and the staff member moved pieces around the board. At time the people engaged in this activity appeared to enjoy this. However, the staff member had not explained what was happening and regularly left the game to attend to other tasks. The game was rather disorganised and people did not always know what was happening.

The majority of other people in this lounge were not engaged in any activity for the duration of the morning. Two people spent most of the morning asleep and a further five people were awake but not engaged in any activity or sustained conversation. The staff did not give them anything to hold or do. One person had brought a magazine into the lounge and was reading this. However, for the majority of people there was no meaningful activity or anything to occupy their time.

The staff spent most of their time attending to different tasks rather than interacting with people. We saw that the assessment in one care plan explained that the person was ''Sociable and likes to be kept busy.'' Throughout the morning the person was left in an arm chair with nothing to do. The staff did not interact with the person and when they called out for the staff or tried to get their attention they were ignored by them.

The records of daily care and interactions did not include details to show that people had engaged in meaningful activities or pursued personal interests.

People's individual interests were not always catered for. For example one person told us that they enjoyed reading but that they had to rely on visitors to bring them books. Some people told us they would like opportunities to go outside. One person said, "On a nice sunny day, it would be lovely to go to the park or the sea" and another person told us, "I'd like a coach trip."

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

During the morning of our inspection there was a religious service held at the home for people who wished to participate in this. The registered manager told us that representatives of the Church of England and the Catholic Church visited the home regularly.

There was a large amount of games and activity equipment available in the lounge on the ground floor.

These included board games, pens and craft equipment. People were able to access these if they wanted and the staff used some of these to interact with people. Throughout the morning of the inspection music was playing. People told us they liked it when entertainers visited the service.

The manager told us that they were trying to reduce the number of domestic and other tasks the care staff were required to undertake so that they would spend more time with the people who lived at the home.

At the inspection of 28 September 2015 we found that care plans were not always in place regarding all the care needs people had and they were not person centred. People and their relatives/representatives had not been involved in the development and review of their care plan. At this inspection we found that improvements had been made.

The care plans included information from the person, or their representative and within this information there were details about their preferences and personal needs. The level of information and detail varied because these had been largely written by or information obtained from the families of the person. Where the provider had not gained a large amount of this background information the care plans tended to be less person specific and did not always record people's preferences.

The care plans themselves included very detailed information about the person's condition or health need. For example, where people had dementia or a specific health condition such as diabetes. This information was a useful guide about the condition for staff, however it was not person specific and took up a large amount of the care document. We discussed this with the manager who agreed that they were planning to create a separate file of this information for staff and have a shorter, more person specific guide in each person's care plan.

The staff recorded care which had been provided and there was clear information when people's needs had changed. However, there was not always a lot of information about how people were feeling and whether their emotional needs were being met.

The provider had a procedure for making complaints. No complaints had been received by the home since the last inspection. All of the staff we spoke with said any problems, concerns or complaints were taken directly to the registered manager who resolved them immediately. Family members confirmed that if they had any concerns or complaints they would feel comfortable with raising them directly with staff and the registered manager. One relative stated, "If need be I just talk to the manager and he is very receptive."

Requires Improvement

Is the service well-led?

Our findings

At the inspection of 28 September 2015 we found that people were not protected against the risks of poor care and treatment because the provider did not operate an effective system to assess, monitor and improve the quality and safety of the service. The systems in place had not identified the shortfalls we found.

At this inspection we found improvements had been made, however the provider had not taken sufficient steps to assess, monitor and mitigate risks to people's wellbeing and safety. For example, some staff practices placed people at risk and the provider had not managed these risks. In addition we found there were not enough staff deployed to minimise these risks and keep people safe.

The provider did not always maintain an accurate or complete record in respect of each person. Nine people on the ground floor had their food and fluid intake monitored and recorded to ensure they had enough to eat and drink. We noted that at 10.40am on the day of the inspection, none of the nine monitoring charts had been completed with any details for that day. There is a risk that staff completing these forms retrospectively would not complete them accurately therefore the wrong information about how much each person ate and drank may be recorded. We saw that people's weight was recorded in their care plan. However, this information was not always up to date. The staff maintained a separate record which included recent weights for everyone, however this information had not been transferred to their individual records. The staff had recorded information about people's nutritional needs and special dietary requirements. However this information was recorded in different places, including the person's care plan and information for the kitchen and sometimes the information had not been correctly updated in all the different records. Therefore there was a risk that people providing care did not have access to the most up to date records.

Ten of the staff working at the service had undertaken on line nutrition training. However, the chef, who had recently started working at the service, had not had training in this area.

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

People living at the home told us they felt the service was well-led. They said the manager was always available and responded when they had a query or needed something. One person who lived at the home told us, "I don't know the manager but overall, Hanwell House is well run." Comments from other people included, "The manager has been good to me", "I have everything I want, it seems well run to me", "Any problems here are dealt with straight away. When there was a confrontation between two residents, the manager came upstairs immediately", "The manager is nearly always around, he is very hands-on" and "The manager is very good with new people when they come in, he makes them welcome."

Comments from visitors to the service included, "The manager runs the home like clockwork and if he sees anything out of order, he'll say'', "The manager will chat with people and their families and if they want a

private conversation he will take them to the office'', ''I'm very sympathetic to the work they are doing here" and ''[The provider] ploughs all his money back into this place, he is always buying new things for the residents and the home.''

The manager owned the company that provided the service. This was the only location operated by the provider. The manager worked full time at the service. He had an in-depth knowledge of all of the people who lived at the service including changes in their needs, their preferences and social history. The manager was popular with people living at the service and staff. He was friendly and approachable and we saw he had positive relationships with others at the service.

There was a welcoming and friendly atmosphere at the service. People who lived there, their visitors and staff reported feeling relaxed and happy there. People were supportive of one another and visitors told us they were welcomed.

The manager undertook a range of audits and checks. For example, the manager audited care records, accidents and incidents, checks on the environment and staff records.

Notifications were being sent to the Care Quality Commission (CQC) for any notifiable events, so we were being kept informed of the information we required.

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 did not take formal enforcement action at this stage. 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 registered person did not ensure that the care and treatment provided to service users was appropriate, met their needs and reflected their preferences. Regulation 9

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The registered person did not ensure that service users were always treated with dignity and respect or ensure their privacy. Regulation 10(1) and (2)((a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered provider did not always do all that was reasonably practicable to mitigate risks to ensure that care and treatment was provided to service users in a safe way. The registered provider did not always prevent and control the risk of the spread of infections. Regulation 12 (2)(b) and (h)

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The registered person deprived people of their liberty without lawful authority. Regulation 13 (5)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered person did not always assess, monitor and mitigate the risks to the health, safety and welfare of service users. The registered person did not always maintain and up to date, accurate and contemporaneous record in respect of each service user. Regulation 17(2)(b) and (c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The registered person did not always ensure that sufficient numbers of suitably qualified and competent staff were deployed to meet the needs of service users. Regulation 18(1)