TWH Residential Home Limited

The Whitehouse Residential Home

Inspection report

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Ratings

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

Overall summary

The inspection took place on 14 and 17 July and 10 August 2015. The visits on 14 and 17 July 2015 were unannounced, which meant we did not notify anyone at the service that we would be attending. On 10 August 2015, we agreed the visit date with the registered manager so that we could ensure it was at a time when they would be available.

The service was last inspected on 3 and 4 July 2014 and was found to be in breach of two of the regulations we inspected at that time. These related to safeguarding people from abuse and assessing and monitoring the quality of service provision. The provider sent a report of the actions they would take to meet the legal

Summary of findings

requirements of these regulations which stated they would be compliant by October 2014. We checked whether these had been met as part of this new approach comprehensive inspection.

The Whitehouse Residential Home accommodates up to 32 older people that require personal care. The home comprises of two buildings, one of which accommodates people who may be living with dementia. 11 people resided on the unit for people with dementia at the time of our inspection and there were a total of 23 people using the service.

There was a registered manager in post at the home. 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.

Although people told us they felt safe, the service did not operate safely. Medicines were not appropriately managed which led to a risk of people not receiving their required treatment in a safe manner. We saw that practices relating to medication were not undertaken in line with the service's own policies.

Staff told us they found the current staffing levels in place to be dangerous and unsafe, particularly at night. No dependency assessment was undertaken to establish the staffing levels required to meet people's needs. For example, we found at least five people required the support of two staff members with some of their care needs. This included the use of equipment, such as hoists, which required two staff members to operate safety. These needs could not be safely managed with the current staffing arrangements in place.

Safeguarding polices were in place and staff received training in safeguarding. We saw that although some incidents of potential abuse were reported and logged by staff, they were not being referred or communicated to the local authority safeguarding team. This led to us forwarding details of these to the local authority following a discussion with them after our inspection. Incidents were not robustly analysed and there was a lack of evidence to show that actions had been taken to effectively minimise risk and prevent recurrence.

We saw evidence of updates to people's care plans and risk assessments but these were not always meaningful as they did not always correspond with our observations and what staff told us. People's views about activities at the home were mixed, with some people commenting they would prefer more activities. We saw few activities take place during our inspection.

The principles of the Mental Capacity Act 2005 were not always followed to show how people were assessed as lacking capacity. We saw some restrictive practices in place and found Deprivation of Liberty Safeguards had not been considered and applied for where there was a possibility they may be required, so that people were not deprived of their liberty without lawful authority.

Recruitment procedures were not sufficiently robust to ensure that staff were assessed as suitable to work at the service.

We saw instances where staff were undertaking care provision that they had not received appropriate training in. Staff told us they felt supported and said they had regular supervisions and appraisals. We found that these had not always identified individual training needs.

People and relatives we spoke with all commented positively about the staff and felt they were caring. We saw instances of caring interactions between staff and people. We observed staff offer reassurance to people when they were providing support. However, we observed some situations where people did not have their privacy and dignity maintained, and where people were not consulted about their preferences.

We saw feedback surveys from last year and saw the results of these had been analysed and actioned with areas for improvement. There was a complaints procedure in place at the service.

Regular team meetings took place with staff. Staff comments varied about how well they felt supported by management. We saw that quality monitoring of the service by the registered provider was not documented and audits undertaken by the registered and deputy manager had failed to identify shortfalls in a number of areas.

Summary of findings

We found eight breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

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

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe. Medicines were not managed and administered in a safe and proper way which meant there was a risk of people not receiving their medication as required.

Staff told us that staffing levels were dangerous and unsafe. No assessment was in place to determine the staff required in order to safely meet people's needs.

Incidents of potential abuse were not routinely referred to appropriate authorities. Actions in risk assessments were not always followed, and updated in response to changes, in order to reduce risks for individuals.

Is the service effective?

Inadequate

The service was not effective. Training was provided for staff but we found instances of staff supporting people without the required training. Staff told us they received supervisions and appraisals.

We identified concerns where people who may have lacked capacity were subject to restrictions without appropriate Deprivation of Liberty Safeguards authorisations in place.

People had access to, and were seen by, a variety of health professionals to support them with their health needs.

Is the service caring?

Requires Improvement

The service was not always caring. People gave positive comments about staff, the care they received and how they were cared for.

Although we saw positive interactions and communication from staff towards people when they provided support this was not consistent. We saw instances where people were not offered choice. People did not always have their privacy and dignity maintained.

Care records contained little, or no, background information about people to assist staff to interact on a personal level.

Is the service responsive?

Requires Improvement

The service was not responsive. Care records were regularly reviewed but not in a meaningful manner. Observations and information from staff about people's needs did not always correspond to information in their records.

The service employed an activities co-ordinator but comments about activities were mixed. We did not observe many occasions of people engaged in meaningful activity.

Summary of findings

Resident meetings took place which meant people had opportunities to feedback about the service and suggest improvements. There was a complaints procedure in place and people said they would feel comfortable in raising any issues.

Is the service well-led?

Inadequate

The service was not well led. Quality monitoring took place to assess how areas of the service operated but this was not effective in identifying areas for improvement and implementing actions to address these.

Incidents and accidents were not sufficiently monitored and reviewed to identify trends and themes and reduce risk of recurrence. Incidents were not referred to other organisations where there was a requirement to do so.

Team meetings took place and most staff told us they felt supported by management. People knew who the registered manager was and spoke highly of the service.

The Whitehouse Residential Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection 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.

The inspection took place on 14 and 17 July and 10 August 2015.

On the first day, the inspection team consisted of one adult social care inspector, a specialist advisor who was a registered nurse 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 had experience in older people's care services. On the second and third day of the inspection, the inspection team consisted of one adult social care inspector.

Prior to the inspection, we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We saw the request that was sent however the registered provider advised us they did not receive this therefore a PIR was not used as part of this inspection. We reviewed information we held about the service which included statutory notifications, such as for deaths and incidents. We contacted commissioners of the service, the local authority safeguarding team and the local Healthwatch, for any relevant information they held. Healthwatch**,** England is the independent consumer champion for health and social care in England. We received feedback from a community nurse whose team had regular involvement with the home.

During the inspection we spoke with nine people and six relatives of people who lived at the home. We undertook informal observations and spent time with people in communal areas to observe the care and support being provided.

We spoke with the regional manager, the registered manager, the deputy manager, seven care workers, the cook, activities worker, housekeeper and maintenance person.

We viewed a range of records about people's care and how the home was managed. These included the care and medication records for seven people, training records for four staff members, policies and procedures, audits and meeting minutes.

Inadequate

Is the service safe?

Our findings

People told us they felt safe and secure at the home. Comments included, "Never had any reason not to feel safe", "I feel safe, they're [staff] very good to me" and "Feel so happy and protected."

We asked about staffing levels at the home. Two people thought staff were busy and hardworking, but managed to come quickly. One commented, "They come quickly unless they are seeing to someone else, they're on the ball." Another person said, "You get occasional lulls but that's life." Relatives told us there was a difference between day and night time. One said "In the day time [my family member] gets immediate attention, but sometimes complains he has to wait at night."

We discussed the staffing levels with the regional and registered manager. They told us staffing levels had recently reduced due to a reduction of the number of people living at the home. No dependency assessment or tool was used to determine the number of staff required in order to meet people's needs. On one day we attended the home at 6.45am and observed night staffing levels. One staff member worked on each side of home. Several people needed equipment to transfer that required two staff members to operate safely. This was confirmed by staff as well as being supported by information in people's care plans. Other care plans reflected the need for two staff to support people with other areas of care provision. At one point seven people were in the lounge and the staff member responded to a call buzzer rang by a person upstairs in their room. They told us had to support the person to get up and said, "You see, I have to go and leave these people [in the lounge] unsupervised now." They said this was common practice. Our observations were that staff were rushed and unable to provide appropriate supervision for people. We did not see how people's needs could be safely met with the staffing arrangements in place.

All staff we spoke with had concerns about the staffing levels. They told us, "It's not safe us working alone, for us and the people. And the most important thing should be their safety", "People need hoisting. I've had to do it on my own before. Training says you need two people", "Need more staff on nights, lots of people get hoisted you see and you can't do that with one person", "The levels have caused a lot of stress for the staff. There is definitely not enough staff on nights, I think current levels are dangerous" and "Day shift levels are just about okay, but it's the nights that worry me. I think it's dangerous having two people on a night shift here." Night staff told us the manager had previously talked about having a sleepover staff member to help but this had never happened". Following the first day of our inspection, the regional manager reintroduced an extra staff member to start at 7am which provided extra care assistance in the morning. However, the night levels which caused most concerns were unchanged. We made the regional and registered manager aware of our concerns to people's safety. They told us they would have a discussion with the registered provider as to how they would address this and we asked them to report back their actions.

Our findings demonstrated that staff were not deployed in a way to meet the needs of people at the service. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

Staff we spoke with told us they received safeguarding training and knew to document and report any witnessed or suspected abuse. The service had policies in place for safeguarding and whistleblowing. Whistleblowing is where a person raises a concern about a wrongdoing and/or bad practice in their workplace. This meant there were processes in place to help minimise the risk of abuse occurring. However we found that these processes were not effective. At our last inspection we had identified that some incidents of alleged abuse had not been referred to the local authority safeguarding team as required. One of the actions stated in the provider's action plan following this inspection stated that 'all incidents of possible abuse between resident and resident, or staff and resident will be reported to CQC'. Such incidents would also have been eligible for referral to the local authority safeguarding team. We saw that this had not taken place. We saw several documented incidents that met these criteria and although the home had taken action, they had not referred the incident elsewhere in line with their own statement. Following this inspection we spoke with the local authority safeguarding team to discuss the nature of some of these incidents. They confirmed they would expect these to have been reported to their department, or at the least advice sought. They asked us to pass on details of the incidents which we did.

Inadequate

Is the service safe?

Systems and processes did not ensure that potential abuse was fully investigated in order to protect people and maintain their safety. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

We found unsafe practice with administration and management of medicines. The service's 'medication dispensing procedure' stated that staff should wear gloves when administering medication. We observed a staff member not wearing gloves and place medicines into the mouths of people. The 'dispensing procedure' stated that medicines spat out should be placed in an envelope, labelled and disposed of appropriately. We saw one person repeatedly spit out their medication. The staff member picked up the discarded tablet and put it in the person's mouth which they eventually swallowed. At all other subsequent observations, we did see staff wear gloves.

There were no medication trolleys which meant staff had to return to the treatment room in between each administration to prepare medicines for the next person. This increased the risks of errors and the time taken to complete medication rounds. In the unit for people with dementia, we saw two plastic medicine dispensing pots in a cupboard in the treatment room, both of which contained tablets. A staff member told us one of these was for a person who was yet to have their medicines. They said about the other, "Oh I don't know who that is for, I don't even know how long it has been there." This led us to have concerns that secondary dispensing was in practice. Secondary dispensing is when medicines are removed from the original dispensed containers and put into pots or compliance aids in advance of the time of administration. One staff member told us. "In the past we've had to take a few medicines together with the MAR charts and do them all at once. You're not supposed to." This practice is unsafe as it increases the risk of people being administered their medicines incorrectly.

Controlled drugs are medicines which must be stored and administered under strict guidelines and legislation, due to their harmful effects if not managed correctly. We reviewed the register of controlled drugs used by people at the service. On checking the register, we saw seven out of 57 entries for one person's medicines where there were not two signatures as required by legislation. On two of these occasions no member of staff had signed the register at all, yet all other fields were populated. This meant there was no full record from these entries to confirm that the drugs had been administered and by whom.

We looked at the current medication administration records (MARs) for six people. These documented a start date of Tuesday week commencing 30th June 2015. However, when we checked the monitored dosage medication system, we saw that the current medicine cycle had commenced a week later on Tuesday 7 July 2015. This meant the medication records which staff were completing to confirm administration did not correspond with the actual date of administration. It was not possible from looking at the MARs to obtain an accurate record of what date a person had their medicines. In addition, we saw several gaps in MAR charts with no record to account for the omission which meant it could not be established whether the person had received their medicine and if not, why not.

One staff member was responsible for ordering medicines yet the service's policy said this should be undertaken by two staff members. No 'carried forward' quantities were taken or recorded which meant medicine stocks could not be accurately checked. We found out of date medicines still in stock. We saw bottles and creams opened and in use that did not contain the date of opening, which meant it was not possible to establish how long these were safe to use for. Some medicines required refrigeration but were kept at room temperature.

Our findings demonstrated that medicines were not managed in a proper and safe way. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

Following our first visit, the registered provider took action and changed their pharmacy supplier and system. At our third visit we saw that the treatment room had been re-sited, new paperwork was in place and new medicines trolleys, CD cupboard and a fridge had been purchased. Training in the new system had been arranged for staff and a new system was due to go live later that month.

People's care records contained risk assessments that covered a range of areas such as pressure care, falls, and evacuation needs in an emergency. We saw some people's assessments were not always updated, reflective of their

Inadequate

Is the service safe?

needs and in place where required. One person at the service managed their own medication but no risk assessment was present. This was also stated as a requirement in the home's 'self-medication policy'.

During lunchtime we observed a staff member assist people to put on plastic aprons. They assisted one person to put on an apron without asking the person if they wished to wear this. The person had a risk assessment in place which said they were at significant risk of eating foreign objects such as the plastic apron and therefore should not wear one under any circumstances. Care was not provided in response to the person's identified risk in order to maintain their safety.

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

We looked at the personnel files of two of the service's most recent staff members who were employed at the service. We saw that each staff member had undergone a Disclosure and Barring Service (DBS) check. These checks help employers make safer recruitment decisions and help prevent unsuitable people from being appointed. One staff member had two written references in their file, which was listed as a requirement in the service's safeguarding and recruitment policies. For the second staff member, we saw only one reference from their current employer and this had been obtained verbally. There was no second reference in place yet details had been provided on their application form. The registered manager was unable to account for this omission when we asked them. This meant appropriate checks had not been undertaken to assess the suitability of staff that had been employed. This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

The fire service were present on the third day of our inspection to check the service was compliant with fire regulations. The maintenance person told us they had some actions to complete as a result of this visit and they would be required to provide confirmation to the fire service of when these were completed. The maintenance person told us about, and showed us the regular safety checks they completed at the home. These included checks of wheelchairs, window restrictors, pull cords and water temperatures. This showed that systems were in place to assess the safety of the premises and equipment for people using the service.

Inadequate

Is the service effective?

Our findings

We asked people and relatives whether they felt staff were competent to meet their needs. One relative said, "The staff are good and trained, they do a good professional job." Another person praised staff in relation to a situation when their partner had been taken ill. The person told us, "Staff did above and beyond when [name] was ill." A community nurse we spoke with said they felt staff were competent and knew about people's needs. They said there had been problems previously but these had "picked up."

We spoke with staff about their induction and training. One commented, "We receive a good induction here." They told us this included mandatory training and working alongside a 'buddy'. They described a buddy as an experience staff member at the service. Another staff member said their induction "wasn't enough for me" and described a lack of information, such as service procedures and safety information. Another staff member told us they had completed shadowing when they commenced their role. Shadowing is where the member of staff observes a current member of staff performing the roles and responsibilities they are to cover. On checking this staff member personnel records we found that they had received no formal induction, and as a result had been provided with no formal training. This was also confirmed by the registered manager who told us this had been an oversight and the person had now been booked onto an induction to receive their mandatory training. We saw this staff member administer medicines and said this should cease this until they had been trained and assessed as competent. We found they had also worked as a lone staff member on the unit for people with dementia which meant they had supported people without having the relevant training.

Staff we spoke with were generally positive about the training they received and told us about various courses they had completed. We looked at the service's training matrix and saw some gaps in people's training and some training that was out date. For example, fourteen out of twenty seven staff were listed as having been trained in infection control. Six staff who had been trained in medication last received training in 2006 or 2007. We looked at additional training that was listed on the matrix. This included subjects such as pressure care, care planning, end of life and dementia awareness but saw that only a small number of staff had completed some of these courses. Only six staff had completed training in dementia awareness, the latest of which was in 2012. The majority of staff had not completed the other courses listed on the matrix.

Supervision is an accountable, two-way process, which supports, motivates and enables the development of good practice for individual staff members. Appraisal is a process involving the review of a staff member's performance and improvement over a period of time, usually annually. Staff told us they received regular supervisions and annual appraisals, which was confirmed when we viewed four staff files. From the omissions in the training matrix and lack of induction for a staff member, these had not been effective in addressing the training needs for staff.

Our findings demonstrated that staff did not always have the relevant skills and training to meet the needs of the service. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

We asked people about the food and found most views were positive. People told us "They feed me well," "We have a real chef" and "I've never left the table feeling hungry." Another person told us, "The chef is good, you can ask for something different and he will get it." We observed this when one person requested something that was not on the menu and the cook made what they wanted. We observed tea and coffee was offered during the morning and afternoon with biscuits if people chose. One person said, "I'm not really impressed with the food. As food goes in institutions it's as good as can be expected, I would prefer more fruit and vegetables." We did not see drinks or snacks available in communal areas for people to access themselves.

We spoke with the cook who told us they aimed to provide a varied menu and told us about people's preferences. They said that people's individual needs such as specialised diets or any allergies would be passed on by staff and documented on a whiteboard in the kitchen. We saw people had care plans in place for their nutritional needs and preferences. Weights were monitored to identify where people's nutritional needs may need to change.

We observed differing experiences in the two dining rooms at the service. In the residential side of the home people sat at tables in twos and small groups. Tables were laid with cutlery and glasses and the room was bright and spacious.

Inadequate

Is the service effective?

Food looked and smelt appetising and there was a calm unhurried atmosphere. Most people ate in the dining room and conversation took place. Staff offered assistance with cutting up food as needed and were helpful where people needed support.

In the unit for people with dementia, the experience was not as relaxed. We saw one staff member eat their own lunch on their knee in the lounge whilst supporting a person to eat their meal at the same time. The other member of staff present assisted one person by offering them a spoon of food and then moved on to assist someone else. This continued throughout the whole meal service and meant people were left waiting for help as a result and their food was eaten cold. No conversation took place during the mealtime service.

The Mental Capacity Act 2005 (MCA 2005) is legislation designed to protect people who are unable to make decisions for themselves, and to ensure that any decisions are made in people's best interests. The Care Quality Commission monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. The Deprivation of Liberty Safeguards (DoLS) are part of the Mental Capacity Act (MCA) 2005. They aim to make sure that people in care homes, hospitals and supported living are looked after in a way that does not inappropriately restrict their freedom.

MCA and DoLS training was provided to staff who demonstrated a varying knowledge of the legislation. Three staff had yet to receive training in this area. We saw that where people had capacity and were able to consent to decisions, such as signing agreements and contracts to reside at the service, these were in place. However, care plans we looked at were not always clear where people lacked capacity and in what areas. For example, one person's care plan stated '[Name] can communicate but lacks mental capacity' with no information about what particular decision they were unable to make. During our inspection, we saw mental capacity assessments had been recently implemented in care plans however these were not sufficiently detailed or decision specific. One person's assessment stated that they lacked capacity to make any decisions regarding their healthcare and had given 'inappropriate responses' in the assessment. No details were provided about what these responses were and why they were inappropriate, nor was the assessment specific to a particular decision. Improvements were required in relation to how the MCA was implemented and applied to ensure that decisions were made in people's best interests where they lacked capacity.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

The registered manager had made three DoLS applications for people in 2014. They told us the local authority had recently informed them to refrain from making further applications and showed us a letter. On reading the letter we saw this was not correct and the service, as the managing authority, still had a responsibility to ensure applications for authorisations were made within the current legislation. On two of our visits, the same person at various times asked us and staff when they could leave. On our third visit we saw the person attempt several times to open the door to the outside which was locked. They said, "I want to get out. How do I get out? I feel like I'm in prison." A staff member present said, "I can't let you out. There's not enough staff to take you anywhere." We looked at the person's care record and saw information from a family member that said the person liked to go on long walks. There was no reference to this in their care plan. We did see daily record entries that the person had previously been supported on a trip out of the home. However, no information was present about how staff were to support the person with their requests and attempts to leave. We believed that the person may be subject to unlawful restrictions and discussed this with both the registered and regional manager. The registered manager agreed to assess the person's capacity with regards to whether they could consent to reside at the home and if not, make an urgent DoLS application to the local authority.

We also had concerns about the appropriateness and lawfulness of other potential restrictions. One person had a bed rails risk assessment in place but this had not been signed by the person to confirm they agreed as stated in the service's bed rail policy. Another person was seated in a specialised chair that is intentionally low down and can be difficult for people with limited mobility to get out of. There was no reference in the person's records that they required use of this specialised chair. This could be perceived as a restriction as it has the ability to limit a person's

Is the service effective?

movement. The registered manager told us the person was able to get up from this although we did not observe the person do this at any time during our presence. Staff told us this person needed two people to support them to walk.

We found that people were not always protected from unlawful restrictions. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

People told us that they saw a GP and other health professionals as and when needed. Several people mentioned they had been visited by the optician and the chiropodist. We saw the district nurse attend during the first day of our inspection. On the third day we saw a professional from the falls clinic assessing a person's mobility and show them some exercises to do to improve this. Care records evidenced involvement from a number of professionals including doctors, specialist and district nurses. Staff told us any recognised change in health needs would be reported to a senior staff member who could then make appropriate referrals as necessary. This showed that people were supported with their health needs.

Requires Improvement

Is the service caring?

Our findings

We asked people their views of the staff that cared for them. People said, "They're [staff] friendly and approachable" "Staff are nice, they are all very kind" , "I've never been so happy since I left home" ,"Staff are superb, they communicate well with you and staff get on with each other", "They are very caring, they do care and some [people] are very difficult" and "[Staff member's name] is ever so nice. They're all nice here." One person told us, "Staff are alright, you have to make allowances, anyone can have a difficult day. I don't make unreasonable demands." No one gave any negative comments about the staff or the care they received.

Relatives also spoke positively about the care their family members received. They said, "Lovely home, nice staff here", "Staff are very jovial and hardworking" and "They are good with relatives, they know me and my [other relative], they accommodate our visits." An entertainer who had recently performed at the home had sent a letter of praise which stated The Whitehouse was, "A home from home with staff that really care about the residents."

Staff we spoke with commented that they would like to be able to spend more time with the people they supported, for example to sit and talk with people. One staff member said they tried to do this in the afternoon and at quieter periods. Most staff expressed genuine care for the people they supported. Two staff members said "I love it here" and spoke about getting to know the people. One commented, "I like to find out about the people". Another staff member said, "It shouldn't be minimum standards. Care should be above and beyond, it could be your mum or dad. People have come to live their lives here and we should make it the best we can for them. I tell others [staff] that the people here had lives like they have, enjoyed things, going out, have likes and loves and we should remember that."

A lot of interactions we saw were caring such as staff offering reassurance to people whilst supporting them. We saw one person was transferred by a hoist and was patiently and kindly assisted by staff. Another staff member spent one to one time walking with a person. We heard good natured chats and laughter between staff and people and saw that people were comfortable in the presence of staff. However, we observed some notable negative interactions. In the unit for people with dementia we saw one staff member, without asking anyone, turn off the television and switch on the music. This was the same music CD that people had been listening to in the morning. We asked the staff member about this and they replied "I prefer music." We asked "What about what the people prefer?" The staff member responded, "But I prefer music. Television numbs your brain." This showed that no consideration was given to people's preferences and the action was designed to suit the staff member's preference only.

On another occasion we saw people were offered a choice of orange or blackcurrant juice. Most people made a choice between the two, however one person said, "Tea please". The staff member said "Have a drink of juice" to which the person again said "I'd like tea". The staff member then poured a glass of orange juice for the person to drink despite them making their preference known. The result was that the person was not able to have their drink of choice and was restricted to what was more convenient for the staff member. Another person was not given a choice of what they would like for their dessert. Instead the staff held a conversation between themselves, "Shall we save [name] a bit of fruit?" "Yeah fruit will be fine." The person was not consulted with or supported to see what they actually wanted to choose for themselves. This again showed a lack of respect and opportunity for people to make their own decisions.

When asked, people said their privacy was maintained and gave examples such as staff knocking on doors when entering rooms. A relative told us, "They don't broadcast accidents, they take [my family member] away to the bathroom to change them." One person said staff, "Would never discuss things in public, they would take you away privately." Although people said this, we did not always see this in practice. Although we saw staff assisted people in a dignified way, this was not always consistent. We observed people have their faces wiped with wet wipes in communal areas without being asked first. We saw one person have topical creams administered in a communal lounge. The staff member said "Let's have a look at your legs" and had to adjust the person's clothing. They then asked to look at their head and back, where the person's top had to be lifted up, to administer cream. The person was not asked if they would like to receive their treatment in their room.

Requires Improvement

Is the service caring?

Our observations demonstrated that privacy and dignity for people was not always maintained and promoted. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

From discussions with staff, they were able provide information about various people's histories and backgrounds yet this information was not captured in care plans. Therefore it was not possible to see from the records alone, information about the person outside of their care and support needs. Such information about people, where known and obtainable, is valuable to provide knowledge for staff in order to understand a person and know how best to support them. This is especially important for staff that may be unfamiliar with the people, such as new staff and for new people who may start to use the service. We discussed this with the registered and regional manager who told us care plans were being reviewed and they would look at including this important information.

Requires Improvement

Is the service responsive?

Our findings

Two relatives told us that they were included in care reviews and had "regular chats with staff." Another relative's family member had attended the home for a period of respite after having spent some time there previously. They told us they had been consulted for information about their relative and commented that the person was able to have the same room they had before which was appreciated. People at the service did not specifically tell us about care reviews but made reference to talking to staff about the care they needed. One relative had seen the changes in care that their family member needed put in place.

People's comments did not reflect what we found in practice. We saw that care records were reviewed at regular intervals but the reviews were not always meaningful. The majority of people's care plans when updated said, 'no changes", 'continue as plan', 'remains relevant' and 'remains the same'. It is important reviews are sufficiently detailed to ensure the needs of the person are fully understood and are being met by the service. We found a number of occasions where our observations and what staff told us, did not correspond with what was documented in people's care plans. Two staff members told us one person had recently had a fall. Both said that the person used to be able to walk independently however now required the support of two people to walk. When we looked at the person's care plan, this information was not reflected in the person's mobility needs. The care plan said only that the person could be unbalanced at times and staff should be aware.

Another person's care plan stated in a review from April 2015 that the person was, 'No longer independently mobile' but did not state what assistance this person needed for their mobility. On the first day of our inspection this person was being cared for in bed and we were told required the use of a hoist if they were to get up. This significant change was not reflected in the person's care plan.

In staff meeting minutes we saw it recorded that night staff should get people up in the morning prior to day staff commencing their shift, unless the person requested to stay in bed. This showed that a task based approach was in place with little regard to people's individual preferences.

We asked the regional manager how people who required support from two people would be supported to get up and they suggested the person would have to wait until extra staff came on shift.

Our findings evidenced that people's individual needs were not always accommodated. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

The home employed an activities co-ordinator who was present only on the third day of our inspection. They told us about, and showed us some pictures of, various activities that had taken place. These involved parties and entertainers performing at the home. We saw some artwork completed by people. They told us that they held regular meetings with people to get feedback about areas of the service, such as food and ideas for activities. They said that they sometimes had to stand in for care staff if the service was short staffed and at holiday periods. This meant that there would be a reduction in the amount of activity time for people.

We saw few activities take place during our inspection. On the first day a staff member held a brief quiz just before lunch. One person told us these were "few and far between." They went on to say, "I want more activity." On another occasion we saw a staff member encourage people to sing along to some 'old time' songs which they said people had enjoyed. Another person told us, "We have remarked before to see if we could have a round of cards or dancing. Staff are too busy to do activities. I can keep knitting and crocheting to keep me active, I like to do that." However, one person felt there were activities to engage in and told us, "[Activity co-ordinator] gets us playing dominoes, they organise things and will take me out in the grounds." We did not see anyone spend time in the grounds during our visits.

A relative said, "There are few activities, they provide food and toileting but then they are sitting around. [My family member] gets frustrated stuck in the home with no trips out." Two staff members also commented they would like more trips out for people.

There was a complaints procedure on display in each reception area of the home which provided details of how to make a complaint and other organisations people could contact with concerns. There were no current complaints at the time of our inspection. People told us they would feel

Requires Improvement

Is the service responsive?

comfortable to raise any concerns. One person said they had never had any complaints and that, "If there is anything to complain about it gets reported and dealt with." They went on to say, "I've no time for folk who moan but don't do anything to alleviate the situation. That's why you have to talk about any problems."

Relatives told us they had received an information pack and knew who to speak to in the event of a problem. One relative told us that whilst they were mostly satisfied with the service, there were no forums for discussion or meetings they could attend. The person told us their main concern was that, "Laundry is a nightmare, it always goes missing." They said they had spoken to staff and suggested ways of managing this but no change had been seen. The registered manager confirmed that no relatives meetings took place and said this was because these had been attempted in the past but had not been well attended. They told us that relatives were able to approach them at any time if they wanted to discuss any issues. We saw suggestions boxes in the reception areas for people to leave feedback if they wished.

Inadequate

Is the service well-led?

Our findings

At our last inspection in July 2014, we found that the provider was not meeting the requirements of the regulation for assessing and monitoring the service. This was because incidents were not sufficiently detailed and robustly monitored, statutory notifications had not been made to the commission where required and it had not been identified that people's care needs were not fully reflected in their records. The provider submitted an action plan which stated how they would address these issues to become compliant.

One action in the action plan stated that all accident/ incident forms would be reviewed by the home manager on a daily basis and a monthly summary maintained. We looked at incidents and accidents ranging back since our last inspection. We saw that although these were documented on accident forms, the actions taken to prevent recurrence often contained a lack of information. For example, one incident where a person had been trying to 'hit out' at staff was to 'watch [name's] moods'. No information was given about how the person's 'moods' were to be monitored and what action should be taken in what circumstance. A number of actions to be taken where people had fallen were documented as 'more regular checks at night' but no details as to the frequency or duration of these. There were a number of unwitnessed falls and unexplained injuries. The incidents were documented on a form each month but there was no evidence to show that any analysis had been undertaken as a means to identify any themes or trends with a view to reduce these and minimise risk. A further action on the provider's action plan stated that the regional manager was to review these on a weekly, then monthly basis but there was no evidence provided to confirm this had taken place.

We asked the regional manager about what their monitoring of the home entailed. They told us that they visited often but their approach was "informal" and they didn't document anything in relation to these visits. We asked how information about any actions were logged and followed up without any record and we were told by both the regional and registered manager that this was undertaken by verbal discussions. This meant there was no method to formally monitor and assess how the service was managed from a provider level.

We saw various audits undertaken by the registered manager, which included medication, infection control, catering and a full home audit. The manager told us the frequency with which she undertook these was normally on a four month cycle. We asked both the regional and registered manager about the service's quality assurance policy and were told there was no policy. This meant there was no formal guidance in place to provide details of how the service should be monitored.

We looked at three medication audits completed in 2014 and one in 2015. Three of these audits included an action that MARs needed to be checked at handover but this had not been implemented. The audits had resulted in a rating of 'good' which did not correspond with our findings at the time of our inspection. We looked at three home audits from 2014 and 2015 and each had the same three areas for improvement documented with no actions plan as to how these were to be addressed in order to improve the home. The audit process had failed to fully identify the issues that we identified at our inspection and were therefore not effective at monitoring the service.

We found that notifications were still not being submitted in accordance with legislation in the Health and Social Care Act 2008 which was a concern we had identified at our last inspection. We found that several residents had passed away since our last visit yet we had only received two notifications in April 2015. Pressure ulcers of a notifiable grade had not been notified to the commission or the local authority. The registered manager told us she had been unaware of the requirement to notify the commission of these. We received these notifications shortly after completing our inspection.

We found that robust systems and processes were not in place to effectively monitor the service and mitigate risks to people .This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

We asked people and relatives their views of the home in general. One relative told us, "I would recommend it to others because of the general ambience." Others commented that, "It's got a very good reputation." Two people who lived at the home said "I would recommend it, very much so I think it's the best nursing home in Sheffield." and "It is a good place, I wouldn't be here if it wasn't good."

Inadequate

Is the service well-led?

People and relatives knew who the registered manager and senior staff were and thought they were approachable. Staff we spoke with felt the registered manager was approachable.

We asked staff how they felt about the management team and how supported they felt. Most said they felt supported by the manager. Some said that although they raised issues, they did not always feel these were addressed suitably. One staff member was afraid of repercussions for expressing their views to us about staffing levels. Another told us staff morale was low.

We saw evidence of regular staff meetings that took place which was confirmed by staff we spoke with. Two staff commented there had not been one recently due to absence of the registered manager. Staff said they were kept updated about any changes to the service and received communication so they were aware of information they needed to know in their roles.

We saw completed quality assurance surveys from November 2014 for people using the service with analysis of the results and actions to take forward. A section titled, 'what we could do better' set out what improvements the service aimed to take as a result of the survey. The majority of questions about the service resulted in positive responses with all people who completed the survey stating they were happy with their overall care.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 How the regulation was not being met: The care and treatment of people was not always appropriate to their needs and did not always reflect their preferences.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect How the regulation was not being met: People were not treated with dignity and respect and in a way that ensured their privacy.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent How the regulation was not being met: The provider did not act in accordance with the Mental Capacity Act 2005 where people lacked capacity to ensure that consent was sought appropriately.

Regulated activity	Regulation
	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met:

This section is primarily information for the provider

Action we have told the provider to take

People were not protected against the risks associated with medicines because the provider did not have appropriate arrangements in place to manage medicines. Risks to people's care and treatment were not suitably assessed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing How the regulation was not being met: The provider had failed to ensure that there were sufficient staff deployed to meet the needs of people. The provider had failed to ensure that staff received the appropriate training to enable them to carry out the duties they are employed to do.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed How the regulation was not being met: The provider did not have effective recruitment procedures to ensure that people employed by the service were of good character and had appropriate skills

This section is primarily information for the provider

Enforcement actions

The table below shows where legal requirements were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment How the regulation was not being met: The provider did not have effective systems in place to protect people from abuse and improper treatment. Care and treatment was provided in a way that restricted people without their consent or relevant authorisations in place.

The enforcement action we took:
We served a warning notice on the provider

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met: Service users were not protected against the risks of inappropriate or unsafe care or treatment because the provider did not have effective systems to monitor the quality of the service provision.

The enforcement action we took:
We served a warning notice on the provider