Venn Care Ltd

Venn House

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This unannounced comprehensive inspection took place on 22, 23, 28 and 29 November 2017. The inspection was to follow up to see whether improvements had been made from the previous inspection in May 2017. It was brought forward because we received a number of concerns about the level of care provided by the service.

Venn House is a care home registered to provide accommodation with personal care for a maximum of 25 people. It comprises of two buildings, the main house, and the Coach House, which is primarily for people living with dementia. 17 people lived at the service when we visited.

The service had a registered manager. 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.

At the last inspection in May 2017 the service was rated as requires improvement overall. Safe and Well led were rated requires improvement and Effective, Caring and Responsive were rated as good. Two breaches of regulations were found in Staffing and Good governance.

Following the inspection in May 2017 the Care Quality Commission (CQC) took enforcement action in relation to staffing, which required the provider to ensure sufficient numbers of staff were deployed to meet people's care needs by 14 Aug 2017. We also made a requirement that the provider must improve their system to assess, monitor and improve the quality and safety of the service. The provider sent us an action plan outlining improvements being made.

At a previous inspection in January 2016, the service was also rated as requires improvement, we found four breaches of regulations in relation to Safe care and treatment, Safeguarding, Staffing and Good governance. At an inspection in October 2013, we found two breaches of regulations in relation to the safety and suitability of premises and recruitment.

At this inspection, people remained at risk because there were insufficient numbers of staff with the right skills to safely meet people's care and supervision needs at all times. The service had admitted five people with complex care needs since we last visited, whilst the needs of others already living at the home had also increased. Eight staff had left the home since we last visited, and were replaced with newly recruited and agency staff. This, combined with staff sickness meant a number of staff working at the service did not know people's needs well or how to safely care for them. Contingency arrangements for obtaining assistance in an emergency were inadequate.

On 22 and 23 November 2017 we witnessed a number of incidents and near misses in the Coach House. For example, on several occasions a person at high risk of leaving the home unaccompanied was able to unlock

a door unobserved and get out on a patio area when it was unsafe for them to go out alone. The previous week the person had climbed over the fence from this patio area and got outside, which put them at high risk. The actions taken to improve security in response to that incident were not sufficient to make this area safe and secure.

Another person was verbally and physically aggressive towards staff and other people living at the home which staff did not have the skills to manage. Staff had not been trained to manage challenging behaviours. People's care records lacked guidance for staff about how to manage these behaviours, which meant people and staff continued to be at risk.

On 23 November 2017, we advised the provider people were at risk because the service did not have enough staff to safely care for people and meet their needs. We identified six people at increased risk and made a safeguarding alert to the local authority safeguarding team about those people. We requested the provider take further urgent action to ensure they had sufficient numbers of suitably qualified, competent, skilled and experienced staff on duty at all times and improve security of the Coach House. We asked the provider to write to CQC by 10am on 24 November 2017 to set out urgent steps being taken to improve safety at the home.

The provider wrote to CQC on 24 November 2017 setting out immediate plans to increase staffing levels and improve safety. They also outlined immediate steps to secure the doors to the patio. The provider undertook a voluntary agreement with CQC not to admit any more people to Venn House until CQC were more confident about people's safety.

On 24 November 2017 a local care manager also visited the service to offer support and planned further monitoring visits by health and social care professionals. On the 29 November 2017 we identified two more people at risk which we made the local authority safeguarding team and local care manager aware of. A whole service safeguarding meeting was convened. The local authority's safeguarding team, commissioners and other agencies are working together with the provider to review people's care and keep people safe. On 28 November 2017 when we next visited the service the provider had increased staffing levels to the levels agreed. Staff said the increased staffing levels of staff had made a "massive difference" and "Things have improved."

People were at increased risk because individual and environmental risks were not adequately managed. Risk assessments and care plans were not accurate or up to date about people's risks and current care needs, and did not provide staff with the guidance they needed. Accidents, incidents, and near misses were under reported, which meant the level of risk at the home was not been recognised or adequately responded to. Actions taken did not sufficiently mitigate risks of verbal and physical aggression or environmental risks. Gaps in training were identified, for example, in managing challenging behaviour and in safeguarding training for some staff. We identified concerns about nutritional risks for one person and choking risks for another which were not being adequately managed. Some aspects of infection control in relation to odour were not well managed. Medicines were not managed safely, and we had concerns about the use of 'as required' medicines.

The service did not have a policy on the Mental Capacity Act to support staff practice. People were not supported to have maximum choice and control of their lives. Staff had not carried out mental capacity assessments or documented best interest decisions in relation to the widespread use of pressure mats for monitoring people's movements. Low staffing levels meant staff could not always support people in the least restrictive way possible. The provider had not acted in accordance with the conditions of a person's Deprivation of Liberty authorisation.

People did not always receive personalised care that met their needs. People's care records lacked detail about how to meet people's individual care needs, and several were out of date. There were gaps in people's food and drink records so it wasn't clear whether they had enough to eat and drink some days. Some complaints had not been dealt with to the satisfaction of the complainant, and complaint information did not provide details of other agencies they could contact.

The registered manager and provider demonstrated a poor understanding of risk management, governance and quality assurance. They did not recognise the impact of low staffing levels on increased risks and the quality of people's care. Staff did not feel valued and described a culture of fear at the service. They said feedback about low staffing levels and risk were not being listened or responded to.

The quality monitoring systems in use failed to identify poor standards of care or take effective action to make required improvements. Systems and processes were inadequate to assess, monitor and improve the quality and safety of the service provided. The service lacked some key policies, other policies, procedures. Individual risk assessments were of poor quality, so did not support staff in their practice. The systems for managing environmental risks were confusing and ineffective.

Some safeguarding incidents which had occurred at the home had not been notified to the local authority safeguarding team or the CQC. A notification is information about important events which the service is required to send us by law.

Health and social care professionals such as GPs, community and mental health nurses regularly visited the home to meet people's healthcare needs. Staff relationships with people were caring and supportive of people's independence. People praised the quality of the food and choices. Meals were freshly cooked and looked appetising. Furniture and décor in The Coach House reflected evidence based practice about best types of environment for people living with dementia.

We found ten breaches of regulations at this inspection. Breaches of regulations were identified at Venn House for the fourth successive inspection. We have rated the Safe and Well led domains as inadequate, and the Effective, Caring and Responsive domains as requires improvement. The previous warning notice served about staffing which was due to be complied with by 14 August 2017 had not been met.

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

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

The warning notice previously served which required the provider to address low staffing levels had not been met.

There was not enough staff with the right skills to support and supervise people, some of whom had complex mental health needs.

People's risks and environmental risks were not managed effectively to keep them safe.

The monitoring of accidents and incidents was inadequate, opportunities to learn lessons and take further action to mitigate risks were missed.

People were not protected from abuse and improper treatment.

Medicines were not managed safely.

Some aspects of infection control in relation to odour were not well managed.

A recruitment process was in place to ensure people were cared for by suitable staff.

Is the service effective?

Requires Improvement

Some aspects of the service were not effective.

The provider had not acted in accordance with the Mental Capacity Act (2005) with regard to consent to day to day care and treatment for people who lacked capacity.

Gaps in training were identified, for example, in managing challenging behaviour and in safeguarding training for some staff.

People praised the quality of the food, although we identified concerns that a person's weight loss and another person's choking risks were not being effectively managed.

People saw health and social care professionals as appropriate to meet their needs.

People's needs were taken into account by the adaptation, design and decoration of the premises.

Is the service caring?

Requires Improvement

Some aspects of the service were not caring.

Staff did not always have time to engage in meaningful interactions with people.

Staff were caring and demonstrated a positive regard towards people.

People's privacy and dignity were respected.

Staff adopted a positive approach and respected people's independence.

Is the service responsive?

Requires Improvement

Some aspects of the service were not responsive.

People did not always receive personalised care that met their needs.

People's care records lacked detail for staff about how to meet their individual needs, and several were out of date. There were gaps in people's food and drink records.

Some relatives' complaints had not been dealt with to their satisfaction.

Is the service well-led?

Inadequate

The service was not well-led.

People were at risk because quality monitoring systems and processes were inadequate to assess, monitor and improve the quality and safety of the service.

The service did not have some key policies and procedures, others were of poor quality and did not provide up to date or detailed guidance for staff.

There was a lack of leadership and poor audit systems meant opportunities to identify and continually improve practice were

missed.

Staff did not feel valued; and described a culture of fear and said concerns were not being listened to.

Some safeguarding incidents which occurred at the home had not been notified to the Care Quality Commission in accordance with the regulations.

Venn 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.

An unannounced focused inspection was carried out on 22 November 2017 by one inspector. The inspection was to check the warning notice on staffing levels had been complied with and whether quality monitoring improvements had been made. The inspection was brought forward because of concerns raised with the Care Quality Commission between 2 October and 11November 2017. Callers raised concerns about the quality and safety of people's care, and about low staffing levels. For example, that three people who lived in the Coach House were allowed to "wander about all day" with no support or activities to engage them, one of whom "was always trying to escape." Other concerns raised with us included medicines management, cleanliness and odours. On the first day of the inspection a number of risks and breaches of regulations were identified. So, the inspection was changed to a comprehensive inspection which was completed by two adult social care inspectors on 23, 28 and 29 November 2017.

There are two buildings at Venn House; the main house, which is an old building and the Coach House nearby. The Coach House had a newly purpose built wing, designed primarily for people living with dementia. Nine people lived in the main house and eight people lived in the Coach House.

In preparation for the inspection we reviewed information we held about the home, such as the provider's improvement action plan and notifications. A notification is information about important events which the service is required to send us by law. We also reviewed all information we had received from health professionals. This enabled us to ensure we were addressing any potential areas of concern.

We spoke with 11 people who lived at the service and five relatives. We looked at seven people's care records, which included risk assessments, care plans, daily records and at medicine administration records, three people's food and fluid charts and at repositioning records. Where people were unable to tell us about their experiences because they were living with dementia, we visited them at regular intervals to see how they spent their day and observed staff interactions with them.

We spoke with both providers, the registered manager and with 15 staff which included employed and agency care staff, housekeeping, kitchen, administrative and maintenance staff. We looked at six staff files, which included two newly recruited staff and checked information held about agency staff. We looked at systems for assessing staffing levels, staff rotas, staff training and supervision records. We looked at accident/incident records, environmental risk assessments, the complaints log, at servicing and maintenance records and audits.

We sought feedback from commissioners, health and social care professionals who regularly visited the home and received a response from six of them.

Inadequate

Is the service safe?

Our findings

The service was not safe.

At the two previous inspections, in January 2016 and May 2017, we identified a breach of regulations in relation to staffing levels. Following the May 2017 inspection, the Care Quality Commission (CQC) took enforcement action. A warning notice was served which required the provider to ensure sufficient numbers of staff were deployed to make sure people's care needs were being met by 14th August 2017. On 12 July 2017 the provider wrote to CQC outlining plans to increase care staff from three to four each day between 4 pm and 8 pm.

At this inspection people were at risk because there were not enough staff on duty at all times with the right skills to safely meet people's care and supervision needs. When we visited, a senior member of staff was off sick and the registered manager was unexpectedly away from work. Since we last visited eight staff had left the home, and were replaced with newly recruited and agency staff. This combined with staff sickness meant a number of staff working at the service did not know people's needs well or how to safely care for them. The registered manager and provider said recruitment had become more difficult recently, which they thought was due to the remote location of home.

Staff rotas between 1 November and 2 December 2017 showed were three care staff on duty (a senior care worker and two care staff) between the main house and the Coach House between 8am and 4 pm each day, with four care staff between 4 pm and 8 pm. At night there were three care staff on duty between 8 pm and 8 am. When there was three care staff on duty, the provider and registered manager said two care staff were based in the Coach House with one in the main building.

Care staff were supported by a cook and a general assistant who mainly worked in the kitchen. An activity co-ordinator worked between 11am and 4pm Tuesday to Friday and an administrative assistant worked between 10am and 3 pm Monday to Friday, both of whom helped people with eating and drinking. A second activities member of staff worked every Monday. A member of housekeeping staff worked 9am to 3pm Monday to Friday, with care staff responsible for laundry. Staff identified weekends as the time when people were most at risk. This was because there was less staff around.

Since we last visited, four people with complex mental health needs had been admitted to the Coach House and a person at high risk of falls had been admitted to the main house. Staff said the mental health needs of two people who already lived at the home had also deteriorated. They described several people living in the Coach House as having "unpredictable" behaviours related to their dementia. Staff comments included; "It's risky all the time," "Staffing levels are not suitable for needs of residents, too many residents here require one to one care"; "People have deteriorated, they are more complex; "All these people need more care, their basic needs are not being met, staff are totally pushed for time." Staff identified two people with risk of verbal and physical aggression and a third person at risk of regularly trying to leave the Coach House, when it was unsafe for them to do so.

On 22nd November 2017, when we arrived at 9.25am there was only one member of staff on duty in the Coach House. They were busy trying to organise cover for that night as a member of staff was off sick. Shortly after we arrived a second agency staff worker was called from the main house to assist. Three of the eight people living there were up and five were still in bed and had not yet had their breakfast. Both care staff were busy all morning helping people to have breakfast, get washed and dressed for the day and have their medicines. The last person at the Coach House was served their breakfast at 11.45am and hadn't had anything to drink before that.

Most people in the Coach House did not have the cognitive ability to use a call bell to ask for help because of their dementia. Instead pressure mats were used which were connected to the call bell system. These were triggered when people were moving around their room, or leaving their room. That alerted staff they needed to go and see the person and offer them assistance or accompany them. People's bells were ringing constantly throughout the morning. This meant people were not receiving care in a timely way.

On 22 November 2017 we identified serious safety concerns for people living in the Coach House because the service did not have enough staff with the right skills to support and supervise people. We witnessed several incidents and near misses. For example, two people were upset and agitated, when an agency staff tried to approach them to provide personal care. One person shouted at the agency care worker and tried to jab them with a fork. When the same agency worker tried to give personal care to a second person who was incontinent, they also became upset, started shouting and refused care. This meant a delay in the person receiving personal care, as agency staff member had to call the second member of staff to help them. Whilst both staff were with that person, another person left their room upstairs, which made their pressure mat alarm go off and went downstairs unobserved. This person's risk assessment showed they were not supposed to use the stairs, as they were at risk of falling and staff were instructed to encourage them to use the lift.

When the person arrived downstairs, they unlocked an external door leading to the patio area, and stepped outside. This set the alarms off, so the agency staff member came running downstairs, but didn't know how to silence the alarm. Whilst they were outside trying to persuade the person to come back in, the alarms continued to ring loudly. So, the second member of staff had to leave the person they were showering, to go downstairs, silence the alarm, and help persuade the person to come back in. This meant the person having personal care was left unattended.

This person was also at high risk of leaving the home, which they had done previously. Their care plan said, "To keep [person] safe he is not to go out alone." On 17 November 2017 when the person went outside and climbed over the patio fence, staff said it took five staff a considerable length of time to persuade the person to return to the home. During that period, staff said a cook and member of administrative staff were supervising the other seven people in the Coach House.

Staff spoke about the challenges of caring for people on two sites when there were only three staff on duty. One staff said, "It's incredibly difficult to get help if there is only one staff on duty in the main house, and it's even harder at weekends." For example, a person living in the main house was at high risk of falls due to their physical health. Daily note entries showed this person was "unsteady" and needed two staff for personal care, to assist with walking and to hoist them. Between 2 October 2017 and 26 November 2017 the person had 14 falls, nine of which were at night. At night if the person fell, this meant calling a member of staff from the Coach House to the main house to help hoist the person. That left one member of staff alone in the Coach House caring for people with complex needs. Three people in the Coach House needed two staff for personal care and two people's care records showed they were up, restless and walked about regularly at night. Both people needed close supervision, one in case they tried to leave the building and the

other due to risk of verbal and physical aggression towards others. This meant risk was increased when there was only one member of staff available. Staff described other occasions where the second staff member went to main house from the Coach House. For example, to administer people's medicines if no other staff member on duty was trained to do this.

Staff used two way radios or the telephone to call for assistance between both sites. They said these contingency arrangements were not responsive enough in an emergency and left people and staff vulnerable. For example, a member of staff used the radio to try and call for help when a person started climbing over the patio fence but said the two way radio was not working. Other staff said often either they did not receive a response to their call for help, or help didn't arrive quickly enough. A member of staff described a recent incident in the dining room where they tried to prevent one person hitting another person by standing between them. They said no one responded to the call bell because both staff were busy assisting a person with personal care in their bedroom. They had to shout for a general assistant to go and find the registered manager.

A relative commenting on staffing levels said, "Staff always seem to be rushed off their feet…they need more staff." Another relative comparing with another home said, "For me, it feels like they manage at lowest levels they could possibly operate. It makes me feel uncomfortable." A third relative said, "I wish there were more staff. Yesterday (staff name) had to go up to other house, which meant (staff name) was here with three quite vulnerable men and (name of person) spent his time trying to get out, I was concerned …it was a bit dicey." Referring to the person's level of risk, they said, "She does need watching, she is completely unaware of any kind of risk and will wander into other people's rooms." A professional speaking about staffing levels expressed surprise that sometimes there was just one staff on duty in the Coach House.

The registered manager said they assessed each person's individual needs to check they could meet them before they were admitted to the home. The service no longer used a dependency tool to monitor adequacy of staffing levels as they had found it unsatisfactory. The registered manager said they relied on their experience and feedback from staff to monitor the adequacy of staffing levels. When we asked the provider about staffing levels, they explained they used comparative data from other homes to check staffing levels. However, that method failed to take account the complex needs of several people who currently lived at the home, or need to deploy staff in two separate buildings.

On 23 November 2017, the second day of the inspection, when we arrived at the Coach House, a person was wandering up and down the corridor, shouting at staff. The person had picked up a crockery cup in each hand, which they were waving at staff in a threatening manner and shouting "get out." An agency staff member and a member of housekeeping staff retreated to the entrance lobby, and one started reversing up the stairs to get away. A third member of staff, who was undergoing induction, did not know what to do. The person then went back down the corridor and hit out at an inspector, who was trying to avoid them. Shortly afterwards another inspector asked maintenance staff who arrived to find the providers and ask them to come and help staff in the Coach House to deal with the situation. They arrived and arranged for a member of staff who knew the person to come from main house. The situation calmed when this member of staff arrived as staff member knew how to approach the person and because their relative visited shortly afterwards.

On 23 November 2017, we advised the provider people were at risk because the service did not have enough staff with skills required to safely care for people and meet their needs. We requested the provider take further urgent action to ensure they had sufficient numbers of suitably qualified, competent, skilled and experienced staff on duty at all times. Also, to ensure all staff were provided with key information about people's needs, any risks and how to manage them. We asked the provider to write to CQC by 10am on 24

November 2017 to set out urgent steps being taken to improve safety at the home.

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

Following the Care Quality Commission's request for urgent action to be taken on 24 November 2017, the provider had increased staffing levels when we next returned to the home on 28 November 2017. They had two staff on duty in both the Coach House and in the main house during the day. They had also arranged for an agency member of staff to work with one person between 2pm and 8pm each day, a period they identified when the person was most restless. Staff said these measures had made a "massive difference" and that "Things have improved." The service were trying to get regular agency staff, wherever possible, who were working alongside experienced members of staff. Kitchen staff helped by answering the phone and the doorbell.

People's risk assessments and care plans did not include sufficient detail for staff about how to manage risks related to behaviours that challenged the service. One person's managing challenging behaviour care plan said staff should "de-escalate the situation" (but did not explain how). Staff were instructed to record and incident report escalating behaviour, test the person's urine to check for signs of infection and monitor the person regularly. The person's records over several previous days showed the person was repeatedly aggressive, shouting at visitors, spitting at staff and refusing personal care. These arrangements were not sufficient to manage this person's level of challenging behaviour and the risks posed.

We had serious concerns about environmental risks relating to the security of the Coach House. On the 18 October 2017 the service notified CQC that a person had left the Coach House unnoticed at 21.50 via the kitchen. When the staff member realised the person was missing, they searched the grounds. They met a member of the public at the main entrance with the person, who said they had found the person lying on their back on the floor and returned them to the home.

Staff said this person was regularly trying to leave the home via doors to an outside patio and trying to climb over the patio fence to unsecure grounds beyond. Once outside this area the person was able to walk to the end of the drive and out into the main road. There were four doors to the patio, which the person could unlock. Three of these doors were alarmed but a fourth door from the dining room was not. This meant staff would not be alerted if person used this door to go outside. Incident reports, care records and staff accounts showed the person had repeatedly tried to climb over the patio fence and had succeeded on at least two occasions. These incidents had not been notified to the local authority safeguarding team or CQC.

In response, the provider had made a gate on the patio more secure, and added timber to the top of a walled area to deter the person from climbing over the wall. However, most of the patio had a waist high picket fence, so these measures did not prevent this person from trying to climb over, even when a member of staff was with them.

On 23 November 2017 we identified these ongoing risks to the provider and asked for immediate action to further reduce them. On 24 November 2017 the provider confirmed they had secured two of the doors to patio, so the person could no longer unlock them. They were arranging to provide an alternative security system to the other two doors the following week (to comply with fire regulations). On 29 November 2017 the new security system was being fitted. However, no further action had been taken to raise the fence height on the patio. The provider said the builder was due to come back to do this work the following week. This work still hadn't taken place when we checked with provider again on 8 December and 13 December 2017. On 14 December 2017 we wrote to the provider about this again, who responded on 25 December

2017 confirming work to raise the height of the fence had now been completed.

The service had no incident reporting policy, only instructions to staff to put completed incident reports on registered manager's desk. So, staff had no guidance about what needed to be reported. Accident/incident reports did not include a section for recording the time of the incident, so it was not clear what time some incidents happened. This made it more difficult to accurately identify times of highest risk. Accident/incident reports, care records and staff accounts showed a high number of recent incidents and 'near misses,' where people were at risk, many of which had not been reported.

Environmental risk assessments lacked sufficient detail to fully or adequately mitigate some risks. At our last inspection in May 2017, we identified people were at increased risk of burns due to unrestricted access to an AGA situated in the dining room in the main house. We followed up what action had been taken to reduce this risk. A warning notice was displayed next to the AGA which advised that it was hot to touch. The risk assessment said, "The AGA is on and does produce heat. We have considered not using the AGA; however feedback strongly suggests the AGA would be sorely missed if decommissioned. We will continue to use the AGA for comfort and warmth, as well as for cooking with." However, the risk assessment failed to consider risk for people who may be unsteady on their feet or who may not understand the danger of burning themselves. For example, if they were living with dementia. This demonstrated the service failed to consider other ways to further protect people, such as by putting a guard in place.

The providers own environmental risk assessment showed risk of 'falls from heights' were being managed by having window restrictors fitted to all first floor rooms. At the May 2017 inspection we identified a faulty window restrictor in the main house. At this inspection, we identified an occupied upstairs bedroom window in the main house which had no window restrictor fitted, only two bars going across. This meant the window was able to be opened wide, which was a fall from a height risk for the person. We immediately reported this to the provider, who installed a window restrictor that same afternoon.

Prior to the inspection a relative raised concerns about the use of 'when required' medicines at the home. For example for pain relief or to treat anxiety or agitation. We followed this up and found it had been addressed with the person's GP. However, we identified concerns about two other people's 'when required' medicines. One person's printed prescription sheet showed they were prescribed a sedative three times a day. A handwritten change made on the prescription authorised staff to give the person a fourth dose "when required" for agitation, which the registered thought was written by a former employee. They said normally changes to prescriptions were confirmed by e-mail from the GP, but were unable to find any record a GP authorised this change. The prescription sheet showed the person was given the fourth dose quite regularly, but staff did not document the reasons why on the prescription sheet, which is good practice. The lack of documentation meant the use of 'when required' medicines could not be monitored to check staff used it appropriately. The person's challenging behaviour care plan had no information to support staff about the use of 'when required' medicines. When we asked staff, they could describe examples of circumstances in which they gave the extra dose, such as for agitation. Another person's care plan was not up to date about their prescription, and referred to use of a medicine which had been discontinued. These examples increased the risk that people may not receive these medicines in a safe and consistent way.

The medicines policy did not include any guidelines for staff on managing 'as required' medicines. The absence of written guidelines had previously been highlighted as part of a pharmacy visit in August 2007. The pharmacist had provided advice about this but it had not been acted on.

Skin creams were not dated when opened in line with good practice guidelines, so it was unclear when they needed to be discarded and replaced. Temperature checks of both medicine fridge and medicine

cupboards were not always carried out on a daily basis, to confirm medicines were being stored in accordance with manufacturer's guidelines. In the home's cupboard we found a medicine prescribed for an individual had not been 'booked in' and commenced. This meant that there was a delay of about five days in the person receiving their new medicine to meet their health needs.

Staff who administered medicines said they were not able to have 'protected' time to carry out this role uninterrupted, as they needed to be available to respond to risks, answer bells and when people needed two staff to assist them. This meant they were worried about making mistakes. Frequent interruptions when administering medicines increases the risk of making errors. Audit findings showed the most common errors were medicines not being signed for.

This is a breach of Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2014 Safe care and treatment

Staff undertook training in medicines management and completed an assessment to check they administered people's medicines safely. Medicines were ordered and audited on a monthly basis to ensure that people received the correct type and dose of medicines, although the current monthly audit was overdue.

People were at increased risk of neglect, physical and verbal abuse particularly in the Coach House because the systems and processes in place weren't always effective in recognising, reporting and taking swift action to protect people. We found several examples of violence and aggression and near miss incidents where people were at high risk of harm which were not recognised or reported as safeguarding to the local authority safeguarding team or CQC. On 23 November 2017 we identified six people at increased risk and made a safeguarding alert to the local authority safeguarding team about those people. On the 29 November 2017 we identified two more people at risk which we made the local authority safeguarding team and local care manager aware of.

Care staff undertook safeguarding training but housekeeping, general assistant, maintenance staff in regular contact with people did not. The activity co-ordinator had not done their safeguarding training, although they started working at the home in September 2017. This meant those staff did not have knowledge to help them identify and report signs of abuse. The service had no safeguarding policy or procedures, to guide staff about their safeguarding responsibilities. The registered manager said the service used the local authority safeguarding guidance, which was available at the home.

The service had a Whistleblowing policy which highlighted that staff who raised concerns in good faith would not be unfairly treated or discriminated against. We asked staff about reporting safeguarding concerns. Three staff said they were worried about losing their job, one didn't want to compromise their chance to progress at the home. One staff said, "I have thought about reporting them but I'm scared of repercussions;" Another they had already told the registered manager and provider they thought staffing levels were inadequate, and they couldn't provide people with a good service. A third member of staff referring to a conversation with the registered manager about how they were struggling to meet people's competing needs said, "It's like speaking to a brick wall."

This is a breach of regulation 13 HSCA 2008 (Regulated Activities) Regulations 2014 Safeguarding service users from abuse and improper treatment.

We followed up concerns raised with us about cleanliness, standards of housekeeping and management of odours at the home. The service had two new housekeeping staff who between them worked Monday to Friday. The communal areas of the main house and the Coach House were clean. However, there was an

overwhelming smell of urine in one person's bedroom in the Coach House, something we also highlighted at the previous inspection in May 2017. One staff said the smell was so overpowering sometimes, staff kept the persons door closed to stop the smell permeating into other areas of the home. Although staff described how they were managing the person's continence, their personal care and hygiene care plan lacked details. This was highlighted to professionals for further action as part of the multiagency safeguarding protection plan.

Housekeeping staff shampooed the person's carpet each day, to remove any urine and used a deodorising spray once a week. We followed this up with the provider, who said they thought the urine odour from the person's incontinence might be more noticeable because of the underfloor heating. Two other people's rooms were slightly odorous.

This is a breach of regulation 15 of the HSCA 2008 (Regulated Activities) Regulations 2014 Premises and equipment.

The registered manager confirmed this was due to be addressed on 14 December 2017. The planned solution included laying vinyl which they said would help staff manage cleanliness, hygiene and odours better. The service had cleaning schedules and appropriate cleaning materials. Recent improvements had been made to reduce risk of cross infection. For example, use of plastic bags to transport soiled laundry from people's rooms to the laundry room. Colour coded bags were used to segregate laundry for washing, to minimise cross infection risks in accordance with the new laundry policy.

Regular monthly checks of water temperatures in baths and showers demonstrated they were maintained within safe limits. Lifts, electricity, gas and equipment were regularly serviced and suitable records were maintained. A maintenance book was used to identify repairs needed and confirm when they were completed.

Weekly fire alarm tests were carried out to ensure staff were familiar with the fire procedures. On 28 November 2017 the fire alarm went off in the Coach House. The senior staff member on duty quickly identified it was a false alarm in the kitchen and authorised the maintenance person to cancel the alarm. Each person had a personal emergency evacuation plan (PEEP) about help they needed to evacuate in the event of a fire, which was in the staff office. A red dot on people's bedroom door also helped staff identify people who needed two staff to evacuate in an emergency.

Appropriate recruitment checks were completed to ensure fit and proper staff were employed including agency staff. Staff had police disclosure and barring checks (DBS), checks of qualifications and identity and references were obtained. The DBS helps employers make safer recruitment decisions and prevents unsuitable people from working with people who use care and support services.

Requires Improvement

Is the service effective?

Our findings

Some aspects of the service were not effective.

People's consent to care and treatment was not always sought in line with the legislation and guidance. The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met.

Staff had undertaken training on the MCA and demonstrated some understanding of the principles of MCA and DoLS. However, the service had no MCA policies or procedures for staff to use and no processes in place to monitor consent met legal requirements. Staff had not undertaken mental capacity assessments where they made decisions about people who lacked capacity. For example, staff had not documented the rationale for best interest decisions made relating to the widespread use of pressure mats, or about providing personal care for people who were resistant. This meant there was no evidence decisions made were the least restrictive option available and protected people's human rights. Similarly, where there were doubts about a person's capacity, decisions were not reviewed. For example, in March 2016 a person with capacity requested to walk around the grounds independently and in October 2016 said they did not want staff to check them at night. Recent daily notes showed this person was 'confused' on occasions. The person's mental capacity had not been reassessed to check whether those decisions were still appropriate.

Where more significant decisions about people's care and treatment were made, staff had involved family members, GP's and mental health professionals. For example, in relation to decisions about people moving to the home, and about the use of 'as required' medicines to manage behaviours that challenged the service. However, the service had no documentation to capture those best interest decisions in a way that was easily accessible to staff.

This is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Need for consent.

The registered manager had made DoLS applications to the local authority deprivation of liberty team for five people who lived at the service and were awaiting assessment for four of them. We looked one person's Deprivation of Liberty authorisation, dated 20 September 2017. The authorisation included a condition by the supervisory body that service "must improve" the quality and clarity of the person's care plans and risks assessments. It said, "This is especially important for personal care routines where additional restrictions on (person's) freedom are being employed." The person's records showed these conditions of the authorisation

were not being met.

Nutrition/hydration care plans identified people at risk and actions needed to promote people to eat and drink to keep healthy. Kitchen staff had information about people's food preferences and any special dietary needs, with the exception of a person that needed a high calorie diet.

Staff were required to record this person's daily food/fluid intake and report any concerns. On several days over last two weeks there were large gaps in their food and fluid charts where they did not eat and drink enough to stay healthy. It was not clear whether these gaps were recording omissions or whether the person had missed meals and drinks. On 8 November 2017 when they were last weighed they had lost nine pounds when. We immediately raised our concern to the registered manager and asked them to follow this up. They contacted us to confirm the person was weighed again on 1 December 2017 and had lost a further five pounds. This meant an overall weight loss of 14 pounds over three weeks, which could indicate serious risks to this person's health.

We also identified concerns about another person's risk assessment. In July 2017 a speech and language therapist (SALT) showed they were at high risk of choking. Staff were advised to cut up the person's food in small pieces and supervise them when they were eating in the dining room. On 23 November 2017 in the dining room we saw this person was given whole peach slices and was not being supervised in accordance with their care plan and risk assessment. We brought this to the attention of three members of staff. A staff member proceeded to sit with the person. The other two staff said they had not read the person's care plan or risk assessment, so were not aware of this persons choking risk. When we raised this with the provider, they said the person is supervised with either staff being present in the dining room or in the kitchen. However, we noted occasions whereby staff were neither in the dining room nor the kitchen, as they were busy helping other people who were in their own rooms and needed assistance.

We highlighted both people to the local authority safeguarding team and local care professionals as being at risk.

This is a breach of Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2014 Safe care and treatment

Since then one person was referred to their GP for review and their care plan updated to include staff offering them assistance to eat and drink. The second person's care plan about their choking risk was updated, and this risk highlighted to staff in a daily handover sheet.

People were at risk because staff did not have skills and had not undertaken any training to help them manage people with behaviours that challenged the service such as verbal and physical aggression. The registered manager used a training matrix to monitor staff training, however, effective action had not been taken where staff had not completed required training or it was overdue. The service used supervision to provide staff with an opportunity for staff to discuss their practice and receive feedback. The registered manager did supervision with four senior staff who in turn provided supervision for remaining staff team. Staff supervision had lapsed over the past few months because of staff changes. The registered manager had a moving and handling qualification completed seven years ago and did all staff moving and handling training. However, they had not completed recommended three yearly update training, which could mean staff are taught out of date techniques.

This is a breach of Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2014 Staffing.

The registered manager has since contacted CQC to confirm they planned to undertake moving and

handling trainer update training in January 2018. The registered manager had an assessor's qualification, which meant they could support and help staff undertaking diploma qualifications in health and social care. They ran a dementia awareness training days, one of which one staff had attended the previous week. Staff gave us positive feedback about this training and said it gave them a better insight into people living with dementia, which they found helpful.

A number of staff had level two qualifications in Health and Social Care and one member of staff was undertaking a level three qualification. Several staff who started working at home this year said they had brought their training certificates from their previous employment but had not yet attended any training at Venn House. The service had a range of DVD's and used electronic learning for training which included fire, food hygiene, health and safety, safeguarding and mental capacity act training. An external company provided first aid training.

As part of their induction, one new member of staff said they worked with another member of staff for the first couple of days to get to know people. The registered manager went through topics with them such as moving and handling, fire safety and incident reporting. Induction checklists confirmed topic areas covered. Staff new to care undertook the Care Certificate, a nationally recognised set of standards that health and social care workers are expected to adhere to in their daily working life.

Since we last visited the service, a purpose built kitchen had opened in the Coach House to serve both sites. A heated trolley was used to transport hot food to the main house. Meals were freshly cooked and were warming and nutritious. For example, people were enjoying stew and dumplings one day we visited. In the main house the mealtime experience was a social occasion for people. Only three people in the Coach House accessed the dining room, mostly at different times, others ate in their room.

People on special diets for example, with diabetes, were offered food alternatives suitable for them such as low sugar jelly and biscuits suitable for people with diabetes. The cook had cooked and frozen portions of rhubarb for one person, who especially liked it. Nutritional care plans emphasised the importance of people having a balanced and nutritious diet to maintain their general well-being. The registered manager outlined the recent introduction of a five week menu which offered people more food choices.

When new people were due to move to the home, the registered manager visited them to undertake an assessment to see if the service could meet the person's needs. The person, family members and relevant professionals were involved in assessments.

The service used a range of tools to identify people needs and any risks. For example, of malnutrition, of falling and of developing pressure sores. People at risk of developing pressure sores (known as bedsores) were repositioned regularly as a preventative measure. At night, records showed people had welfare checks every two hours to see if they needed anything.

Health and social care professionals such as GPs, community and mental health nurses regularly visited the home to meet people's healthcare needs. A GP said the service was currently caring for some people with complex needs but they had no concerns. Community nursing staff visited Venn House three times each week to provide nursing care to several people who lived there. They said staff reported any health concerns to professionals in timely way and said, "Staff are lovely, they know about people's needs." People also had regular chiropody, hearing and eye tests.

Relatives praised the facilities in the Coach House which had improved disabled access for people. All rooms were single and had ensuite shower and toilet facilities. One relative said, "It's a lovely place, it could be so

nice." The provider had attended a Sheffield university talk about dementia friendly environments, which influenced the design of the new extension at the Coach House. The furniture and décor reflected evidence based practice about best types of environment for people living with dementia. For example, plain carpets, and a shutter on a person's bedside mirror, so they couldn't see their reflection, which was a known trigger for their agitation and aggression. In addition to call bells, people had pendant bells they could wear around their neck so they could call staff if they needed help anywhere in the home.

Requires Improvement

Is the service caring?

Our findings

Some aspects of the service were not caring.

People and relatives gave us mixed views about the care provided in the service. People's comments included: "I like living here. I have a nice room"; "The staff are very caring", and "They are ever so good to me, it's excellent." Relatives said staff were very welcoming. They commented "staff always seem quite pleasant and nice,", "Staff are very friendly" and "I'm very happy she has settled in well." Threes relative felt staff shortages meant people were not always getting enough attention or interaction with staff.

People and relatives confirmed staff and the registered manager involved them in decision making about their care and treatment. Care records included details of close family members, and family or legal representatives who needed to be consulted about their care. Relatives said the registered manager was in regular contact by phone and e-mail about people's care. However, two relatives with legal power of attorney for decisions about the person's care and welfare said they would like more involvement in decision making.

Seven of the eight people in the Coach House were living with dementia, so staff needed to be available to engage with them at a time and pace that suited them. During the first two days of the inspection, although staff checked on people regularly, their interactions with people were brief. This was because they were fully occupied making sure people's basic daily needs were met, so had no time for chatting, socialising or to respond to people's individual cues. Staffing issues meant people could not always be offered support from staff who knew them, and how to approach them. This was distressing for some people who then refused personal care. This meant, at times, some people looked unkempt, with food stains on their face and clothing.

On the second two days of the inspection, when staffing levels were increased, the atmosphere in the Coach House was more relaxed. Staff had more time to spend with people. For example, one staff spent time reassuring a person who was anxious and persuaded them to come to the dining room for breakfast. At lunchtime, a staff member was able to sit in the dining room with a person and have a chat with them. The person responded positively to this one to one interaction, whereas on previous visits they had been aggressive.

Staff told us how they maintained people's privacy and dignity when assisting them with intimate care. For example by knocking on bedroom doors before entering, being discreet such as closing the curtains and gaining consent before providing care. When a person started to remove their clothing, a staff member noticed and discreetly helped them to get dressed again.

Staff relationships with people were caring and supportive and care was kind and compassionate. For example, when a staff member noticed a person had a pain in their shoulder they started rubbing it for them which ease their discomfort. Staff spoke with people in a respectful way, and allowed them time to communicate their wishes. In the main house, we observed a member of staff holding two people's hands,

swaying to music. They were smiling and appeared to enjoy this interaction.

Staff respected their independence. For example, they encouraged people to do as much as possible in relation to their personal care. A person commented: "I am encouraged to stay as independent as possible." In the main house, when a person started to walk without using their walking frame, a member of staff noticed and gently prompted them to use it. A relative of a person in the Coach House said staff tried to encourage the person to walk along the landing when they last visited.

People were offered choices and staff sought people's agreement before carrying out any care and treatment. For example, about the time they wished to get up or go to bed, what they wanted to wear and how to spend their day. A section in people's care plans "Voice, choice and control" highlighted people's abilities to make choices and decisions about their day to day care. For example, one person's care plan said, "I rely on staff to help me choose what to wear."

Staff communicated with people and gave information to them in ways they could understand. For example, letting people know when lunch was ready and reminding them of activities due to take place. In the main house and the Coach House there was a range of information available for people and families about local services, support and advocacy. For a person with limited vision, their care plan said, "Staff to be aware of (person's name) limited vision and ensure no trip hazards or obstacles in her pathway." In the Coach House there was suitable signage on doors to toilets, bathrooms and communal areas for people with a range of communication needs. This included words, pictures and braille for visually impaired people.

Requires Improvement

Is the service responsive?

Our findings

The service was not always responsive to people's individual needs.

People did not always receive personalised care that met their needs. During the first two days we spent in the Coach House, we saw a number of people spent long periods in their room. They did not have much interaction with staff, other than mealtimes and when staff were giving them their medicines or providing personal care. Low staffing levels meant the service was not always able to support people to participate in social activities or pursue their hobbies and interests at times suitable for them. A relative who contacted the Care Quality Commission (CQC) said, "He is left on his own for far too long, it's not on, I've been worried about him." The relative of another person in the Coach House said they wished there was more space for activities. A professional commenting on activities for a person living with dementia, said the person was usually in their room when they visited. They said the person needed more distraction and engagement, to manage their challenging behaviours, as there were not much going on for them.

In the Coach House a person was sitting in their room alone with music on in background each time we visited them. At one stage, they person called out when they recognised the voice of a member of staff who was nearby. The staff member called back to them but they were busy on their way to see to another person. This person's mental health assessment showed it was important for them to remain socially and physically active with activities suitable for people living with dementia. For example, that the person needed regular opportunities to engage positively in activities, one to one time and short trips in the local community. This person's activity record over the last few weeks showed their recent activities were mainly a chat or listening to music. Earlier in the year their activity records showed the person enjoyed more sensory activities suitable for a person with dementia, such as sensory games, crafts, lavender bags and going for walks.

Some staff also commented on people in the Coach House being isolated. One staff said, "Staff have no time to sit with residents, which leaves them very lonely, all these people have personalities, it's not the carer's fault." Other staff comments included, "A lot of residents are in their rooms all the time" and "People are not getting enough stimulation." A staff member said they thought things had deteriorated for some people living in the Coach House over the past few months due to the impact of people with more complex needs being admitted. They said, "(name of person) and (name of second person) can't mobilise anymore because (name of third person) kicks off, and everyone has to be quiet because of (name of fourth person)."

The service employed an activity co-ordinator between 11am and 4pm Tuesday to Friday. In the morning they worked in the main house and engaged people in a variety of activities. For example, arts and crafts, walks in the grounds and pamper sessions. They then helped with lunches. In the afternoon, they spent two hours in the Coach House. They said people who lived there had more complex needs, were less inclined to join in group activities and responded better to one to one interaction. In reality they said they spent almost all of their time in the Coach House with one person, who was restless in the afternoon. Referring to that person, they said their family had brought in some photos and their local newspaper, which they went through with person if they were in the 'right' mood. They said, "It depends on type of day he is having." Speaking about another person living in Coach House, they said, "If I can I spend five minutes with him, we

walk along the corridor or we look at (name of paper) together."

This is a breach of Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2014 on Person centred care.

On 28 November 2017 when we visited the Coach House again, staffing levels had improved. A member of staff was looking at a person's memory book with them. In the afternoon, when the person became restless and wanted to go downstairs and walk around, the staff member accompanied them. This kept the person interested and occupied and distracted them from wanting to leave the home.

People were encouraged to maintain relationships with their friends and family. For example, care plans documented those people important to individuals. Relatives were visiting throughout our inspection. It was one person's birthday and relatives visited to help them celebrate. That afternoon, they enjoyed a birthday cake with other people.

Each person's records had information about their day to day preferences such as the time they wished to get up and go to bed and the food they liked. For example, one person liked to get up about 7am, only wore top dentures so liked a softer diet, such as cornflakes or porridge for breakfast. Referring to people' hobbies and interests, care plans showed one person liked to listen to radio and watch TV and another person liked football, rugby and cricket and enjoyed watching Songs of Praise on Sundays.

The complaints log showed there had been three complaints since the last inspection. The relative of a person who no longer lived at the home contacted CQC to say they were dissatisfied with how the service had responded to their complaint. Another relative who complained said the response they received did not address several aspects of their complaint. They said they were made to feel a nuisance for complaining and they were making unreasonable demands.

The service had a complaints policy which outlined internal processes and timescales for investigation complaints. However, it did not include any information about further steps a complainant could take if they were dissatisfied with how their complaint was dealt with. For example, details of the local authority if they funded the persons care or contact details of the local Government ombudsman.

This is a breach of Regulation 16 HSCA 2008 (Regulated Activities) Regulations 2014 Receiving and acting on complaints.

A relative and a member of staff also made us aware of other verbal complaints made about a limited selection of food available for people's supper, which wasn't captured in the complaints log. This related to a communication issue which has now been resolved. A selection of food choices for supper was prepared and stored in the new kitchen in the Coach House for both sites. Staff had to collect food at suppertime and transfer it to the main house, which some staff had not been aware of. Instead, staff had made sandwiches for people, as they thought no other supper choices had been prepared.

Inadequate

Is the service well-led?

Our findings

The service was not well led.

At the last inspection in May 2017, we found a breach of regulations related to good governance. On 30 October 2017 the registered manager sent us an action plan outlining actions to improve their quality monitoring systems. They outlined they had devised a governance matrix; which they used to monitor quality using a red, amber and green code to identify and prioritise areas needing further action. They also outlined plans for a monthly "holistic audit." The registered manager said, "We will be able to robustly monitor any shortfalls" and "We believe that we have now met the regulation."

At this inspection, ten breaches of regulations were found which had not been identified or addressed. This included a breach of the Good governance regulation, for the third successive inspection. Breaches have been identified at this service for the fourth successive inspection. Previous improvements made have not been sustained. The 'Well led' domain has been rated 'inadequate.' This demonstrates the providers' quality monitoring systems have not improved, and were not effective.

Risk management was reactive rather than proactive. Risks were not identified, or were not adequately managed in a timely way to reduce them to an acceptable level. For example, we asked the registered manager what actions they had taken in response to incident relating to a person going into other people's bedrooms. The registered manager showed us a risk assessment which showed a keypad had been fitted to another's person's room to keep the person out. They said this action had successfully addressed the problem. However, another person's daily records showed the same person had gone into another person's bedroom on 27 November 2017, which had caused an altercation. So, this was an ongoing risk, which had not been fully addressed.

We looked at the governance matrix described in the action plan. This included checklists for various areas such as maintenance and the internal/external environment, health and safety and catering. The registered manager had delegated monitoring the environment to the maintenance person and catering to the cook. Effectively this meant those staff, who already had their systems in place for checking their areas of responsibility, were auditing their own systems. Environmental checks last completed on 31 October 2017 highlighted actions such as keeping external areas clear of leaves and organising a date for electrical testing. However, the audit had failed to identify the security risks at the Coach House or identify that an upstairs window in the main house didn't have a window restrictor fitted.

The registered manager had completed the health and safety audit section. However, a number of accidents/ incidents in care records had not been reported and were not identified through audits. This put people at risk of harm. They were unable to demonstrate how they used monitoring of incident reports, staff feedback and entries of incidents in people's care records to identify and take further improvement action to reduce existing risks. There were no systems to identify and share with staff themes or lessons learned from reviews of incidents, falls audits, safeguarding concerns or complaints.

We asked the provider about their quality monitoring arrangements. They said they worked around the home on a daily basis with people, relatives and staff. They also met with the registered manager to discuss their quality monitoring findings. They did not undertake any formal quality monitoring, to check improvement actions being taken were effective.

The systems for managing environmental risks were confusing. The provider had completed an environmental risk assessment for the Coach House, dated 2016, which had not been updated despite the new environmental risks identified. For example, the security risks related to the patio. The registered manager had developed separate individual risks assessments about these risks, which did not always clearly identify what actions were being taken or how those risks should be managed in the meantime. No consideration was given to whether environmental risks for one person may be relevant to others.

The provider and registered manager failed to comply with the warning notice on staffing. The arrangements for assessing and monitoring staffing levels staffing and the contingency for managing emergencies across both sites were inadequate.

The service lacked some key policies, such as safeguarding, mental capacity act and incident reporting. Other policies and procedures were of poor quality, so did not set the standard to support staff in their practice. There were no systems in place to monitor consent met legal requirements. The recommendations of an external pharmacy audit report in August 2017 which highlighted improvements needed, had not been addressed when we visited.

The service had a key worker system, whereby named keyworkers were responsible for leading on each person's care, and making sure their care records were kept up to date. The registered manager said currently, the keyworker system had lapsed somewhat, due to a number of staff leaving and the high level of agency staff.

People's care records lacked sufficient personalised instructions about how to manage risks related to their care and treatment. Although people's care plans were reviewed regularly they were not always up to date about people's needs, and were not evaluated to see what was working well or what needed to be changed. Staff said it was hard to keep up to date with the paper work when the service was so busy. For example, on 22 November 2017, at 6.20pm people's food and fluid charts had not been filled in since 8 am. This meant it was much more likely important information about food, drink and details of each person's day could be forgotten or not recorded accurately. No audits of care records were carried out, so opportunities to identify and address issues identified about care plans, risk assessments and gaps in records were missed.

The quality assurance arrangements hadn't identified that staff didn't have time to read the care records, therefore putting people at risk. They relied on verbal handover meetings to communicate pertinent information about people's day to day needs. We were concerned as some staff didn't know people's key needs or risks, as there were so many new and agency staff. At our visit on 23 November 2017, we asked the registered manager to provide staff with a written summary of key information about each person.

This is an ongoing breach of Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2014 Good governance.

When we visited again on 28 November 2017 a handover sheet had been developed and was in use. All staff said this was helpful to refer to, senior staff said it saved them time writing a list for agency staff at beginning of each shift.

Most people, relatives and professionals expressed confidence in the provider and registered manager but two relatives and a professional had some concerns. One relative said, "I'm not confident in the manager, I don't feel as though I'm listened to." A health professional referring to two people recently admitted to the Coach House said they had begun to worry about whether Venn House had enough staff with the right skills needed to look after those people.

There was a high turnover of staff, eight had left since May 2017 and nine new staff had been employed. One new staff still undergoing induction left during the inspection. The provider and registered manager said staff who left recently had cited leaving to work nearer home to reduce travel time, cost and personal issues as reasons for leaving. Other staff said they thought staff had left because they felt they were not being listened to. Speaking about turnover of staff one staff member said, "Staff change here so quick, like the wind."

The service had four senior care posts but two senior care staff had recently left. The Venn House 'On call procedure" showed senior staff did on call out of hours to support staff on duty. So they were first to be contacted by night staff for advice and were expected to attend in an emergency. Currently only two senior staff were available for on call, so they were doing seven nights on call alternate weeks. Staff said they were not paid for being on call or taking calls out of hours, only if they needed to come into work, which the provider confirmed. Senior staff said they had been called about four times in past couple of months, once to come in during the night because of staff sickness, when they had already worked a 12 hour day.

Senior staff felt they had a lot of responsibility delegated to them, and struggled to keep up with their lead role responsibilities such as supervision and audits. One said, "It's a lot to do, management say prioritise." When we discussed these concerns with the provider, they said senior staff could come in on their day off to complete overdue tasks and would be paid for doing so. However, they were reluctant to do so as they said their days off were precious.

Many staff said they felt undervalued, and described a culture of fear about feeling able to raise concerns. One staff said, "They (provider and registered manager) are not listening, we feel devalued, everyone is looking for other jobs." Other reasons staff cited for feeling undervalued included being expected to undertake staff training and attend staff meetings in their own time unpaid.

Providers are required to give the Care Quality Commission (CQC) a statement of purpose which includes details of the services provided including the service types and the health or care needs the service sets out to meet, for example, older people or specialist dementia services. They are required to keep this document under review and notify CQC when there are any changes.

The providers most recent statement of purpose, dated February 2016 said; "The range of needs cared for are the frail elderly, aged 65 years and over." However, the providers' website described Venn House as an "Elderly care home specialising in dementia care needs." The registered manager and provider confirmed the Coach House was primarily but not exclusively for people living with dementia.

This provider failed to update their statement of purpose about of the change of use in Coach House to a more specialist dementia service or notify the CQC about this change. Had they done so, this would have afforded CQC with an opportunity to seek additional assurances about this change. For example, whether there were sufficient staff with the right skills and whether the environment was suitable for people's more complex needs.

This is a breach of Regulation 15 of the registration regulations 2009.

The inspection identified several safeguarding incidents which occurred at the home where people were at risk of abuse. These had not been notified to the CQC in accordance with the regulations. This meant opportunities for CQC to identify safeguarding risks, and take follow up actions may have been missed.

This is a breach of Regulation18 of the of the registration regulations 2009.

The service had a registered manager who registered in July 2016. They explained they came on duty at about 10am each morning and received verbal feedback from the staff member in charge. Then they walked around home to check on people. They did not do any planned shifts to provide direct care to people, or work alongside staff, although said they were available if needed in an emergency. This meant they did not directly experience the day to day challenges staff described.

People were consulted and involved in day to day decisions made about the home. In response to people's feedback, cards to offer menu choices at breakfast time was introduced. A residents, relatives and professionals survey was used to monitor satisfaction with the service. Four responses were received from the October 2017 survey. One was from a person who used the service, two from relatives and one from a professional. All showed high levels of satisfaction with the service, with no areas for improvement identified. One relative said, "Lovely place, lovely people." A professional said, "Staff always appear caring and residents dignity is always considered."

The service received national patient safety alerts, to help staff keep abreast of any equipment or products identified nationally that may pose risks for people. The registered manager was a member of a registered manager's network which shared ideas and good practice tools with one another. In relation to further improvements the registered manager hoped to introduce electronic records in the future.

The provider had displayed their previous inspection report in the home, and on their website in accordance with the regulations.