Avenues South East

Avenues South East - 4 Westhall Park

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

Westhall Park is a care home which provides care and support for up to six people who have a learning disability, such as autism. At the time of our visit there were six people living at the home, all of whom were male.

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

There were not enough staff on duty to meet people's needs, particularly during the night. Staffing levels were such that during the night only one member of staff was present to support six people, some of whom suffered from epilepsy and one of whom was meant to have one to one support 24 hours a day. This meant there was a potential that if an incident occurred there would be no staff to support people. People were not always enabled to go out because of the staffing levels.

Accidents and incidents were recorded and monitored by staff to help ensure they could mitigate against further incidents happening. However, records were sparse and notifications of serious events had not been reported to CQC.

Where there was a risk to people this had been identified but staff did not always act in order to reduce people's risks. If an accident occurred there may not be enough staff to support people. Staff had a clear understanding of how to safeguard people and knew what steps they should take if they suspected abuse. There was an effective recruitment process that was followed which helped ensure that only suitable staff were employed to work in the home.

The provider had plans in place to ensure people would continue to receive care and support in the event of an emergency, however their fire risk assessment had not been updated in line with the provider's policy.

Staff were not provided with regular training to assist them with carrying out their role. Staff did not have the opportunity to meet regularly with their line manager regularly to check they were following best practice, or to discuss any aspect of their work.

Staff did not have a good understanding of the requirements of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards, which meant people had restrictions in place without the proper procedures being followed.

People were not always shown respect by staff and staff did not always engage in a meaningful way with people. People lived in an environment that was not homely or cared for by staff or the provider.

Individualised activities were not available for people and activities that took place within the home were limited. Care records in relation to people were comprehensive, however some information was contradictory or missing. Complaint information was not made readily available to people.

Quality assurance monitoring was not always completed and actions from provider and internal audits had not always been addressed by the registered manager or the provider. The provider had not taken action in relation to the welfare of staff.

Staff were not always involved in all aspects of the home and did not regularly attend staff meetings. Staff told us they did not always feel supported by the registered manager or provider and their morale was low. Relatives were asked for their feedback in relation to Westhall Park and they said they were made to feel welcome when they visited.

The registered manager was not complying with their legal requirements in relation to registration as they had not submitted notifications when they should.

People were able to choose the foods they ate, however people's dietary requirements were not always known by staff.

Medicine management procedures were followed by staff, although staff did not take the time to describe people's medicines to them. People had access to external healthcare professionals when required.

Relative's we spoke with said their family members appeared happy within the home and felt safe with staff. Relative's told us they were made to feel welcome and one relative said things had improved for their family member since the new registered manager had started. Relatives said staff were caring to their family member and knew their needs well. Although, relatives had a positive view of the care provided we found evidence that not everyone was living in a home where they were encouraged to live independent and fulfilling lives.

During the inspection we found seven breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and one breach of the Care Quality Commission (Registration) Regulations 2009. 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 has therefore been placed 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.

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.

There were not enough staff to meet people's needs.

Staff followed good medicines management procedures.

Staff did not always act to help reduce the risk to people. Accidents and incidents were recorded and action taken when required but they had not led to lessons being learnt to minimise them being repeated.

Staff understood what abuse was and knew how to report it should they suspect it. Appropriate recruitment processes were followed.

Guidance was in place for staff and people should there be an emergency at the home, although the home's fire risk assessment had not been reviewed.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff did not have a good understanding of the Mental Capacity Act 2005 and people's capacity assessments or DoLS applications were not always completed appropriately.

Staff were not provided with support in relation to their role, for example through supervisions. Staff had not always received the most up to date training.

People were supported to be involved in developing the menus around the food they ate. However, staff were not always aware of people's dietary requirements.

People had access to healthcare services although this was not always recorded in people's care records.

Is the service caring?

Requires Improvement

The service was not always caring.

People were not always treated with kindness or respect.

People lived in an environment that was not well maintained. People's rooms were sparse and the décor was tatty.

People's individual characteristic were recognised by staff but staff did not always respond to or interact with people.

Relatives told us they had the opportunity to maintain contact with their family member.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People were not provided with activities that were meaningful to them.

Care plans were extensive and contained relevant information but this was not always complete. People did not always receive care responsive to their needs.

Complaint information was not made readily available to people.

Is the service well-led?

Inadequate

The service was not well-led.

There was a lack of systems in place to monitor the safety and quality of the home. Actions identified were not followed up.

People were not involved in the running of the home and although relatives were invited to comment on the service provided, the outcome of their feedback was not made readily available.

Staff did not feel supported by the registered manager and attendance at staff meetings was poor.

The manager was not aware of their responsibilities in relation to submitting notifications to CQC.

Avenues South East - 4 Westhall Park

Detailed findings

Background to this inspection

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

This was an unannounced inspection which took place on the 17 May 2016. The inspection team consisted of two inspectors.

Prior to the inspection we reviewed the information we had about the service. On this occasion we did not ask 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. Instead we reviewed all of the notifications of significant events that affected the running of the service. A notification is information about important events which the service is required to send us by law.

As people living at Westhall Park were unable to tell us about their experiences because of their complex communication needs, we observed the care and support being provided and talked to relatives and other people involved following the inspection.

As part of the inspection we spoke with the provider's regional director, the registered manager, three staff and three relatives. We spoke with two professionals to gain their feedback about the care people received. We looked at a range of records about people's care and how the home was managed. For example, we looked at two care plans, medication administration records, risk assessments, accident and incident records, complaints records and internal and external audits that had been completed. We also looked at four recruitment files.

The last inspection of Westhall Park took place in April 2014 when we had no concerns.

Inadequate

Is the service safe?

Our findings

We asked relatives if they felt their family member was safe living at Westhall Park. One relative told us, "He always seems happy and he never shies away from staff. I have seen no signs of anxiousness."

There were insufficient members of staff to meet people's needs which meant there was an actual risk for people particularly during the night. The registered manager told us that two people had a set number of hours of one to one support whilst in the home and, "Quite a few" had two to one support when going out. They also told us that one person required one to one support 24 hours a day.

The registered manager said that four care staff would be on duty during the day, with a fifth member of staff working a mid-shift on a Monday and Tuesday. During the night the home was staffed by one waking staff member. However two people had epilepsy which meant when there was an incident during the night there was insufficient staff available to attend to the person as well as ensure the remaining people were safe. We looked at the staffing rotas for a period of 28 days and noted that levels were not in line with what we had been told were required by the registered manager. For example, on 13 occasions only three staff were on duty during the morning which meant that only two staff were available to support five people whilst also undertaken household tasks and cooking.

The registered manager told us she currently relied heavily on bank as well as agency staff. She told us, "We are quite short staffed; we are helping each other out." Staff had concerns about staffing levels. One member of staff told us it was an issue that only one member of staff was on duty at night as one person, "Is on one to one care 24 hours a day." Another staff member told us, "I don't think it's enough. Two guys have seizures, things happen. X banged his head and refused to go to hospital with the ambulance crew." They added, that even if the person had agreed to go to hospital because there was only one staff member either people in the home would be left unsupported or the person would have to go to hospital unaccompanied.

Another member of staff said that agency staff were brought in to cover the night duty, but they were afraid to be on their own. The registered manager had not taken action or planned ahead to ensure that people were provided with the staff to meet all of their needs at all times. On one occasion a staff member had to work straight through from their day shift because no one had been booked to work at night.

During the day we observed that three people required one to one support because of their behaviours. One person's care records stated, 'monitor x at all times from other residents' (because of conflicts) but we saw that this did not happen. We did not see staff present in the lounge with this person at all times. Both inspectors were pushed by two individual people. This was because staff were not available to support them at the time. Staff did not feel there were enough staff on duty during the day. One staff member told us, "I think it should be six. People could get better care and there would be more support." Another said, "Yesterday there were only three carers in the morning. The minimum is four." A third told us, "We feel stretched; we need to enhance their (people's) quality of life."

People were not always able to attend activities outside of the home and staff could not spend time with

people because of their workload. Staff were expected to carry out all caring tasks as well as undertake the cooking, laundry, housekeeping and maintain the garden. Staff said this did not give them time to interact with people as they should. This was evident on the day. The registered manager told us that currently there were short of staff able to drive the house vehicle which sometimes prevented people from attending their external activities. They told us, "We do the outings in smaller groups but it's a struggle. We don't have any permanent drivers at the moment."

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

Following the inspection, we checked the one to one funding arrangements as we had been told by the provider that the registered manager had given us misleading information. It was confirmed to us that no one was on 24 hours one to one support each day. We were told one person was funded for 20 hours per week and another person funded for 56 hours one to one support a week. Three people required two to one support when they went outside of the home. However this still meant that staffing levels were not sufficient to support everyone to go out as they would wish independently or all together. The provider confirmed to us they had increased staffing levels to four staff on early and four staff on late with one mid-shift staff member.Night staff were increased to one waking and one sleeping.

Where people suffered an accident or incident staff took immediate action and this was followed up by completion of an accident and incident report. However, information contained in reports did not always include full details of the event and what preventative action staff had taken to reduce reoccurrence.

People may not always be protected from risk as although risks to people had been identified staff did not always act to help protect people from reoccurrence of injury. One person required 'corner covers' on their bed to reduce the risk of injury when they had a seizure, but these had not been provided. This person also required a larger bed again, to reduce the possibility of injury. We noted in February that staff had discussed the need to purchase this bed however the registered manager told us this had not been actioned. However risks to other people were acted upon by staff. For example, one person had assessments around their risk of choking. This included information on how staff should prepare this person's food and we saw this being followed. Staff explained to us how they would reduce risks to people. For example, by making sure no obstacles were around if people had reduced mobility.

Where people had identified risks in relation to their diet, staff were not always knowledgeable in this. Staff were aware of one person who was at risk of choking and relevant guidance and information was in place to ensure this person received appropriate foods. However, this person's care records stated, 'x's food should be of low cholesterol, low salt diet'. We found no guidance in place to inform staff on how this should be achieved and when we asked staff about this we were told, "No, he's fine, just pureed food." This same person's care notes recorded, 'stay upright for 30 minutes after eating' but staff did not support them to do this after lunch. As the registered manager was currently reliant on agency staff this meant staff may not provide this person with the correct foods or appropriate support and the risk of choking was increased.

People did not always receive care which helped reduce the risk of harm to them. For example, one person's care plan noted, 'staff should offer x a short walk within the home around every hour and a half', (this was for medical reasons) but we saw that this did not happen. This same person required their health to be closely monitored and any concerns reported to the GP. There was a concern recorded in some daily notes and although the registered manager told us this had been referred to the GP their care records did not reflect this had happened. Two sets of guidance from the Speech and Language Therapy team were stored in the folder in the kitchen for this person. One was dated 2011 and the other undated. Both contained slightly

different information.

Another person was seen several times struggling to get up from the settee and a member of staff said, "The chair (settee) is too low for you." There were no suitable chairs for this person to sit on. This left them vulnerable to harm as due to their poor movement, getting up and down from the settee caused them extreme effort. The registered manager confirmed new seating was required for this person. The registered manager confirmed that a new chair had been needed for some months now. They told us however that nothing had been done to address this.

Assessments in relation to the risk of fire were not up to date. A fire risk assessment had been carried out on the home in January 2015 but although there was a review date of January 2016 there was no evidence this had taken place. There was a contingency plan which detailed what staff needed to do to protect people and make them safe in the event of an emergency. Each person had their own personal evacuation plan (PEEP) in their care plans which staff were aware of. However, these might not be easily accessible should staff need to evacuate people quickly because staff did not hold a separate copy of these in a central location which could be seized quickly by staff.

The lack of systems and processes to ensure people are not at risk of unsafe care was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Safe medicines management processes were carried out by staff. We saw staff administer medicines to people and sign the Medicines Administration Record (MAR) after they were assured the person had taken their medicines. We reviewed other MARs and found these had been completed correctly, with no gaps. The temperature of the medicines cupboard was recorded each day. Staff were able to tell us what the safe temperature levels were in order to ensure the effectiveness of medicines was not compromised and they remained fit for use.

MARs had people's personal information on them together with any allergies and they had a photograph to ensure staff gave medicines to the correct person. Most people had 'as required' PRN medicines and protocols were in place which gave information to staff on signs to look out for and maximum dosage.

The provider had recruitment procedures which helped ensure that only suitable staff worked at the home. These were undertaken by staff at the head office and the registered manager was informed when all checks had taken place. Staff were appointed following submission of an application form with evidence of full employment history, proof of identity, proof of address and a criminal record check certificate before they started work.

People were safeguarded from the risk of abuse. There was a safeguarding policy that guided staff on the correct steps to take if they had a concern and staff knew how to access this. Most staff told us they had received safeguarding training and also understood how to whistleblow if they had a concern they wished to report. Staff knew about the role the local authority played in safeguarding people. One staff member said they would report safeguarding to the registered manager and if they saw something happen in front of them they would, "Stop the abuse."

Requires Improvement

Is the service effective?

Our findings

We found the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) were not always being implemented appropriately. The MCA protects people who may lack capacity and ensures that their best interests are considered when decisions that affect them are made. The Care Quality Commission (CQC) monitors the operation of DoLS which applies to care homes. These safeguards protect the rights of people by ensuring if there are any restrictions to their freedom and liberty these have been authorised by the local authority as being required to protect the person from harm. DoLS ensure that people receive the care and treatment they need in the least restrictive manner and only in their best interests.

People had mental capacity assessments completed around the locked front door, personal care and safety. However, the majority of these had been completed in 2013 and no review had taken place. This matters because people's capacity to make decisions can fluctuate and change depending on the health. One person had a listening device in their room due to their regular seizures, but no mental capacity or best interest decision was recorded for this. This is a restriction to their freedom and their capacity to make a decision in relation to having the device should be assessed. There was a locked cupboard in the kitchen and wardrobe doors in some people's rooms were locked but there was no record of a best interest meeting being held in relation to how the decisions to lock these doors had been made. One record showed a GP had made the decision for a person to undergo hospital treatment, but it was not clear whether this decision had been discussed or agreed by anyone else involved in this person's care.

Staff did not understand the MCA as the wording they used in relation to this was contradictory. For example, people's mental capacity assessments read, 'I do not have the capacity to sign or understand the consent of this form, however I do give consent to the support'. On other documentation it was written, 'I give consent by the behaviour I display'. There is a specific test for mental capacity consideration and this had not been used.

Where the provider had submitted applications for DoLS authorisations to the local authority, these were not always completed fully. For example, one person's application made no mention of the locked front door or the locked cupboard in the kitchen.

The failure to follow the legal requirements in relation to the Mental Capacity Act 2005 was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were cared for by staff who were not always provided with regular training. The registered manager provided us with a matrix which recorded which training staff had received and where training had expired. This showed us that five staff had not received or were overdue their food hygiene, basic life support and safeguarding training. Two staff did not have up to date medicines training and three up to date de-escalation training to safely manage behaviours that challenged.

Staff had not all received training specific to the needs of the people they cared for. For example, five staff had not had autism training and four had not had epilepsy training which meant they may not always know

how to react to a situation.

Staff did not have the opportunity to meet with their line manager on a regular basis which meant they may not receive the support they needed. The registered manager told us that staff had not received supervisions in line with the provider's policy. The registered manager said that, rather than monthly, staff received supervisions approximately six-weekly. However, records showed that these were less frequent than we had been told. For example, of the 11 staff, five had not received a supervision since January 2016 and four since February 2016. Supervisions are important as they enable management to check staff are putting their training into best practice and they give staff the opportunity to discuss any aspect of their work with their manager.

The failure to support staff was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were involved in choosing what they had to eat and drink. Pictorial menu cards were used to develop weekly menus in conjunction with people and lunch was the same as the meal shown on the weekly planner. Apart from one person not receiving their personalised diet other people were getting a range of food as and when they needed it.

People were in the kitchen whilst lunch was being prepared and assisting where they could in making drinks. People who were able to were supported by staff to make this own hot drinks.

People had involvement from health care professionals. We saw evidence in people's care records that external health care professional advice and input was sought when appropriate. For example, the doctor, dentist or chiropodist. One person required a referral to a specialist and we saw this had been done. One relative confirmed that the GP was called if their family member was unwell.

Requires Improvement

Is the service caring?

Our findings

We asked relatives for their opinion of how caring staff were who supported their family members. One relative said, "They seem to understand him and know him well." Another told us staff were kind and showed respect. A professional told us, "It's lovely. People are well looked after and staff are very involved." Another professional said, "X seems happy enough." Despite people and relatives' positive view of the care staff provided we found there were areas that required improvement.

People were not respected by staff as staff had not ensured people lived in an environment which was well cared for or homely. People's rooms were sparse, with stained walls and flooring. Items in the sensory/activity room were covered in dust and grime and windows smeared. The flooring in the sensory/activity room had spilt tea stains on it. There was thick dust and muck underneath the sofas in the lounge area and one sofa had collapsed in the middle. The garden which surrounded the home was not well maintained with the grass overgrown and a trampoline in one area of the garden was not fit for purpose. The registered manager told us this needed to be replaced as a tree had fallen on it and damaged it. A professional told us, "When you pull up outside the home looks tatty and unkempt and inside the home is barren with big empty spaces."

Staff did not take action to help ensure people felt as though they mattered. For example, a notice board displayed in the hallway of the home was titled, 'who is in our house today?' this should have displayed pictures of staff on duty; however it had not been completed.

Staff were not always able to anticipate people's actions or show positive interaction with people when they used these actions to indicate a request. Staff explained the gestures of some people and what they indicated. For example, one person raised their arm to show they did not want people in the home or they took a person's hand if they wished to go for a walk. When this person did this to us, staff told us, "He has already had his walk" but did not offer to take this person out again. One person struck out at an inspector and another pushed an inspector. These incidents happened because staff were not always around, however we also observed staff having to constantly try and calm people to avoid further incident. People's dignity was compromised. For example, one person had undone their lower clothing and was walking around semi-naked. We heard staff call, "Quick, quick" alerting other staff to follow this person to support them.

People were not always treated with respect. During lunch time a staff member stood over someone with their elbows resting on the table. When staff gave people their lunch time medicines they told them, "There's your one o'clock medicines" and did not take time to explain the medicines to them. When a person had cream applied to their face it was not done in the most gentle of ways by the member of staff. One person asked staff for a drink during the morning and was told, "Later" by staff. The registered manager overheard this and told the person, "Yes, of course you can have a drink." However, we noted this person was not brought their drink until much later when everyone had a hot drink.

Staff did not always consider people's individual ways of communicating. For example, one person had a

certain amount of speech and regularly attempted to converse with staff. It was clear this person knew what they were saying. However staff did not always make time to listen and try to respond appropriately and they had not considered introducing anything to assist this person to be understood. For example, items of reference or pictures. During a music session in the morning this person was trying to speak with staff, but the music was so loud they had difficulty making themselves understood.

The lack of respect and dignity shown to people was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We did see some examples of good care. For example, people were supported to participate. During the music session staff assisted people to play percussion instruments and dance or move around to the music. People were encouraged to choose particular songs they wished to hear. At lunch time one person was in the kitchen with staff helping to make drinks. Although we noticed several occasions when staff sat in the lounge area completing care records they did not ignore people if they wished attention.

People were shown attention by staff. One person liked to look at car magazines and staff showed an interest in this and talked about which cars they preferred. Another person rested their cheek against staff's cheeks as they liked them to sing. Staff did this often and the person responded to staff by smiling. During the morning staff were playing catch with a ball with one person in the garden.

People could have privacy when they wished it. We saw people go into their rooms when they wished to.

Visitors were welcome in the home. Relatives told us they could visit at any time and did not have to tell staff when they were coming. One person was supported by staff to go to their family member's home.

Requires Improvement

Is the service responsive?

Our findings

We asked relatives if they felt there was enough for people to do whilst living at Westhall Park. One relative told us, "They take him out for a walk and he goes on holiday or bowling." Another said, "They try and do things with him and we've seen external activities come in, such as a music man." Despite these comments however we found people were not being provided with individualised, meaningful activities. A professional had told us, "I always see people sitting around in chairs and in the house."

The registered manager told us the activities board was out of date and required updating and said that due to a lack of drivers that it was sometimes difficult to take people out as often as they would like. They told us they used drivers from other Avenues South East homes and if necessary a taxi would be arranged. However, records showed that little outside activity took place for people. For example, one person's daily notes showed over a period of 13 days they did not go out once. Another person's records noted they had gone out three times.

Staff had not considered the age range of people living in the home which meant that some activities were not always personalised, age-appropriate or suitable for the people living at Westhall Park. For example, in-house items included jigsaws with quite complicated pictures and a large number of small pieces.

Staff told us, "There is not enough to do indoors and they (people) need to go out a bit more." Staff told us people's behaviours would reduce if they had more to do. One staff member said, "People haven't been out for months. Everybody likes going out and it affects their behaviours." A second staff member told us, "I must admit there are not enough activities. There isn't enough inside either. The lack of activity impacts on people's behaviour. They need to go out, stimulus is needed and more engagement."

People did not always receive care and support from staff reflective of their care plan. For example, one person's care plan noted, 'x eats his meals with one to one staff support without other people present'. Although we saw this person was supported by a staff member at lunch time, they were being given their lunch at the table with three other people. A physiotherapy assessment recorded, 'take him to the local pool, he likes swimming and this will help him'. However from this person's daily records it was clear this had not happened.

Care plans were comprehensive and provided a lot of information for staff, however information was at times conflicting or not complete. For example, the person who should be offered a, 'walk around the home every hour and a half' had three different entries in relation to this, ranging from a prompt, 'every half hour' to, 'as advised by the GP every hour'.

People had hospital passports in their care records. This was a document which recorded important information about a person should they have to go into hospital. People also each had a health action plan (HAP) which recorded intervention from healthcare professionals. However, information had not always been updated so it was unclear whether or not people had received care in line with their care plan or staff had not recorded information as they should. For example, one person's care plan stated they should be,

'weighed monthly' and yet the last record in their HAP showed they were weighed in March 2016.

The lack of person-centred care was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Complaint information was not always made available to people in a way they would understand. Although the complaints policy was in pictorial format and the registered manager told us they had given each person a copy to keep in their rooms, they were unable to find these on the day. The registered manager told us they had no formal complaints currently open. We asked relatives if they had ever had the need to complain. One relative told us they had and said the registered manager had listened to their complaint and acted on it. However, the relative said they had never been told the outcome of the investigation the registered manager said they would carry out in response to their complaint.

We recommend the registered provider ensures their own complaints procedures is followed in response to all complaints.

Inadequate

Is the service well-led?

Our findings

We asked relatives whether they felt Westhall Park was managed well. One relative told us, "I have only met the manager once. She seems professional and does contact us if she needs to." However, during the inspection we identified some concerns in relation to the management of the home.

The registered manager was not aware of their statutory requirements to notify us of particular incidents. For example, serious injury or safeguarding events. We identified at least four incidents which had occurred at the home in the last six months which had not been notified to the CQC.

The lack of notification of other incidents within the home is a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

Records in relation to people were not contemporaneous or complete. Daily records for one person noted they had a seizure on a particular day but the daily notes recorded, 'fine – no issues' without any mention of the seizure. Another person had written, 'I can get anxious and angry thus abuse people I come into contact with' but there was no further information around this, for example, what made this person angry or anxious or how staff should provide appropriate and safe care. We spoke with staff about people's individual needs and they were able to describe to us relevant detail which showed they knew people well and how to respond to people's needs. However contemporaneous and complete care records were important because the registered manager was reliant on the use of agency staff who might not know people as well.

Quality assurance audits were not regularly carried out by staff and any identified actions from these had not been completed. For example, the provider's policy stated both weekly and monthly medicines audits would take place; however staff were only carrying out monthly audits, the last of which was completed in March 2016. The registered manager told us weekly audits were completed but they were unable to provide evidence of this. The last recorded weekly fire check was dated 19 March 2016 and weekly wheelchair check March 2016. A health and safety check in April 2016 identified the laundry sink tap and kitchen cupboard handles needed to be replaced/fixed. We found that these two actions were still outstanding.

The provider undertook regular quality assurance audits to check the quality of care being provided at the home. We noted that some actions from the April 2016 visit had not yet been completed and information contained in the audits not followed by staff or transferred into an action plan. For example, the provider had noted, 'two fully trained staff present when liquid medicine is to be administered' but this did not happen during the lunch time medicines round. Other actions included, 'more activities to be put in place', 'complete supervisions for April' and 'sofa replacement - sunken sofa will need to be replaced as this could pose a risk to service users'. We spoke with the registered manager about this who told us the request for a new sofa had yet to be submitted. Some actions had been identified at previous provider visits.

People were not always given the opportunity to be involved in the running of the home which meant people were not being given the opportunity to be involved in any decisions or choices. The registered manager told us that house meetings were not held because people, "Can't communicate." The registered

manager told us that instead people had monthly personal planning meetings with their key worker (a member of staff responsible for an individual in terms of their support and care records). However, we found from the records this was not always the case. One person last met with their key worker in January 2016. We noted it was recorded at this meeting, 'he is waiting for his new furniture since August 2015. New chair needed for bedroom.' Neither of these had happened.

The provider had not ensured people were receiving the care or service promised to them. For example, people's 'service user guides' stated people would be entitled to a, 'well maintained garden, two comfortable chairs in their rooms and a residents meeting every three months'. The provider's mission statement stated, 'opportunities for people we support to take part in a variety of activities and experiences of interest to them within the home and community', 'take part in meaningful everyday activities' and 'the home should be suitably equipped with facilities and equipment for individual needs'. None of this was currently being provided to people and we noted in people's contract for living at Westhall Park that they would be required to pay for specific activities outside of the home, such as swimming or the cinema which may restrict people in participating in some of their preferred leisure pursuits.

Staff did not feel supported and the provider had not taken action in relation to the welfare of staff working at the home. Staff told us morale was low and there were often times when they felt unsupported by the registered manager and provider. One staff member said, "I don't like working here now. We used to be fully staffed, it was a good team. I don't feel valued or supported." They told us that despite being promised by Avenues South East that their concerns (in relation to staffing and management) would be addressed this had not happened. Staff said that substantive staff had reduced and they were really struggling for permanent staff. A member of staff said, "There is a lack of staff and people could do more. I'm so tired and stressed out."

Following our inspection the provider was able to demonstrate to us they had taken robust and immediate action in response to the concerns we had identified. The registered manager had been suspended from duty and a temporary, highly experienced, manager brought in to oversee the home. An internal action plan had been developed and both the provider and area manager were carrying out regular visits to monitor staffing levels, support staff and take action in response to our concerns. Staffing levels had increased and new furniture purchased for people and the provider was updating us on progress regularly. Although we had total reassurance from the provider that action had been and would continue to be taken, because of the concerns we had found during our inspection there remained an element of risk to people until compliance was fully achieved.

The lack of overall governance within the home was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff were asked for their views at team meetings. Staff told us they had staff meetings, although we did note that attendance at meetings was poor. Meetings included discussion on all aspects of the home and gave the registered manager the opportunity to cascade any important information in relation to Westhall Park or Avenues South East to staff. Although the registered manager told us meetings were held monthly, they were only able to provide us with the minutes from the February and April 2016 meetings.

Relatives were encouraged to give their feedback about the home but the response was poor. The registered manager told us that the last relatives' survey was carried out in July/August 2015, but they had not yet received the results of this which were collated by head office. We checked this with the regional director who told us, "I checked out the stakeholder questionnaire for 2015 and our records show that these were sent out to various parties and there was a nil return for Westhall Park. This is not uncommon for

questionnaires and our QA department reviews the format of these questionnaires each year partly to look at ways to increase return rates." One relative told us they had been sent a questionnaire previously.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The registered provider had not ensured notifications of important events had been submitted.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The registered provider had not ensured people were always provided with person-centred care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The registered provider had not ensured people were always treated with dignity and respect.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The registered provider had failed to follow the requirements of the Mental Capacity Act 2005.