Strathmore Care Limited

Whittingham 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

Our previous comprehensive inspection to the service was on 5 and 7 February 2018. The overall rating of the service at that time was judged to be 'Requires Improvement'. A breach of regulation 17 [Good governance] with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 was made. However, the service remained in 'Special Measures'. We do this when services have been rated as 'Inadequate' in any key question over two consecutive comprehensive inspections. The 'Inadequate' rating does not need to be in the same question at each of these inspections for us to place services in 'Special Measures'.

Whittingham House provides accommodation and personal care for up to 70 older people and people living with dementia. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Whittingham House is a large detached building situated in a quiet residential area in Southend on Sea and close to all amenities. The premises is set out on two floors with each person using the service having their own individual bedroom and adequate communal facilities are available for people to make use of within the service on each floor. The service is separated into units and consists of Lemon and Lavender suites on the ground floor and Blossom and Bluebird suite on the first floor. At the time of this inspection Bluebird suite was not in use.

This inspection was completed on 27, 28 and 30 November 2018 and was unannounced. There were 44 people living at the service.

The overall rating for this service is 'Inadequate' and the service therefore remains 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.

A registered manager was in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Quality assurance checks and audits were not robust, as they did not identify the issues we found during our inspection and had not recognised where people were placed at risk of harm and where their health and wellbeing was compromised. The management team of the service had not taken appropriate steps to ensure they had sufficient oversight of the service which ensured people received safe care and treatment. The lack of managerial oversight at both provider and service level had impacted on people, staff and the quality of care provided. Therefore, the management team were unable to demonstrate where improvements to the service were needed, how these were to be made and had been addressed; and lessons learned to ensure compliance with regulatory requirements and the fundamental standards.

The management team had not ensured the service was being run in a manner that promoted a caring and respectful culture. Although some staff were attentive and caring in their interactions with people using the service, we observed some interactions which were not respectful or caring and failed to ensure people were treated with respect and dignity. People's healthcare needs were not consistently monitored and referrals to appropriate healthcare professionals made. Staffing levels were being maintained but the deployment of staff was not always responsive to meet people's care and support needs. Improvements were also required to the service's medication arrangements as discrepancies relating to staff's practice and medication records were found.

The dining experience for people was not consistently positive and improvements were required, particularly in the way this was organised. Although the service was without an activities coordinator, people received little opportunity to participate in meaningful social activities.

Care records were not accurately maintained to ensure staff were provided with clear up to date information which reflected people's current care needs. Where people were judged to be at the end of their life, information relating to their end of life care needs were not recorded and not all staff had received appropriate training. Suitable control measures were not put in place to mitigate risks or potential risk of harm for people using the service as steps to ensure people and others health and safety were not always considered, and risk assessments had not been developed for all areas of identified risk.

People's capacity to make day-to-day decisions had been considered and assessed. Nonetheless, improvements were required to ensure staff had a better understanding of the main principles of the Mental Capacity Act and best interest assessments completed for all areas.

Not all staff that were newly employed had received a comprehensive robust induction and the role of senior members of staff was not effective in monitoring staff's practice and providing sufficient guidance and support. The majority of staff had attained up-to-date training but improvements were required for newer members of staff to receive training in a timely manner.

The service worked with other organisations to enable collaborative joined-up care. The registered provider's arrangements for the prevention and control of infection at the service was satisfactory. Effective safeguarding arrangements were in place whereby the Care Quality Commission was notified of safeguarding concerns and staff had received training.

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.

Risks were not identified for all areas of risk. Risks were not suitably managed or mitigated to ensure people's safety and wellbeing and improvements were required relating to medicines management.

Staffing levels were being maintained but the deployment of staff was not always suitable to meet people's care and support needs and improvements were required to ensure staff spent time with people talking and engaging with them.

Effective safeguarding arrangements were in place and staff had received appropriate training.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Not all staff employed at the service had received a robust and comprehensive induction or training in a timely manner.

The dining experience for people was not consistently positive and improvements were required to ensure outcomes for people were better.

The service does not consistently make referrals at the right time to make sure that people's health and wellbeing is monitored and maintained.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People using the service did not always receive good quality care or treated with respect and dignity. Care provided was primarily task focused and 'service-led' rather than person-centred.

Staff did not always effectively communicate with people using the service, particularly people living with dementia.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People did not always receive care and support that was responsive to their individual needs.

Improvements were needed to ensure all of a person's care and support needs were recorded and the information up-to-date and accurate.

People were not supported to participate in a range of social activities.

Is the service well-led?

Inadequate

The service was not well-led.

Systems to measure the quality of the service did not identify the concerns and risks to people that we found as part of this inspection.

The views of people and others were sought about the quality of the service provided.

Whittingham House

Detailed findings

Background to this inspection

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

This inspection took place on 27, 28 and 30 November 2018 and was unannounced. The inspection team consisted of two inspectors on 27 and 28 November 2018. On 27 November 2018 the inspectors were accompanied by an expert by experience. An expert by experience is a person who has personal experience of caring for older people and people living with dementia. On 30 November 2018 feedback of the inspection findings was provided to the registered manager and representatives of the organisation.

We reviewed the information we held about the service including safeguarding alerts and other statutory notifications. This refers specifically to incidents, events and changes the registered provider and registered manager are required to notify us about by law.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We spoke with 11 people who used the service, five people's relatives, six members of care staff, the service's previous deputy manager and the registered manager.

We reviewed six people's care plans and care records. We looked at the staff recruitment records for three members of staff, staff training information for the service, supervision and appraisal records. We also looked at the service's arrangements for the management of medicines, safeguarding, complaints and compliments information and quality monitoring and audit information.

Inadequate

Is the service safe?

Our findings

Safe was rated as 'Requires Improvement' at our last inspection on the 5 and 7 February 2018. At this inspection, we found that safe had deteriorated to 'Inadequate.'

People did not always receive care that was safe. Not all risks were identified, and suitable control measures were not in place to mitigate the risk or potential risk of harm for people living at Whittingham House.

Although staff had received manual handling training, we observed one incident whereby staff performed an unsafe manual handling practice. On the first day of inspection during the morning, two members of staff were observed to mobilise one person from a comfortable chair to a wheelchair so that staff could assist them to have their comfort needs met. The person was placed at potential risk of harm as one member of staff placed their hands under the person's armpits when assisting them to mobilise. This technique is unsafe, can hurt and cause injury because the person's armpits have too much pressure on them. The person's facial expression suggested they found this procedure uncomfortable as they grimaced whilst this practice was completed.

Additionally, whilst the above procedure was being carried out by staff, we observed that staff did not ensure the brakes were being utilised on the wheelchair. The brakes are designed to hold a wheelchair in place, to stop it moving while staff transfer a person and act as a safety mechanism to help prevent accidents. This meant while staff assisted the person to a standing position and to transfer to a wheelchair, the wheelchair moved away from the person on two occasions before staff could successfully place the person, using this item of equipment. The above observations were discussed with a senior member of staff who was deployed to the service to assist with the inspection. They confirmed to us after further enquiries that the wheelchair was faulty as the brakes were no longer working. Immediate action was taken by them to remove the wheelchair from action. A rationale was not provided as to why the wheelchair was not taken out of use and removed sooner.

On the first day of inspection one person was observed to be seated in a comfortable chair within one communal lounge. The chair had a pressure cushion in place which was electronically pressured to ensure it remained inflated according to the person's weight. This item of equipment is designed to relieve pressure when sitting down for extended periods of time and to help prevent the development of pressure ulcers. However, although the pressure cushion was plugged in the plug socket was not switched on and staff did not notice this for a further 20 minutes. It was unclear as to how long the person had been sat without this item of equipment in full working order.

On the third day of inspection the same person was seated in a comfortable chair within the communal lounge but without the pressure cushion being in place. We brought this to the registered manager's immediate attention and staff were instructed by them to reposition the person. It was not possible to determine how long the person had been sitting without this item of equipment in place. On review of this person's care plan, a formal assessment tool which gives an estimated risk score for the development of pressure ulcers was being used. This was last completed in November 2018 and identified the person was 'at

risk' of developing pressure ulcers. Information showed between 2 November 2018 and 23 November 2018, the person had developed a pressure ulcer on their sacrum and support was provided by visiting healthcare professionals. A risk assessment had not been completed to demonstrate suitable control measures were put in place to mitigate the risks or potential risk of harm. Senior staff spoken with could not provide a rational for this omission.

Prior to our inspection, the Care Quality Commission was advised of concerns relating to poor risk management arrangements in place relating to the development of pressure ulcers for one person. Documentation was found to be poorly completed and did not accurately reflect the person had developed three pressure ulcers during October 2018. The risk assessment provided generic information only and did not reflect specific data relating to the risks posed because of tissue damage to the person's skin. Although the risk assessment recorded the severity of risk as 'medium', this did not concur with the formal assessment which gives an estimated risk score for the development of pressure ulcers, as this recorded the person as being at 'high risk'. No information was recorded detailing what was being done to mitigate further risks and to demonstrate actions taken following the development of the person's pressure ulcers.

On the second day of inspection, inspectors visited several people's bedrooms, of which 10 freestanding wardrobes did not have a retaining bracket to prevent the furniture from falling, or being pulled forward with a potential to cause significant injury and harm. The registered manager was advised by us that a review of all rooms where wardrobes were located required appropriate remedial action taken to ensure peoples safety and to mitigate any risks. On 17 December 2018, we emailed the registered manager to find out what action had been taken. The registered manager confirmed via email that remedial action had been initiated and as of 14 December 2018, 20 freestanding wardrobes had been made secure. The email further stated that remaining actions would be completed by 19 December 2018, 21 days after the registered manager was first made aware.

We looked at the Medication Administration Records [MAR] for 12 of the 44 people who resided at the service and found discrepancies relating to staff's practice and medication records. There were gaps on the MAR forms for three people, where staff had failed to sign to confirm the person had had their medication administered, however this was a recording issue as we found the medication had been dispensed from the blister pack. Where people were prescribed a variable dose of medication, the specific amount of medication administered was not routinely recorded. The MAR form for one person detailed they were prescribed a PRN 'when required' medication for 'aggression and agitation'. Medicines with a 'when required' dose are offered to people outside the normal medicine round. The MAR forms for the period 8 October 2018 to 21 November 2018, recorded four occasions when this medication was administered. The rationale for this decision by staff was not recorded on the reverse of the MAR form and the 'Ongoing Care Recording Booklet' provided no evidence to indicate the person had been anxious or distressed at these times.

Handwritten entries on the MAR form were not consistently double-signed by staff to ensure the accuracy of information recorded. PRN 'when required' protocols to evidence the specific circumstances when these medicines should be administered were not available. This was not in line with recommendations from the National Institute for Health and Care Excellence [NICE], 'Managing Medicines in Care Homes'. A senior member of staff told us the protocols had been archived as the local Clinical Commissioning Group [CCG] had stated these were no longer needed. Following the inspection, we contacted the CCG and it was confirmed that no such directive had been given. Staff had received medication training and had their competency assessed. As part of this assessment process relating to the latter staff were required to complete a multiple-choice test paper of 20 questions. Although staff had completed this, not all answers marked as correct by the assessor were and this gave an inaccurate score. This showed that the registered

provider's arrangements to assess the competency of staff was not as robust as it should be and improvements were required.

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

People's comments about feeling safe were variable. Two people told us they felt safe, settled and relaxed. One relative told us about their member of family, "I feel they're in safe hands here, and they [staff] will ring me if there's any concerns." However, others referred to the lack of staff which led them to feel less safe than they otherwise would feel. One person told us, "They [registered provider] never have enough staff, they are always rushing, doesn't matter when, any day, any time, there's just not enough of them. If I press my alarm I reckon it's on average 10 to15 minutes I wait, sometimes a lot longer." A second person told us, "The staff are good, but there's not enough of them. If I want to go to the toilet I call them [staff], but I can wait for a long time. You press it once, get no response, so you press it again and again. When they [staff] come they're often very apologetic and say they've been with someone else." They further explained that one day after having pressed their call alarm facility and no staff responding, they had been incontinent and their clothes were soiled. They explained how embarrassed, uncomfortable and angry this had made them feel.

Whilst we spoke with one relative and their family member who resided at Whittingham House, we noticed a member of staff was sitting on a chair within the small communal lounge on the ground floor. The relative told us, "There's not normally a member of staff sitting in here, they [staff] might sit there briefly filling in some paperwork, but not for any length of time like this." The person using the service was asked how they would call for help if they needed to whilst sitting within this communal lounge. They told us, "There's an alarm behind me, but there's been a few times when I'd have liked to call for them [staff], but I can't reach it and I'm the nearest to it."

Staffing levels as told to us by the registered manager were being maintained and staff rosters confirmed this, however the deployment of staff was not always suitable to ensure there were sufficient staff available to meet people's needs and to support communal lounge areas. Observations on the first and second day of inspection showed there were occasions whereby communal lounge areas were left without staff support or staff presence for between 10 to 15 minutes. This potentially could place people at risk of harm or injury. On the second day of inspection no staff were present within one communal lounge for a period of 10 minutes and during this time one person was seen to slip from their chair but not quite reaching the floor. We immediately brought this to staffs' attention and support was provided to assist the person back onto the chair.

Suitable safeguarding arrangements were in place to keep people safe. Staff could demonstrate satisfactory understanding and awareness of the different types of abuse, how to respond appropriately where abuse was suspected and how to escalate any concerns about a person's safety to the registered manager and external agencies such as the Local Authority and Care Quality Commission. The registered manager was aware of their responsibility to notify us of any allegations or incidents of abuse at the earliest opportunity.

Staff recruitment records for three members of staff were viewed. Staff recruitment procedures were thorough and in line with the registered provider's policy and procedure. Relevant checks were carried out before a new member of staff started working at the service. These included processing applications, including a full employment history and exploring any gaps, obtaining written references, ensuring the applicant provided proof of their identity and undertaking a criminal record check with the Disclosure and Barring Service [DBS]. Prospective employee's equality and human rights characteristics were also recorded and considered when recruiting staff.

Appropriate arrangements were in place to manage the control and prevention of infection within the service. Staffs' practice was suitable, with the majority of staff following the service's policies and procedures to maintain a reasonable standard of cleanliness and hygiene within the service. Staff told us and records confirmed that the majority of staff received infection control training and understood their responsibilities for maintaining appropriate standards of cleanliness and hygiene; and following food safety guidance.

Requires Improvement

Is the service effective?

Our findings

Effective was rated as 'Requires Improvement' at our last inspection on the 5 and 7 February 2018. At this inspection, we found that effective remained 'Requires Improvement.'

The recruitment files for three newly appointed members of staff were viewed. Although newly employed staff at Whittingham House received an induction, these arrangements were not robust enough to meet staff members support requirements or to prepare staff for their role. Three separate induction documents which were designed to record the staff member's progress over a three-month period, were fully completed within 48 hours of their start date by either the registered manager or other senior staff members. One staff member confirmed all their induction documents were signed whilst in the office with the registered manager for approximately two to three hours. When asked if they had been observed undertaking the tasks listed on the induction forms, they told us, "No, we talked." When the registered manager was asked how and why the induction process was completed in such a short time when the documentation was intended to be achieved over a longer period, they responded by saying, "It was a very long day." Another member of staff who commenced employment in 2017 confirmed the above was common practice and none of the tasks listed within their induction were formally assessed.

Two out of three members of staff newly appointed did not have previous experience in a care setting. None of these staff had attained a National Vocational Qualification [NVQ] or qualification undertaken through the Qualification and Credit Framework [QCF] and had not commenced the 'Care Certificate' or an equivalent industry recognised induction. The registered manager confirmed this was accurate and the 'Care Certificate' was not being undertaken at this time but was planned to be rolled out across the organisation in 2019. The 'Care Certificate' is a set of standards that social care and health workers should adhere to in their daily working life.

A copy of the staff training plan was requested and provided. The staff training plan confirmed most staff employed at the service, had attained up-to-date mandatory training in line with the registered provider's expectations and this consisted of both 'face-to-face' and online training. However, the staff roster for one newly employed member of staff showed that following an initial three-day induction, of which two days were 12 hours long, the staff member undertook two further 12-hour shifts as part of the 'workforce' in their first week of employment, completing a total of over 54 hours. The staff member confirmed they had not received any training other than for manual handling and records verified what we were told.

Where staff had been promoted to a more senior role, they had not always received an appropriate induction. This referred specifically to a member of staff who was promoted to the role of trainee supervisor in March 2018. Additionally, they confirmed that they had received no training to supervise others. Staff told us they felt supported and received supervision at regular intervals. Staff confirmed that not all supervision sessions were conducted face-to-face and included observations of practice. Not all staff were aware if the supervisory sessions were recorded and staff confirmed they had not seen a copy of the information recorded.

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

People's comments about the quality of meals provided were variable. People told us they could have a cooked breakfast. Comments included, "The food's OK, but there's not a lot of choice" and, "Food was always very boring, there's a bit more variety now. Tea was always sandwiches, which I don't like, so now occasionally we have Cornish pasties, or something toasted." Observations showed in addition to sandwiches at teatime, people received a hot meal option.

At our previous inspection to the service in February 2018, the dining experience needed to be improved, particularly in the way this was organised. During both days of the inspection, people were taken into the dining room 30 to 40 minutes prior to the lunchtime meal being served. Although changes to the dining arrangements were made following that inspection, these arrangements had not been adopted and sustained. On the first day of inspection, we found that our previous concerns remained as people were once again taken into the dining room at 11.50, 50 minutes prior to the lunchtime meal being served at 12.40. Some people were observed to become restless and bored, getting up and walking around the dining room. One person was observed to make several attempts to try and move one of the heavy dining chairs and at another table an altercation took place between four people and this resulted with one person becoming distressed and anxious; and shouting whilst walking away and out of the dining room.

At 12.30 one person was observed to call out, "Is anyone there?" whilst sitting in the dining room. A member of staff was standing next to them, but walked away without providing a response or explanation. The person had a sensory impairment and when their lunchtime meal was provided, it was served on a standard plate with no plate guard. The person was noted to struggle to pick up food with the cutlery provided and some of their food spilled over the plate and onto the table. A plate guard is a flexible plastic surround that is fitted to ordinary plates to prevent food from falling off their plate and can be used as a barrier to push food against to load onto a spoon or fork.

In the large communal lounge area, three people had chosen to remain there rather than go to the dining room. At 13.05pm we had to remind staff that none of these people had received their lunchtime meal and were still waiting to eat. One person was given their meal but was not assisted to eat by staff until 10 minutes later. Staff were asked to check that the plated meal provided remained hot and palatable. Observations undertaken within another communal lounge demonstrated some people were kept waiting for their meals for extended periods and those who required support and assistance to eat did not receive continuity of care, as more than one member of staff provided support. We discussed our concerns relating to the dining experience with a senior member of staff. On the second day of inspection, we observed a more positive dining experience despite people being assisted to the dining room at 12.20pm, just 15 minutes before lunch was served. However, we remained concerned that this was only because the Care Quality Commission had provided feedback to the management team.

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

Several people told us a GP surgery was held at the service every Wednesday to check on people's wellbeing. People suggested to us their healthcare needs were met and they received appropriate support from staff. One person told us, "I had a bad lesion on my leg, I told them [staff] about it, and now the district nurse comes in every two days to check and dress it, it is improving now." Another person confirmed the GP came out recently to see them because they had developed a chest infection. However, prior to our inspection safeguarding concerns were raised about one person's significant weight loss over a three-month

period. A review of this person's records showed they had lost just over 10 kilograms in weight. The person's weight record had not been updated since September 2018, despite the person's care plan recording they should be weighed each month. There was no evidence to show a referral had been made to the GP or dietician to make sure this person's health and wellbeing was being monitored effectively. We discussed this with the management team but a rationale for this omission was not provided.

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 the mental capacity to make 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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation 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 demonstrated a basic knowledge and understanding of MCA and Deprivation of Liberty Safeguards (DoLS). Information available showed people living at Whittingham House had had their capacity to make decisions assessed. Nevertheless, not all assessments had been reviewed and a best interest assessment had not been completed for one person who had been assessed as requiring their medication to be administered covertly. Where people were deprived of their liberty, applications had been made to the Local Authority for DoLS assessments to be considered for approval and authorisation. Once approved the Care Quality Commission had been notified.

Requires Improvement

Is the service caring?

Our findings

Caring was rated as 'Requires Improvement' at our last inspection on the 5 and 7 February 2018. At this inspection, we found that caring remained 'Requires Improvement.'

Overall people and their relatives told us that staff cared for people in a considerate and kind way. This meant that people were generally satisfied and happy with the care and support they received from staff. One person told us, "It's brilliant here, everyone's very good, they treat me well." A second person told us, "Most staff are pretty good, they're quite caring people." Another person told us, "Most of the staff are friendly, they try to help as much as possible, but they just don't have the time." A relative confirmed to us they were happy with the care and support provided for their family member. They told us, "The staff are lovely to [relative], they couldn't be better. They are all full of hugs, they [relative] smile at them more than us, sometimes they ignore us and they [relative] are perfectly happy when we go. Most of them [staff] know [relative] well and understand them."

The above was inconsistent with our observations as most interactions by staff were task and routine led. This referred specifically to staff providing drinks, supporting people to eat their meals and assisting people with their personal care and comfort needs. There was an over reliance on the television despite people using the service being predominately either asleep or disengaged with their surroundings and not watching the television. Staff did not sit and talk with people for a meaningful length of time and staff interactions did not always ensure people got the support they needed. People who spent the majority of their time in their room told us staff did not have time to engage in any meaningful conversations with them, and spent most of their time on their own behind closed doors. One person told us, "The staff are good here, but there's not enough of them to have time for us."

Staffs' communication with people living at Whittingham House was not always appropriate. Although some members of staff engaged appropriately, others used raised voices to communicate with each other across the communal lounge and down hallways. Two members of staff were observed to provide manual handling support to one person. Whilst delivering this support neither member of staff spoke to them and did not gain their consent to undertake the task. Staff were also overheard to talk loudly and openly about people's comfort needs. For example, one person requested assistance from staff with their comfort needs. Another member of staff overheard this and stated loudly, "[Person using the service] has been to the toilet." This showed staff did not understand the need and importance of maintaining people's dignity and respect.

People's independence was promoted and encouraged according to their capabilities and abilities. People told us they could manage some aspects of their personal care with limited staff support. They also confirmed if they needed assistance this would be provided. Many people were observed to eat and drink independently.

People were supported to maintain relationships with others. People's relatives and those acting on their behalf visited at any time. Relatives confirmed there were no restrictions when they visited and they were always made to feel welcome.

Requires Improvement

Is the service responsive?

Our findings

Responsive was rated as 'Requires Improvement' at our last inspection on the 5 and 7 February 2018. At this inspection, we found that responsive remained 'Requires Improvement.'

On the first day of inspection one person was observed and overheard on three separate occasions from 14.35pm to shout out. Although two members of staff were near, neither member of staff approached the person to find out what they wanted, they were then observed to walk away. The person using the service continued to shout to gain staffs attention and it was evident they wished to have their comfort needs met. A senior member of staff approached and told them they would go and get another staff member to assist them. During this time a further three members of staff walked past them whilst they continued to call out without offering any support or comfort. The senior member of staff came back with another member of staff at 15.00pm but by this time the person was distressed as they were swearing and crying.

On the second day of inspection the same person was overheard at 8.50am to request their comfort needs to be met. No staff acknowledged this request, but at 9.10am a wheelchair was brought in; however, the person was told by a member of staff that they needed to wait for their colleague to become free. At 9.30am, the person was assisted to have their comfort needs met, 40 minutes after their initial request. This demonstrated not all people using the service received person-centred care that was responsive.

People's comments about social activities provided at the service were not favourable. One person told us, "I'd like a buddy here, but 95% of people have got dementia. I feel very lonely. I get depressed and watching TV gets on my wick. I used to read, but I've got no books here, at least when I'm in hospital there's always stuff going on, but nothing goes on here." When we left this person's room we noted a shelf of books in the corridor. We suggested to this person about staff introducing them to another person living at Whittingham House who had similar interests. They told us, "Nobody's thought of that, I don't think, but I would like it if they [staff] could find someone." The person's care plan dated August 2018 recorded the person as having no hobbies other than they enjoyed watching television. This had not been reviewed or updated to confirm if further discussions had been undertaken to ascertain their social care needs and how they wished to spend their time. Another person when asked about activities at the service replied, "Most of us find it boring here, you can't occupy your mind. They [staff] think if the television's on, then everyone's okay, I'd like more games, I'd like to go outside." Relatives confirmed there were insufficient social stimulus for people other than the occasional external entertainer.

There was no activities coordinator in post at the service at the time of the inspection. The registered manager confirmed the service had been without an activities coordinator for over three months. It was their expectation that all care staff were responsible for facilitating activities until an appropriate person was recruited and appointed. Observations during the inspection showed limited opportunities were provided for people to participate in meaningful social activities and there was an over reliance on the television in one communal lounge and music within another. On the first day of inspection the activities programme recorded tea and cake would be provided at 10.30 and 14.30 within the service's café. A professional's meeting was held in the morning in the café and consequently this activity did not take place but occurred

in the afternoon. This was very well attended by people using the service and their relatives.

Care plans did not always fully reflect people's holistic care and support needs or provide sufficient guidance for staff as to how these were to be met. Improvements were needed to ensure care plans included accurate information relating to a person's specific care needs and the delivery of care to be provided by staff. For example, the care records for one person showed they were admitted to the service in August 2018. Although an 'Assessment of Need' was recorded detailing the person's identified care and support needs, this provided insufficient detail relating to their individual care needs and the delivery of care to be provided by staff. In addition, only three specific care plans relating to personal care, nutrition/hydration and continence were completed. Healthcare professional records demonstrated the person had two pressure ulcers but no care plan relating to their skin integrity, how this was to be monitored and the care interventions to be provided were recorded. The 'Assessment of Need' highlighted that the person was unable to weight-bear and our observations during the inspection confirmed this as accurate. However, a manual handling assessment was not completed detailing the support required for specific tasks, equipment type and size and number of staff required for each task. The above demonstrated you did not have appropriate arrangements in place to ensure care plans accurately reflected people's care and support needs. This was not an isolated case and other care plans viewed were incomplete.

The registered manager told us there were two people using the service that were judged as requiring end of life care. Neither person had an end of life care plan in place to identify if the person has expressed a wish to be cared for at the service or to go to hospital and if potential treatment options have been discussed with the person's GP or relevant healthcare professionals. No information was recorded relating to pain management arrangements and how the person's end of life care symptoms was to be managed to maintain the person's quality of life as much as possible. Although there was no evidence available to suggest either person was not receiving appropriate end of life care, not all staff had received end of life care training.

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

The service had a complaints procedure in place for people to use if they had a concern or were not happy with the service. People told us they would speak to their relative, staff or the registered manager if they had any concerns. Records showed there had been five complaints since our last inspection in February 2018. A record was available detailing the specific nature of each complaint, however there was a lack of evidence to show if a thorough investigation had been completed, actions taken and outcomes. Not all complaints had been acknowledged by the registered manager in line with the registered provider's complaint policy and procedure. A record of compliments was maintained detailing the service's achievements.

A record of compliments was maintained to evidence the service's achievements.

Inadequate

Is the service well-led?

Our findings

Well-led was rated as 'Inadequate' at our last inspection on the 5 and 7 February 2018. At this inspection, we found that well-led remained 'Inadequate' and therefore remained in 'special measures.' This is where the standard of care falls below this standard and is judged to be 'inadequate,' services enter 'special measures'.

Since our last inspection to the service in February 2018, the management arrangements at Whittingham House had not changed, except for the role of deputy manager. The registered manager confirmed that the service's deputy manager had been successfully appointed to manage one of the registered provider's 'sister' service's. The registered manager confirmed that a new deputy manager had been appointed but had not yet commenced in post as recruitment checks were still being undertaken.

There were inadequate arrangements in place to effectively monitor the quality of the service, ensure that the service was operating safely, and lessons learned when things go wrong. It was apparent from our inspection that the lack of robust quality monitoring and auditing was not as effective as it should be to recognise breaches or potential breaches with regulatory requirements. Although there were many audits and checks in place which were completed at regular intervals these checks had failed to identify and address the concerns found as part of this inspection. None of the audits or quality monitoring reports provided by the registered manager had picked up issues relating to medication and the lack of robust arrangements relating to staff inductions and training for staff newly employed at the service.

The standard of record keeping was inconsistent and not being effectively audited and monitored to ensure this improved. At previous inspections of Whittingham House between November 2016 and February 2018, we identified not all people's care plans were sufficiently detailed, accurate or fully reflective of people's needs. Following the inspection in February 2018 an internal quality assurance report dated June 2018, confirmed a new care planning format was to be introduced at the service.

A quality assurance review was also undertaken by an external consultant in July 2018 as part of the organisations on-going quality assurance processes and was a follow-up to the visit undertaken in January 2018. This report confirmed care plans were not reflective of people's needs and did not show how care was to be delivered by staff, including no evidence of robust care plans for people judged to be at the end of their life. Internal quality assurance reports completed in July 2018, August 2018 and November 2018, made little comment relating to the service's care planning arrangements and progress made to ensure compliance with regulatory requirements.

At this inspection we found the required improvements had not been made and this included the arrangements to identify and mitigate risks to people's safety and wellbeing. Following discussions with the management team, it was apparent they were unaware that the above required significant improvement and appeared somewhat surprised when presented with the evidence during the inspection feedback.

The culture of the service was not positive and systems in place did not always promote a 'person-centred'

culture that centred on people's needs or valued them as individuals. The care and support delivered by staff was not consistent to ensure people received safe care and support. Previous inspections between November 2016 and February 2018 failed to effectively measure the experience of people being supported and cared for at Whittingham House. This meant there was a lack of oversight based on observations of actual care being provided by staff and being experienced by people living at the service.

Staff practices were not monitored to ensure people received safe care, were always treated with respect and dignity and ensuring care provided was 'person-led' rather than 'service-led.' Staff employed in a senior role were not effective role models as they failed to provide clear direction and support to staff to enable them to undertake their responsibilities to a good standard. For example, at this inspection the dining experience continued to require improvement, particularly in the way this was organised. This was despite the inspections in July 2017 and February 2018 highlighting the dining experience was not a positive experience for people using the service. Despite identifying issues around activities at the inspections in July 2017 and February 2018, at this inspection, people continued to have little opportunity to participate in meaningful activities and this impacted on people using the service.

It was not always evident from the service's safety certificates and internal checks and reports relating to the premises, if adequate actions had been completed to ensure issues highlighted were resolved and monitored. Where equipment was faulty or required repair, we were not assured that all necessary steps were being undertaken to resolve these in a timely manner. For example, we observed that one person's bed did not support the person to sit up for them to take their medication safely, as the mechanism on the bed to enable it to be repositioned did not work. The person using the service confirmed at the time of the inspection that it had not been working for at least a week and this was impacting on their quality of life. Specifically, they were unable to sit up to receive their medication, food and drink safely. The service's maintenance log detailed the person's bed was not working on 14 November 2018. This was discussed with the registered manager and they told us a new part for the bed had been ordered on 19 November 2018 and were waiting for this to be delivered. We asked the registered manager to provide proof of this, but they were unable to do this. The person using the service received a replacement bed 14 days after it was first recorded as not working.

We asked the registered manager as to the formal support they received. The registered manager confirmed they had regular contact with the registered provider and had received two formal supervisions since our last inspection to the service in February 2018. This was concerning given the service's overall quality rating of 'Requires Improvement,' the service remaining in 'Special Measures' and continued scrutiny from the Local Authority. Additionally, the registered manager confirmed that since our last inspection in February 2018 they had been appointed a new 'line manager.'

Staff meetings had been held to give the management team and staff the opportunity to express their views and opinions on the day-to-day running of the service. Minutes of the meetings confirmed this and although a record had been maintained, where matters were highlighted for action or monitoring, it was not possible to determine how these were to be or had been monitored and the issues addressed. For example, one staff meeting raised concerns that staff were not interacting with people who used the service and staff response times to people's call alarms required improvement. No information was recorded how this should be monitored and the issues addressed. Meetings for people's relatives were held and this was confirmed as accurate. However, minor concerns were raised that individual issues relating to specific people using the service and/or their relatives were discussed and it was felt this was not the most appropriate forum.

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

People told us that the registered manager was approachable. One person told us, "He's a nice guy, he's around a lot." Another person told us that they had raised a concern with the registered manager and felt they had been listened to. They stated, "I do think he'd always listen to us."

People using the service and their relatives had been given the opportunity to complete an annual satisfaction survey for 2018. The report confirmed 13 completed questionnaires were analysed, with five undertaken by people using the service and eight completed by people's relative's or those acting on their behalf. The report included a sample of comments made and a summary of the findings. Overall this highlighted most responses were positive. An action plan was completed with a completion date of 30 November 2018 and 7 December 2018.