West House

West House - 2a Waterloo Street

Inspection report

2a Waterloo Street
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Ratings

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

Overall summary

We carried out an unannounced inspection on the 12th and 13th February 2015. We last inspected the service on the 30th June 2013 and we found the home was complaint with the regulations.

2a Waterloo Street is a care home for ten people who live with a learning disability, some of whom also have support needs associated with older age. The home is an old church building adapted for its current use as a care home and it is situated just off the main street in the town of Cockermouth. Accommodation is provided on two floors and there is a stair lift to help people to access the first floor. The home has a range of equipment suitable to meet the needs of people living there. On our visit there were nine people living at the home, and another person was due to move in.

West House, a local not for profit organisation, is the provider who runs the home.

There was a new manager employed at the home and they had applied to be the registered manager of the service. A registered manager is a person who has

Summary of findings

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.

Everyone we spoke with told us people were safe and well cared for in this home. This included people who lived in the home, their relatives and professionals visiting the home.

People who lived in the home knew how they could raise a concern about their safety or the quality of the service they received.

Though people we spoke with told us that they felt safe, we judged that staffing numbers were unsafe. A number of people's care support needs required two members of staff, while at least four other people required increased supervision to keep them safe. At times there were only three staff on duty and two of these were based downstairs; and all staff had to undertake care, cleaning, laundry and cooking duties. This meant there were insufficient staff to meet people's needs and to keep them safe.

We found that a number of people who had recently moved into the home had not been assessed thoroughly enough to ensure the home could fully meet their current and future needs. We found that this impacted across most of the areas we looked at.

We found that not all areas of risk had been assessed particularly when a person's condition had changed. For example a person's mental health need required a risk assessment of how to respond quickly to a change in their health and this was not in place.

Staff told us that while they had a lot of training from the organisation they did not feel as confident and as qualified to support those people with more specialist areas of behaviours that challenge, dementia care and mental health needs.

We found that staff did not have the training and expertise to meet some people's needs and the environment had not been adequately adapted to meet these needs.

We found examples where staff had failed to report incidents that were potentially forms of abuse. This included reporting these to adult social care as safeguarding alerts for further investigation.

We found that the provider had not properly trained their staff in understanding how the requirements of the Mental Capacity Act 2005 impacted on the people in the home.

People were provided with meals and drinks that they enjoyed. We found that people's nutritional needs were not routinely assessed on arrival to the home and then monitored from time to time

People in the home had regular access to health care. They went out to health appointments and there was evidence of good measures in place to prevent ill health.

The home was caring. We saw examples during our visit of people being treated with dignity, respect and care. There were affectionate and caring relationships between the care staff in the home and the people who lived there. The staff knew how people communicated and gave people the time they needed to make choices about their lives and to communicate their decisions.

People had limited access to developing occupational skills, being involved in activities and to engage with their local community. This was especially the case for people with a limited mobility.

There was no restriction on when people could visit the home. People were able to see their friends and families when they wanted.

The service was not well-led. The recently appointed manager had begun to make improvements in some areas but we found the organisation was slow to respond. The way the service was managed did not always identify risk, and when risk was identified it was not always acted upon.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of this report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was not safe.

There were insufficient staff to meet people's needs and to keep them safe.

We found that risk assessments were not robust enough to protect people.

Requires Improvement

Is the service effective?
The service was not effective.

Staff did not have all the skills, expertise or links with external organisations for specific guidance and training linked to best practice. Staff lacked knowledge of the Mental Capacity Act 2005.

The home was not suitably adapted to meet the needs of the people who lived in the home.

Requires Improvement

Is the service caring?
The service was caring.

People received the support from staff who they knew and who treated them with kindness and respect.

The staff spent time with people and understood that this was an essential part of caring for people. There were warm and positive relationships between staff and people in the home.

People could see their families and friends when they wanted to and could maintain relationships that were important to them. Staff went out of their way to be welcoming to visitors and to support people to maintain relationships.

Good

Is the service responsive?
The service was not responsive.

Care was not always planned and delivered in a way that met people's needs and ensured their welfare.

Some information in people's care records was not accurate and action was not always taken promptly when a person's needs changed.

People were at risk of becoming socially isolated. People had limited access to developing occupational skills, being involved in activities and to engage with their local community.

Requires Improvement

Is the service well-led?
This service was not well-led.

Some issues highlighted during the inspection had not been identified through the internal or external quality audits.

Requires Improvement

Summary of findings

People were asked for their views of the home but their comments were not always acted upon in a timely way.

There was a manager employed. The manager had applied to the Care Quality Commission to be registered.

West House - 2a Waterloo Street

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked whether the provider was 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 over two days, Thursday 12 and Friday 13 February 2015. This was an unannounced inspection which meant the staff and provider did not know we would be visiting. The inspection was carried out by one adult social care inspector.

During the visit, we spoke with nine of the people who lived at the home, one visiting relative, five care staff, and the manager. We spoke with a visiting healthcare professional. We observed the way people were cared for and the interactions with staff. We looked at three care files in detail, which included checking medication handling and records. We also looked at the home's statement of purpose and a sample of training and induction records for staff employed at the home.

We checked the information we hold on the service and the service provider prior to our visit, this included notifications the home must send to us under the Health and Social Care Act 2008. We also spoke to social workers from the local authority and to staff from the local health commissioning team. No concerns had been raised since we completed our last inspection.

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Requires Improvement

Is the service safe?

Our findings

People who were able to communicate told us that they felt safe living in this home. People told us that they would speak to a member of staff if they had any concerns about their safety or about how the staff treated them. People who lived in the home, and the visitors we spoke with, told us that they had never heard or seen anything that concerned them and said that all the staff treated them well.

All the staff we spoke with told us that they felt there were enough staff to meet people's needs but did say that it was sometimes difficult to keep an eye on everyone. We found that on the upstairs unit that at times there was only one member of staff on duty and some people had conditions that meant they could be confused, prone to wandering or exhibit unpredictable behaviour. The layout of the building, and when there was only one staff member available for this upstairs unit, meant that meeting people's needs safely could not always be guaranteed. For example, we saw in people's notes that one person had managed to get downstairs when it was recorded it was unsafe for them to do so without staff support.

We found that the registered person had not taken appropriate steps to ensure that, at all times, there were sufficient numbers of suitably qualified, skilled and experienced staff to meet peoples needs . This was in breach of regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at how medicines were stored and handled in the home. We saw that medication was stored securely to prevent it being misused. All the staff who handled medicines had received training to ensure they could do this safely. While the majority of people received their medicines as they had been prescribed by their doctor, we found one medicine prescribed to be given an hour before or two hours after food was given with breakfast. We pointed this out to the manager who said she would ensure it was given at the correct time. She said that this type of issue would normally be picked up on monthly medicines audits.

We saw good details on the side effects to watch for but not the reasons why the person was taking the medication or what its purpose was. We saw that people were having their medication regularly reviewed by a doctor to ensure that it was correct and some people had had their medication reduced to ensure that they were not over sedated.

We recommend that the service consider current guidance on medicines so that staff have clearer instructions on their use, and take action to update their practice accordingly.

All the staff we spoke with told us that they had completed training in how to recognise and report abuse. They all said that they had never had any concerns about how people were cared for or protected from harm in the home. The new manager reported that the organisation had recently had a renewed emphasis on promoting safeguarding within its services.

However, we did find examples where staff had either not recognised or failed to report incidents that were potentially forms of abuse. These incidents were mainly between people living in the home having altercations. We could see from reading notes, talking to staff and people living in the home that some measures had been put in place to keep people safe but opportunities had been missed to refer incidents and behaviours to outside agencies for additional support. This included reporting these under the local safeguarding protocols to the Local Authority as safeguarding alerts for further investigation.

We recommended that the provider re-enforce staff understanding of what constitutes abuse and makes clear the actions staff should take to protect people.

We saw examples of how the home managed risks. Records demonstrated that some risks had been assessed and measures had been put in place to reduce the identified risk. For example, some people had been assessed as being at risk of developing pressure areas. We saw how personal care had been planned to reduce the risk of people developing a pressure area and to promote good skin care. However, not all areas of risk had been assessed particularly when a person's condition had changed. For example a person's mental health care need required a risk assessment of how to respond quickly to a change in their health and this was not in place.

We checked how the home responded to emergencies. The registered provider had plans in place to deal with

Requires Improvement

Is the service safe?

foreseeable emergencies in the home. Emergency plans were in place for staff to follow, including in the event of a fire or flood. The staff we spoke with told us that they had regular training in the actions they needed to take if there was a fire. This meant the staff knew, and had experience of, how to protect people if there was an emergency in the home.

We saw records that showed that the equipment in the home was serviced and maintained regularly to ensure that it was safe to use. The training given to staff and the regular maintenance of equipment ensured that people who lived in the home were protected against the unsafe use of equipment. The manager was a qualified moving and handling assessor and staff told us that they had to complete training before they were allowed to use equipment to assist people.

The registered provider used safe systems when new staff were employed. All new staff had to provide proof of their identity and have a Disclosure and Barring Service check to show that they had no criminal convictions which made them unsuitable to work in a care service. We saw that the organisation had policies in place to manage staff disciplinary and competency issues. This meant people could be confident that the staff who worked in the home had been checked and continued to be monitored to make sure they were suitable to work with vulnerable people.

Requires Improvement

Is the service effective?

Our findings

We were told by the manager that the home was intended for older people who had a learning disability. This also included issues related to old age such as limited mobility or health care. This was set out in the home's statement of purpose guide. We looked at the assessed needs of people who had come to live in the home over the last year. We found that these people had been assessed on referral as having dementia as well as a learning disability, and one person had support needs arising out of a mental health condition. We were also told that some people in the home required help to manage behaviours that could at times be challenging to the service and other people.

Staff told us that whilst they had a lot of training from the organisation they did not feel as confident and as qualified in the more specialist areas of behaviours that challenge, dementia care and mental health needs. One staff member told us that they had training to manage behaviours that challenge while working in another of the organisations services. They told us that while behaviours that challenge were at a much lower level here at Waterloo Street they thought it would be very helpful to their role and felt that other staff would also benefit from it.

We found that the registered person had not taken appropriate steps to ensure that staff had the skills, expertise and training to meet people's assessed needs. This was in breach of regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 18(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked the manager about her understanding of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLs). She said she had received some training in this area but felt that she needed more support in understanding how it should be applied in the home. We saw that people who lived in the home had some restrictions placed on them. For example people did not leave the home without staff accompanying them, and we observed a gate that prevented people from going downstairs. This is a restrictive practice and was in place in order to protect and ensure peoples' safety and wellbeing. The home's operations manager was undertaking a piece of work with the manager to identify and then apply for DoLs for those people in the home who potentially had their liberty restricted. We saw that contact had been made with the DoLs assessor from the local authority and the issue of the gate will be discussed.

When we looked at people's care files we saw that in some files people's capacity had not recently been assessed and documented, and on other files there was no assessment or mention of capacity. This is the first step of the Mental Capacity Act Code of Practice and sets out how to ensure that the rights of people who cannot not make their own decisions were protected.

We saw that the legal status of people was not clearly documented and it was difficult to tell who had control over people's affairs and who could make important decisions for them. We did not see any evidence to confirm that family and friends had the legal right to give consent or make decisions on behalf of people who used the service. When we asked staff about this matter, they were unsure about this too.

We found that the registered person had not ensured sufficient measures were in place to protect people's rights and to gain, wherever possible, their informed consent . This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We checked to see how people were supported to eat and drink enough and maintain a balanced diet. People told us that they enjoyed the meals provided. People said they had a choice of meals and that they could have a hot or cold drink whenever they wanted one. People's weights were regularly monitored. This helped staff to identify the need to involve healthcare professionals such as the dietician or speech and language therapist in a timely manner. Some people needed support through prompting from staff to eat. We saw that this was provided in a patient and discreet way.

However, for people with more complex issues affecting their diet such as diabetes. Care plans and risk assessments were not recorded in sufficient detail to give staff clear instructions on how to manage these conditions. We found that people's nutritional needs were not routinely assessed on arrival to the home and then

monitored from time to time. The home was not using a recognised nutritional assessment tool. There were some references in files to nutritional needs but no nutritional plans in place for any of the people in the home.

We recommend that the home use a national nutritional assessment tool and set out peoples nutritional needs in more detail with the support from a dietician where necessary.

We saw that some elements of the MCA 2005 had been used in the home. We did see that people had access to advocates and advocacy services. We saw that advocacy services had been arranged for one person who did not have the support of friends or relatives to help them to make decisions or to express their wishes about their care. The home had arranged for the person to be supported by an Independent Mental Capacity Advocate, (IMCA). An IMCA is a person who is not connected with the home but who is trained to support people who are not able to make major decisions themselves and who have no family or friends to represent them. The IMCA's role is to ensure that a person's rights are protected when major decisions have to be taken.

All the staff said they felt well supported by the manager and registered provider. They said they had formal supervision meetings where their practice was discussed and where they could raise any concerns. We saw staff had effective ways to communicate, for example through daily diaries, communication books and we listened to an informative staff hand-over. We looked at the record of training provided in 2014/15. We saw that staff had received suitable basic training in the core subjects identified by the organisation to meet the needs of people with a learning disability.

Good

Is the service caring?

Our findings

People told us: “Staff are lovely” “I love the staff” “The staff take me places I like to go, they know the things I love to do”.

We observed warm, positive and relaxed interactions between staff and people who lived in the home. People who had little or no verbal communication showed positive reactions when staff approached them and clearly enjoyed the time they spent with staff.

We heard from visiting relatives and professionals that they always observed caring interactions. They said that the staff were professional but caring and kind. One person said, “I can come whenever I like and every time everyone has been happy. Staff are really caring and always make me welcome.” Staff and people living in the home were genuinely affectionate towards each other. There were visible displays of warmth and affection. Staff used humour appropriately and we saw that they treated people with respect and dignity.

We had evidence to show that staff in the home understood people's needs and treated them as individuals. We also saw that the staff team understood issues around equality and diversity. Staff reported that they had attended a recent course on dignity which had covered topics of human rights and discrimination and they had found it helpful in their role. They were able to talk to us about how they involved people in decision-making and about their individual rights, preferences and needs. For example we saw that people were supported to express their personalities and interests. This was demonstrated in the way they had their bedrooms decorated.

A visiting nurse commented that people always looked very well cared for and the staff made sure people dressed in their own style, saying, “Some of the ladies like to wear make-up, jewellery and scarfs. I think this is nice as sometimes it’s these small things that show they care.” They also reported that staff always accompanied a person when they went into hospital and would visit frequently to ensure support, continuity and reassurance for the person. One member of staff said, “We wouldn’t dream of not visiting someone in hospital, and we take it in turns to go and care for them.”

People told us that the staff encouraged them to maintain their independence and to carry out tasks for themselves. One person told us, “I like to do things for myself. I think I’m a big help to the staff. I always find things to do.” We saw that the staff gave people time and encouragement to carry out tasks themselves. This helped to maintain people’s independence and promote their self-worth.

We also saw that people were given privacy when they needed support with personal care or with eating. Staff worked discreetly and supported people to be as dignified as possible even if they needed a lot of help and support.

During our inspection we found that the home was clean and free from odours. This helped to ensure people’s dignity was maintained. We saw that staff took a real pride in making sure the home was not only clean and tidy but also that it was decorated and furnished to high standards.

Staff took the time and went to considerable effort to help each person to personalise their rooms.

Requires Improvement

Is the service responsive?

Our findings

On checking people's files, talking to staff and observing how people's care was delivered we found that some aspects of this service were not responsive to people's needs. Care was not always planned and delivered in a way that met people's needs and ensured their welfare.

The initial assessments of people referred to the home did not explore in enough detail whether their assessed needs could be met by the home. This had led to the home not being able to respond effectively to people's needs. For example people living with dementia were not receiving support from staff qualified or skilled in delivering this more specialised care. We saw that some people's abilities were deteriorating and staff were unsure of how to intervene. There had been no referrals to other health and social care professionals for support in managing this deterioration.

The care plans we looked at for people with behaviours that maybe more challenging were not in enough detail to give staff step by step instructions on what triggers to look for and how to de-escalate and to intervene to manage a situation. It would be good practice for people that had a mental health care need to have a crisis intervention plan to identify when a person was becoming unwell or unstable with details of how to manage this safely. There had been no recent contact with mental health services and staff had little knowledge of this person's mental health need.

We found that the registered person had not protected people against the risk of receiving care or treatment that was unsafe or inappropriate by means of thorough care plans based on people's assessed needs. This was in breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 9(3)(b)-(h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We spent time discussing people's leisure, social and occupational opportunities. People's day to day experiences seemed to differ. Some people went out less than others. No one was able to go out without staff supervision or support. Two people used wheelchairs all the time, and a further three used a wheelchair just for going out. Staff said that those people requiring a wheelchair went out the least.

We did see that some people were supported to maintain hobbies and interests within the home, such as knitting, jigsaw puzzles and puzzle books. However, we did not see, and staff said they did not use, any specific activities for people living with dementia or with limited communication. There was no use of computers, IT, music therapy or sensory activities for people with dementia. We asked if 'skype' or similar technology was used to help people keep in touch with family or friends. We were told that it wasn't and some staff said that they weren't very good on computers themselves. Over the two days we spent in the home we saw that people's main activity was to watch TV.

We were told that most days three care staff were on duty, with the manager working weekdays. A new shift had been added recently from 7am-3pm "for extra care downstairs and for going out". Staff told us that two staff worked downstairs with five people and one staff upstairs for four people, soon to be five when a new person moves in. We were told that one person upstairs needed close supervision and could not be left alone. Staff also reported that people in the home had increasingly complex health conditions and therefore had frequent visits to GPs, clinics and hospitals etc.

People's opportunities for stimulation both within the home and for going out where becoming increasingly more limited. People living in the home interacted mostly with the staff and looked forward to staff coming on duty to have a chat and to socialise.

People said; "I don't do as much now. I watch TV and I play my CDs." and "We have to have enough staff on duty to go out and we haven't got a car now. I used to like swimming and the horses but I haven't been for ages." This person said a manager from the 'office' came to take them to work on computers occasionally but they would like to do it more often. Another said, "We walk into town for coffee and for lunch with staff. I love shopping." One person walked into town every morning with staff for a newspaper. Another person said "No I don't go to work or a day centre. Sometimes I go out to a café." There was limited evidence to show that people had been given sufficient opportunity to participate in occupational skills or to demonstrate how they were involved in activities and engagement with their local community. People were at risk of becoming socially isolated.

Requires Improvement

Is the service responsive?

The full extent of people's independence and ability to do tasks and meaningful activities for themselves was not always explored to the full. For example staff prepared and cooked all the meals, and made the majority of snacks and drinks. There was a lack of setting personalised goals for people to promote their independence skills. Staff reported that this was due to staffing levels and at quieter times they may do cooking or baking with people as an activity.

We found that the registered person had not ensured that suitable arrangements were in place to provide appropriate encouragement and support to people in relation to promoting their autonomy, independence and community involvement. This was in breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at how people received care that was personalised and responsive to their needs. We saw that everyone in the home had three types of files. One that gave staff instructions on how to meet peoples care needs. These files included assessments of need, risk assessments and care plans. People also had a separate file called a person-centred planning (PCP) file. These were held in each person's bedroom and were written or displayed in an easy to read style and showed people's strengths, life story's and social networks and activities they liked to do. One person in the home was keen to show this file which contained holiday photos, pamphlets of concerts and shows they had been to with support from staff in the home.

The third file was specifically to detail people's healthcare needs. It contained important information that would be needed to transfer to other services, such as a person being admitted to hospital. This particular section was termed a "Health Passport."

We spoke with the district nursing team who told us the home was good at identifying risk to peoples' health at an early stage and therefore preventing avoidable deterioration in people's health. We saw that two people had been advised that they needed to spend some time each day on their bed. We observed these and other prevention measures, such as the use of equipment, were in place. The risk had been discussed with people and they had been included in agreeing to the planned care to manage the risk and ensure that they received effective care.

The service promoted person-centred care and individuality.

All of the people we spoke with said that they could tell staff if they felt ill and that they would ring for the doctor. We saw from care records that people had access to a range of health professionals. They attended regular check-ups with their dentist, chiropodist, optician and doctor when required. People also had support from the community nurses who supported the home in managing more complex healthcare conditions. We checked to see how people's individual needs were met by the adaptation, design and decoration of the service. We saw the home had aids and adaptations such as an assisted bath, hoists and moving and handling aids to meet people's physical personal care needs. The upper floor had a stair lift for people who have restricted mobility. The home had recently accommodated people who were living with dementia and one of whom had mobility problems on the upstairs unit. The manager said that so far no additional adaptations to the home had been made for these people.

We saw that a person, who staff also described as being increasingly confused, had closed the toilet door without putting the light on. They had become upset and distressed. The home had no environmental aids, such as signage, automatic lights, or equipment to help people living with dementia be orientated with their surroundings. We discussed with the manager the need to assess and further adapt the environment to accommodate people's assessed and changing needs.

We recommend that the service research and develop a dementia care strategy for the service. This would include adaptations to the environment, training for staff, and ways of working with people based on current best practice in relation to the specialist needs of people living with dementia and a learning disability.

The staff on duty showed they knew the procedure people could use to make a formal complaint. They said they would be confident supporting people to make a formal

Requires Improvement

Is the service responsive?

complaint if they needed to do so. We had not received any concerns or complaints about the service. The provider had not received any complaints but had systems in place for dealing with these.

Requires Improvement

Is the service well-led?

Our findings

We looked at how the service promoted a positive culture that was person-centred, open and inclusive. We saw that the registered provider used a range of methods to monitor the safety and quality of the service. An audit manager in the organisation carried out unannounced visits to the home. Regular checks were carried out to ensure the safety of the environment and the equipment used in the home. A monthly inspection was carried out with an accompanying action plans from these visits. These audits were mostly around the environment and the running of the service. We did not see any evidence of how people living in the home were involved in the way the home was run or managed.

The staff said they were confident that people were well looked after in the home. They said they had never identified a concern about the behaviour or performance of any other staff member. They said they were encouraged to report any concerns and were confident that action would be taken if they did so. One staff member told us, "I've never had any concerns, but I'd speak up if I saw something I thought wasn't right".

All the staff we spoke with told us they thought the home was well managed. They told us that they felt well supported by the manager and said that they enjoyed working in the home. One member of staff told us, "West House is a good organisation to work for; we get plenty of training and the opportunity to take part in groups and meetings."

The way the service was managed did not always identify risk, and when risk was identified it was not always acted upon. We raised the risks of people not receiving safe and effective care with the manager due to lack of training, expertise, care plans and the environment. These had not been identified by the homes auditing systems. The issue of the unsafe stairway had been identified by the home as a risk but only very rudimentary measures had been taken to keep people safe. Staff reported that they sometimes put clothing draped over the gate in an attempt to disguise it and baffle the person.

We found that when unmet needs of people had been identified the organisation was slow to respond. For example the problem of accessing the community with an adapted car. The manager said that the lack of transport had been flagged up to the organisation sometime ago and options were being explored but in the meantime people were not going out as often as they would like to.

The manager had been in post for approximately three months when we inspected the service and had submitted an application to become registered with Care Quality Commission. In the change over between managers we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. However, the organisation did not return a PIR and we asked them to ensure that they improved how managers emails were managed once they had left the home.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care The registered provider had not taken proper steps to ensure that accurate needs assessments were carried out or that care was planned and delivered to meet people's needs and to ensure their welfare.

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 made suitable arrangements to provide appropriate encouragement and support to people in relation to promoting their autonomy, independence and community involvement.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing People who use services were not protected against the risks associated with inadequate staffing levels because staffing levels did not always meet the levels of dependency in the service. Staff did not have all the skills, expertise and training to meet peoples assessed needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent People could not be confident that their rights were protected because the Mental Capacity Act 2005 Code of

This section is primarily information for the provider

Action we have told the provider to take

practice had not been followed when people were not able to make their own decisions about their care. The provider did not have robust systems in place to ensure that decisions about people's care were made by those who had the legal right to do so or that they were made in the individual's best interests.