B Gelfand

West House

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

We carried out an unannounced comprehensive inspection of this service on 28 and 29 September 2016 and 6 October 2016 and found breaches with regulatory requirements. As a result of our concerns we served a warning notice on 7 November 2016. The date for compliance to be achieved was 5 December 2016. The provider shared with us their action plan on 28 November 2016. This provided detail on their progress to meet regulatory requirements. We found at this inspection the warning notice had not been fully achieved and the provider had not made all of the improvements they told us they would make.

West House provides accommodation and personal care for up to 26 older people and older people living with dementia. The inspection was completed on 12, 13 and 16 January 2017 and was unannounced. There were 25 people living at the service when we inspected.

The overall rating for this provider is 'Inadequate'. This means that it has been placed into 'Special measures' by the Care Quality Commission. The purpose of special measures is to:

- Ensure that providers found to be providing inadequate care significantly improve.
- Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.
- Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.

Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains 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 the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will be kept under review and if needed could be escalated to urgent enforcement action.

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

There was a lack of provider and managerial oversight of the service. Quality assurance checks and audits carried out by the provider and Customer Services Manager were not robust, as they did not identify the issues we identified during our inspection and had not identified where people were placed at risk of harm or where their health and wellbeing was compromised.

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.

Staff newly employed at the service had not received a robust induction. Suitable arrangements were still needed to ensure that all staff received regular formal supervision and an annual appraisal of their overall performance. Improvements were required in relation to the provider's recruitment procedures so as to safeguard people using the service.

People and their relatives were not fully involved in the assessment and planning of people's care.
Not all of a person's care and support needs had been identified, documented or reviewed to ensure these were accurate and up-to-date. Improvements were required to ensure that the care plans for people who could be anxious or distressed, considered the reasons for people becoming anxious and the steps staff should take to comfort and reassure them. Improvements were needed in the way the service and staff supported people to lead meaningful lives and to participate in social activities of their choice and ability, particularly for people living with dementia.

Although staff had a good understanding of safeguarding procedures not all staff had received safeguarding training. Robust procedures and processes that make sure people and others are protected had not been considered and followed.

Improvements were needed to ensure people using the service were treated with respect and dignity. Not all people who used the service had had their capacity to make decisions assessed. Staff did not always understand the importance of giving people choices.

People were supported to have enough to eat and drink. People were supported to maintain good health and have access to healthcare services as and when required. Medication practices and processes were generally safe and much improved.

Arrangements were in place for staff to receive appropriate training opportunities for their role and area of responsibility. The majority of mandatory training for staff was up-to-date.

Staff knew the care needs of the people they supported and people told us that staff were kind and caring.

You can see what actions we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

Although staff had a good understanding of safeguarding procedures not all staff had received safeguarding training. Robust procedures and processes that make sure people and others are protected had not been considered and followed.

Risks were not identified for all areas of risk, suitably managed or mitigated so as to ensure people's safety and wellbeing.

Improvements were required in relation to the provider's recruitment procedures so as to safeguard people using the service.

The management of medicines were safe.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff had not received a robust induction. Improvements were still required to ensure staff were formally supervised and staff received an annual appraisal of their overall performance.

Not all people who used the service had had their capacity to make decisions assessed. Staff did not always understand the importance of giving people choices.

Staff supported people to meet their nutritional needs. People were supported to access healthcare professionals when needed.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People deemed on end of life care did not have an end of life care plan in place and improvements were required.

Little information available to demonstrate that people using the service and those acting on their behalf are actively involved in

making decisions about their care, interventions and support.

Staff did not always respect people's privacy and dignity and improvements were required.

People told us that staff were kind and caring.

Is the service responsive?

Inadequate

The service was not responsive.

Not all people who used the service had a care plan in place detailing their care and support needs. People's care plans were not sufficiently detailed or accurate to include all of a person's care needs and the care and support to be delivered by staff.

Not all people who used the service were engaged in meaningful activities or supported to pursue pastimes that interested them.

The complaints log required up-dating so as to evidence all complaints received and the actions to be taken to resolve these.

Is the service well-led?

Inadequate

The service was not well led

Although systems were in place to regularly assess and monitor the quality of the service provided, further improvements were required as they had not highlighted the areas of concern we had identified.

Quality monitoring processes were not robust and working as effectively as they should be so as to demonstrate compliance and to drive improvement.

Systems were in place to seek the views of people who used the service and those acting on their behalf.

West 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 12, 13 and 16 January 2017 and was unannounced. The inspection team consisted of one inspector. The inspector was 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.

We reviewed the information we held about the service including safeguarding alerts and other notifications. This refers specifically to incidents, events and changes the 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, eight relatives, eight members of staff, the provider and the Customer Services Manager.

We reviewed seven people's care plans and care records. We looked at the service's staff support records for eight members of staff. We also looked at the service's arrangements for the management of medicines, complaints and compliments information and quality monitoring and audit information.

Requires Improvement

Is the service safe?

Our findings

At our previous comprehensive inspection to the service on 28 and 29 September and 6 October 2016, medication practices and procedures required improvement as they were not safe for people using the service. Additionally, we found that risks to people's safety and wellbeing were not always identified and suitable control measures were not put in place to mitigate risks or potential risk of harm for people using the service. Improvements were also required in relation to the provider's recruitment and selection procedures. As a result of our concerns relating to poor medication practices and procedures and ineffective risk management arrangements, a warning notice was issued on 7 November 2016. The date for compliance to be achieved was 5 December 2016.

The provider shared with us their action plan on 28 November 2016. This provided detail on their progress to meet regulatory requirements and to make the necessary improvements. Although at this inspection medication arrangements at the service were much improved, the provider had not made all of the improvements they told us they would make. This related specifically to assessing risk and doing all that is reasonably practicable to mitigate any such risks to people's safety, health and wellbeing. This meant the warning notice issued in November 2016 had not been fully complied with.

At this inspection risks relating to specific areas were not always identified and suitable control measures were not put in place to mitigate the risk or potential risk of harm for people using the service. For example, the pre-admission assessment for one person, admitted to the service 14 days prior to our inspection, recorded them as being immobile and requiring their manual handling needs to be met by staff. However, a risk assessment had not been considered or completed to identify the person's manual handling needs. This included the assistance needed for all transfers, overall equipment needs and the manual handling required in emergencies, such as fire evacuation. Another person who was admitted to the service 16 days prior to our inspection did not have a manual handling assessment in place, despite their pre-admission assessment stating they required two members of staff for all transfers. We discussed this with the provider and they confirmed risk assessments had not been identified and completed for one person. For the other person, it emerged that all of their information, including risk assessments, was held on the service's computer and had not been printed out and placed within the person's care file. Although staff spoken with at the time of the inspection were aware of both people's needs, both permanent and agency staff employed at the service had not had this information until our intervention and it being brought to the provider's attention.

Our observations showed that several people throughout the service had bedrails fitted to prevent them from falling out of bed and injuring themselves. Where these were in place a risk assessment had not always been completed to determine that these were suitable for the individual person so that any risks identified were balanced against the anticipated benefits. Where three people had bedrails fitted we found no formal bedrail assessments had been completed to evidence that this item of equipment was suitable. No information was recorded to show the provider had considered all potential risks, such as the risk of entrapment, rolling over the top of the bedrails or climbing over the bedrails and ensuring the bedrails were fitted correctly. The manual handling and bedrail assessment for another person showed this had not been

reviewed and updated since August 2016, so as to ensure this equipment continued to remain suitable and safe to meet their needs.

The care records for another person revealed they had a pressure ulcer. A formal risk assessment tool was in place to provide an estimated risk score for the development of pressure ulcers and showed the person was at 'very high risk' of developing pressure ulcers. Staff confirmed to us and records showed that the person had a pressure ulcer and this was being attended to by healthcare professionals at regular intervals. Nonetheless, no risk assessment relating to pressure ulcers had been considered or completed, taking into account and linking other risk factors, such as the person's nutritional status, reduced mobility or immobility and lack of sensation to pain. This meant that we could not be assured that the above person's pressure management was effective in ensuring the person's safety and wellbeing.

Staff told us and records confirmed for one person they had a catheter fitted. No risk assessment was completed detailing suitable control measures put in place to mitigate the risk or potential risk of harm for the person. For example, such as, the development of urinary tract infections, bladder spasms and leakage around the catheter site which could be a sign that the catheter was blocked.

This is a continued breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff were able to demonstrate a satisfactory understanding and awareness of the different types of abuse and how to respond appropriately where abuse was suspected. Staff confirmed they would report any concerns to external agencies such as the Local Authority or the Care Quality Commission if required. Staff confirmed they would do this without hesitation in order to promote people's safety and wellbeing. However, the staff training information provided to us by the provider showed seven out of 20 members of staff employed at the service did not have up-to-date safeguarding training and one member of staff had not received refresher training in this topic since 2010.

Prior to this inspection concerns were raised in November 2016 about an incident that had arisen in May 2016, whereby a person using the service had become anxious and distressed; and as a result of their behaviours and actions this had resulted in the police being called. Robust procedures and processes that make sure people and others are protected had not been considered and followed by the provider. No consideration had been made by the provider to notify the Local Authority or Care Quality Commission of the potentially serious incident or to complete an internal investigation relating to the incident. This meant that we could not be assured that lessons had been learnt so as to mitigate future risk to people living at the service.

This is a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff recruitment records for five members of staff were viewed. Improvements were still required to ensure the right staff were employed at the service. For example, one written reference for two members of staff were received after they had commenced employment at the service and no recent photograph was evident for one member of staff. Where staff had previous experience of working within a care setting, there was no evidence to demonstrate what qualifications had been attained.

People told us they felt safe living at the service, and that this gave them peace of mind. One person told us, "I feel I'm in safe hands here. They've got just enough staff to look after us well." Another person told us, "Oh yes dear, I feel safe here. If I wasn't safe I wouldn't be here." One relative told us, "There's a friendly, homely

feel here, which gives me confidence in them that they do the right thing for people. I don't worry about [Name of relative] when I'm not here."

Medicines were stored safely for the protection of people who used the service and that the arrangements for the management of medicines were now safe. There were arrangements in place to record when medicines were received into the service and given to people. We looked at the records for seven of the 25 people who used the service. These were in good order, provided an account of medicines used and demonstrated that people were given their medicines as prescribed. Relatives told us they were confident that medicines were appropriately managed and given to their member of family as prescribed and they had no concerns.

Observation of the medication rounds during the inspection showed these were completed with due regard to people's dignity and personal choice. However, the lunchtime medication round on the first day of inspection did not complete until 3.10 p.m. Although the senior member of staff responsible for administering medication wore a red tabard which stated 'Do Not Disturb', they were regularly disturbed and interrupted by staff for both advice and to help provide assistance for people using the service. Consideration was not given by staff to seek another senior member of staff or to request assistance from the provider.

All but one member of staff involved in the administration of medication had received appropriate training in 2015 and 2016. Staff confirmed and records showed that all staff who administered medication had had their competency assessed, to ensure they had the skills and capability to administer medication safely to people using the service. The provider confirmed that medication audits should be completed each month and a senior member of staff was delegated this responsibility. However, no medication audits had been completed since our last inspection in October 2016. When asked as to the rationale for this, the senior member of staff told us, "I just haven't had the time." The provider confirmed they had not been aware of this.

People's comments about staffing levels were positive and the majority of people told us that, in their opinion, there were enough staff on duty during the day and at night. One person told us, "They [staff] don't rush in and out of my room, so I think there are enough of them; they [staff] don't seem overworked." Two people sharing a room confirmed this, saying, "If we press our buzzer, day or night, they [staff] come quickly enough, they're all very good." Another person told us, "There's always staff here in the lounge, they watch us. If someone's not well, has a bad turn or something, they [staff] know what to do." Staff's comments about staffing levels at the service were positive. Although prior to the inspection we had been told that staffing levels were poor and people's care and support needs were not met, the deployment of staff during the three days of inspection was observed to be appropriate.

Requires Improvement

Is the service effective?

Our findings

At our previous comprehensive inspection to the service on 28 and 29 September and 6 October 2016, a robust induction had not been completed for newly employed members of staff. Additionally, staff had not received regular formal supervision or an annual appraisal of their overall performance. Improvements were also required relating to the completion of Mental Capacity Act [MCA] 2005 assessments so as to show these were in people's best interest. The provider shared with us their action plan on 28 November 2016. This provided detail on their progress to meet regulatory requirements and to make the necessary improvements. The provider had not made all of the improvements they told us they would make.

The provider confirmed that all newly employed staff received a comprehensive induction. This consisted of an 'in-house' orientation introduction to the service and the Skills for Care 'Care Certificate' or an equivalent. Although the provider confirmed that the 'Care Certificate' or an equivalent formed part of the induction process, this was not completed for the newest members of staff employed. In particular, this related to one member of staff who had no previous care experience and one member of staff who had limited experience working within a care environment. This meant there was no evidence to show that the provider had assessed their competency against the core standards as outlined within the 'Care Certificate' or an equivalent robust induction program. Five staff personnel records were viewed and these showed that none of the staff employed had received an 'in-house' orientation induction. We spoke with one member of staff about the quality of their induction. The member of staff told us they had not been shown around the premises on their first day and had been immediately placed in the laundry. They told us this had left them feeling "lost and unsupported." Another member of staff stated their induction had been basic as it solely consisted of being shown people's bedrooms and the service's fire exits. This remained outstanding from our previous inspection to the service in October 2016 and was not in line with the provider's own induction policy and procedure.

Positively, staff also told us that they had been given the opportunity to 'shadow' and work alongside more experienced members of staff. Staff confirmed they had found this to be an invaluable experience. The provider confirmed that this could be flexible according to a member of staff's previous experience and level of competence.

Staff told us they were supported by the management team and other team members. The Customer Services Manager told us the completion of formal supervisions for care staff had now been delegated to a senior member of staff to complete. Staff confirmed and records showed the majority of staff had received one supervision since our last inspection in October 2016. Whilst a record was maintained of each supervision, no actions or areas for improvement had been highlighted for the majority of staff supervised. Where one action was recorded, it was unclear as to how this was to be actioned and monitored. We discussed this with the senior member of staff responsible for undertaking staff supervisions. We found that despite being delegated the above task; they had not received supervision since their appointment in July 2016. Neither had they received training so as to carry out this task to an appropriate standard. This was not in line with the provider's own supervision policy and procedure.

Prior to our inspection concerns were raised in relation to an incident that had arisen in May 2016, whereby a person using the service had become anxious and distressed; and this had resulted in the police being called. Records showed that the member of staff involved in the above had not received formal supervision relating to the incident or been offered an opportunity for debriefing and reflection. This meant formal arrangements were not in place to help the member of staff to deal with the emotional reactions that resulted from the incident or to learn from adverse events.

Staff told us and records confirmed that staff employed longer than 12 months had still not received an appraisal of their overall performance for the preceding 12 months. The Customer Services Manager confirmed that this information was accurate and appraisals were due to commence on 30 January 2017 to 3 February 2017. This remained outstanding from our previous inspection to the service in October 2016.

The provider forwarded us a copy of the staff training matrix. This showed that the majority of staff were provided with a range of training to enable them to carry out their role. Records showed that staff had attended training in for example, manual handling, safeguarding, food hygiene, infection control and first aid. Additionally, some staff were noted to have received specialist training relating to the medical conditions of the people they supported, for example, Diabetes, Parkinson's and Epilepsy. However, at the time of this inspection two members of staff who were newly employed in November and December 2016 respectively, had only received manual handling, health and safety and fire awareness training. A list of training to be undertaken for the period 23 January 2017 to 26 April 2017 was sent to us; however the information did not provide any detail as to who was to attend this.

These failings were a continued breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. 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.

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 application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

Staff were able to demonstrate a basic knowledge and understanding of MCA and Deprivation of Liberty Safeguards (DoLS). Records showed that not all people who used the service had had their capacity to make decisions assessed. This meant that people's ability to make some decisions, or the decisions that they may need help with and the reason as to why it was in the person's best interests had not always been recorded. Our observations showed staff did not always understand the importance of giving people choices and respecting their wishes or how to support people that could not always make decisions and choices for themselves. For example, aprons were made available for some people at mealtimes as a means to protect their clothes. The aprons were placed around some people's necks. Consideration had not been made by staff to discuss this with the individuals concerned. Additionally, people were not always routinely given a choice of hot or cold drinks, despite a variety of drinks being readily available.

People were generally positive about the meals provided. One person told us, "The food is Okay, I like most meals provided. If I didn't like it I wouldn't eat it." A second person told us, "The food is quite nice." Another

person told us, "The food's Okay, but I get fed up with mash every day. We don't have any other sort of potato, I love a roast potato, but we don't get them." They further added, "I would like a choice, if you go to a café, you get a choice don't you?" When asked what would happen if they did not like the food on offer, people looked quite bemused at the thought of asking for something else. One person told us, "They might do me a sandwich, I suppose."

In general the dining experience was satisfactory and the majority of people were able to eat independently. People were supported to use suitable aids to eat and drink as independently as possible, for example, to eat their meal using a spoon and use of specialist beakers. This showed that people were enabled and empowered to maintain their independence and skills where appropriate. Where people required assistance from staff to eat and drink, this was provided in a sensitive and dignified manner, for example, people were not rushed to eat their meal and positive encouragement to eat and drink was provided by staff.

Our observations showed people were not offered any condiments with their meal and staff failed to provide sufficient information, explanation or reminder to people about the actual meals provided. For example, people were not told or reminded what food items were on their plate so as to give people living with dementia an indication what they were about to eat. We discussed this with the provider and they told us the menu was normally displayed within the communal lounge. On the first and second day of inspection it was not there and the provider was unable to provide a rationale for its absence. By our third visit date this had been rectified?

People's care records showed that their healthcare needs were recorded and this included evidence of staff interventions and the outcomes of healthcare appointments. Each person was noted to have access to local healthcare services and healthcare professionals so as to maintain their health and wellbeing, for example, to attend hospital and GP appointments and District Nurse. One relative told us that due to their member of family's healthcare needs, this had led to them now being confined to bed most of the time. They told us, "They [staff] dealt with it very well. Staff called paramedics out when they were concerned." They told us they were grateful that the staff always kept them informed of their family member's healthcare needs and condition.

Requires Improvement

Is the service caring?

Our findings

At our previous comprehensive inspection to the service on 28 and 29 September and 6 October 2016, information relating to people's end of life care needs and wishes were poorly completed or not in place. The provider shared with us their action plan on 28 November 2016. This provided detail on their progress to meet regulatory requirements and to make the necessary improvements. The provider had not made all of the improvements they told us they would make.

At this inspection the provider, Customer Services Manager and staff confirmed that one person was deemed as requiring end of life care. On review of the person's care file we found their preferences and choices for their end of life care were not robust or as detailed as they should be. We found that the needs of the person approaching the end of their life and associated records relating to their end of life care needs contained minimal information. For example, the care plan provided no information detailing the person's pain management arrangements and the care to be provided so as to provide comfort and dignity for the person nearing the end of their life. No information was recorded in order to aid care planning arrangements and discussions with the person and those acting on their behalf. A Preferred Priorities for Care [PPC] document was completed by the person's representatives one day prior to the commencement of our inspection. This is designed to help people prepare for the future and gives them an opportunity to think about, talk about and write down their preferences and priorities for care at the end of their life.

Records showed healthcare professionals, including the local palliative care team had been involved since November 2016 and the GP was providing support in relation to the person's pain management symptoms. We discussed this with the provider and were advised that the care plan would only be put in place once the GP formally agreed that the person was deemed at end of life. Whilst this satisfies the GP requirements, it does not provide an assurance as to how people at West House are to be supported at the end of their life to have a comfortable, dignified and pain free death. The above meant that people's 'end of life' wishes were not recorded, in line with new guidelines issued by the National Institute for Health and Care Excellence [NICE]. This remained outstanding from our previous inspection to the service in October 2016. The latter places emphasis for a more individualised approach to 'end of life' care. We discussed this with the provider and they confirmed that they were aware of the Gold Standards Framework. This is a joint approach used by all professionals involved in a person's care that ensured they received appropriate and co-ordinated end of life care.

This is a continued breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was little information available to demonstrate that people using the service and those acting on their behalf are actively involved in making decisions about their care, interventions and support, other than as part of the pre-admission assessment process. There was no evidence to show that where able, people and those acting on their behalf had been involved in the development and review of their care plan. People did not know what a care plan was and others were unable to tell us if they had been involved or not.

Although staff were able to verbally give examples of what dignity meant to them, for example, knocking on people's doors before entering, keeping the door and curtains closed during personal care and providing explanations to people about the care and support to be provided, this did not happen in practice. Our observations showed that staff did not always respect people's privacy and dignity. For example, as already stated within the main text of the report, not all staff explained things clearly to them or gave people the time to respond. On three occasions staff were noted to enter people's bedroom without knocking or telling the person whose room it was, who they were. We noticed when entering one person's room after the lunchtime meal that they had remnants of food on their face and on their top, however the person's plate had been removed. This showed that whoever had taken the person's plate away had not cleaned their face, or picked up the dropped food from their top. Some members of staff spoke very loudly whilst in the communal lounge, relaying personal information relating to people using the service to another member of staff in the same area. Additionally, two members of staff were overheard during the inspection and on several occasions to use inappropriate bad language and swore in front of people using the service. This could result in people using the service and others not always feeling they are respected or valued.

Despite these shortfalls, people told us that staff were kind, caring and treated them with compassion. One person told us, "They're [staff] very good, they treat me well." Another person told us, "They're [staff] very good, nothing's too much trouble and they do care." Relatives told us they were happy with the care and support provided for their member of family. One relative told us, "Nothing's too much trouble; they [staff and the management team] are all very kind and supportive to us all." During the day we witnessed several interactions between people living at the service and staff which was positive and where staff demonstrated how well they knew those in their care. We overheard staff talking about peoples' families and we noted staff and people using the service, sharing jokes together and engaging in natural friendly banter.

People were supported to maintain relationships with others. People's relatives and those acting on their behalf visited at any time. Staff told us that people's friends and family were welcome at all times. Relatives confirmed that there were no restrictions when they visited and that they were always made to feel welcome. Visitors told us that they felt welcomed when they visited the service and could stay as long as they wanted.

Inadequate

Is the service responsive?

Our findings

At our previous comprehensive inspection to the service on 28 and 29 September and 6 October 2016, care plans were not in place for all people using the service. Additionally, information was not always as reflective or accurate of people's care and support needs as they should be. Social activities for people using the service were limited. The provider shared with us their action plan on 28 November 2016. This provided detail on their progress to meet regulatory requirements and to make the necessary improvements. The provider had not made all of the improvements they told us they would make.

Although some people's care plans provided sufficient detail to give staff the information they needed to provide personalised care and support that was consistent and responsive to their individual needs, others were not as fully reflective or accurate of people's care needs as they should be. No care plan had been developed for one person despite having been admitted to the service 14 days prior to our inspection. The care plan for another person had remained on the provider's computer 16 days prior to our inspection and not printed out and placed on the person's care file for staff to access. When the latter was brought to the provider's attention, the provider reacted promptly and commenced to print out the information. However, whilst doing this and following a review of the information, the provider told us not all of the information recorded was accurate. The care plan for another person showed that although they were admitted to the service in the middle of November 2016, the majority of their care plan was not compiled and completed until the middle of December 2016. This meant there was a risk that relevant information was not captured for use by other care staff and professionals or provided sufficient evidence to show that appropriate care was being provided and delivered.

Staff told us there were some people who could become anxious or distressed. Improvements were required to ensure that the care plans for these people considered the reasons for becoming anxious and the steps staff should take to reassure them. Guidance and directions on the best ways to support the person required reviewing so that staff had all of the information required to support the person appropriately and to reduce their anxiety. Where information was recorded detailing the behaviours observed, the events that precede and follow this and staff's interventions; improvements were required. There was little evidence to demonstrate staff's interventions and the outcome of incidents so as to ensure positive outcomes for people living at the service. For example, the daily care records for one person made reference to them being anxious and distressed towards staff, particularly when being assisted during personal care. No care plan or risk assessment was completed. Records relating to specific incidents were not always recorded and the lack of appropriate guidance relating to suitable interventions, meant the person was often left in their bed to calm down rather than other measures which could be more appropriate, being explored.

Daily care records were completed each day. Nonetheless, they provided little information as to how people spent their day. The majority of information recorded related to tasks provided by staff, such as, personal care and did not provide in sufficient detail the summary of a given day's care and the daily events that a person experiences. For example, the daily care records for six people were viewed in relation to their experience of Christmas Day and New Year's Day. No information was recorded detailing how people had spent either day, whether or not there had been any special food, activities or their overall experience of the

day. One person's records for both days solely recorded they had been in bed sleeping.

Although the service employed a member of staff to provide social activities to people living at the service for three to four hours a day Monday to Friday. Staff told us that it was the responsibility of the activities co-ordinator to provide activities in the main. Our observations throughout the three days of inspection showed there were few opportunities provided for people to join in, particularly for people living with more advanced stages of dementia and who required more support to benefit from occupation and stimulation. During the inspection, the person responsible for activities was observed to take one person out to the local shops for personal shopping and coffee. Another member of staff was noted to give two people a manicure. No other social activities took place and there was an over reliance on the television.

Although an activity record was in place for each person, these confirmed our observations. One person's notes recorded them between 21 December 2016 and 15 January 2017 as either in bed or asleep. When we spoke with this person they told us, "It's not the girls' fault, but they don't have the time, and I get so lonely in here. Nobody ever just talks to me." The person's care plan relating to 'Work and Play' recorded them as requiring one-to-one stimulation and for staff to chat with them. It also stated they should go out with the activities co-ordinator once weekly. Records showed this was not happening. Care plans relating to social activities were not robust. Although they provided information relating to people's personal preferences they did not provide the relevant detail about how this was to be delivered by staff and some of the information appeared uniform and generic. Another person, lying in bed, became distressed when we asked them if staff were able to spend time with them. Initially when we spoke with this person they had seemed quite low and disinterested, but soon became animated when we discovered they had grown up in London close to where the expert by experience had worked many years ago. They told us, "Normally the girls can't waste their time talking to me, but it's so nice to have someone to chat to. I'm so glad you came in to see me." They also told us that they often felt isolated and alone.

Several people were very reliant on the care and support provided by staff as a result of them living with varying levels of dementia. Whilst we observed that some staff interactions with people were positive and staff had a good rapport with the people they supported, this was in contrast to other observations. These showed that some staff's practice when supporting people living with dementia required improvement and development. For example, some staff were observed to spend little time with people using the service, particularly where people were not able to verbally communicate or who seemingly appeared asleep. The majority of staff were seen to primarily focus solely on tasks and actions, for example, providing people with a drink, manual handling or assisting them with personal care tasks.

These shortfalls were a continued breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Appropriate arrangements were in place to assess the needs of people prior to admission. This ensured that the service were able to meet the person's needs.

Staff told us they were made aware of changes in people's needs through regular handover meetings and following discussions with senior members of staff and the management team. Staff told us that handover meetings were undertaken between each shift and were important in making sure that they had up-to-date information each day about people who used the service. Our observations confirmed what staff told us. This meant that staff had day-to-day information about the welfare and needs of the people they supported.

Information on how to make a complaint was available for people to access. People and their relatives told us that if they had any worries or concerns they would discuss these with the management team and staff

on duty. Relatives stated they felt able to express their views about the service and in their opinion they would be listened to.

Staff told us they were aware of the complaints procedure and knew how to respond to people's concerns. Complaint records showed there had been no complaints since our last inspection in October 2016. However, the Care Quality Commission were aware that concerns had been raised in relation to one person who used the service. We discussed this with the provider and were advised that all of the information was held on the service's computer. The provider was recommended to maintain an accurate log of all concerns raised and evidence of action taken.

Inadequate

Is the service well-led?

Our findings

At our previous comprehensive inspection to the service on 28 and 29 September and 6 October 2016, we found the provider's quality assurance and monitoring processes were ineffective so as to demonstrate compliance with regulatory requirements and to drive improvement. The provider shared with us their action plan on 28 November 2016. This provided detail on their progress to meet regulatory requirements and to make the necessary improvements. The provider had not made the improvements they told us they would make.

The provider was able to demonstrate to us the arrangements in place to regularly assess and monitor the quality of the service provided. This included the use of questionnaires for people who used the service and those acting on their behalf. In addition to this the provider monitored the quality of the service through the completion of a number of audits. These included audits relating to infection control, health and safety and medication. Additionally, audits were also completed in relation to the incidence of pressure ulcers, accidents and incidents and hospital admissions. The Customer Services Manager confirmed they had been delegated the responsibility of completing the latter since our last inspection in October 2016. They also told us that a daily 'walk around' was completed Monday to Friday by either themselves or the provider to ensure everything was appropriate. However, they confirmed a record to evidence and support this was not maintained.

Although the above was positive, the arrangements had not recognised where people were either put at risk of potential harm or where their health and wellbeing was compromised. There was evidence to show that because of this some people did not always experience positive outcomes and the lack of robust quality monitoring meant there was a lack of consistency in how well the service was managed and led. Had there been a more effective quality assurance and governance process in place, this would have identified the issues we found during our inspection. It would have enabled the provider to identify where improvements were needed and to monitor and analyse trends.

This related to shortfalls in governance of the provider's care planning and risk assessment processes and procedures. An audit had not been devised or implemented to monitor and mitigate risks relating to the health, safety and welfare of people using the service. Suitable arrangements were not in place to ensure an assessment of a person's care and treatment needs had always been undertaken and completed. Systems were not in place to ensure the information recorded remained accurate and accessible for staff in order to deliver people's care and treatment safely. Had an audit of people's support plans been implemented and completed sooner, the shortfalls highlighted as part of this inspection could have been identified and action taken sooner to resolve the issues raised. This referred specifically to the completion of risk assessments for all areas of assessed risk and ensuring a care plan was in place each person detailing their care and support needs. Had these audits been completed, this may have alerted the provider sooner so as to ensure these were in place, information was up-to-date and information to mitigate risks recorded.

Additionally, improvements were required to ensure the provider had effective arrangements in place to protect people from abuse. Improvements were also required to ensure that staff employed received a

proper robust induction that prepared staff for their role. Furthermore, improvements were required to ensure all staff received regular supervision and an annual appraisal of their overall performance. For example, it was evident that the Customer Services Manager had not received formal supervision or an induction since commencement of their role. This meant that the provider's quality monitoring processes were not robust and working as effectively as they should be so as to demonstrate compliance and to drive improvement. Furthermore, the provider had not picked up that social activities for people using the service was not as good as it should be and improvements were required.

Whilst clinical audits were in place in relation to pressure ulcers, accidents and incidents and hospital admissions, information was not as up-to-date as it should have been and an analysis of the data had not been undertaken. For example, the Customer Services Manager told us that a weekly pressure ulcer audit was undertaken. On review of this we found this had last been updated on 19 December 2016 and the data recorded was a duplicate of information already provided by senior staff to inform the audit. An analysis of the above had not been undertaken so as to gain an overview of how the service was managing the prevention and management of pressure ulcers. For example, identifying new or deteriorated pressure ulcers. Additionally, we found the accident and incident audit replicated information already recorded within people's individual accident records. The data had not been collated so as to provide a clear picture as to the increase or decrease of accidents and incidents on any given month and the rationale for this. Information recorded within the hospital admission summary was not always accurate. For example, the summary report stated there had been two hospital admissions in October 2016 and three in November 2016. This was not accurate as the data recorded should have read five and four respectively. This had not been picked up by either the provider or the Customer Services Manager.

As already stated within the main text of the report medication audits had not been completed since our last inspection in October 2016. The provider confirmed to us that they were unaware of this and had assumed the audits had been completed by the senior member of staff. Additionally, the provider and Customer Services Manager had failed to assess and monitor the audit relating to the timing of the administration of medication by staff for people using the service. This showed there had been numerous occasions whereby medication had been administered to people using the service too soon, between the morning and lunchtime medication rounds. This potentially placed people at risk of receiving their medication too soon and not in line with the prescriber's instructions.

Prior to our inspection, concerns were raised that toiletries for people using the service were 'bulk purchased' and the cost of the items provided were too expensive. The Customer Services Manager confirmed to us that toiletries for people were 'bulk purchased.' However, when we asked for a price list they told us this had not been formulated. This meant that people and those acting on their behalf had not been given clear and open information about the expected costs involved with purchasing toiletries directly from the service. In addition, where people had purchased toiletries, receipts provided recorded an overall cost and not a breakdown of specific items bought. We also found following an audit of people's monies, two out of five people's balances and records were inaccurate. The Customer Services Manager confirmed an audit of people's monies and financial transactions were not routinely completed. This meant an accurate and complete record in respect of each person had not been maintained, assessed or monitored.

The provider confirmed that the views of people who used the service, those acting on their behalf and staff had been sought in September 2016. The survey for people using the service and those acting on their behalf showed that a response was received from seven people. The majority of comments were very positive. Comments included, 'The staff are friendly and attentive', 'It is a lovely home and more than happy with our relative's first month here' and, 'I have no concerns regarding the care given to [Name of person using the service].' The only negative comment related to missing laundry items. The staff survey indicated variable

comments. Staff spoke positively about teamwork and the management of the service. However, less favourable comments related, for example, to better communication, use of bad language in front of people using the service and care planning training to be provided. An action plan had not been devised as to how this was to be addressed.

Staff told us they were given the opportunity to express their views and opinions on the quality of the service through staff meetings. However, staff stated these were infrequent and more were required. This was highlighted as part of feedback provided within the staff survey in September 2016. It was not clear as to how this was to be addressed for the future.

These shortfalls were a continued breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.