Alliance Care (Dales Homes) Limited

Houndswood House Care Home

Inspection report

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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?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

We carried out this inspection on 10, 11 and 16 August 2016 and we contacted people to obtain further feedback on 18 August 2016. The inspection was conducted in response to concerning information received by the Care Quality Commission. At the previous focused inspection carried out on 7 January 2016 in response to whistle blowing concerns we assessed Safe and Well Led and found breaches of the regulations around people's safety and the overall management of the service. This was because the provider had failed to put adequate processes in place to keep people safe.

Following the Focused inspection, the provider wrote to us on 18/01/2016 to tell us how they would make the required improvements to meet the legal requirements. At this inspection we found that the provider had failed to make sustainable improvements around the safety and consistency of care and support provided to people.

Houndswood House is registered to provide accommodation and support for up to 50 people with health conditions, age related frailty and people living with dementia. It also provides nursing care. At the time of our inspection there were 46 people living in the home.

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

We could not be assured that there were adequate numbers of staff on duty to support people safely at all times. People were not always assisted in a timely way and at times people were left alone without any staff present to promote people's safety and wellbeing.

People appeared unkempt and the support provided for their personal hygiene needs was not of a consistently good standard. People's beds were not made properly and some had soiled sheets. Slings used to assist people to transfer were shared and some had other people's initials and room numbers on which meant they may have been placed at risk of injury if they were not using the slings that they had been assessed as needing.

Recruitment processes were not always consistent in ensuring staff employed at the service were suitable to carry out their responsibilities and meet people`s needs. For some of whom English was not their first language. We found they did not always understand the questions we asked them or what we were saying to them. The majority of the people who lived at the home had limited communication and therefore it was difficult to fully assess how this impacted on their health and welfare. We also noted that there were inconsistencies in the checks made for example about the validation of references and completion of documentation.

Most of the staff understood how to promote and protect people's rights and maintain their privacy and dignity. However, we observed several instances where members of staff failed to respect people's privacy or dignity.

Engagement with activities and hobbies was poor. Loud music was playing from the radio in conjunction with a television. We observed people were uninterested in either option and staff made no attempt to engage with people or offer people alternative choices of activities.

People's care plans lacked detail or accurate information relating to people's care and were not subject to regular review. Care plans were not person centred, and did not always contain sufficient detail to ensure they reflected people's current needs and choices.

People were supported to take their medicines by appropriately trained staff. However, we found the process for the administration of medicines was not consistently safe.

Staff received some support through induction and a training schedule but most of the training was E learning which is training they completed online and was not consistently effective in providing them with the appropriate skills to help them meet the needs of the people who lived at the service. Staff told us that some of the training was completed at home and we could not be assured that staff were competent following completion of the training.

The service was not consistently well led and had not identified many of the issues we found during the course of our inspection. Where areas of concern had been identified appropriate actions had not been put in place to address these. Records were not completed in a timely way. Some of the staff were positive about their experience of working at the home while others were less positive.
The risk assessments in place were not personalised or detailed enough to support staff to keep people safe. Instructions were not always followed to minimise the potential for harm to occur.

People's consent was gained before care and support was delivered. However, not all staff understood the principles of the Mental Capacity Act. Most of the staff understood the processes in place to protect people who could not make decisions and followed the legal requirements outlined in the Mental Capacity Act 2005 (MCA) and Deprivation of Liberties Safeguards (DoLS).

Staff told us people were able to choose their own meals and the meal choices were completed the day before. However, people were not offered an alternative choice on the day if they had changed their minds. There were no snacks or drinks available other than tea and biscuits during the mid- morning and mid-afternoon. The quality of the food we observed being served to people was of a poor quality and we were told it was 'portion controlled'.

There was little engagement between staff and people who used the service and the care provided was very 'task orientated'. Some people who were more able had developed relationships with staff who treated them kindly. Most of the staff were knowledgeable about how to meet people's needs and understood how people preferred to be supported. However, we observed that staff sometimes assisted people without following their care plan and to fit in with the limited availability of staff.
Staff were knowledgeable about safeguarding procedures and we saw that they had received training. They were able to tell us what actions they took to keep people safe from possible abuse.

People had access to health care professionals to make sure they received care and treatment to meet their individual healthcare needs. Staff supported people to maintain their health where possible.

There were systems in place for recording, investigating and responding to complaints. People and their family members knew who to speak to if they wanted to raise a concern.
The registered and regional manager were extremely responsive to our feedback and took appropriate action to both alleviate our concerns and to work with senior staff to put a sustainable action plan in place to make the required improvements within an appropriate timeframe.

You can see what action we told the provider to take at the back of the full version of the report. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

There were not always sufficient staff members to meet people's needs safely and in a timely way.

Risks to people's health and wellbeing were not always managed effectively to maintain their safety.

People's medicines were not always managed safely or effectively. Medicines were stored securely and there was a robust system for ordering medicines.

The recruitment process was not consistently robust and some staff had a limited command of English.

People were kept safe by staff who received training in safeguarding and knew how to report any concerns regarding possible abuse.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People received support from staff who had received some training and support. However, the training did not always support staff to meet people's needs effectively.

Some people were involved in decisions about their care. Staff were aware of the need to obtain consent but only some of the staff knew about the principles of the Mental Capacity Act.

People had a limited choice of food and healthy and nutritious snacks were not provided regularly. Mealtimes were not a sociable experience but task orientated. Fluids were not offered regularly.

People had access to health and social care professionals to help maintain their health and wellbeing.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People did not always receive personalised care and support that met their individual needs and wishes.

We observed staff to be kind and caring. However, people were not always given choices.

People's privacy and dignity was not always protected and maintained.

People were supported to develop relationships with staff when possible.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Care plans were detailed but were not always personalised and reflective of people's individual needs and did not clearly demonstrate how people wanted to be supported.

Engagement and activities were not planned around individual interests and abilities and did not support people's preferences.

People were supported to raise concerns or issues about the service and these were dealt with through the complaints policy.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

The overall quality and monitoring of the service had not been effective in identifying many of the issues we identified as part of our inspection.

There were systems in place to audit aspects of the service but these were not always acted upon to improve the service to people

Records were not consistently maintained.

Staff were clear about their roles and responsibilities and received some support.

Satisfaction surveys to obtain feedback were in progress with regard to the quality of the service people received.

Houndswood House Care Home

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 was brought forward in response to concerns we had received and was carried out by two inspectors. We visited the service on the 10, 11 and 16 August 2016 and we contacted people on the 18 August 2016 to obtain feedback about how the home operated.

The provider had completed a Provider Information Return (PIR) in advance of our inspection. This is a document that requires them to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed information we held about the service including statutory notifications relating to the service. Statutory notifications include information about important events which the provider is required to send us.

During the inspection we spoke with four people who used the service, three relatives, five care staff, and a member of activities staff, the assistant chef, the registered manager, the deputy manager and regional area manager. We contacted family members and relatives to obtain feedback and also sought feedback from health and social care professional's familiar with the service. We looked at seven care plans, four staff files, complaints, records relating to food and fluid monitoring and other information which related to the overall monitoring of the service.

Requires Improvement

Is the service safe?

Our findings

The majority of people were unable to tell us if they felt safe living at Houndswood House. However, we observed that people were not always kept safe and on occasions were left for short periods of time in the lounge areas without staff being present. On one occasion we observed nine people were left for a period of eight minutes without any staff supporting present despite people being assessed as requiring staff supervision.

We saw that two people had ill- fitted and loose slippers. One person was wearing a pair of slippers that were too big which caused them to slip off the back of their feet. We saw that this made it difficult for them to walk and placed them at risk of falling over.

We observed that call bells were out of people's reach and staff could not give us any explanation why. For example, we saw that in five bedrooms where people were being cared for in their bed, the call bell was placed under clothes and draped over an armchair. In one of the bedrooms the call bell was unplugged. Staff told us this was because the person had a sensor mat to prevent them from falling. However, the sensor mat was under the bed and therefore if the person had tried to get out of bed unaided they would have been placed at risk of falling. A member of staff told us the person pushed the mat under the bed themselves. However the provider had not managed the risk effectively to keep the person safe. We asked staff how people would attract attention in the event of them requiring assistance. The staff member told us they checked on people at 'least hourly'. However one person told us if they needed assistance an hour was too long for them to wait.

People had risk assessments that identified specific and individual risks which helped inform staff about how to keep them safe. For example, people who required the assistance of two staff to be transferred using a hoist. People had been assessed for their individual sling size and type. The registered manager told us each person had an individual sling. We checked five people who were supported to transfer by means of a mechanical hoist and found that none had their own sling in their own bedroom. Three people who required hoisting were in the lounge but we found the slings used to transfer these people were hanging on the back of a communal bathroom door. Some had other people's initials and room numbers on which meant they may have been placed at risk of injury if they were not using the slings that they had been assessed as needing. Therefore we could not be assured that people were being transferred safely using the correct slings.

We saw that in addition to moving and handling risk assessments there were some general risk assessments in place for other aspects within the home. For example, for risks associated with skin integrity, fire risk assessments and environment to help to keep people safe. There were, however, no risk assessments in place in relation to personal care, medicines, vulnerability to abuse or behaviour in some of the care plans we reviewed.

Staff did not always demonstrate a good understanding of the needs people living with dementia and how to keep them safe. For example, with behaviour that may place them or others at risk. We observed that staff

were writing up records in the lounge while a situation occurred between two people, one person was pushing the other person and displaying anger towards them. The staff member said, "don't do that" calling the person by their name. They did not try any distraction techniques and only after the situation continued for a couple of minutes did the staff member approach the person to intervene.

We reviewed information in relation to the numbers of accidents and incidents at the home and saw that they were appropriately recorded. However, accidents and incidents were not always analysed and actions were not consistently put in place or care plans updated in order to keep people safe and meet their needs more effectively. For example, we noted that a number of falls were 'unwitnessed' and the registered manager explained that staff could not be present every time a person fell. But there was no analysis about the times of the falls or the circumstances in order to identify trends or patterns so that preventative actions could be put in place. One care plan we looked at demonstrated that one person had six falls from June to August 2016. However the falls assessment had not been reviewed or updated or any additional control measures put in place to reduce the risk to this person. In the case of six people had fallen their urine was checked for an infection, however the approach was inconsistent

People medicines were not always managed safely. We found there was an appropriate system in place for the ordering and disposal of medicines and found that medicines were stored correctly in suitable lockable storage facilities on each of the two units. The stock balances we checked corresponded to the records. Staff had received training in the safe administration of medicines and had their competencies checked. However this had not been effective in supporting staff to administer people's medicines safely.

We observed staff administering people's medicines on two separate occasions and checked the stock balance of nine people's medicines. On the second day of our inspection we found tablets had been left in a pot on a person's table. The nurse had signed the MAR (Medication Administration Records) chart to say they had been given. We brought this to the registered manager's attention who took appropriate remedial action to do some additional training and supervision with the nurse. Furthermore we found from an audit completed by the regional manager that a MAR chart had been signed to say a person had been given a tablet but the tablet had not been administered and remained in the pack. This demonstrated that staff did not always follow the correct procedure to ensure people received their medicines as prescribed.

On the third day of our inspection we observed the morning medicines round on Magnolia and noted the nurse was still administering medicines at 10.40 am. The nurse told us this was the 8.30am medicines round but as they were short staffed and had been interrupted on several occasions, they were running late. This meant that people were receiving their medicines outside of the prescriber's recommended times for administration. The nurse told us they would be finished by 11am. We asked what time the next medicines round would commence and they told us by 1pm. This meant that there was an inadequate period of only two hours between the morning and lunch time medicines.

Due to the ineffective systems in place to keep people safe this was a breach of Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014.
On the first day of our inspection we arrived at 7.30 am and we observed that seven people were already up sitting in the lounge on Primrose unit and six on Magnolia unit. We asked staff why people were up so early and were told that the night staff always assist five or six people to get up to take the pressure off the day staff. Care plans did not specify that this was people's choice. Furthermore the people that were up did not have pressure areas. We saw that although there were five staff members deployed on Magnolia, which included one nurse and four care staff, there was 23 people living on the unit all with complex needs. We observed people had to wait to be assisted with personal care throughout the morning. We discussed our findings with the registered manager who told us that there was not a requirement for night staff to get

people up unless they were at risk of falls or trying to get up themselves. We noted that three people who were assisted to bed early in the evening were also the ones who were up early in the morning. This meant that people were sat in the lounge for up to twelve hours at a time doing very little.

People were unable to tell us if they felt there were sufficient staff on duty at all times. However, feedback obtained from five relatives along with our observations suggested that there was not enough staff. Staff told us that they managed with six staff but if anyone called in sick or they were one staff member short for the shift it put them under pressure. The registered manager told us that six staff were usually allocated to each unit, and if they were one staff member down either the deputy manager and another staff member for example from the activities team would support the shift. We noted from the regional managers audit completed the day before our inspection that eleven staff member were 'randomly absent' during July and in addition three staff members were on long term sick. They told us that they had a full complement of nursing staff however they had 180 hours of vacant care worker hours which they were currently recruiting to. On occasion both the registered manager and deputy manager supported shifts either in a nursing or care worker shift when they were short staffed. The managers were responsible for all monitoring, checking and auditing of the home. The deputy manager provided most of the supervision for care staff and the registered manager for the nurses.

Staff were able to tell us about people's individual care needs. However, one staff member said they had a detailed care plan but sometimes the routine and plans changed depending on what else was going on. For example, one relative told us their family member required the assistance of two staff and required support with all aspects of personal care and support with eating and drinking. They told us, "When the shift has five carers on duty it is just about manageable - when there are four or less it just doesn't work. Carers are often having to go out on hospital appointments or ring in sick and then we end up with 3 or 4 which is totally unmanageable and putting people at risk." They went on to say "We can't rely on staff having enough time to give 'relative' the time they need."

A relative told us their family member was often not up out of bed when they visited. When they asked staff they were told that the family member was tired and needed to go back to bed or had not been got up for the same reason. However this happened frequently and when the family member was present they did not feel the relative was too tired and had not been offered the choice to be got up. The family member told us this situation occurred regularly at the weekend when staffing levels appeared to be more stretched than normal.

Another relative told us, "The staff are generally very competent and caring - I don't have any complaints about any of them - other than there aren't enough of them. They also double up in other areas on occasions so although it might look like there are 5 carers on duty you will find one might be working in the kitchen or out on a hospital visit which can take the whole morning or afternoon." This would mean the shift is short and impacts on the level of care and support people received.

The registered manager told us that 70% of people living at Houndswood house required the assistance of two care staff. We reviewed the allocation sheet and saw that staff were assigned people to provide personal care to however they were no times around when people were to be supported and we observed people still being assisted to get up at 11am. We asked the staff if the person could be assisted earlier and the staff member told us, "We work our way through the list."

We spoke to a person at 8.15am who asked if we could assist them to get up. We explained that we were not staff members and would ask a member of staff to assist. We spoke to a staff member who assured us they would come and assist the person in a few minutes when they had finished what they were doing. At 9.21 we

observed the same person to be distressed and again asking to be assisted to get up. The person said, "I am hungry and thirsty; please help me up, my hip is hurting." I spoke to the member of staff and the registered manager to establish why this person had still not been assisted one hour after their original request. The staff member told us they had offered to help the person but they had declined. However there were no written records to support this statement. We checked the daily allocation documentation and found that the care worker we had spoken to was not assigned to support the person concerned and the staff member who was looking after the person was busy supporting other people and was not free to assist the person when requested.

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

Staff told us, and we saw that, they had received training about how to recognise and report abuse and how to protect people from harm. Staff demonstrated that they knew how to identify and report potential abuse. For example, staff told us that people living at the service were observed for any unexplained bruising or any changes in their behaviours which may be signs of potential abuse. Staff were confident that any concerns reported to the registered manager would be effectively dealt with to make sure people were safe.

The process for the safe and effective recruitment of staff was not robust or consistent. Staff told us they did not start working at the service until they had all their pre-employments checks completed by the registered manager. These included completion of an application form, an interview, a criminal records check and written references. However we found that application forms were incomplete in the case of three of the four we reviewed. References also had not been validated and in the case of two peoples recruitment files the references were 'standard letters' of introduction from another country and were not specific to the person applying for the job as the document contained Mr/Mrs and He/she and her/him throughout the document. We spoke to the registered manager about this lack of clarity and personal references and they told us, "This is usual for people from other countries." These checks were in place to help to ensure that staff employed to support people were suitable for the roles they were being employed for. However we could not be assured about how effective the checks were as they were so general. We found that when speaking with staff whose English was not their first language they could not always respond to our questions without the assistance of a colleague to interpret. We spoke to the registered manager about this as we were concerned if people who used the service said something to the staff members they may not be fully understood and this could place people at risk of harm.

Requires Improvement

Is the service effective?

Our findings

People were not always supported to eat and drink a range of healthy and nutritious foods. We observed that snacks were not available and asked staff if people were able to have snacks or finger food if they wanted. We received mixed responses. Some of the staff said people could have a snack if they requested one. Other staff members said people had tea or coffee and biscuits mid-morning and mid-afternoon. The registered manager told us snacks could not be left out because people living with dementia put them in their bags on one unit and on the other unit three people had diabetes and had in the past helped themselves to snacks which had a negative impact on their health.

We spoke to the assistant chef who told us the day before our inspection people had fruit in the morning and cake in the afternoon and that snacks were provided two or three times a week. However we found that people were not offered snacks on the day of our visits because the assistant chef told us they were shot staffed in the kitchen this meant that people were not consistently provided with snacks between meals. People were not given the choice to eat and drink when they wished and were reliant on staff offering them or them requesting a snack or a drink.

We observed the lunchtime meal and found that the menus were displayed for the wrong day. People were unable to tell us if they were happy with the standard of food they received due to their limited communication abilities. We saw that there were nine people in the dining room who had been served roast beef and parsnips. We saw that the meal was overcooked. We observed that two people tried to chew the meat but were unable to eat it. We spoke to the assistant chef who explained that the steamer on the oven was broken causing the meat to become very dry. Despite the food being inedible we saw staff continued to serve food to people and no alternative choice was offered. This meant that people were at risk of not receiving a nutritionally balanced meal and were at risk of being hungry. We told the registered manager we were concerned about the standard of food being served. They tested the beef and discarded it immediately. They asked the assistant chef to offer people a choice of omelettes and salmon steaks which were the second choice on the menu for the day. The registered manager told us they would be addressing our concerns with the assistant chef.

We saw from records that people were weighed monthly unless there were concerns about people's weight and in which case they were weighed weekly. Overall people had sustained their weights and where people had lost weight this was monitored appropriately and referrals had been made to the speech and language therapist or a dietician for professional intervention and support. However, we saw that food and fluid monitoring records were not always completed in a timely way. Staff told us they completed the charts when they had time usually toward the end of their shift. This meant that we could not be assured of the accuracy of the records. We noticed that people did not have access to drinks within one of the lounges and had to request that staff offer people drinks as it was a very hot day.
This was a breach of Regulation 14 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

We saw from the regional manager's audit completed the day before our inspection that there had been seven urinary tract infections in the previous month which was recorded as being 'high' and was being

discussed with the home manager. Some of the actions being considered in response to this was additional training for staff, proactive encouraging of fluids, accurate recording.

People were unable to tell us if staff had the appropriate skills and were knowledgeable about how to support and care for them due to their limited communication abilities. We therefore asked people's relatives and received mixed views, with some relatives having concerns about the skills and abilities of staff. One relative told us, "It is my opinion that there are insufficient numbers of qualified staff at the home. It would be so much better if there was a permanent nurse in post there have been over the years, but they do not stay. Sometimes staff do not communicate in a professional manner."

Staff told us they had received an induction and that they had on-going training. However the training was all computer based and was not always effective in providing staff the skills required to meet people's needs effectively. One staff member told us, "I had induction before I started working here. Since then we have regular training to make sure we are up to date and we know what we need to do." However the registered manager told us that they had recognised that the E learning had proved ineffective and the training programme was being changed to incorporate face to face training as this was more interactive. They told us that they anticipated this would be more effective in providing staff with the skills required to care for people effectively. We looked at training records and saw that staff had completed training in a range of topics which included safeguarding people from the risk of abuse, Mental Capacity Act (MCA) 2005, infection control and medication.

Some of the staff told us they felt supported by the management team, while other staff members told us they did not always feel supported. One staff member said, "The managers have their favourites." We saw that staff had intermittent supervisions and an annual appraisal. However, some of the records we saw did not demonstrate effective supervisions and were incomplete. We spoke to the manager about this and they could not give us an explanation why this was. Staff did tell us that they were supported. However one staff member said, "The [registered] manager spends a lot of time in their office and not in the units."

People could not tell us if staff always asked them before they provided the support people needed due to their limited communication abilities. Staff spoken with told us they did always obtained people's consent before supporting them. However, we observed that this was not always the case. On three occasions we saw staff taking people by the hand and leading them from one area to another without explaining where they were taking them. Consent had been recorded in people's care plans and where appropriate relatives had been involved in the process where they had the legal right to do so.

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.

Some of the staff had some understanding of the Mental Capacity Act 2005 (the MCA) and how to make sure people who did not have the mental capacity to make decisions for themselves had their legal rights protected. The registered manager told us about the process they would follow to ensure any decisions put in place were in the best interest of the person. This included liaising with the local authority and other professionals or family members involved in the person's life to decide the best action necessary to ensure that the person's needs were met effectively and that met the legal requirements.

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). We found that four applications had been made under DoLS, three people had their application authorised and another application was pending authorisation.

People were supported to maintain their health and records of health related appointments or any medical interventions were recorded in people's care plans. Staff told us and records confirmed that they made referrals to relevant healthcare professionals should the need arise including GP appointments. One person told us they had their eyes tested recently. Staff also told us that they made appointments for people to be seen by the chiropodist or dentist when required. People were supported to attend Hospital appointments if family members were not available to support. This showed that people received support from healthcare professionals to help maintain their health.

Requires Improvement

Is the service caring?

Our findings

We saw some kind and caring interaction between staff and the people who used the service. One staff member wiped the mouth of a person who had spilt their lunch – they explained that they were going to wipe their face and clean it up for them. However, the majority of care was basic. We saw that people were rushed and only one staff member sat down and spoke to a person in Magnolia unit. We observed one person whose slipper had fallen off sit for 15 minutes without any staff noticing that they only had one slipper on and finally the inspector assisted the person in putting their slipper back on. People in Magnolia looked unkempt and uncared for. Several people had not had a wash; hair brushed or had a shave. Finger nails were dirty and long and clothes had dried food on them, were generally dirty and with holes in. Four people had unsuitable footwear which was too big and could cause them to fall over.

People were not consistently cared for in a way that demonstrated staff respected people's choices or followed their personalised care plans. We also observed that people's glasses had not been cleaned. This lack of attention to detail meant that people were sometimes left in an undignified manner. One relative told us, "Possessions are not looked after very well and I think there is a lack of communication on this. Clothes often seem to go missing despite being clearly and labelled, and they sometimes get shrunk in the wash. Cleaners tidy away important things like photographs. Plants aren't always watered. The rooms are in serious need of redecoration; curtains are shredded." This demonstrated that people were not always treated in a way that supported their dignity.

We spoke with staff and reviewed allocation of work schedules to help us understand the process for supporting people with their daily routines. Staff told us they assisted people from their daily allocation. However one staff member said, "We do not always have time to bath people it is often a lick and a promise." Another staff member said, "Yes we would like to give people a nice bubble bath but it does not happen, we sometimes have to offer people a bath in the afternoon when we are not so stretched." We saw from one person's care plan that they liked a shower or a bath three times a week. However, neither the bathing record or the daily care records demonstrated that this person had been receiving regular baths or showers. The weekly allocation sheets also demonstrated that people were allocated a bath or shower just once a week. This suggested that people's personal care needs were sometimes decided based on the availability of staff rather than their preferences.

We observed a situation where a person had lost their glasses and were becoming extremely upset. We heard the staff tell the person they would help to find their glasses. However the person was becoming increasingly distressed and started to cry, the staff member said, "I told you we will find your glasses, stop panicking." They failed to reassure to the person who remained distressed until staff had located the glasses and had given them to the person.

We saw that care was very task orientated and the routines were based on the availability of staff, rather than responding to people's needs. We also found that some staff did not use terminology that promoted people's dignity. There were occasions where we heard staff speaking to people in an infantile and derogatory manner. For example, one staff member said, "Come with me darling, that's a good girl." They

then brought the person and seated them at the dining table. This approach failed to demonstrate that staff addressed people by their preferred name or in a respectful manner.

Staff did not always respect people`s choice and wishes. When we asked staff why three people had been assisted to bed at 6.15pm on a bright summer's evening one staff member told us, "It was to manage their pressure areas." However, none of the three people were at risk of developing pressure ulcers and they were not given a choice or asked if they were happy to go to bed so early. Likewise when we asked staff why they had been got up so early and left to sit in the lounge we were told it was because they were at risk of falls. They told us that if they were not got up they may try to get themselves out of bed. This meant that we could not be reassured that people were given a choice about when they went to bed or what time they liked to get up.

Care plans detailed people's likes and dislikes however staff did not always know about people's likes and dislikes for example in relation to their preferred routines. For example, one staff member told us, "They just sit there all day with nothing to do." Care plans did not detail how people liked to spend their time and staff told us they liked watching the television when asked but from our observations five out of eight people were asleep when we observed them.

The registered manager told us that care plans were developed with people's involvement and where appropriate the input of family however this was not clearly evident from the care plans. Staff demonstrated they knew people's basic needs but did not know about the detail of people's choices. One staff member told us that a person had a wash, when we asked if this was their choice the staff member did not know. We were told that another person should be offered a bath twice a week however a family member told us, "It was more close to two baths a month." depending on the availability of staff. This demonstrated that people's personal care needs were not always met in accordance with their assessed needs, wishes or preferences.

An audit completed the day before our inspection by the regional manager described people living on the Magnolia unit as 'Residents in the Magnolia unit are less presentable but not because the staff have not been trying. Amazing efforts are made by the staff to ensure residents are presentable at all time'. However these were not our findings during our inspection. Furthermore no actions were recorded on how 'people's presentation' was going to be monitored or why despite the staff efforts a good standard of personal hygiene could not be achieved.

People were unable to tell if their privacy and dignity was respected due to their condition and limited verbal communication. However we saw that staff did not always knock on people's doors before entering or offer choices about where they spent their time. A staff member said when people are in the lounge we can monitor them more regularly. However they did not tell us whether this was people's choice.

We found that people did not receive SAFE and EFFECIVE care that met their needs in a timely way therefore this was a breach of Regulation 9 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

The registered manager told us visitors were able to visit at any time, and we saw from the visitor's book that people visited regularly and at different times of the day. We saw that information held about people's health, support needs and medical histories was kept secure and information was only shared with people who had authority to access it.

Two people on Primrose unit told us they got on well with staff and we observed they appeared to be comfortable in their presence. One person told us, "I do like some of them (staff), but others I am not so keen

on." Many people had resided at Houndswood House for a number of years and one person told us, "The staff keeps changing, so it's not so easy to get to know them well." Two relatives told us the staff were very caring and that they were quite happy with the standard of care their relative received. One relative told us, "The staff do their best there is just not enough of them."

Requires Improvement

Is the service responsive?

Our findings

People were not able to tell us if they were happy with the support they received. However several family members raised concerns about how responsive the service was to meeting people's needs. For example one relative told us, "The activity programme looks good on the wall but very rarely happens. Most days there is nothing going on in the lounge. Probably once a week at the moment something happens for about half an hour from what I have seen." They went on to say, "A lot of activities time is spent creating posters and doing crafts but quite often the residents aren't engaged in this. Activities staff also help with feeding which takes them away from their main focus of doing activities."

People were encouraged to participate in activities. However we found these did not reflect people's needs. We found that care plans did not always include information about people's hobbies and the type of social activities they enjoyed. For example, we observed in the lounges on each unit the television was on but there was also music was playing. People were not engaged with what was on and the volume was so loud it drowned out any potential for communication or conversation. On the other unit for people living with dementia quiz was in progress, however, again people were not engaged with the activity and it was only a member of staff that kept calling out the answers. In the afternoon we observed staff throwing a balloon to people sitting in chairs in the lounge. People were not interested and eventually staff put on some music; however the same song played three times over again and again. The staff members present made no attempt to change it, or asked people what they would like to listen to. We saw from resident meeting minutes that people had said they would like Bingo as an activity but this was not on the activities planner that was provided to us to us.

One relative told us, "There are not enough activities and not much at all at the weekends." Another relative said that, "When they knew you were coming [CQC] they seem to have more going on but that's not the normal routine." We found that people living with dementia had to listen to music and although they were able to walk around feely, there was little stimulation or interaction from staff. There were limited objects available that could stimulate and engage people. Staff told us that in the morning people were getting their hair done but this was limited to just a few people and others were left sitting in the lounge for long periods of time. We noted that staff did not provide any activities or engagement for people who were cared for in bed. They told us that due to being busy this rarely happened. One staff member told us that, "When we have time we sit and chat to people individually."

People's care plans contained information about how they needed to be supported. However, care and support was not always provided in accordance with their care plans. Some care plans were more detailed than others. However in the case of some of the care plans we reviewed they did not always contain specific information for example about people's preferred times for getting up and going to bed and whether people preferred their bedroom door left open or preferred it closed.
People's care plans lacked detail or accurate information relating to people's care and were not subject to regular review. Not everyone had a picture within their care plan to help identify them. No background or social history to support staff to understand the person better in four out of five care plans. Each care plan contained a basic list of the tasks that care staff would follow when providing support, and some

information in relation to continence, mobility, communication and diet. However this information was not person-centred and did not provide enough detail to enable staff to carry out tasks consistently and safely. From our observations we saw that staff provided only basic and functional care and this was not always in accordance with their care plans.

We found that the environment, in particular for people living with dementia, was not well maintained and was in need of some updating. Paint was chipped and the environment had nothing of interest for people to engage with. People's bedrooms were numbered with just the person's name but all were the same colour and there was little that people could identify with. We also found that people's beds were not made properly with the outer cover just being pulled up over the pillow. When we checked mattresses we saw that some sheets were soiled and there were malodours present. We spoke to managers about this and as a result all beds were to be stripped on a daily basis. Also new bed linen has been purchased to help ensure people did not have old worn or soiled bed linen.

Due to the lack of meaningful engagement for people living with dementia and poor care delivery and care plans we found that this was a breach of Regulation 9 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

People's complaints were responded to appropriately. There was a robust process in place for the recording and investigation of complaints. However one relative told us that complaints made had not always been responded to as they would have expected as they found the registered manager to be defensive. Another relative said, "I have brought concerns to the attention of the registered manager in the past and they did listen." We reviewed the complaints log and saw that complaints were investigated and responded to in accordance with the complaints policy. Compliments too were recorded.

Requires Improvement

Is the service well-led?

Our findings

At our last inspection of the service we found management systems were not robust and required improvement to identify areas of shortfall and drive forward improvement. An action plan was received on the 18 January 2016 with actions scheduled to be completed by 28 February 2016. However, during this inspection we found the provider had not made sufficient improvements.

At this inspection we found that further improvements were still required as the management systems were not effective in identifying many of the issues we found during our inspection. People were unable to tell us if they were happy with the overall management of the service. We observed that care was basic and often reliant upon the availability of staff.

We found that the management of the service lacked leadership, was not transparent or open and did not consistently support its staff. Feedback from staff did not demonstrate that they were being given the appropriate training to carry out their role effectively. Also we found concerns in relation to the recruitment process when two staff members had great difficulty in understanding our questions and required another staff member to translate what we were asking. We could not be assured that they were trained effectively if they could not understand English and all the training that is provided is E learning.

We found that there were some quality assurance systems in place. However, these were not being used effectively. The registered manager showed us that they undertook a range of audits and checked paperwork and records. They also walked around the home on a daily basis; however they had not found some of the concerns we discovered during our inspection.

A recent audit undertaken by the area support manager on the 8 and 9 August the two days prior to our inspection also failed to identify many of the issues we identified insufficient staffing levels including poor care delivery and a lack of safe and effective processes to 'monitor and manage the service. For example, the audit completed said 'End of life care, Infection prevention, Residents' involvement, Recreation & Activities, Health & Safety, Kitchen and safeguarding all completed'. In relation to the general hygiene the audit stated 'Generally clean despite the environment. Some areas in the EMI unit could be better cleaned. Especially the bathrooms and toilets'. The action stated 'Housekeeper to ensure EMI unit is not overlooked and establish cleaning protocols for all areas'. However it did not say how, when or who would be overseeing this action. The audit finding around activities said 'very good interaction between residents and team members. Calm and collective workforce with much humour and support to facilitate the daily requirements of each resident'. However feedback from relatives and observations during our inspection did not find this to be the case.

The registered manager was supported by a deputy manager. We found that audits were not effective for example records were not always completed in a timely way. Also although the registered manager told us everyone had their own sling in their bedrooms we found that this was not the case.

We spoke with staff about the management of the home. Staff gave us mixed feedback but were consistent in telling us they were often short of staff and this did put pressure of the rest of the team. One staff member told us, "We have all been told to complete records including food and fluid charts, and positioning, care, however we are often too busy and do them when we have time, it is not always possible to do them when we are so busy supporting people."

The regional manager's audit stated 'schedules have to be compromised at times when housekeeping staff have to cover other areas'. They went on to say 'cleaning standards are good'. However we did not find cleaning and infection control to be well maintained or effectively managed. We found on one of the days of our inspection a member of staff who told us they were a 'cleaner' was assisting the deputy chef with the cooking.

Staff, resident and relative meetings were held bi- monthly. Meeting minutes showed that the agenda covered a range of topics as well as providing an opportunity to share and update people about what is happening in the home. Although we could see some suggestions had been actioned, for examples around a review of food and menus, there were no action plans to ensure that all people's suggestions were actioned. Such as around activities and the availability of a range of foods, fluids and healthy snacks, which were not always offered to people who were cared for in bed. We also noted that during our inspection in January 2016 we were told by the registered manager that the home was due for a major refurbishment which had previously been put on hold. However we found that the refurbishment had still not commenced at the time of our inspection.

Governance systems were not robust. We found that this was a breach of Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014. Record keeping was a continued breach of regulation 17 from our inspection in January 2016.

Feedback was obtained through the completion of an annual survey. This was in progress at the time of the inspection so we could not report on the findings. However the registered manager told us that once complete the feedback would be analysed an actions put in place to address any areas of concern that were raised.
The management team took appropriate action to the feedback given following our inspection and a number of systems have been put in place as well as a detailed action plan to achieve the required improvements.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People did not receive personalised care that met their needs.

The enforcement action we took:
warning notice and NOP to restrict admissions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The systems that were in place were not robust to ensure people were kept safe at all times.

The enforcement action we took:
warning notice and NOP to restrict admisssions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs People did not have regular access to snacks and drinks and food served was a poor quality with a lack of choices.

The enforcement action we took:
warning notice and NOP to restrict admissions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems in place were not robust in the overall quality monitoring of the service.

The enforcement action we took:
warning notice and NOP to restrict admissions

Regulated activity	Regulation
Accommodation for persons who require nursing or	Regulation 18 HSCA RA Regulations 2014 Staffing

personal care

There were not enough staff deployed to enable them to meet peoples needs in a timely way.

The enforcement action we took:

warning notice and NOP to restrict admissions