Central Bedfordshire Council

Westlands Residential 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

This inspection took place on 3 and 7 June 2016 and was unannounced. This was our first inspection of this service.

Westlands is a residential care home in Leighton Buzzard, providing accommodation and support for up to thirty older people. The home operates over three floors. The first and second floors are accessed by stairs and a lift. At the time of our inspection there were twenty-five people living at the home, some of whom were living with dementia.

The home had a registered manager in post at the time of our inspection. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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.

People who lived at the home were not always safe because the staffing levels were not sufficient to meet their care and support needs. Their medicines were administered as prescribed but there were unexplained gaps in medicines administration records and their risk assessments did not always provide adequate guidance to staff on keeping them safe. Risk assessments that related to the safe running of the home had not been reviewed since 2013. Staff were trained on safeguarding people and they understood the process they needed to follow, if there were concerns about people's safety.

Some of the areas of the home and furniture were dirty and this exposed people to the risk of acquired infections. People were also exposed to hazards because cupboards with cleaning detergents were not always locked.

People's care was not always effective because regular use of agency staff meant that they did not always receive consistent care. The requirements of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards were not always met, and people were not involved in menu planning. Although staff were trained in areas that were relevant to their job roles, we found that the training was not always effective in meeting people's care needs. People were supported to access other health and care services when required.

The service was not always caring because the interactions between staff and the people who lived at the home were mainly task led. People were advocated for by their relatives or social care professionals where needed but there was no evidence that showed people had support from independent advocacy services if required. Staff were spoke with people appropriately and called them by their preferred names. People's privacy and dignity was observed.

Improvements were also required in the responsiveness of the service because people and their relatives

were not fully involved in the assessment and planning of people's care. People were not always supported by staff to take part in activities that were of interest to them.

There was an effective system in place for handling complaints, but improvements were required in senior management's oversight of this home and the frequency of audits so that any issues could be addressed quickly.

The provider was not meeting the regulations in relation to consent, safe care and treatment, the safety of the premises and equipment, staffing, person-centred care, good governance and notification of other incidents. You can see what action 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 always safe.

The staffing levels were not sufficient to fully meet people's needs. Staff were trained in safeguarding and understood how to keep people safe from avoidable harm.

People's medicines were administered as prescribed but there were unexplained gaps in people's medicines administration records.

People's risk assessments did not provide adequate guidance to staff on how to keep people safe.

Some areas of the home and furniture exposed people to the risk of acquired infections because they were dirty.

Is the service effective?

Requires Improvement

The service was not always effective.

The requirements of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards were not always met.

Improvements were required in the home environment.

People had enough to eat and drink, but they were not involved in menu planning.

Staff training was not always effective in enabling them to acquire the right skills and knowledge to meet people's care needs.

People were supported to access other health and care services when required.

Is the service caring?

Requires Improvement

The service was not always caring.

The interactions between staff and the people who lived at the home were positive, but mainly task led.

Staff spoke with people appropriately and called them by their preferred names.

People were advocated for by their relatives or social care professionals where needed. There was no evidence that showed people had support from independent advocacy services if required.

People's privacy and dignity was observed.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People and their relatives were not fully involved in the assessment and planning of their care.

People were not always supported by the staff team to take part in meaningful activities that were of interest to them.

There was an effective system in place for handling complaints.

Is the service well-led?

Requires Improvement

The service was not well-led.

The home had a registered manager in post. However, improvements were required in senior management's oversight of the service and the frequency that audits were carried out so that any issues could be addressed quickly.

There was mixed feedback about the effectiveness of the home's management team, but people agreed the manager was visible and approachable.

People, their relatives and staff had opportunities to give feedback about the service.

Westlands Residential 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 took place on 3 and 7 June 2016 and was unannounced. It was carried out by one inspector from the Care Quality Commission (CQC).

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed information we held about the service including notifications and other information received from the provider. A notification is information about important events which the provider is required to send to us. The local authority had recently carried out a monitoring visit of the home, so we gathered feedback from their visit.

During the inspection we spoke with five people who used the service and four of their relatives to get their feedback about the quality of the care provided to them. We also spoke with four members of the care staff, a temporary member of staff from the agency, the cook, a visiting health care professional, the deputy manager, the regional manager and the registered manager. We observed how care was delivered and reviewed the care records and risk assessments for three people who lived at the home. 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 looked at four people's medicines and medicines administration records, and four staff recruitment, training and supervision records. We also reviewed information on how the quality of the service was monitored and managed.

We reviewed further quality monitoring documentation that was sent to us by the regional manager.

Requires Improvement

Is the service safe?

Our findings

The service was not always safe because people's medicines were not managed effectively, their risk assessments were not robust enough and the staffing levels were not sufficient to ensure people's needs were safely met.

The service did not have enough permanent staff so they had a number of agency staff who worked at the service. People who used the service told us that the staffing levels needed to be increased to safely meet their needs. One person said, "I don't think there is enough staff. You don't see them a lot and they don't have time to talk to you. There's not enough of them at night either to help get us to bed or anything like that. Nobody pops in to see if you're all right and help you with a drink if you want one." Another person told us, "There isn't enough staff. There is too many temporary staff and they don't always do the job right." One other person added, "I think the home is going down. We don't get the care we should. The staff are leaving and the temporary staff don't know what they are doing." People's relative also said that the staffing numbers needed to be increased. One relative said, "You don't get to see staff much, I think I have only ever seen three of them around [during visits]." Another relative told us, "You have the regular staff and the agency ones, but sometimes they are stretched." Staff's views were similar to the ones of the people who used the service and their relatives. A member of staff we spoke with told us, "We are short staffed. We use agency staff to back fill but they don't do the job as it is supposed to be done. We need five or more care staff and one senior on shift during the day at least."

We reviewed the duty rotas and found that there were four care staff and one senior member of staff planned to provide care and support to people, across three floors during the day and three care staff at night. We observed the interactions between staff and people and found that they were rushed and mainly task led. People were left on their own for lengthy periods of time without any meaningful interactions with staff. Some people's requests for support were not met. For example, one person had not been supported when they asked two members of staff on two different occasions, to be taken to the garden as it was a sunny day, and they wanted to sit outside to smoke their cigarettes. Both members of staff appeared rushed as they were needed elsewhere. They both asked the person to wait, promising they would return to support them but failed to return. We observed on the first day of our inspection this same person being supported by a member of staff to go to one of the lounge areas. The person was very excited and told us, "I am going to sit in the garden." We later on found the person sat in one of the armchairs in the lounge. We asked them if they enjoyed the garden and why they did not stay out in the garden long and the person said, "I haven't been yet. The staff will take me in a minute." We observed again that the staff failed to return to support this person to access the garden. We raised this with the manager and the deputy manager and they told us that the difficulty was that this person required staff to remain with them when they were in the garden as they were at risk of falling, and the staffing levels did not allow for that. The manager further explained that plans were in place to increase the number of permanent staff who worked at the home because of the closure of another home owned by the provider and that they would get staff from the closed home. This we found would possibly reduce the number of agency staff used at the home, but did not address the low number of staff expected to provide care and support to people on a day to day basis.

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

People's medicines were administered as prescribed by the senior members of staff. Medicines were stored in locked cabinets within the home's medicine room. There were protocols put into place by the provider for people to receive medicines that had been prescribed on an 'as and when required' basis (PRN). We checked the stock of medicines held for four people against the medicine administration records (MAR) and found unexplained gaps on three people's MAR charts. We looked at the stock of medicines for the people concerned and found that they had been given their medicines. We raised this with the manager along with our concerns that senior members of staff who administered people's medicines did not take any action to report and rectify these recording errors. The manager was unable to account for these errors and why they had not been picked up.

People had risk assessments in place to safely manage the risks posed to them by the care and support they received. Risk assessments covered areas such as moving and handling, use of wheelchairs and people falling. We found that these risk assessments were not robust enough because they did not contain enough information to guide staff on what action they could take to keep people safe. For example, one person's 'falls prevention' risk assessment stated that if they were found to have fallen and not sustained any injuries, staff were to hoist them back up. This did not detail any guidance for staff to follow in instances where this person sustained an injury nor did it detail any reporting processes. A person we spoke with told us they did not know if they had a risk assessment in place. A relative we spoke with said, "No, I haven't been involved in any paperwork. [Relative] had a fall and they now need two people to help them to mobilise. I sat with them after the incident and they let me read part of the plans to make sure it does not happen again." A member of staff told us, "Yes [people] have risk assessments, but I haven't seen them." Another person said, "Everyone has their own risk assessments, yes I have seen them. I would report any changes to risk assessments to my senior, I have already done this when I found a resident needed two staff to help [them] with personal care. I told my senior and now we have two staff supporting the person."

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

Improvements were required in the decoration and cleanliness of some of the furniture within the home. Some areas of the home were being redecorated at the time of our inspection, but we found most parts of the home appeared dated, with several scuffs and scratches on doors and door frames. This meant that they could not be cleaned properly and could put people at risk of acquired infections. We found the chairs in the lounge areas to be dirty, stained and smelled of urine. The odour, especially in the lounge areas was unpleasant and the carpets in these areas needed to be replaced. We observed some members of staff avoided sitting on the chairs, with one member of staff choosing to sit on a side table instead of the chair when they interacted with a person who was sat on one of the chairs. A relative of a person who lived at the home said about the home, "It is way behind times." We found exposed hot water pipes in the bathrooms which could have presented a risk of burns to people, staff and visitors if they accidentally came into contact with these. Some bathrooms had lockable cabinets in them where staff could lock away personal protective equipment, but this was left unlocked. The lockable utility room was also found to be unlocked during our inspection. Inside we found what was left of a ten litre plastic bottle of detergent which clearly stated 'hazardous if consumed'. This could have caused harm to people who lived with dementia had they accidentally drank this. We spoke with the manager who said, "It is supposed to be locked," and then made sure the door was locked.

This was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations

2014.

The provider had carried out health and safety risk assessments to safely manage risks posed to people by the environment. These risk assessments identified hazards that could cause harm, those who might be harmed and what was being done to keep people safe. They covered areas such as infection control, moving and handling and electrical safety. The registered manager told us that these were supposed to be reviewed every three months or earlier if required. We found that the last review was carried out in 2013 and the registered manager could not give us an explanation as to why they had not been reviewed in accordance with the timelines she told us. The provider had an emergency protocol in place to keep people safe in the event of a fire, adverse weather or any other unforeseen circumstances. This was accompanied by the home's business continuity plan which detailed the steps the provider would take to ensure people's safety, in an event that stopped the home running the way it should.

People told us they felt safe living at the home. One person said, "It is safe, there is no nastiness or aggravations." Another person told us, "Yes I feel safe because I am used to the place." People's relatives also felt people were safe. One relative told us, "Yes I think [relative] is safe. [They] are looked after." A visiting professional we spoke with said, "I have no concerns at all. There was a deep in the quality of care when they relied on agency staff heavily, but it is safe."

The provider had an up to date safeguarding policy in place. Staff had been trained on safeguarding people, and they demonstrated a clear understanding of their responsibilities in this. They were able to tell us the types of risks that could affect the people they supported and the actions they would take if people were unsafe. One member of staff said, "Yes my safeguarding training was done last year. I would report any abuse if I suspected it to my senior, the deputy manager or the manager and the safeguarding team." The provider also had an up to date whistleblowing policy in place. This gave staff a way in which they could report concerns within their workplace without fear of consequences of doing so. Staff told us they had read and understood this policy and would use it if there was a need to do so. One member of staff said, "Yes we have a whistleblowing policy. The numbers to call to whistle blow are all in the staff room. I would definitely whistle blow if I had concerns, you've got to think these are vulnerable people at the end of the day."

The provider had a recruitment policy in place which included checks with the Disclosure and Barring Service (DBS) to ensure that applicants were suitable to safely care for people. Potential staff were also required to complete health questionnaires to ensure they were fit for the role they applied for. The provider also requested previous employment references. This supported the provider to determine whether applicants were suitable for the roles they were being considered for. We reviewed four staff records and found that requests had been made in writing to their previous employers for references. However, we saw only one written reference had been received for one member of staff. We discussed this with the registered manager and they told us that most of the staff records were held by the provider's Human Resources (HR) department and that they were going to request that these records were sent to us within forty-eight hours of our inspection, which they did.

Requires Improvement

Is the service effective?

Our findings

The service offered to people who lived at the home was not always effective because the requirements of the Mental Capacity Act 2005 were not met, people were not always involved in decision making around their meals and meal times and improvements were required in the home environment.

The home had a lift which was not working on the day of our inspection. We spoke with the manager about this and they told us, "It broke down yesterday at 10am. They have come to fix it, but didn't have the part but they will be coming back today to fix it." A person who lived at the home told us, "The lift has been broken for over three days now. It broke down on Friday and was broke all over the bank holiday weekend. One [member of staff] was stuck in it. Some of the people here can't get up and down the stairs. The lift is a requirement in case of emergencies." A member of staff added, "The lift was broken over the bank holiday weekend from Friday and was fixed on Tuesday. It broke down again on Tuesday evening and was fixed temporarily on Wednesday. It has broken down again today." The home also had an indoor smoking room on the first floor with a strong smell of smoke that lingered on that part of the building. The people and staff we spoke with all expressed their unhappiness the smoking room being there and the fact that they could be affected by passive smoking. A member of staff said, "I am a smoker and even I don't like it." We raised this with the manager and the area manager and they were going to explore ways of addressing this issue.

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. Staff we spoke with did not demonstrate an understanding of the Mental Capacity Act 2005 (MCA) or Deprivation of Liberty Safeguards (DoLS). They showed a lack of awareness of how this impacted on people who lived at the home. One member of staff told us, "The MCA refers to people who are aggressive." Another member of said, "I am not sure what the MCA means." We raised this with the registered manager who explained that staff were trained on this framework and the training records confirmed this, with the latest training having been completed in 2015. A review of people's records showed that there were areas of people's care that required the assessment of their mental capacity to make decisions, but they were not carried out. This raised a question about the effectiveness of the training staff received.

People can only be deprived of their liberty to 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). DoLS applications had been made to the relevant supervisory body and authorisations were in place for the some people, with further applications made as necessary to the local authority.

Some people told us that staff did not always ask for their consent before they provided care or support. One person said, "No they don't always ask permission before helping you in your room." One other person told us staff asked their permission before they supported them. They said, "They knock on my door and ask permission before coming in." We observed staff's interactions with people and saw some instances where

people's consent was not sought before staff provided care. For example, on one occasion staff moved one person without asking for their consent. We also observed two people's plates being removed after lunch without the staff saying anything to them.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People had enough to eat and drink but they told us they were not involved in choosing the menus. One person told us, "Sometimes the food is good and sometimes it's not. There is not enough variety. There's always fish and I don't like fish. Sometimes you get a choice and I am grateful for that, but we don't have that every day." Another person said, "They can do with a bit of improvement on food. We don't get alternatives if we don't like what's on the menu. Food prices are high and they can't waste any money. They have to cook exactly what they need." One other person added, "The food is good, we don't get to choose what to eat, you get what is on really." A relative we spoke with told us, "I am not happy with the food. If [Relative] doesn't eat they don't get alternatives. They just get what they are given. I spoke with staff about it and they told me if they don't like what is on offer they get something else but the residents can't do that." We raised this with a member of staff. They showed us the menu which offered three meal choices in the mornings, lunch and dinner time. They also showed us the 'meal choice recordings' and said, "We go around and ask residents individually what they would like as first, second and third choices." The member of staff added, "The budget is getting squeezed, we are using a menu from another home as they are cost effective. You always have spare food in the fridge for alternatives."

We observed people during lunch time and noted that the food was of sufficient quality and looked nutritious. Food choices included battered cod with peas, chips and mashed potato or fish in white sauce. People were supported to eat where necessary and staff were patient when they helped people to eat. During the inspection we saw staff bringing around the biscuits and drinks trolley and offering people drinks and snacks in between main meals. We observed staff interrupted some people whilst they were eating their lunch to administer their medicines. The manager confirmed that the medicines that were being administered were not time sensitive and therefore staff could have waited until people had finished their meals.

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

People's healthcare records showed that they were actively supported to maintain their health and well-being. They had access to healthcare services when required and their known health conditions were recorded in their care plans. The service routinely monitored people's healthcare needs and supported them to access the right health care services when changes occurred. We saw that a GP from a local surgery visited every Tuesday and consulted with people who required their services. People told us if they needed to see their GP they did not have to wait until the GP visited on Tuesdays because if required, staff were able to arrange an earlier appointment. One person said, "Dr [Name] comes every Tuesday to see people who need to but they take me to see [them] if I need to because I can't do it myself."

People who lived at the home and their relatives felt that sometimes they were looked after by staff who understood their needs. One person said, "They understand my needs yes." A relative told us, "They know what they are doing."

Staff told us they had received a full induction at the start of their employment. A member of staff we spoke with said, "Yes, I received an induction. It showed me everything I needed to know about the job." The

home's induction programme gave new staff the opportunity to read through people's care plans and work alongside experienced members of staff on shift till they became confident to take up their full job roles. New members of the staff team were given the opportunity to complete the care certificate.

Although staff told us they were trained in areas that were relevant to their job roles, we found that the training was not always effective. This was demonstrated in areas within this report where we highlighted that people's care was not always person centred, people were not always supported or involved in making decisions about their care, and people's medicines not always managed appropriately.

Staff told us that they were supported in carrying out their job roles by way of regular supervision meetings with the home's management team and annual appraisals of their performance. A member of staff said, "I have supervision every month. We discuss everything like the residents, how I am feeling and any concerns I have." We reviewed the home's supervision records which confirmed this was actively carried out.

Requires Improvement

Is the service caring?

Our findings

People we spoke with told us they liked living at the home. One person said, "I have always found it pleasant." Another person told us, "I choose to live here. The care is about average, it's not perfect. You get a lot of these agency staff and they do as little as they can. Some of [the staff] are good, I wish they could stay longer with us, they are in and out so quickly it makes you feel unwanted sometimes." One other person added, "They look after you, some of them are rude but you can't like everybody." The relatives of the people we spoke with told us the staff were caring. One relative said, "They are kind and careful with [Relative]." Another relative told us, "Staff are good and they are approachable." A visiting professional we spoke with added, "The staff are skilled, they know residents well. If I had a relative [that needed care] I would want them to come here."

The provider was not always caring towards the people who lived in this particular home. This was because, for example, the provider's area manager visited the home on a regular basis and would have been aware of the shortfalls within the home. However, no action was taken to address this. We also found that the provider did not take into consideration the impact the decisions they made had on people or fully involved people in making decisions about the home. This for instance was evident where the registered manager independently changed the meal times without consulting with people who lived at the home. This some people told us caused them a great deal of anxiety and frustration. The service delivered to people was not person-centred and felt as though it ran for the benefit of the staff and organisation, not that of the people who lived there.

Staff were knowledgeable about people's care needs, they spoke with people appropriately and called them by their preferred names. The atmosphere within the home was relaxed and people appeared to be at ease in the company of staff. The interactions between staff and the people who lived at the home were positive but mainly task led. Some people interacted with one and other or their relatives that visited, where they could. Where this was not possible, we observed that people were left on their own for lengthy periods of time resulting in them looking bored.

People's care records contained information about their preferences and things that were important to them. There was a specific part of people's care records called 'Map of life' that detailed information about their history. This included details of where people were born, where they lived most of their childhood, where they lived as adults, the schools they attended, names of any pets they had and their family tree. The registered manager showed us a new booklet called 'This is the personal life history of [person]. They told us this would detail information about people's relatives for example their parents, siblings and children, details of their childhood, religion, work and education, memories about when they turned twenty-one, love and marriage, their pets, hobbies and interest. This was aimed to enable staff to understand people's backgrounds or history so that they were supported in a more individualised way. However, we found that people were not always involved in decision making about aspects of their care. For example, one person told us that the meal times were not always consistent. They said, "The manager keeps altering the meal times, we should be told about these things. We go to the dining room and keep waiting then they say she's changed the time."

People were able to maintain relationships with the people who were important to them. We were told by people, their relatives and staff that there were no restrictions on visiting time and that people could visit the home at any time if they wanted. One person told us, "People can just come to visit, there are no restrictions on that." Another person said, "There are no restrictions on visiting times. They are pretty good at that." A relative we spoke with added, "Yes, we can visit anytime."

People were supported by their relatives to express their views. One relative told us, "Yes, we as a family help [Relative] to make decisions." The registered manager showed us the home's welcome pack which was provided to people and their relatives at the time that they moved to the home. This detailed information about the home, the services offered to people and who people could raise concerns with, if they had any. Some people's relatives acted as their advocates to ensure that they understood the information given to them and that they received the care they needed. Other people were able to do this themselves. The service did not have a process in place to access advocacy services. One person told us, "advocates? No not here."

People's privacy and dignity was being observed. One person told us, "They are respectful, they knock on the door before coming in." One member of staff said, "We always treat residents with respect and give them our best. Everybody here is nice to them, no one is rude." We observed staff knocking on doors before they went into people's rooms and where people wanted to spend time in their rooms, this was respected. For example, one member of staff told us, "Everybody comes down to the dining room to eat their meal apart from [one person] who always likes to stay upstairs so we take their meal up to them."

Requires Improvement

Is the service responsive?

Our findings

People who used the service and their relatives told us that people's needs were met by the service. However; they said they were not involved in the assessment and planning of people's care. One person said, "They don't ask what is important to us." One relative told us, "Yes, [Relative's] needs are being met, they are good." Another relative said, "No, we were not part of the assessment, they didn't really ask me about [Relative's] likes and dislikes. It is difficult if staff don't have time, they are always flying around. We asked around for a care home and people recommended this one so we came and met the [former] manager." We reviewed three people's pre-admission assessment records and found that in one person's case, the local authority had carried this out and the provider had completed the other two. We saw that these assessments detailed people care needs around communication, personal care needs, skin integrity, mobility, nutrition and hydration, but there was no evidence that indicated that people or their relatives had been involved in carrying these out.

Each person who lived at the home had a care plan that followed a standard template used within the home. Care plans held information about people's history, their health and care needs, and preferences. These care plans gave guidance to staff on how people wanted to be cared for. We saw that people's care plans were reviewed on a monthly basis by the provider. From our observations and in talking with people, it was evident that the care plans lacked involvement from the people who received care and did not take into account their wants, needs and were not person centred.

People were bored and spent much of the time just sitting throughout the day which was punctuated by mealtimes or tasks delivering their personal care. The registered manager showed us the home's activities folder, where activities such as playing count down, making music, people having their hair done and word searches had been recorded. However, people told us they were not able to take part activities and hobbies that were of interest to them because of insufficient staff to support them with this. One person said, "No we don't do many activities, I tend to do my own thing. They should allocate more money for going out because we don't go out often. There should be more entertainment as well and they don't really converse with a lot of people." Another person said with a smile, "Staff very seldom have time to talk about the past that is what I would have liked them to do." We observed only on one occasion a member of staff playing 'pass the ball' and supporting one person in doing word searches on the newspaper during our two days of inspection. When the member of staff was supporting the person with the word search, we saw that the other people within that particular floor were left unattended, with some of them looking bored and eventually fell asleep. One person told us, "The only thing I wish was there were more activities, you get bored and there is not much going on to keep you occupied." This showed that people were not always supported to pursue their hobbies and interests.

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

The provider had a system for receiving and handling complaints. People and their relatives told us they knew who to raise concerns with if they had any. One person said, "I don't have a complaint right this

second but if I had one I will speak to the C.E.O." Another person said, "Yes, I will talk to the staff if I was not happy." One other person said, "I will speak to my social worker if I was not happy, [they] don't visit often because [they] are busy. If I tell staff they don't always get to the bottom of it." We found that the provider had 'comment, compliment and complaints' leaflets that were placed in the home's entrance hall for people to access. A review of the complaints records showed that where required, the registered manager or the area manager had investigated complaints and had taken steps to address these.

Requires Improvement

Is the service well-led?

Our findings

The home had a registered manager in post. The registered manager was supported by a deputy manager, senior members of staff, the care and domestic staff team and the provider's area manager. We noted that the manager was new in post having been there for eight weeks at the time of our inspection. The feedback we received from people and their relatives about the home's management was mixed. One person told us, "Oh yes, [Manager] is approachable and if she has to, she helps out. In fairness she's come over but she does not mix with us that much. I'd rather liked [the former manager], he interacted with us. If something needed doing he did it and found out why it was not done. Now they ask someone else to do it and it doesn't get done anyway." Another relative said, "There is a new manager now, she hasn't introduced herself, I don't think she is a people person." One other relative said, "The new manager is very good, very approachable." One other relative added, "She is very new I don't know her." Although the staff commented positively about the management team, there was a real apathy within this home. For example, one member of staff told us that the high usage of agency staff whose work was not always up to standard, caused a lack of motivation to the rest of the team.

The manager was knowledgeable about their role and responsibilities. They had recognised the challenges and improvements that were required and had developed action plans to address these. There was an area of concern whereby the lift had broken down, but this was not reported to the Care Quality Commission (CQC) as an event that stopped the service from operating as normal. We raised this with the manager and they noted it for future reference.

This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

The provider had a quality monitoring process in place to drive improvements in the service delivered to people. The home's management team carried out audits on a monthly and quarterly basis. These audits included checking of five people's medicines and medicines administration records every month, checking ten percent of the people's care plans, monthly housekeeping walk about to check the state of people's bedrooms, lounge areas, bathrooms and the utility areas. Audits also included three monthly infection prevention and health and safety audits. The provider's area manager visited the home at least once every month and carried out night visits to see how people were cared for at night. The manager told us that the results of audits and actions plans were shared with the provider for quality monitoring purposes.

We found that improvements were required in the auditing processes particularly around people's medicines management, care records and the home environment. For example, there had been a number of opportunities for the provider to pick up the medicines recording errors we found during our inspection, had the auditing processes been more robust. The odour of stale urine that lingered in the lounge areas could have also been addressed had the senior management maintained a robust oversight of the home. Some of these failures had been raised by the local authority's contracts monitoring team during their inspection of this home in 2015. The fact that these failures were again identified during our inspection of this home would be attributed to the provider's inaction or lack of senior management's oversight.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
Monthly 'residents meetings' were held. One person told us, "I didn't attend the last meeting but I have said to the new manager I would like to know when the next meeting would be so I could attend. I like attending things like that." We reviewed the minutes of the last meeting held in April 2016. The topics of discussion included keyworkers, suggested activities such as animals being brought in for people to interact with, staffing and the decoration of one of the lounges. We saw that regular meetings that involved people's relatives were held. The last meeting involving relatives was also held in April 2016 where the topics of conversation included staffing, activities and the decoration of one of the lounge areas. We saw that one of the lounges was being decorated at the time of our inspection which showed the provider was listening to people's views. However, there were improvements required in the quality and quantity of activities provided to people.

Daily 'ten by ten' meetings were held where staff and the manager had discussions about issues that affected the home. For example, maintenance issues and people's care needs. This was in addition to monthly staff meetings where issues such as changing the times that people had dinner, staff breaks, maintenance, CQC inspections and other topics that affected the home were discussed. A review of the home's team meeting records confirmed the last staff meeting was held on 16 May 2016.

Annual satisfaction surveys were completed. These gave people and their relatives the opportunity to formally give the provider feedback on their experiences of the service. We found that the feedback received from the last survey was mainly positive with people and their relatives saying they were satisfied with the level of service.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The lift had broken down over a number of days but this was not reported to the Care Quality Commission (CQC) as an event that stopped the service from operating as it normally should.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People were not involved in choosing the food that was on the menus and they were not offered alternative meals if they did not like what was on the menu. This we were told was to manage the food budget. People were bored and spent much of the time just sitting throughout the day which was punctuated by mealtimes or tasks delivering their personal care. people told us they were not able to take part activities and hobbies that were of interest to them because there wasn't enough staff.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Some people told us that staff did not always ask for their consent before they provided care or support. We observed staff's interactions with people and saw some instances where people's consent was not sought before staff provided care. For example, on one occasion staff moved one person without asking for their

consent. We also observed two people's plates being removed after lunch without the staff saying anything to them. Staff showed a lack of awareness of the Mental Capacity Act 2005.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People's risk assessments were not robust because they did not contain enough information to guide staff on what action they should take to keep people safe. For example, one person's 'falls prevention' risk assessment stated that if they were found to have fallen and not sustained any injuries, staff were to hoist them back up. This did not detail any guidance for staff to follow in instances where this person sustained an injury nor did it detail any reporting processes.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment Most parts of the home appeared dated, with several scuffs and scratches on doors and door frames. Chairs in the lounge areas were dirty, stained and smelled of urine. The odour, especially in the lounge areas was unpleasant and the carpets in these areas also smelled of urine. There were exposed hot water pipes in bathrooms which could harm people and hazardous substances were stored appropriately which have caused harm to people who lived with dementia had they accidentally accessed these.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The service had a poor auditing system and a lack of oversight from senior management, which had been a contributory factor to all the

breaches of regulation in this report. The local authority's contracts monitoring team also carried out an audit of this service in 2015 and found very similar issues but there had not been improved.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were insufficient staff to safely meet people's needs. The service relied heavily on agency staff and people had to wait for long periods of time for care. One person told us, "We don't get the care we should. The staff are leaving and the agency staff don't know what they are doing." We also found that people were not being engaged by staff in any meaningful activities because the staff did not have the time, this was a direct result of the staffing deployments.