Westgate Healthcare Limited

Westgate House

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**

Overall summary

This inspection was carried out on 21 and 24 October and was unannounced.

At our last inspection we found the service to be meeting the requirements of the regulations, However, at this inspection we found the service to be in breach of Regulations 9, 10, 12, 13, 14, 15, 20 and 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of the report summary.

Westgate House Care Centre is a nursing and residential care home that provides accommodation and personal care for up to 109 older people some of whom live with dementia. The home has three floors with a residential dementia care unit on the ground floor and nursing units on the upper floors.

The provider had recently appointed a manager who had submitted their application as a registered manager on 07 October 2014. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are

Summary of findings

'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run.

The CQC is required to monitor the operation of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) and to report on what we find. DoLS are in place to protect people where they do not have capacity to make decisions and where it is considered necessary to restrict their freedom in some way, usually to protect themselves or others. At the time of the inspection applications had been made to the local authority in relation to some people who lived at Westgate House. The provider had therefore, acted in accordance with the MCA 2005 and DoLS.

There were insufficient numbers of care staff available to meet people's care needs. We observed that people had lengthy waits for personal care in circumstances that compromised their dignity and care needs.

Guidance published by the Department of Health for prevention and control of infection in care homes had not been followed. There were a lack of cleanliness and infection control procedures in place throughout two of the three units at the home and we noted a prominent malodour in both. This meant that people were not adequately protected from the risk of infection.

Effective and safe recruitment practices had been followed.

Medicines were safely ordered and stored but not safely managed in the home. Staff who administered medicines had been appropriately trained. However guidance for when required (PRN) medicines were not clear which resulted in people being administered medicines when they may not require it. People were not encouraged to manage their own medicines and where people were prescribed medicines that made them drowsy these had not been regularly reviewed in line with published guidance.

People and relatives gave mixed views about the food provided. People who required assistance with their meals did not always receive this.

Where people were at risk of malnutrition or dehydration staff ensured people's fluid and food intake was monitored effectively to ensure they had adequate amounts to meet their needs. However, we found that healthy snacks were not always offered to people, and those at risk of malnutrition had not always had their meals fortified to support a high calorific dietary intake.

People's individual needs were not met by the adaptation and decoration of the service. Rooms were sparsely decorated with some rooms cluttered with chairs and equipment. The ground floor which supports people living with dementia was not decorated to ensure people were orientated and stimulated.

Staff were supported by the manager and told us the training they received supported them to provide care to people.

People were happy with the care they received from staff and we observed positive interactions when staff assisted people with their care needs. People were generally treated in a courteous and respectful manner.

People and relatives were aware of how to make a complaint and the manager responded to them effectively. People's personal preferences were not always acted upon when providing care and support and records relating to people's care did not always sufficiently detail the care needs of the person or what had been reviewed. Records were also written illegibly at times.

Activities were in place but were not reflective of people's specific interests or needs, particularly where people lived with dementia.

There was a quality assurance system in place, however robust auditing had not always been completed. Prior to the appointment of the new registered manager, the provider had not ensured robust auditing had been completed. Action plans were not always in place to address issues of concern, such as staffing. Where concerns had been identified there had not been a timely response to reduce the risk of harm for people who used the service.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not safe.

There were not sufficient numbers of staff available to meet people's needs.

Effective recruitment procedures were followed.

People had not been adequately protected against the risk of infection because published guidance on cleanliness and infection control standards had not been followed.

Staff were able to demonstrate a good understanding of the types of abuse that may occur and knew how to report their concerns.

People's medicines were not managed safely as people did not always receive them on time and had not always had a review of their medication when required.

Where people used pressure relieving devices these were not always set correctly for the individual person's needs.

Is the service effective?

Requires Improvement

The service was not effective.

Where people were at risk of weight loss or dehydration, they were not always supported as required by their care plan.

Staff had received training to understand the requirements of the Mental Capacity Act in general, and the specific requirements of DoLS.

People had access to healthcare services and a range of healthcare professionals when they needed them.

The home was not suitably decorated or equipped to support people living with dementia.

Is the service caring?

Requires Improvement

The service was not always caring.

People's privacy was protected when providing personal care

Staff knew people well and care records detailed people's preferences and choices. However, people's preferences were not always acted upon.

People did not have access to independent advocacy services to support them with their affairs or concerns regarding the home where necessary.

End of life care plans lacked information about people's preferences for the end of their life care needs.

Summary of findings

Is the service responsive?

Requires Improvement

The service was not responsive.

People and their relatives were involved in developing care plans.

Activities were in place but were not reflective of people's specific interests or needs, particularly where people lived with dementia.

People and relatives told us that concerns were dealt with promptly.

Meetings were not held for staff and people's relatives to provide feedback.

Is the service well-led?

Requires Improvement

The service was not well led.

The service did not have a registered manager in post, however an application had been made on October 07 2014 for a newly recruited manager.

People, their relatives and staff told us that the manager was approachable and supportive.

Prior to the appointment of the new registered manager, the provider had not ensured robust auditing had been completed.

Westgate House

Detailed findings

Background to this inspection

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

This inspection took place on 21 and 24 October 2014 in response to concerns and was unannounced. The inspection team was made up of four inspectors and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. Their experience was in residential care.

Before we visited the home we checked the information that we held about it including statutory notifications and enquiries relating to the service. Statutory notifications include information about important events which the provider is required to send us. We reviewed the home's statement of purpose. The statement of purpose is an important part of a provider's registration with CQC and a legal requirement, it sets out what services are offered, the quality of care that can be expected and how the services are to be delivered.

We spoke with contracts monitoring officer for the local authority which commissions services from the home prior to our inspection and the safeguarding team for Hertfordshire.

During the inspection we spoke with18 people and eight relatives. We also spoke with the manager, the cook, one domestic worker, one nurse and 12 care workers. We reviewed the care records for nine people and the files for three members of staff. We also reviewed management records on complaints, premises and quality. We carried out observations and used the short observation framework tool (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us due to their complex needs.

Requires Improvement

Is the service safe?

Our findings

We found that appropriate standards of cleanliness had not been adequately maintained and there was an odour present throughout the home. We found that shower rooms and bathrooms were unclean. For example, in one shower room we found commodes being stored, the floor was dirty and there was a clutter of people's personal items on the floor. There was also a dirty and stained trolley with an open box of pads on it in the same room. Later in the day we saw that staff had placed clean items on the trolley including people's laundered clothes and unused mouth swabs.

We observed that where staff provided personal care to people they used appropriate personal protective equipment such as aprons and gloves. One person was suspected to be unwell, and staff had taken the necessary steps to prevent the spread of infection. However, we found the standards of infection prevention were not consistent and that people had not been adequately protected in all cases. For example, a person was isolated from other people on the unit due to a condition they had. However there were no precautions in place to protect staff and visitors, and people were not advised of this when entering the unit.

We saw that people were hoisted using shared slings which presented a risk of cross infection or contamination. Slings we looked at were not unclean, and were regularly washed however good infection control practise is for each person to be allocated their own individual sling. The manager told us they would review this and ensure people were allocated their own slings in future.

We found a vacant room that staff told us was clean and ready for use, however we saw the room was dirty and there was a strong smell of urine. We found dirty linen, shoes on the floor and the strong odour in this room. We highlighted this to staff and the room was then cleaned.

Throughout the communal areas we saw staining to armchairs and carpets, food stuff that was splashed on the walls and fallen between cushions, and spillages that had not been thoroughly cleaned. The kitchenette areas were unclean with staining to the worktops and splash backs. There were also tiles falling away from the walls and gaps in the worktop sealants all of which may harbour infections and be difficult to clean. People we spoke with told us that the cleanliness of the home varied from day to day. One person told us, "It's not always kept clean."

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We found that there was insufficient staff available to meet the needs of the people. One person told us about an incident one lunchtime and there was no staff available in the dining room to call for help. People in the dining room were not able to reach an emergency call bell. They told us that this was very worrying to them and also presented a risk that people may not receive emergency assistance when required. One staff member said, "People ring the bell because they would like us to get them dressed, but sometimes we have to say no. There is just is not enough of us to support them, and the nurse's never help us."

On one unit we were told that the staffing requirement was one nurse and nine carers up until 2pm. Then one nurse and eight carers from 2pm to 8pm. On the day of our inspection there was one nurse and seven carers. On a second unit two carers had called in sick and the unit manager was only able to fill one of the gaps in the rota. One staff member said, "It's ridiculous, I mean there is me and [carer] to assist ten people. All of them need two carers to hoist, bathe, dress and support, but how can we get it done when they would like. [Person] over there likes us to get them up at [time given] however we can't do it in time."

We saw that people did not always receive care or support when required due to a lack of staff. Staff we spoke with told us there was very rarely the required number of carers available. They told us it was difficult to meet people's individual needs all the time. Our observations on all three units were that staff were working under pressure to meet people's needs due to staffing shortages and these not reflecting people's needs. On the first floor we spoke with staff who told us there were ten people who required two carers to assist them with personal care. One staff member said, "Today like most days we will get them up when we get them up. It's not that we don't want to but how can we do it when they want us to, they need two of us to hoist them, bathe them and dress them. That is a morning's work in itself, so what do we do about the rest."

Breakfast was served between 9.30am and 10.30am. However, lunch was served only two hours later from 12.30.

Requires Improvement

Is the service safe?

We observed one person supported to eat their breakfast at 10.00am and later supported with their lunch at 12.30pm. They subsequently did not eat their lunch. Staff told us that in the mornings, due to a lack of care staff, it was difficult for them provide assistance with eating in a timely manner. This meant that meals were not appropriately spaced or flexible to meet people's needs to ensure people's nutritional needs were adequately met.

We asked the manager how staffing levels were established and monitored for each of the units. They told us that at that time it had not been formally reviewed. However they told us that going forward this would be reviewed on a weekly basis with each unit manager to respond to the health needs of people. They also told us that recruitment within the home was ongoing and that interviews for carers were scheduled for the following week. After our inspection the manager sent us information that demonstrated how they planned to meet with Unit Managers and the Clinical Lead Manager on a weekly basis to review the rotas, falls and staffing to ensure consistency within the staff levels that respond to people's needs.

We identified that the service was in breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Medicines were safely ordered, stored and staff who administered medicines had been appropriately trained. However medicines were not safely administered or managed. We saw that people's preferences about how they wished to receive their medicine was taken into account.

One person was prescribed a medicine that was to be taken at equally spaced intervals and with food. They were given this medicine at 10.00am and then three hours later; however neither medicine was administered with food. This meant that the medicine may not be absorbed as prescribed by the Doctor and therefore may not be as effective. People who required medicine to manage illnesses such as Parkinson's or infections also did not receive their medicine as required as they were not administered at the times prescribed. This meant that people may suffer a significant reduction in their health.

People may have been sedated through unnecessary administration of sedatory medicines. When we arrived on the ground floor dementia just before 8am people were not moving around the unit or getting ready for the day. We reviewed one person who had been prescribed a sedatory medicine to be used only when needed, (PRN). However, when we looked at the corresponding care plan there was no clear instruction when to use the medicine for staff to refer to. Records demonstrated that this medicine had been regularly given to the person. However daily records of the person's behaviour did not suggest they were unusually agitated or unsettled and a reason for administering the medicine was not documented.

One person had been prescribed three medicines that made them drowsy and sleepy however these had not been reviewed by the GP or a review requested by care staff. When we looked at the daily records we saw that staff had not monitored the person for any side effects of using the medicine. This meant that staff had not ensured the side effects of the medicine had not contributed to a worsening of the person's dementia.

We spoke with the manager who told us they will ensure all people who take sedatory medicines are reviewed as a matter of urgency.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We saw from care plans that a suite of risk assessments had been completed for areas of identified risk. For example falls assessments, pressure ulcers, risk of choking, mobility and use of bed rails. Where people were bed bound and assessed as being at risk of developing pressure ulcers they were provided pressure relieving mattresses. However the mattress pressure was incorrect for their weight and was also noted differently on the 'daily check sheet' that had been signed by staff. Pressure relieving mattresses must be set to the weight of the person to achieve optimal pressure care relief at the mattress level. We saw throughout the home that three other mattresses had been incorrectly set. Leaving people on an incorrect setting put people at an increased risk of developing a pressure ulcer.

This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People told us they felt safe at the home. One person who was unable to communicate verbally gave a 'thumbs up' sign when asked about the home and the staff. Another person told us, "I feel safe, if I fell, I could call someone."

Staff had received training in relation to safeguarding people from the risk of abuse. We saw that the provider

Requires Improvement

Is the service safe?

had up to date policies designed to protect people from abuse which included safeguarding adults and whistleblowing. Staff were knowledgeable about the risks of abuse and how to report concerns. They were also able to demonstrate their awareness of the whistleblowing policy and which external agencies they could report their concerns to.

Incidents and accidents such as falls, injuries and medicine errors in the home were recorded for review by the home manager, and further investigation if necessary. Records held us demonstrated that accidents and incidents had been reported. However incidents for August, September and October had not been reviewed to identify recurring trends or frequency, as a manager had not been in post. During the inspection the manager told us they would be implementing a robust auditing system from November. However at the time of the inspection this meant that there was an increased risk of a reoccurrence of an accident or incident that impacted on a person's safety and welfare as steps had not been taken to reduce the risks.

Staff were recruited in line with good practise and staff we spoke with confirmed this. We looked at recruitment files for newly employed staff and noted that safe and effective recruitment practises had been followed. For each staff member we found appropriate checks had been undertaken for example, references had been sought, criminal records checks had been carried out and training had been verified. The manager told us they had recruited a new HR manager who had vastly improved the recruitment processes since their appointment.

Requires Improvement

Is the service effective?

Our findings

People who were assessed as requiring support from staff with eating and drinking were at risk of not receiving sufficient to eat and drink We spoke with three people on our arrival at the service who had been awake for some time. They told us that they had not been offered any food or drink and were thirsty. We saw from their care records that they were at risk of dehydration so not being provided with frequent fluids meant they were at risk of not having sufficient to drink.

People at risk of having too little to eat and drink had their food and fluid intake closely monitored. However, we found that in some cases staff had failed to respond when people were losing weight. We raised this with staff and they responded by making the appropriate referral to a dietician. However we also found that food had not been routinely fortified for people at risk of weight loss. Fortification is a way of providing people with a higher calorific diet by incorporating creams, butters and fats into a person's meals. Staff confirmed that the only meal that was fortified was porridge for breakfast. This meant that people who required additional calories to stabilise their weight were not receiving these as required.

People were not provided adequate support to help them eat and drink where necessary. We observed lunch being served on two of the units. Most people required support, prompting and assistance from staff to eat their meal. We observed care staff assisting multiple people during lunchtime which meant that people only ate when being assisted therefore only consuming small amounts of their meal. We observed one person, who had eaten very little as they had not received sufficient support, fed a few mouthfuls of food so the nurse was able to administer their medication.

One person told us that they would prefer to have a choice of healthy snacks; we found that there was very little fresh, healthy food available for people. We saw that fruit used for puree was tinned and contained syrup. A person who had been given this puree told us that they would like to have more fresh fruit to support a healthy lifestyle. We saw that pureed fruit was on the menu daily and there was very limited options for people that require a soft diet. People and their relatives gave mixed views about the choice and availability of food provided. One person told us, "The food is generally OK though there is not a choice every day and the meat is usually mince."

This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

During our inspection we became aware of areas in the home that were tired and in need of repair and decoration. People's individual needs were not met by the adaptation and decoration of the service. We observed that some of the communal rooms were cluttered with chairs; the walls were damaged in places and required decoration and the day rooms lacked any sense of homeliness. There were no tactile areas for people to use, and bold colours to help orientate people had only been used in some areas, such as the bathroom and kitchen. People's bedrooms did not utilise appropriate means to help people orientate and identify their room, for example a photo outside the room to help people identify which room was their own. The sensory room had recently been redecorated, however a radio played a chat show which did not enhance the surroundings and could be confusing for people. People and their relatives told us they had not had any involvement in the scheme. One person's relative told us, "None of us like that room, it feels like visiting my [family member] in a pre-school." This meant that the environment in Westgate House did not meet the needs of the people living there because they were not in surroundings that promoted their wellbeing.

This is a breach of regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People told us that staff explained what they were doing and waited for people to agree before providing personal care. One person said, "They will always check with me if I am happy and ready to be helped, they don't just get on with it without asking first." Our observations throughout the inspection confirmed that staff sought people's consent and explained what they wanted to do prior to providing care to people. However, people who had capacity to make their own decisions had not been encouraged or assessed to self-medicate. One person told us, "I felt more comfortable at home when I managed my own medicines, I don't mind them checking that I would take them, but it seemed to be assumed that I can't do it on my own."

Requires Improvement

Is the service effective?

There were policies and procedures in place in relation to the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS). Staff told us that they had received training on the MCA 2005 and DoLS. DoLS authorisations had been applied for where necessary. Staff were able to demonstrate to us through discussion how they supported people who may lack capacity and provided examples of this to us. This showed that the requirements of the MCA 2015 had been followed.

Staff were knowledgeable about people's care needs and preferences and told us about their choices, personal histories, relationships and health needs in detail. People told us that they were able to access healthcare services when they needed them. One person told us, "If I need to see the doctor for anything [staff] arrange it for me with no hesitation." A relative told us, "[Relative] needs quite of a bit of care, and whenever the staff or I am worried they call the doctor or whoever immediately." During our inspection we saw the GP, physiotherapist, nutritionist and social workers attending to review people's needs.

Staff told us the training provided was good. Training records showed us that the majority of staff had recently completed training and refresher courses where needed.

Staff had attended training in areas such as moving and handling, dementia awareness, food and nutrition, fire safety and mental capacity. We observed that training had been effective as we saw staff positively assisting a person to transfer from their wheelchair to armchair. We spoke with two carers who had completed dementia awareness training. They were able to describe how they would support people in a positive manner who became distressed or agitated. Staff told us they felt supported by the newly appointed manager. They told us they received supervision sessions with their line manager although this wasn't regular. We spoke to the manager about staff training which had elapsed and inconsistent supervision. They told us they were in the process of carrying out an audit to identify those staff who required training and supervision and they were to receive this shortly. We recommend that the provider ensures all staff receive professional development to ensure they remain safe to provide care to people.

This meant that staff had not always received appropriate support and development, however we were satisfied the manager was taking action to remedy this.

Requires Improvement

Is the service caring?

Our findings

People were positive about the care they received from staff. One person told us, "They are kind." One relative told us, "I am happy with the welcome we received when my relative was admitted. The staff asked lots of questions so as to get to know my relative well." All said that they think the staff are caring and generally gentle and respectful when helping them. One person chose to come here because she was happy with the care that her husband had received here several years ago.

People and relatives told us that the staff kept them informed of any changes to people's care needs or any incidents. One person's relative told us, "Just out of courtesy the nurse called me last week to let me know how [person] was after they had been unwell. It was nice that they took the time out to keep me informed." One person told us, "Do I feel involved, I should think so, when I first came here they asked about this and that, how I wanted things and it hasn't stopped since."

However where people had expressed their views in relation to developing their own care plan these instructions were not always followed. One person's relative had noted clearly in the care plan that the person wished to socialise with others during the day, but eat in their own room. However, we found that this person had not been supported to socialise with others and had not left their room to be part of the community for two weeks. We intervened and spoke with the manager and nursing team When we returned to the home on 24 October 2014, staff had supported this person to get up and socialise and the manager reported they had appeared much happier as a result. However care provided to this person was not provided based upon their views.

We observed staff relating to people in a kind and warm manner. For example, two staff members were observed hoisting and transferring a person from their wheelchair to an armchair. They continually talked with the person, asking them about their visit the previous day from family, and any plans they had for the day. This distraction assisted in calming the person who then told us, "[Staff] not only has the hands of an angel but knows I don't like the hoist and talks to me every time so I don't panic." We saw one person trying to pull a locked door to leave the unit. They were angrily banging on the door and became distressed. One of the senior staff responded, opened the door and invited them out into the reception for a coffee. This instantly settled the person, who then sat peacefully with the staff member and was content.

There was no advocacy service available. If people required the services of an independent advocate to support them with matters relating to their care or personal affairs, they were unable to seek independent advice. This is particularly important for people who may wish to make a complaint about the home, but required support to do so. We spoke with the manager who told us that they were looking at introducing advocacy advice and information services to the home shortly.

We found that where appropriate, people were not involved in the planning for their end of life care. We looked at end of life care plans for three people. These contained only the practical arrangements. For example, whether people wished their families to be informed or whether they wished to be cremated or buried. People and their relatives had not been involved in discussions relating to a dignified death. For example, we saw that there were no arrangements in place or agreements relating to pain management for end of life. This meant that people had not planned their end of life care at a time where they were well enough to ensure their views were fully included. The home manager and unit managers told us this was a work in progress and had planned to address this in the near future.

Requires Improvement

Is the service responsive?

Our findings

When reviewing people's records of care, we found it difficult to read many of the entries due to ineligible writing and recording. Where staff who are employed at Westgate House do have English as their first language, the provider had not sought support with literacy for staff. This meant that care plans did not sufficiently record a detailed account of people's needs to ensure care was provided safely according to their care plan.

Where needs care had been identified and assessed they were not always plans in place to review them. One person did not have a care plan in place for the management of aggression or the monitoring of side effects of their medicines and these were both identified as risks for this person. A second person had been described as having Alzheimer's and as being aggressive. However there was no guidance for staff about how to respond effectively to their behaviour within the rest of the care plan. Whilst there were monthly reviews of all of the care plans we viewed, they all stated 'no change' so did not reflect how the review was managed or who may have been involved.

People told us that staff asked them about their preferences however care plans did not always record this and how they wished to receive their care. One person told us, "They miss the little things like a cup of tea when I wake up with my crossword." On looking at the daily notes it was not possible to know if people's preferences had been adhered to, as the entries were very general and vague and some were illegible. There was no times stated in the entries, nor any details of the care and support offered. This meant that care plans did not portray a sufficiently detailed account of people's preferences and wishes to ensure care was provided according to their individual needs.

This was a breach of regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People told us there was usually a range of activities provided but they did not support their own hobbies and interests. The manager and staff had recently celebrated a religious festival which included having a meal and entertainment which reflected this cultural diversity. We found this had been a success with most residents who had enjoyed the event. One person told us, "It was lovely, such a refreshing change and so interesting to learn about other people's cultures." However, some people also told us they felt bored and isolated in the home. One person told us, "What can I do all day?" A second person told us, "TV is my friend and keeps me entertained, I don't really like to leave my room much, but I would like people to come and see me for things other than a wash or change." Several people we spoke with told us that they preferred to stay in their rooms. One person echoed their sentiments by telling us, "The day rooms have become quiet, lonely and unpleasant because nobody talks and staff, even if present, do not talk or do anything."

There was an activity worker who was on one unit in the afternoon and worked with individuals both in their rooms and in communal areas. However this was not the experience for people across the home. One person who had recently come into the home told us, "It is just like waiting for God; they [staff] zoom backwards and forwards past my room but never pop in for a chat."

We spent time on each of the floors in the home however only observed some meaningful activity taking place on one unit. For example, we saw people seated in the dining room table with little interaction or stimulation. We observed people sat in various lounges for long periods with no stimulation or staff interaction. People were not always able to decide where and how they spend their time. One person told us, "There isn't anything here that really interests me, I am more of an outdoors person, and at home I had a beautiful garden full of flowers and birds. I've never been given the opportunity to go into the grounds here or be taken out."

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People told us that when they raised concerns with staff they tried to resolve them quickly and that the new manager was, "Always present, approachable and available." When asked whether people or staff were able to raise complaints with the new manager they told us, "Absolutely, I hope this manager stays with us, when I have raised any concerns [manager] has swung into action and dealt with it." There was an effective complaints system which showed that people's complaints were listened to and action taken to rectify a situation to the person's satisfaction. People were provided with a copy of the complaints procedure within their welcome packs. Further copies were available within the home for relatives and visitors to access.

Requires Improvement

Is the service responsive?

People we spoke with told us that they had recently felt more informed about developments within the home. One person's relative said, "It's been a bit hit and miss what with all the management changes, but [manager] is very keen on our views." One person told us, "I have spoken to the manager a lot, [manager] is very open and honest so I guess the next few months will show if there are any changes."

Requires Improvement

Is the service well-led?

Our findings

People and relatives told us that their views had not been previously sought in relation to the management of the home. They told us that meetings between themselves and the management team had not been arranged for a long time. Some people we spoke with told us that the newly appointed manager had approached them on a one to one basis to ask about their care. However, this had not been completed for all those residing in the home. Nobody we spoke with had been given a survey to provide annual feedback on their experience.

Regular auditing, monitoring and analysis was not being routinely completed. Action plans had not been developed to address identified concerns that were found through inspection because the manager was recently recruited; however they were aware of the issues. A temporary manager had been based at the service until the current manager took up their post but had not taken steps to identify or address concerns. The manager was carrying out an audit to identify when staff had last received a supervision and appraisal and was implementing the organisational policy of four supervisions annually as a minimum.

However as we identified areas of concern around infection control, record keeping, staffing and medicines management this meant there not was an effective continuous quality improvement system in place to protect people and others who may be at risk.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Staff, people who use the service and relatives told us that the felt they could go to the newly appointed management team and discuss concerns where needed. One staff member told us, "I would have no concerns going to [manager] if I needed to as they listen to me. I think they have been here for four weeks, but have made their presence known" One person told us, "The whole staff team and new manager are approachable, I feel comfortable with making my feelings known." One staff member told us, "It's been difficult here lately with managers coming and going, but this new one seems to be good. She talks to us, not at us like the others did and makes me want to support her supporting me." The newly appointed manager told us that they were taking their time getting to know the people, relatives and staff and how the home operated. They told us they had identified many of the issues we had brought to their attention. They had developed an action plan through tentative discussions with staff which included areas such as care planning, medication, infection control, and activities. We felt that the manager was committed to developing the home with staff, people and relatives, however it was too soon to measure the impact of their actions.

At the time of the inspection it was too early in the manager's employment to determine if there was a clear vision in the home regards the values, beliefs and behaviours that should be demonstrated. The manager showed us how they were in the process of building community links with organisations, such as advocacy organisations and training and development, however this was still in the beginning stages. Staff were however positive about the appointment of the new manager. One staff member told us, "[Manager] has an infectious energy about them which I think is great." A second staff member told us, "[Manager] has hit the floor running and is tirelessly supporting us and the residents, I'm sure they are finally the quality manager we need here."

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing **The registered person did not ensure there were sufficient numbers of suitably qualified, skilled and experienced staff to carry on the regulated activity.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control **The registered person did not ensure that people were protected against acquiring a healthcare associated infection.** **Regulation 12 (1) (a) (b) (c) (2) (a) (c)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records **The registered person did not ensure that people were protected from unsafe or inappropriate care and treatment because care records did not sufficiently assess and review people's needs and were not clearly written.** **Regulation 20 (1) (a)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010 Meeting nutritional needs **The registered person did not ensure that people were protected from the risks of inadequate nutrition and dehydration.**

This section is primarily information for the provider

Action we have told the provider to take

Regulation 14 (1) (a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines The registered person did not ensure people received their medicines safely in accordance with recommended prescribing regimes.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services The registered person did not ensure that people received the appropriate care to reduce the risk of acquiring pressure ulcers and did not ensure that people had access to activities and stimulation.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers The registered person had not regularly assessed and monitored the quality of the services provided in respect of staffing levels, care plan reviews, infection control, nutrition and dehydration and medicines management. Plans were not in place at the time of our inspection that satisfactorily addressed these areas. Regulation 10 (1) (a) and (b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises

This section is primarily information for the provider

Action we have told the provider to take

The premises were not suitable for people using the service as the current decoration and adaptation of the premises did not protect people's rights to privacy, dignity, choice and autonomy