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Westbury House Nursing Home

Inspection report

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Date of inspection visit:
21 March 2016
22 March 2016
04 April 2016

Date of publication:
01 June 2016

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

The inspection took place on 21 and 22 March and 4 April 2016 and was unannounced.

Westbury House Nursing Home provides accommodation and nursing care for up to 35 older people. The home provides accommodation and nursing care for up to 35 people over the age of 18 who have physical disabilities and neurological related diseases and disorders such as Huntingdon's Disease and acquired brain injuries. At the time of our inspection 33 people were using the service.

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

At the last inspection in June 2015, we found the home to be 'Good' overall. Improvements were required in infection control.

During our visit on 21 and 22 March 2016 we were concerned about the safety of people using the service. Following this visit we wrote a letter to the provider to highlight our concerns and to request an urgent action plan to ensure people's safety by 31 March 2016. We revisited the home on 4 April to check whether the actions set out in the action plan, and confirmed as completed by the provider had been carried out and to gather evidence in this respect. The provider was unable to provide all of the required evidence on 4 April 2016 and requested until the 6 April to be able to provide this. We found much of the evidence was dated after our visit on 4 April 2016 and therefore contradicted the provider's action plan dated 31 March 2016 which stated that actions had already been taken.

People were not protected from abuse, because safeguarding concerns were not appropriately reported or investigated.

Risks to people were not identified and mitigated to ensure people's safety. Care plans included risk assessment tools to assess people's individual risks; however, not all identified risks had been appropriately mitigated.

The dependency tool used to identify appropriate staffing numbers did not identify the required ratio between nurses and care workers for day and night shifts to ensure people's needs were met. It was not possible to determine staffing levels in the home because we were given conflicting information by the provider.

Not all staff were suitably qualified to meet people's needs because they did not have a standard of English which meant they could be understood by people using the service.

Recruitment and induction practices were not safe. We found that staff had gaps in their employment history, references from friends and girlfriends and one person had a criminal record which had not been risk assessed. This meant it was not possible for the provider to determine their suitability for employment because staff pre-employment checks were not complete.

People were not protected by the prevention and control of infection. During our inspection we observed a lack of effective cleaning practices throughout the home. Carpets were frayed and dirty and smelt urine, floors were visibly soiled, walls and floor coverings indicated visible stains and discolouring with dirt and grime. We found bathrooms to be grubby, bath hoists showed signs of rust and were not clean.

Medicines were stored safely in locked medicines trolleys and a locked cabinet attached to the wall. Whilst observing a medicines round we noted that the nurse left the keys on top of the medicines trolley when unattended. There was a risk that people who were independently mobile would be able to access the medicines in the absence of the nurse. There was no clear procedure for ensuring that people admitted to the home for respite care received their medicines safely and consistently.

The provider had not taken steps to ensure that people received sufficient nutrition to sustain good health. One person's condition meant they were at high risk of weight loss. The provider only took action to address this after we raised concerns during our inspection

The chef showed us a four week rolling menu for main meal choices. There were two choices available each day; one of the choices did not always include a vegetarian option. No options were provided for breakfast of supper on the menu. Staff told us that people were not offered a hot breakfast.

The provider did not comply with the requirements of the Mental Capacity Act 2005 (MCA). Mental capacity assessments had been carried out, which were decision specific, however, the provider demonstrated a lack of understanding of other elements of the MCA. For example, where it had been determined, by assessment, that the person lacked capacity for a decision, a best interest decision making process had not been recorded. This meant there was no outcome for the person and therefore the provider may not have been acting in the person's best interests.

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 for this in care homes is called the Deprivation of Liberty Safeguards (DoLS). We found that there were some applications appropriately in place which legally deprived people of their liberty.

Staff had received training in relation to key areas such as fire safety and moving and handling. No trained nurses had received training in specialist areas such as Huntingdon's disease, motor neurone disease, Parkinson's disease or multiple sclerosis. These areas are identified in the provider's statement of purpose as areas where they have a particular speciality.

People and their relatives felt that staff were kind and compassionate and treated them with respect. However, we observed staff supporting people without any interaction. Rooms were dirty and lacked personalisation.

People had not signed their care plan and there was no evidence they had been involved or consulted in their development. Care plans were divided into main sections to address need, however people's individual plans of care were not always accurate and did not appropriately address the need in a person centred way.

Activities were planned and organised by the activities co-ordinator. The activities co-ordinator explained that each session was planned 'as it comes' tailored to those who attended sessions.

The registered manager was not familiar with CQC reporting requirements. During the inspection we found evidence of serious incidents and allegations which should have been notified to CQC. This meant that CQC were unable to monitor incidents in the home or check the appropriateness of actions taken by the provider as a result.

Although the provider carried out regular checks there was no system of quality monitoring involving audits and related action plans in order to strive for continual improvements in the service.

The atmosphere in the home was not open and empowering. Staff were not encouraged to question practice or be involved in the development of the service.

During our inspection we found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'.
The service will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Risk assessments were not complete and did not include all known risks. This meant people were at risk of unsafe care or treatment.

Staff were not able to meet people's needs because they did not have an appropriate standard of English in order to communicate with them to keep them safe.

Recruitment procedures were unsafe. People were at risk of being cared for by staff who were unsuitable for the role.

Incidents of potential abuse had not been appropriately reported, therefore CQC and the local authority could not be assured that steps had been taken to protect people from abuse.

People were at risk of infection because the home was not clean.

Medicines were not managed safely.

Is the service effective?

Inadequate

The service was not effective.

People's food and fluid intake was not monitored to ensure people had sufficient fluid and dietary intake to meet their needs.

Staff had not received sufficient training to meet people's needs.

The principles of the Mental Capacity Act 2005 were not always followed to ensure people's rights were upheld.

Appropriate DoLS applications had been made, for some people, to ensure they were not illegally deprived of their liberty.

A local GP visited the home regularly to support people to maintain good health.

Is the service caring?

Requires Improvement

The service was not caring.

Some kindly treatment of people was observed, but not all staff were observed to interact in a caring way with people, for example by supporting them without speaking with them.

People were not involved in developing their plan of care, therefore there was a possibility that, care may not have been given in accordance with their personal preferences.

Is the service responsive?

Inadequate

The service was not responsive.

People's individual needs were not met because care planning was not accurate, did not involve people and did not address people's individual requirements.

The service did not respond appropriately to concerns raised by relatives, staff and people living in the home.

An activities programme was in place which people enjoyed.

Is the service well-led?

Inadequate

The service was not well led.

There was not a positive culture in the home. Staff and people were fearful of the provider.

The provider did not encourage open communication and did not respond appropriately to any concerns raised.

Appropriate notifications about key events were not made to CQC in order for CQC to monitor and ensure that appropriate actions were taken to keep people safe.

There was no effective system of quality monitoring in order to drive through improvements.

Westbury House Nursing 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 checked 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 21 and 22 March and 4 April 2016 and was unannounced. The inspection was carried out by four inspectors, an expert by experience, two specialist advisors and the oversight of an inspection manager. An expert by experience is a person who has personal experience of using or caring for someone who uses nursing and dementia care services. Our specialist advisors were specialists in the nursing care of people living with neurological conditions and health and safety in nursing and care homes respectively.

Before the inspection, we reviewed all the information we held about the home including previous inspection reports and notifications received by the Care Quality Commission. A notification is information about important events which the service is required to tell us about by law. We used this information to help us decide what areas to focus on during our inspection. Prior to the inspection we reviewed information included on the 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.

During our inspection we spoke with 15 people using the service and one person's relative. We also spoke with the clinical lead, the registered manager, the administrator, a management consultant, three nurses, nine care workers, the maintenance assistant/driver, the chef, the activities co-ordinator, the laundry assistant, a domestic and a visiting GP. We reviewed records relating to nine people's care and support such as their care plans and risk assessments, medicine administration charts and daily records of care. We looked at a range of records relating to the management of the service including records of complaints, accidents and incidents, quality assurance, recruitment files and policies and procedures.

Not all people were able to tell us about their experiences due to their complex needs, therefore we used other methods to help us understand their experiences, including observation of their care and support.

Inadequate

Is the service safe?

Our findings

People were not protected from abuse and avoidable harm. We were unable to determine from records provided that all staff had received up to date safeguarding training. The provider stated, in their action plan dated 31 March 2016, that 'all care staff are fully aware of the necessary actions should allegations of abuse be stated by service users.' However we found this not to be the case. Evidence provided showed only 22 of the 37 staff had completed safeguarding training. Three staff members were not aware of the term whistleblowing and one staff member did not understand our question about safeguarding due their poor understanding of English. In addition we found that telephone numbers provided to staff for the purposes of reporting safeguarding concerns were out of date and had they been called, would not have directed staff to the adult services safeguarding team.

During the inspection we identified safeguarding concerns which should have been reported to the Care Quality Commission (CQC) and adult services. One person had made allegations of abuse about a member of staff. These had not been reported appropriately to CQC and adult services or investigated by the provider. No action had been taken to ensure people were protected from the staff member while an investigation was being carried out. The provider had determined that the person confabulated. In psychiatry, confabulation is a memory disturbance, defined as the production of fabricated, distorted or misinterpreted memories about oneself or the world, without the conscious intention to deceive. Based on their own assessment the provider had determined that the allegation was not true and had therefore decided not to investigate it. The person's risk assessment in relation to confabulation stated that any allegations should be investigated, however the care plan had not been followed and the allegation had not been investigated. The provider did not appropriately report or investigate allegations of abuse and therefore people were not protected from abuse.

There was no system in place to effectively investigate, and take immediate action upon becoming aware of, any allegation or evidence of abuse. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, relating to Safeguarding service users from abuse and improper treatment.

Risks to people were not identified and mitigated to ensure people's safety. Care plans included risk assessment tools to assess people's individual risks such as the risk of malnutrition or the risk of acquiring pressure ulcers. However, not all identified risks had been appropriately assessed and managed. We identified further risks during our inspection which had not been appropriately mitigated by the provider. For example, an incident form showed that one person had choked and had had to be resuscitated by staff carrying out cardiopulmonary resuscitation (CPR). This life threatening incident was not reported to CQC, so that CQC could monitor and ensure that the provider had taken appropriate actions to keep the person safe. Following the incident the provider did not seek guidance from a speech and language therapist (SALT) in relation to the consistency of food which the person could safely consume. There was no plan in place advising staff what to do if the person choked again. We asked a member of staff what they would do if the person choked and they said they did not know. The home did take some action by adding to the person's care plan that they should not be left unsupported whilst eating. On 21 March 2016 we witnessed that the

person was left unsupported whilst eating, while a care worker went to get a drink. This meant the person was not protected from the risk of choking.

Another person had been identified as at high risk of acquiring pressure ulcers. There was no care plan in place to address this risk and ensure the person's skin integrity was maintained. The person's night time care plan stated that the person used a pressure relieving mattress but no other mitigating actions had been taken such as regular skin checks or repositioning. The provider stated that the person had 'not developed any pressure sores since admission' and that 'care staff carry out daily skin integrity checks.' However, we found that the person had developed pressure ulcers since admission and that the GP had been consulted about them. There was no evidence that any skin integrity checks had been carried out. The person remained at high risk of acquiring pressure ulcers due to a lack of appropriate risk assessment and care planning.

An incident form showed that one person told staff they had taken an overdose of medicine. The provider acted appropriately by calling an ambulance, but took no further action in respect of developing a risk management plan to guide staff on how to reduce the risk of the person taking another overdose. Following our visit on 4 April 2016 and our request that appropriate actions be taken to keep people safe, the provider has now completed a risk assessment in this respect.

The provider was not able to demonstrate learning from incidents and accidents. Incidents and accidents had not been analysed to identify trends from which to identify action required to minimise recurrence. Incidents were not discussed at staff meetings to ensure staff were able to learn from these and discuss how they would do things differently in the future. Staff told us that incidents and accidents were dealt with by the provider. An incident form described how one person had been put to bed, because there were no staff available to sit with them in their wheelchair. The person climbed over their bed rails and fell, injuring themselves. There was no evidence that this incident was discussed at staff and team meetings to derive learning. Two weeks after the incident a bed rail assessment form was completed for the person in which it was determined that there was no risk that the person would climb over their bed rails. This put the person at risk of falls, because the provider had not appropriately assessed and managed the risk to the person.

There was no effective system in place to pro-actively identify and manage risks to ensure people's safety.

The provider had not considered the risks of asbestos to people, staff and visitors to the home. The Control of Asbestos Regulations 2012 states that if the premises were built before 2000 and there has been no assessment of the building in relation to the presence of asbestos, the duty holder must assume asbestos is present. Westbury House was rebuilt following a fire in 1904. We asked the provider for a survey and risk assessment in relation to the presence of asbestos in the building. We were told 'there is none.' People were not safe from the risks in relation to asbestos because the provider had not established (as required by law) whether there was any asbestos present in the building and taken any necessary steps to protect people from those risks.

During the inspection we found that the main electrical intake plant room was being used by staff as a sleeping room. There was a mattress in the room, a curtain draped over the window, personal clothing and footwear as well as flammable and combustible materials such as an aerosol can of deodorant. Due to high voltage and danger of an electric shock access to plant intake rooms is normally controlled. Access to the room was not controlled and the presence of flammable materials in the room was a fire hazard.

The provider did not assess the risks to the health and safety of service users of receiving care and treatment and did not do all that was reasonably practicable to mitigate those risks. This was a breach of regulation 12

of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, relating to Safe care and treatment.

The provider was able to demonstrate that a staffing level dependency tool had been used to identify appropriate staffing numbers for the home. However, the accuracy of the tool was unclear because it included staff who did not provide care or nursing care and did not identify the appropriate ratio of nurses and care workers to people to ensure their needs would be met at all times. It did not calculate the required nurses and care worker numbers for day and night shifts. Over the two days 21 and 22 March 2016 we were given three different versions of the staff duty rota. For each version, the information differed. We were therefore unable to ascertain the actual staffing levels for each shift in the home from these rotas. We asked members of staff about staffing levels in the service. One member of staff said there was one registered nurse and five care workers on an 8am to 8pm shift and one band three nurse and three care workers on duty during the night. One of the three rotas we were given demonstrated this. Band three nurses are not registered nurses and their contract shows they have been employed as care workers until they are able to qualify as registered nurses. The home's statement of purpose states "A registered nurse will be on duty at all times." A band three nurse told us they were in charge of people's clinical care when on duty, although the clinical lead confirmed they were not allowed to give injections or administer controlled medicines to people. Our observation was that staff were difficult to find 'on the floor.' People told us that staff were busy and didn't have time to stop and chat. One person said "Mostly they're short staffed."

From the evidence it was not possible to determine whether staffing levels in the home were sufficient and that staff were suitably qualified to meet people's needs.

Not all staff were competent to meet people's needs because they did not have a standard of English which meant they could be understood by people using the service. People we spoke with told us that long term staff were leaving and being replaced with staff who spoke very little English. They felt this made it difficult to tell staff how they would like things done. One person gave an example of asking for a cup of tea. The staff member smiled and left the room but did not return with a cup of tea. The person believed the staff member did not understand what had been said. Everyone we spoke with said the language barrier was a problem. One person said "There's quite a few foreigners here which doesn't make it easy." Another person told us that the foreign staff just shrugged their shoulders at them (indicating they didn't understand what was being asked of them).

Staff felt the language barrier was a serious problem. One member of staff said "We have a lot of foreign staff, haven't had any training in care, can't speak a word of English, how can they provide care, it's so unfair." One member of staff described how difficult it was to work with staff who didn't speak English, explaining "If I tell him to go and do this, he'll do something else instead. Some residents have complained that they can't understand him. They're all nice people but communication is a problem." We asked one member of staff, who's first language was not English, whether they found it difficult to communicate with people. They told us "It makes it difficult sometimes to speak to the residents and to support them." They told us they had worked in the home over a year and during that time had not received any help or support from the provider in developing their English language skills. An interview with one member of staff was terminated because they did not understand our questions about how they provided people's care. On at least three occasions the language barrier with foreign staff was raised as an issue at residents meetings but there was no evidence that any action had been taken by the provider to address the problem.

In our letter dated 30 March 2016 we raised concerns that some care workers demonstrated very little knowledge and understanding of English. We asked for an urgent action plan by 31 March 2016 to address our concerns. An action plan was provided however, no information was provided about what actions

would be taken to address the issues about the standard of English spoken by some staff.

There were insufficient suitably qualified, competent, skilled and experienced staff to meet the needs of people meeting the service. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, relating to Staffing.

Recruitment and induction practices were not safe. We checked recruitment records for six members of staff. For one member of staff we were unable to find evidence that a Disclosure and Barring Service (DBS) check had been completed. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services. One member of staff's DBS demonstrated a criminal record which would require a risk assessment. There was no evidence this had been risk assessed to determine the person's suitability for employment with vulnerable people. There was a space in the personnel file prompting risk assessment following DBS but that section of the form had been left blank in this case. Four staff members had unexplained gaps in their employment history and another person had not given specific dates in their employment history so it was not possible to determine whether there were any gaps. The provider was not able to assure themselves that staff were suitable to be employed because a full employment history had not been demonstrated and they had not sought an explanation for any gaps in employment. One person's reference was from their partner who already worked in the home. This was not an independent reference of satisfactory conduct in previous employment which would inform a robust recruitment decision.

Incomplete recruitment procedures was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, relating to Fit and proper persons employed.

People were not protected by the prevention and control of infection. Under the Health and Social Care Act 2008 Code of Practice on the prevention and control of infections, the provider is required to 'demonstrate systems to manage and monitor the prevention and control of infection. They are required to provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.' During our inspection we observed a lack of effective cleaning practices throughout the home. Carpets were frayed and dirty and smelt of the urine which was ingrained in them, floors were visibly soiled, doorways were damaged and there was evidence of water damage in several areas. Walls and floor coverings indicated visible stains and discolouring with dirt and grime. We found bathrooms to be gunclean, bath hoists showed signs of rust and were not clean and there were cobwebs in the hoist mechanism. Raised toilet seats were soiled and repeatedly checked throughout the inspection but remained soiled and one toilet had mould around the seat. Records demonstrated that they had not been used in the four days prior to the inspection.

Of particular concern was Cedar Unit. Upon entering the unit there was a strong odour of body fluids. In the communal lounge area there was liquid on the table and on the floor, which staff thought might be urine. The carpet was damp and mouldy and the furniture was worn and soiled and needed replacing. The floor of one person's bedroom was very dirty and sticky and remained so throughout the inspection despite CQC making staff aware of this. The person's bed was heavily stained; this included the frame, the headboard, the mattress and the mattress protector. We requested that the person's bed and mattress be changed for the person's own safety. On 4 April 2016 we observed that the person's bed had been replaced with a profiling bed. Bed rails and bumpers were in place and were worn and disintegrated in places representing a safety and infection risk. The mattress, although confirmed by staff as being changed, was heavily soiled. In the same person's room, a commode chair was found with significant amounts of food debris and black and brown staining on it. This had built up over time and indicated the chair may not have been cleaned for some time. We noticed throughout the inspection that although the person had a sink in their room, there

was no access to soap, towels, toothbrush, toothpaste, deodorant or anything that would support the person to maintain cleanliness and personal hygiene. One member of staff commented on the cleanliness of Cedar Wing, they said "It's filthy, it stinks, it's really disgusting, I come home and cry." Another member of staff said "I can't bear it, it's so disgusting" and in relation to the whole home commented "There's curtains on the stairs that have been there 35 years and never been washed, windows are filthy and the lights in the dining room were full of flies until recently."

On 4 April 2016 we were told by staff that there were not enough clean sheets for people. A person had been admitted for respite but there had been no clean sheets to put on the person's bed. Another person told us that their bed had become wet during the night but they had not been provided with a replacement sheet. People's fundamental needs were not being met. One member of staff called the home to say they were too ill to work on 4 April 2016. We later found the person working the kitchen. We asked the person why they were working in the kitchen when they were ill. They told us they had taken an antibiotic and felt well enough to work. This indicated the person may have had an infection and preparing food in the kitchen area therefore represented a risk to people of cross infection.

There was no designated infection control lead, which has been identified as a requirement in the Code of Practice (Health and Social Care Act 2008). The role of the infection control lead involves identifying the risks to people and staff from infection and taking responsibility for implementing and monitoring actions to manage those risks. The infection control lead must be appropriately trained to carry out the role. This meant there was no one in the home responsible for identifying infection control risks and ensuring those risks were managed. The provider did not carry out infection control audits in order to assess and monitor the effectiveness of infection control processes and ensure that improvements were made.

Staff paid little attention to hand hygiene practice. They did not wear gloves when performing procedures that exposed them to blood and they did not wash hands in between patient care. Domestic staff did not change gloves or perform hand hygiene in between rooms. Staff were observed to be wearing gloves but they were not observed discarding them and changing them. One person was MRSA positive and hand hygiene in the home was especially important to reduce the risk of cross infection between people and staff. There were no domestic cleaning facilities within the home. Staff filled buckets and disposed of contaminated water in kitchen sinks, in areas where food was prepared, which represented a contamination risk to food. Used mops and buckets were stored in various areas around the home. There was no colour coding of mops to distinguish their use between different areas of the home such as bathrooms and bedrooms. This meant there was a risk of cross contamination between rooms. Mop heads were changed on the first day of the inspection but there was no evidence that these were regularly washed and dried. The ventilation in the sluice room did not work and the whole room was cluttered with equipment making it difficult to use the room effectively and safely. The lack of ventilation led to a strong and overpowering smell in corridors. We found COSHH (Control of Substances Hazardous to Health) items such as de-scaler and cleaning products in unlocked cupboards representing a risk to people who may not have identified the dangerous nature of these products. Ivy was observed to be growing in a window cavity in the kitchen area. This had been identified during a recent inspection by environmental health but the provider had failed to remove the ivy at the time. There were no effective procedures within the home for the effective monitoring and management of infection control in order to keep people safe from the risks of infection.

The failure to assess and prevent the risks in relation to the spread of infection were a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, relating to Safe care and treatment.

Medicines were securely and stored safely. On the second floor was a medicines fridge. Room and fridge

temperatures were monitored daily and were within safe limits. Medicines were clearly labelled and dated upon opening. We observed a medicines round and noted that medicines were dispensed appropriately. Medicines were administered by a band three nurse and we noted that each time they left the medicines trolley; the keys were left on top of the trolley unattended. There was a risk that people would be able to access the medicines in the absence of the nurse. On the 21 March 2016, during the observed medicines round, we observed one person who was staying in the home for respite. There was no Medication Administration Record (MAR) or any prescribed medicines for the person. We were informed by the clinical lead that this was because the person was only in the home for a short period for respite and they had expected the person to return home. However, the person continued to stay in the home and there was still no medicine available for them on 22 March 2016. The clinical lead told us they would contact the pharmacy to obtain medicines for the evening medicines round but this did not happen. On 3 April 2016 another person was admitted to the home for respite care. During handover on 4 April 2016 it was noted that the person's medicines had arrived 'loose', not in labelled containers and it was therefore difficult for staff to know what medicine the person was taking and when they needed to take it. The person had not been asked to bring their medicine in original packaging and therefore it was not possible for staff to safely administer medicines to the person. Staff said the person could self-administer but there had been no risk assessment around this, ensuring the person's safety when administering medicines.

The lack of proper and safe management of medicines was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, relating to Safe care and treatment.

Inadequate

Is the service effective?

Our findings

The provider had not taken steps to ensure that people received sufficient nutrition to sustain good health. One person's condition meant they were at high risk of weight loss. Previous records indicated the person had been losing weight although the person had not been weighed for the four months prior to the inspection. The provider said the person was non-compliant with weighing but had not taken any steps to use alternative methods to establish whether the person was losing weight. The provider could not be sure whether the person was losing weight and their condition meant they were at high risk of weight loss. There were no recent records in relation to monitoring of food intake and the person continued to remain at risk of weight loss. A member of care staff when asked about food monitoring charts said that monitoring wasn't necessary because they had seen the person eat 'a lot'. The provider had not taken steps to ensure the person was receiving adequate nutrition to meet the specific needs of their medical condition. In a letter to the provider dated 30 March 2016 we asked the provider for an action plan to address these concerns. On 31 March 2016 an additional care plan had been written for the person entitled 'what I need to eat well' and included information that the person required five meals day and should receive extra calories and sugar in their meals.

During our visit on 4 April 2016 we found incomplete food intake records for the 1, 2 and 4 April for this person and there were no records in relation to fluid monitoring. This meant it was unclear whether this person had actually received the required five meals per day required to maintain their weight.

The provider did not ensure that the nutritional needs of people were met. This was a breach of regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, relating to Meeting nutritional and hydration needs.

The chef showed us a four week rolling menu for main meal choices. There were two choices available each day for lunch; one of the choices did not always include a vegetarian option. Some people in the home preferred a vegetarian diet. No options were provided for breakfast or supper on the menu. Staff told us that people were not offered a hot breakfast and there were not enough plates to serve people their breakfast. They told us they had to serve toast on paper napkins. One member of staff said they had brought in eggs from home so that people could have a choice of breakfast. People's specific dietary requirements were recorded in the kitchen and included diabetic, gluten free, vegetarian, soft and pureed. These meals were plated up in the kitchen and labelled with people's name to ensure they received the appropriate meal for them.

Whilst the main meal served on 21 March 2016 demonstrated a balanced and nutritious diet for most people, it was not clear that people were able to make choices about their main meal in advance or that they were able to make choices about their breakfast and supper. People did not have the choice of hot food for breakfast and breakfast was not always served using appropriate tableware.

The provider did not comply with the requirements of the Mental Capacity Act 2005 (MCA). The MCA provides a legal framework for making particular decisions on behalf of people who may lack the 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. Where they lack mental capacity to make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. Mental capacity assessments had been carried out, which were decision specific, however, the provider demonstrated a lack of understanding of other elements of the MCA. For example, where it had been determined, by assessment, that the person lacked capacity for a decision, a best interest decision making process had not been made or recorded. This meant there was no outcome for the person and therefore the provider may not have been acting in the person's best interests.

We found evidence of restrictions of people's rights and freedoms. For example one person had signed a consent form which clearly stated that they did not consent to living in the home. There was no evidence in the person's care plan that the provider had investigated this or taken any steps in line with the person's wishes. The person regularly left the home and was returned to the home by staff and on occasion police, putting them at risk from traffic on a road with no pavement. In a letter dated 30 March 2016, we raised concerns about the lack of risk assessment in place to support the person to leave the home safely. The provider responded that the person had capacity to make the decision themselves and they had considered the risk by accepting that the person made 'unwise decisions.' However, by repeatedly returning the person to the home, the provider was acting in a way which indicated they felt the person didn't have capacity. This is contrary to the MCA. The person had an acquired brain injury and alcohol dependency and was making decisions which put their life in danger. This was sufficient evidence for the provider to consider if the person had capacity to understand their decision to leave the home and put their life in danger. The provider placed restrictions on the person without considering their capacity and without undertaking further work and investigation around their decision making. There was no evidence to demonstrate that the person had been supported regularly to leave the home safely with the support of staff.

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 for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. We found that there were some applications appropriately in place which legally deprived people of their liberty.

The failure to consider people's capacity appropriately and to act in accordance with the requirements of the MCA was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, relating to Need for consent.

Staff had received training in relation to key areas such as fire safety, first aid and moving and handling. Only a few staff had received additional training to meet the specific needs of people living in the home and all of these were past their expiry date. For example one care worker had received training in managing challenging behaviour in 2012. This training expired in May 2015. This meant training was not up to date to meet people's needs. The provider had identified specialist training to be undertaken by nurses in areas such as wound management, catheterisation and fall safety awareness. Where nurses had undertaken any specialised training records showed that the training had needed refreshing in March or April 2015 but this had not been carried out. One nurse, for example, had not received up to date wound management training since 2007. There was no evidence of training to keep up with current guidelines and nursing techniques, which nurses are required to do by the Nursing and Midwifery Council (NMC). Furthermore, no trained nurses had received training in specialist areas such as Huntingdon's disease, motor neurone disease, Parkinson's disease or multiple sclerosis. These areas are identified in the provider's statement of purpose as areas where they have a particular speciality. People were supported by staff who had not completed training to

meet the specific needs of people using the service.

Whilst records showed that staff had received training in relation to mental capacity and DoLS, care staff we spoke with had no understanding of the term DoLS or what it meant for people. The Provider, whilst offering training through 'social care TV' had not taken steps to ensure staff's understanding of that training, especially staff whose first language was not English. A member of staff told us "We have staff here who just haven't been trained properly." This meant staff may have been unable to meet people's needs or keep them safe due to a lack of understanding of the training provided.

The provider was unable to provide an appropriate staff induction policy despite repeated requests. There were no available records to evidence any kind of induction training in line with The Care Certificate. The Care Certificate is the minimum standards that should be covered as part of induction training of new care workers. This meant people could not be assured all staff had achieved these standards in order to provide safe care.

The lack of appropriate support, training and professional development was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, relating to Staffing.

Healthcare professionals visited the home regularly. A local GP visited the home weekly in order to treat anyone who was unwell and made extra visits if there was an emergency. There was evidence in some care plans of the involvement of a speech and language therapist (SALT), although SALT were not always referred to appropriately for advice. A SALT referral would be required if a person had a swallowing difficulty. If appropriate referrals are not made, people can be at risk of choking. It was not evident that support from psychologists, mental health nurses, behavioural specialists or drug and alcohol team had been sought to assess people's identified needs. A relative told us their loved one had a problem with their tooth and they had asked to see a dentist but nothing had been done. A physiotherapist visited the home.

The home was not well maintained and did not contain appropriate adaptations for people with limited mobility and those who required the use of a wheel chair to mobilise. Floors were uneven and there were creases in carpeting. One person told us that the uneven floors made it difficult to get around. Wood panelling on walls was seen to be damaged, rough and with splinters representing a risk to people. Areas of the home were in a state of dilapidation including crumbling walls, rotting windows and paint peeling off walls in the main corridor. People who required the use of a wheelchair were unable to move freely around the home without the support of staff as they were unable to open doors. There were no appropriate sanitary fixtures so that people using a wheelchair would be able to access washing facilities without the support of staff. There were no adaptations which made the home suitable for those with a physical disability.

Requires Improvement

Is the service caring?

Our findings

Some people and their relatives felt that staff were kind and compassionate and treated them with respect. They also felt people's privacy and dignity were maintained. One relative said "He has his own room, they keep the doors closed. He's never complained." Some staff were observed to be caring and interactions between staff and people were observed to be mostly positive. One person said "(X member of staff), she's lovely, she did my nails for me." However, we found that any evidence of kindness was due to the efforts of individual members of staff. Some staff had not been able to develop positive caring relationships with people, because they were not able to communicate effectively with them due to a language barrier. We observed some care which was not kind or caring because staff carried out a care task without speaking to the person. For example, a member of staff was supporting a person to eat their lunch; they stood over them and did not engage in any conversation or interaction with the person. Another staff member supported a person to eat with the radio playing in the background. The radio was badly tuned in, but the staff member didn't notice and didn't take any action to tune the radio in so that the person could have listened to what was being played on the radio. This would have enhanced their mealtime experience.. Staff spent their time carrying out set duties and didn't have time to sit with people to get to know them on a personal level. People did not experience an overall culture of compassion and understanding.

The lack of attention to the environment that people lived in, demonstrated a lack of consideration and respect for people. Rooms lacked personalisation. In one person's room, there were two clocks, neither showing the correct time and no towel or hand washing facilities. In another person's room was a calendar which was showing the month of August and other clocks around the home showed incorrect times. There was no evidence in people's records that this lack of personalisation was their choice or that they had been consulted. There was no evidence to support current practice in dementia care to support people's wellbeing.

One person had been living in the home for three weeks and still had the name of the previous occupier (who was deceased) on their door. Although there was no evidence of direct impact on the person, it didn't show consideration for the individual as there was a risk they could be referred to by the wrong name. Some staff were upset by the environment people were living in and the impact it may have on them. The provider's statement of purpose says that the home aims to 'recognise the individual uniqueness of service users, staff and visitors and treat them with dignity and respect at all times.' This was not people's experience in the home.

People were not consulted about their preference for a male or female care worker to support them. This was particularly upsetting for one person who had been supported by a male care worker despite their preference for a female. One person told us they had been woken, washed and dressed by two male members of staff. They said this had made them feel uneasy. People's dignity and choices were not respected and this made people feel unsafe.

People were not always treated with dignity and respect which was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, relating to Dignity and respect.

Formal processes were not in place to support people to make decisions about their care. One person who had been admitted to the home recently told us they were very concerned because there was no care plan in place. They said "No instructions, no care plan. I'm paying for this and I've been saving all my life for care when I retired." It later transpired that there was a care plan in place for the person, however they didn't know about it because it hadn't been discussed with them. We asked people if they had the opportunity to tell staff what they wanted recorded in their care plan. One person said "Oh yeah, they'd listen to me!" Another person told us "I expect I do have the opportunity but they don't provide what I want." There was evidence that care plans were reviewed by staff. This process did not include obtaining the views of those concerned.

There was some evidence that people were supported to make some day to day decisions about their person needs, such as what personal care they received and what meal they would like to have. However, their views and decision were not always acted upon, for example, people did not always have a bath or a shower when they wished or as often as they wished.

Inadequate

Is the service responsive?

Our findings

Although our June inspection identified that people's needs were regularly updated and people were involved in their plan of care, this had lapsed. During this inspection we found that care plans did not address people's needs and people were not involved in their care planning and reviews. Care plans were divided into main sections to address specific needs such as behaviour, breathing or personal care. However people's individual plans of care were not always accurate and did not appropriately address the need in a person centred way. For example one person's care plan mistakenly recorded the person as living with a learning disability which was inaccurate. One person had a risk assessment in place for alcoholism. The plan asked staff to ensure the person was adequately hydrated and received sufficient fluid intake, however there was no food and fluid intake monitoring for the person. Staff would not have been able to determine the food and fluid intake levels for the person to check they had received the care described in their plan.

One person's 'hobbies and interests' care plan stated that they liked to go out but there were no records about how the person was supported to meet this need. Their 'personal care' care plan stated that the person liked a shower before going to bed, however bath and shower records showed that the person had not received a shower or bath between 22 February 2016 and 18 March 2016. The person was unable to have a bath or shower without support from staff. Another person had a 'moving and handling' care plan in place which stated that the person was a high risk from falls and wore hip protectors. We did not observe the person wearing hip protectors at any time during the three days of our inspection.

One person's diabetic care plan stated that the person's blood glucose levels should be read twice a day. Records showed that the person's blood glucose reading had not been recorded since 6 October 2015. The care plan described what kind of diet the person should eat but did not detail any other concerns or risks in relation to the person's condition such as deteriorating eye sight, skin integrity or nerve damage. There was no plan in place to ensure these areas were regularly checked for signs of deterioration so that appropriate action could be taken in a timely way. The person's 'communication' care plan stated that the person could communicate verbally so would be able to inform staff of any deterioration. A plan of care should be designed to meet people's needs. Relying on the person to inform staff would not be appropriate as the person may not be informed of all the signs and related risks in relation to their condition. The person's plan of care was not in line with national guidance in respect of diabetic care and did not meet their diabetic needs.

On 4 April 2016 we were given a copy of a 'Contract of Expectations' for one person using the service. This contract was with the provider and dated Friday 1 April 2016. The contract stated that it was the person's responsibility to take their medicine when out of the home. The provider would not deliver the medicine to the person if it was later discovered they had not taken their medicine with them. The provider had a responsibility to ensure the person's medicines were administered appropriately. The contract also stated that if the person made any further false allegations, this would constitute a breach of the contract and the person would be given notice to leave the home. The provider had a responsibility to meet the person's needs and this included behaviour which may be difficult to manage. The provider did not take appropriate steps to work with the person to manage their behaviours, but instead attempted to control the person's

behaviour by threatening eviction. We reported this to social services who asked the provider to remove the 'Contract of Expectations' as this was not an appropriate method of meeting the person's needs.

The provider had a system in place to handover information between staff shifts. However, we found the handover sheet to be inaccurate. On 21 March 2016 it took over an hour to establish by discussion with the clinical lead which people were living in the home at the time. We could not establish this from the handover sheet, because it included people who had passed away or left, it excluded recent admissions and people temporarily in the home on respite. Additionally the handover sheet did not accurately reflect people's room numbers as there were frequent room changes. The clinical lead was unable to provide a clear rationale in respect of the frequent room changes. It was not clear who resided in the home and where those people resided. This would have made it difficult for staff unfamiliar with the service and with the people living there to provide appropriate care.

On 4 April 2016 we observed morning handover, just after 8am. Present during the handover were a day nurse, a night nurse and four care workers. One care worker had called in sick and a replacement was being sought and one nurse did not arrive to start their shift until 9am. Both members of staff missed the information given at handover. We observed that care staff did not have handover sheets (including key information about people) and only one care worker took any notes. Key information was discussed about people's up to date needs. This included two new people admitted for respite care, one of whom had epilepsy, one person with very a high blood glucose level, people with infections and ulcers. There were 33 people living in the home, which would have made it difficult for care staff to remember everything about people's needs. We asked one member of staff if they could remember information imparted during handover and they said "Need to write, sometimes you remember, sometimes not." Staff were not provided with sufficient information during handover to meet people's needs. This was because the handover sheet did not provide accurate information, had not been provided to staff and because staff did not write down key information about people's up to date needs.

During our inspection, we found examples of staff not meeting people's needs. For example one person asked a member of staff to change their soiled incontinence pad. The request was made at 12.22pm. The person waited over three quarters of an hour before this need was met by staff at 1.05pm. Night staff told us that when they came on duty they often found a person 'soaking' because day staff had failed to meet their continence needs. Another person had their bed changed to a profiling bed during the inspection, at our request because the bed was soiled; however the person's care plan stated they should be sleeping in a profiling bed. This had not been the case until the change. Profiling beds have height adjustability, a knee break and an adjustable back rest. One person told us that when they arrived recently to be admitted to the home, they had not been able to get into their room, due to the storage of other items in their room. The person had paid for the room to be redecorated and have new flooring installed. They were very upset saying "I'm paying for this!" The person was unable to access the room until staff had cleared the room of other items of storage not belonging to the person.

As part of our inspection we sought feedback from visiting health professionals about care provided by the service. The GP reported an incident which had happened on 28 January 2016. He had been called to the home and found a person in a serious condition called diabetic ketoacidosis. Diabetic Ketoacidosis is a serious condition that can lead to diabetic coma or even death. It is caused by a lack of insulin. The GP said that after discussion with nursing staff he was told that they were unable to obtain any insulin and so simply hadn't given any. This had led to a serious deterioration in the person's condition which required admission to hospital. The provider had not met the person's needs, had not taken any action to meet the person's needs and the person had become seriously ill.

People did not receive responsive person-centred care which met their needs. This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, relating to Person-centred care.

There had been two complaints since the last inspection. One person rang a relative to complain that they had been shouting for help for hours but there was nobody around. The relative complained to the provider and was assured by the provider that such an incident would not happen again. The provider recorded an action that a call bell monitor diary was in place. The second complaint was received by the home on 16 September 2015 and was recorded as sent to the registered manager by email on 17 September 2015. There was no evidence that the complaint had been responded to. On 21 March 2016 we asked the administrator whether there had been any response to the complaint. The administrator said she didn't know. The provider's complaints policy stated that complainants would receive an acknowledgement within 24 hours, setting a time limit for the investigation of the complaint, with resolution of the complaint to be within 28 days. The provider did not respond to the complaint and did not comply with their complaints policy.

The lack of response to complaints was a breach of regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, relating to Receiving and acting on complaints.

The provider did not listen and learn from people's experiences. Staff told us that staff meetings were held every four or five months. The meetings coincided with staff feedback surveys. The staff survey for January reported that 31 surveys were given to staff and returned, however at the time of the inspection Westbury employed 37 members of staff. This indicated that not all staff members were included in the feedback. The results of the survey were recorded as positive with staff reporting that they received adequate induction, they were able to approach management with concerns or problems and that their training needs were being met. Evidence within this inspection report has demonstrated that staff did not receive adequate training or induction. We asked staff about the staff satisfaction survey and they told us they were not able to give honest answers in response to the survey questions. One member of staff told us they gave an honestly completed form to the deputy manager who refused to hand the form in if included anything negative. They were asked to redo their form. Another member of staff said they had been honest in their feedback stating that there was no support from management. They told us "They didn't keep the real answers." Staff told us they were afraid to put real feedback on the forms because the right to anonymity had been removed and staff were required to add their name to the questionnaire. One member of staff said they had been closely questioned by the provider regarding their feedback and following this incident had only given positive feedback on future forms because they felt intimidated telling the truth. This meant the provider was unable to improve the home in response to concerns from staff, because staff were unable to raise their concerns in an open and honest way.

Residents meetings were held every three to four months, coinciding with resident feedback surveys. We reviewed minutes of the meetings and found the same issues were raised by people; the lack of English speaking staff, the lack of trips out and the lack of entertainment. Although these issues were repeatedly raised none were appropriately addressed by the provider to meet people's needs. For example at a residents meeting on 24 February 2016 'The residents were assured that steps have now been put in place for all new staff struggling with English to take English classes.' However, we were told by a member of staff during our inspection that English classes had not yet been arranged. During a residents meeting in January 2016 one person said they felt let down because they had no one to talk to and they felt lonely at times. The response to this in the meeting on 24 February 2016 was 'with 2 drivers we hope to be able to provide more activities, please feel free to join the activities downstairs.' This was not an adequate response to the person's concern. There had been no investigation into why the person felt lonely and what action the provider could take to support the person to feel less isolated. There was no indication of whether the

person was physically able to 'go downstairs' to join in activities. Some people said they 'wanted more biscuits' and the response to this was 'you are always welcome to ask.' No action was taken to ensure more biscuits were available to people. The provider did not listen and learn from people's experiences and concerns.

Activities were planned and organised by the activities co-ordinator, known within the home as an occupational therapist. The activities co-ordinator explained that each session was planned 'as it comes.' They explained that attendance at each event was highly variable, as was their approach to providing activities which appealed to those who attended. For example if the activity was a quiz and four people attended, they would change the activity to one which appealed to those who had attended. During the inspection we observed a lively game of monopoly instead of the scheduled activity. People enjoyed the activity sessions. One person said "I love coming down here, it takes you away from things and (the activities co-ordinator) is excellent, he is so patient and kind."

Inadequate

Is the service well-led?

Our findings

There was a registered manager in post, as required by CQC, at the time of the inspection. However, prior to the inspection there had been a number of anonymous concerns raised about the absence of the registered manager from the home. This was confirmed by the provider. People and staff gave differing and sometimes conflicting information about the presence of the registered manager in the home and his ability to actively manage the home on a day to day basis. Staff told us that the registered manager was rarely in the home. Two different staff members told us that the registered manager visited the home once a week and one said "I think he should be here all the time." Another member of staff said "We don't see Dr Naqvi and (the registered manager) much. They come in every couple of weeks." Whilst another staff member told us, regarding the registered manager "He'll turn up when you do and be in the office for a couple of days and then he goes."

People were confused about who the registered manager was. Two people were unable to name the registered manager. Another person said "The owner, he's away a lot." A relative told us they had concerns about the care provided to their relative. They said "I have tried to raise concerns with management but (the registered manager) is never in." The GP also told us they had rarely seen the registered manager in the past few months. "I saw him about a month ago, then a month before that and then not for six months before that." The absence of the registered manager from a day to day managing role impacted on people's care. During our inspection we identified multiple breaches of regulations which meant people received care which was not safe, did not meet their needs, was not responsive to their feedback and was not designed to meet their individual preferences.

The management structure made available by the provider during the inspection did not show anyone as the registered manager. The person registered with CQC as the registered manager and legally responsible for managing regulated activities and ensuring compliance with the Health and Social Care Act 2008 was shown on the diagram as a management consultant. The person identified as the assistant manager had left the home and we were told there were no plans to replace the person. In their Provider Information Return (PIR), the provider stated there was a clear hierarchical structure which included a registered manager, a deputy manager and a head of care. During our inspection we found the assistant manager had left and was not to be replaced and the registered manager was not managing the home on a day to day basis. There was not a clear structure providing effective leadership and governance in the home.

The provider's statement of purpose says there are onsite education courses two days a week, but we did not see any evidence of this. It also states that a 'service user/principal carers' committee has been formed in order for service users and family members to air their views. It states that participation in decision making is encourages and valued. We saw no evidence of this. Resident meetings did not include family members and any concerns raised were not appropriately addressed. The statement of purpose did not accurately reflect service provision the home at the time of our inspection.

The provider held Head of Department meetings usually attended by the clinical lead, head of maintenance, domestic manager and office administrator. We looked at minutes of those meetings dated 18 February

2016 and 25 February 2016. There was no record of any issues being identified and discussed at these meetings. The inspection findings demonstrate key issues in relation to care and people's safety which had been addressed by the provider.

The registered manager had not met CQC notification requirements in respect of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009. During the inspection we found evidence of serious incidents and allegations which should have been reported under this regulation. The registered provider failed to notify CQC or the local safeguarding authority of an allegation of abuse by a member of staff. They also failed to notify CQC of a choking incident in which a person had to be resuscitated. They did not notify CQC about a person that had been admitted to hospital with diabetic ketoacidosis, which if left untreated could have resulted in the person's death. This meant that CQC were not aware of serious incidents and were not able to check that the provider had taken appropriate actions to keep people safe.

The failure notify CQC about any abuse, allegation of abuse or serious injuries to was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009, Notification of other incidents.

Although the provider carried out regular checks there was no effective systems of quality monitoring involving audits and related action plans in order to strive for continual improvements in the service provided to people. For example we saw evidence that the pressure in air mattresses was checked on a daily basis and that fire exits were also checked daily. Fire alarms were checked weekly. However there were no audits in relation to infection control, care planning, catering, health and safety or any other areas which the provider should have been monitoring and striving to drive through improvements. We were shown what the provider described as a 'domestic audit' but this was a cleaning schedule, listing areas of the home which should be cleaned. There was nothing to demonstrate how the cleaning had been audited and no action plan to describe the improvements required, including timescales for completion. The impact of a lack of effective quality monitoring systems was that we found the home to be unclean, there were issues around health and safety, risk assessments were incomplete and care records were inaccurate. This affected the quality of care people received.

The lack of effective quality monitoring in the home was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, relating to Good governance.

The atmosphere in the home was not open, inclusive and empowering. People and staff were fearful of the provider. This was evidenced by information given to us by staff about how they could not give honest feedback in the staff survey. Staff told us they were fearful that if they were seen talking to CQC, they would lose their jobs. Two members of staff told us they were later questioned about their conversation with CQC staff during the inspection. People were also afraid to speak out. On the second day of our inspection two people told us they had been told not to speak to CQC staff. They said that all the staff were concerned that they had been speaking to CQC and they had been told they would lose their home as "it will be closed." Another person told us "I just keeps quiet." Two other people told us they were not able to speak freely to staff in the home about any concerns. Visiting healthcare professionals who visited the home also told us about the culture in the home. One said there is "no training, no support, no encouragement when things are done wrong to get things right. Nurses are stressed and not supported, not put on courses and not respected as people." The overall culture in the home was one of fear; people and staff were not listened to. Staff were not encouraged to question practice, raise concerns or be involved in the development of the service.

Staff told us they were frustrated about the care they were able to provide for people. One member of staff

told us "There's never enough of anything, not enough sheets, not enough plates to serve breakfast, we have to serve toast on napkins. Sometimes there's not enough milk." At night time if people wanted a milky drink they had to provide this themselves as staff were only able to offer a choice of tea and coffee. One member of staff said "Our clients deserve better." The provider failed to provide basic facilities for people, which they had a right to expect, such as clean sheets and plates.

Two visitors to the home described the atmosphere as 'friendly' and said they were always welcomed by staff. Despite, the issues described above, staff were warm and welcoming to people's relatives when they visited.