B Gelfand

West House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

West House provides accommodation and personal care for up to 25 older people and older people living with dementia.

The inspection was completed on 28 and 29 September 2016 and 6 October 2016 and was unannounced. There were 25 people living at the service when we inspected.

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

There was a lack of provider and managerial oversight of the service. Quality assurance checks and audits carried out by the provider were not robust, did not identify the issues we identified during our inspection and had not identified where people were put at risk of harm or where their health and wellbeing was compromised. The provider was unable to show us how they identified where improvements to the service were needed and lessons learned. However, by the third day of inspection the provider had started taking action to address the shortfalls in the service, including improvements to quality monitoring and staff training arrangements.

Suitable control measures were not put in place to mitigate risks or potential risk of harm for people using the service as steps to ensure people and others health and safety were not always considered. Risk assessments had not been developed for all areas of identified risk and pressure mattresses were not correctly set in relation to people's weight. The management of medicines was not always safe and improvements were required to staff's practices and procedures to ensure these were in line with current legislation and guidance.

Improvements were required to the provider's recruitment procedures so as to safeguard people using the service. Robust systems were not in place for newly employed staff to receive a thorough induction. Although staff felt supported, suitable arrangements were required to ensure that formal supervision and appraisal measures were in place.

Although some relatives did not always think there were sufficient numbers of staff available to meet their member of family's needs, our observations showed that staffing levels and the deployment of staff were suitable at the time of this inspection. However, the majority of interactions by staff were routine and task orientated and improvements were required. Whilst some staff's interactions with people were positive and staff had a good rapport with the people they supported, this was in contrast to other observations. These showed that some staff's practice when supporting people living with dementia required further improvement and development.

People's care and support needs had not always been identified and documented as required and reflected in their care plans. Improvements were required to ensure that the care plans for people who could be anxious or distressed, considered the reasons for people becoming anxious and the steps staff should take to comfort and reassure them. Improvements were needed in the way the service and staff supported people to lead meaningful lives and to participate in social activities of their choice and ability. Assessments had been carried out where people living at the service were not able to make decisions for themselves, however the arrangements for the use of covert medication were poor and 'best interest' meetings to evidence decisions had not been considered.

The dining experience for people was positive and people had their nutrition and hydration needs met. People were supported to access appropriate services for their on-going healthcare needs. People knew how to make or raise a concern or complaint.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Risks were not appropriately managed or mitigated so as to ensure people's safety and wellbeing.

The management of medicines was not safe as staff did not always follow medication policies and procedures in line with current legislation and guidance. This referred specifically to the supply, dispensing, administration and recording of medication.

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

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff did not receive a robust induction and improvements were required to ensure that appropriate arrangements were in place for staff to receive formal supervision and an appraisal.

Although assessments had been carried out where people living at the service were not able to make decisions for themselves, the arrangements for the use of covert medication were poor and 'best interest' meetings to evidence decisions had not been considered.

The dining experience for people was positive.

People were supported to access appropriate services for their on-going healthcare needs.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Although some people stated that staff treated them with care and kindness, care provided was often task and routine focused.

Improvements were required to ensure that people were supported at the end of their life to have a comfortable and

dignified death and that information relating to a person's end of life care needs were clearly recorded.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People's care plans were not sufficiently detailed or accurate to include all of a person's care needs and the care and support to be delivered by staff.

People were not always engaged in meaningful activities or supported to pursue pastimes that interested them and improvements were required.

Concerns and complaints were taken seriously and responded to in good time.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

There was a lack of managerial oversight of the service as a whole. The provider's systems to check the quality and safety of the service required improvement because it had not identified the areas of concern that we found or ensured that the principles of good quality assurance were followed to ensure a proactive approach. The provider took immediate steps to improve their practices during our inspection.

West House

Detailed findings

Background to this inspection

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

This inspection took place on 28 and 29 September 2016 and 6 October 2016 and was unannounced.

The inspection team consisted of one inspector on all three days of the inspection. On 28 September 2016 the inspector was accompanied by two representatives of Southend Borough Council.

We reviewed the information we held about the service including safeguarding alerts and other notifications. This refers specifically to incidents, events and changes the provider and manager are required to notify us about by law.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We spoke with five people who used the service, eight members of care staff, seven relatives, the provider who is also the registered manager and the 'Customer Service's Manager.

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

Inadequate

Is the service safe?

Our findings

Prior to our inspection concerns were raised about staff's medication practices. In addition concerns were raised that steps to safeguard the health and safety of people in relation to falls management was inconsistent and placed people at risk of harm.

Although people told us they received their medication as they should and at the times they needed them, the arrangements for the management of medicines required improvement. Whilst medicines were stored safely for the protection of people who used the service, we found a number of discrepancies relating to staff's practice and medication records. Observation of the medication round on the second day of inspection showed this was not completed with due regard to people's dignity. A senior member of staff was observed to directly handle four people's medication by placing their tablets in the medicine pot with their fingers. This meant that poor hygiene methods were being used and there was a potential risk of cross-infection. In addition, some medicines may be harmful to the care worker if they have direct contact with them and this could change the original properties of the medication. Staff involved in the administration of medication had received appropriate training. However competency checks to ensure that staff who administered people's medication remained proficient had not been completed at regular intervals. For example, staff newly appointed at the beginning of July 2016 had not been assessed to confirm that their medication practices were appropriate or safe.

It was not clear if medication for one person was being used appropriately and to support their wellbeing. The Medication Administration Record [MAR] showed they were prescribed a specific medication to deal with agitation on an 'as and when required' basis. The MAR over a four day period demonstrated that this medication had been given by staff on seven occasions; however the person's behavioural records and daily care notes provided no rationale to demonstrate the circumstances surrounding the medication being administered by staff. Additionally, following concerns raised by an external source, it was confirmed that some senior members of staff dispensed people's medication into pots, administered several people's medication and completed the MAR forms at the same time. This meant there was a risk of inadvertent mistakes which could lead to people receiving the wrong medication and recording errors. We discussed this with two senior members of staff and they confirmed this practice as accurate but provided an assurance that this would stop with immediate effect.

We found unexplained gaps on the MAR form for one person, giving no indication of whether they had received their medication or not, and if not, the reason why it was not recorded. However, on further review we found that the medication had been administered. We discussed this with the senior member of staff on duty and they acknowledged that they had not completed the MAR form correctly. Where people were prescribed a topical cream to help aid their skin care or for the prevention of skin breakdown and the development of pressure ulcers, a 'Topical Medicines Application Record' was not in place and daily care records were not always completed to demonstrate that this had been applied as prescribed. The provider advised that this would be corrected and a form implemented as soon as possible.

Concerns raised by an external source prior to our inspection suggested that a significant amount of

medication for one person had gone missing. We discussed this with the Customer Relations Manager and they confirmed that there had been a recent incident whereby 14 tablets of the same medication for one person could not be traced. Although the Customer Relations Manager advised that all efforts had been undertaken to account for the missing medication and that there had been no impact for the person as a result of this; consideration had not been given by the provider to notify the Care Quality Commission or the Local Authority. Furthermore, the provider had not considered conducting an internal investigation into the incident and/or undertaking formal supervision with all staff who administered medication to consider the reasons for this and learning to ensure prevention of this type of incident in the future.

Where one person had oxygen in place to help them to breathe more easily, we observed on the first two days of inspection that their oxygen concentrator which is used for the sole purpose of relieving breathlessness had not been used. We discussed this with the provider, however no rationale was provided as to why the person's oxygen was not in use. We reviewed the person's care plan and this stated that the person could be breathless, had a long-term medical condition which affected their breathing and required the use of oxygen. Although the flow rate of oxygen was recorded, no information was documented detailing the amount of oxygen required [hours per day] or the specific instructions to ensure that accessories, for example, the nasal cannula tubing and mask should be checked and changed on a regular basis to ensure that the equipment was clean and to ensure that the equipment was maintained properly. There was no evidence to show that the equipment was being checked by staff or that they had received appropriate training. This meant that we could not be assured that the person was receiving appropriate oxygen therapy in line with the prescriber's instructions and this placed them at risk of respiratory depression. Following discussions with the provider they made arrangements to source suitable training for staff.

Some people were assessed as at high risk of developing pressure ulcers. We checked the setting of pressure relieving mattresses that were in place to help prevent pressure ulcers developing or deteriorating and found that three out of three viewed were incorrectly set in relation to people's weight. For example, the pressure mattress setting for one person was fixed on setting five and this was for a person who weighed 108 kilograms; however their weight records detailed that 14 days prior to our inspection they weighed 82 kilograms. This meant that we could not be assured that the amount of support the person received through their pressure relieving mattress was correct and would aid the prevention of pressure ulcers developing or deteriorating further. The provider and staff confirmed that no records were in place to monitor this so as to ensure that these were set correctly. The provider stated that they would devise and implement a process to monitor this for the future. We also found that where people were required to have their body repositioned at regular set times so as to relieve pressure from an existing pressure ulcer, and to prevent the development of pressure ulcers, records in some cases were poorly completed. For example, the instruction for one person stated that they should be repositioned at two hourly intervals. Over a seven day period these showed that there were several occasions whereby it was not possible to determine if the person had been repositioned or not over several hours. At the time of the inspection two of the three people had a pressure ulcer. The provider could not be assured that their pressure management processes were effective in ensuring people's wellbeing.

Risks relating to other areas were not identified and suitable control measures were not put in place to mitigate the risk or potential risk of harm for people using the service despite a 'Rag Rating' or 'traffic light' rating system as a visual cue of risk being in place. For example, where people were at risk of dehydration, we could not always determine if people had been given sufficient fluid to drink as the records were poorly completed. For example, the fluid records for one person showed that there were occasions whereby they had not received a drink for between six and seven hours. On another occasion the records showed that they had not received a drink for up to 20 hours. We discussed this with the provider and in their opinion this was solely due to a lack of effective recording of by staff. The lack of monitoring could also indicate that

actions to mitigate any risks to the service user had not been addressed, placing them at risk of harm.

Prior to our inspection concerns were raised that the provider's arrangements for managing falls for people using the service did not ensure their safety and wellbeing. Information available showed that improvements were required. For example, accident records were not completed for all falls experienced, body maps were not always completed to identify where injuries had been sustained and people had not been referred to the local falls clinic despite experiencing a significant number of falls. For example, we found that since March 2016 to the time of our inspection, one person had suffered a total of 13 falls. An accident record was not evident for one fall and one record was completed retrospectively one day later. Although a sensor mat was in place to alert staff to the person getting out of bed, there was no evidence to show that the provider or staff had contacted healthcare professionals, such as the local falls prevention team, despite this being suggested by the person's GP five weeks earlier. Additionally, no observation records had been considered or completed for this person or others over a 24 hour period, particularly where a head injury had occurred. Improvements were required to ensure that the provider was up-to-date with best practice guidance relating to falls management, for example, the National Institute for Health and Care Excellence [NICE].

Where assessments used numerical data to provide a risk score, this in some instances contradicted other relevant information. For example, the falls risk assessment for one person recorded numerical data to indicate that the person was at high risk of falls. However, the mobility care plan for the same person provided a 'rag rating' score of green and suggested no risk. The latter was not correct and the person was at significant risk of falls.

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

The provider's recruitment and selection procedures required improvement. No recent photograph was available for two out of two employee files viewed and there was only one reference for one applicant. Although an 'ISA First Response' was received for both members of staff, their Disclosure and Barring Service [DBS] certificate was not received until they had commenced employment at the service. No rationale was recorded by the provider for not waiting for the full DBS check to be undertaken before both members of staff had taken up their post and there was no evidence to show that they were supervised and the above decision to commence employment had been risk assessed. Additionally, there was no information recorded as part of good practice procedures relating to the interview as a written record had not been completed or retained by the provider to demonstrate the outcome of the discussion. No rationale was provided by the provider as to why this had happened.

This is a breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us that there was always enough staff available to support them during the week and at weekends. Relative's comments about staffing levels at the service were variable. We discussed this with the provider and they confirmed that there had been a recent occasion whereby a member of staff had telephoned sick at the last minute and an external agency were unable to provide cover and therefore staffing levels as stated to us had not been maintained. Staff told us that in general staffing levels were appropriate for the numbers and needs of the people currently being supported. Although the provider did not have suitable arrangements in place to determine the basis for the service's staffing levels, our observations during the inspection indicated that the deployment of staff was suitable to meet people's needs. For example, we noted that communal lounge areas were supported by staff throughout the day.

Nevertheless, the majority of interactions by staff with people using the service were routine and task orientated. In addition to the above we were made aware that one person who used the service received an additional five one-to-one hours per day to help mitigate the risk of falls. However, there was no evidence to show when these hours were being utilised or the staff rostered to provide this support. We discussed this with the provider and they confirmed that they would speak with the person's funding authority so as to get clarity as to how best to use the hours.

Staff told us that they felt people living at the service were kept safe at all times. People confirmed to us that staff looked after them well, that their safety was maintained and they had no concerns. The majority of relatives told us that they had no concerns about their member of family's safety.

People were protected from the risk of abuse. Staff had received appropriate safeguarding training. Staff were able to demonstrate a good understanding and awareness of the different types of abuse, how to respond appropriately where abuse was suspected and how to escalate any concerns about a person's safety to a member of the management team. Staff were confident that the provider would act appropriately on people's behalf. Staff also confirmed they would report any concerns to external agencies such as the Local Authority or the Care Quality Commission if they felt that the provider was not responsive.

Requires Improvement

Is the service effective?

Our findings

The provider confirmed that all newly employed staff received a comprehensive induction. This consisted of an 'in-house' orientation introduction to the service and the 'Care Certificate' or an equivalent. Staff told us that in addition to the above they were given the opportunity to 'shadow' and work alongside more experienced members of staff. The provider confirmed that this could be flexible according to a member of staff's previous experience and level of competence. Although the provider confirmed that the 'Care Certificate' or an equivalent formed part of the induction process, this was not completed for the newest members of staff employed. This meant there was no evidence to show that the provider had assessed their competency against the core standards as outlined within the 'Care Certificate' or an equivalent robust induction program.

Although staff told us that they felt supported by the management team, staff confirmed and records showed that they had not received regular formal supervision. For example, two members of staff employed since the beginning of July 2016 had not received a formal supervision at the time of our inspection. Evidence showed for another member of staff that since March 2014 they had only received one formal supervision. Where subjects and topics were raised, there was no information available to show that these had been followed up to demonstrate actions taken. Staff told us and records confirmed that staff employed longer than 12 months had not received an appraisal of their overall performance for the preceding 12 months. The provider confirmed that the above information was accurate and that steps would be taken to address this for the future.

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

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

Not all staff were able to demonstrate a good knowledge and understanding of MCA and Deprivation of Liberty Safeguards (DoLS) despite having received training. The provider confirmed that they would look at sourcing additional training in this area for staff as soon as possible. Records showed that where appropriate people who used the service had had their capacity to make decisions assessed. This meant that people's ability to make some decisions, or the decisions that they may need help with and the reason as to why it was in the person's best interests had been recorded. Where people were deprived of their liberty, the provider had made appropriate applications to the Local Authority for DoLS assessments to be considered for approval. Where these had been authorised the provider had notified the Care Quality Commission, however a number of these assessments had expired and a further DoLS assessment was required to be re-submitted to the Local Authority. The provider understood and confirmed that this would

be completed as soon as possible.

We found that the arrangements for the administration of covert medication for one person using the service were not in accordance with the Mental Capacity Act (MCA) 2005. 'Covert' refers to where medicines are administered in a disguised format without the knowledge or consent of the person receiving them, for example, in food or in drink. Although there was evidence to show that the person's GP had agreed for some of their medications to be mixed with food, the provider had not instigated a 'best interest' meeting with all necessary parties involved. This is to agree a management plan and to ensure that the properties of the medication remain effective once mixed with food or drink and ingested. Additionally, an assessment had not been considered or completed where people had an alarm mat in place to alert staff when they got out of bed to mobilise. This showed that a management plan had not been completed to confirm that this decision was in the person's best interest and the least restrictive option available.

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

The provider forwarded us a copy of the staff training matrix. This showed that staff were provided with a range of training to enable them to carry out their role. Records showed that staff had attended training in for example, moving and handling, safeguarding, food hygiene, infection control and first aid. Additionally, some staff were noted to have received specialist training relating to the medical conditions of the people they supported, for example, Diabetes, Parkinson's and Epilepsy.

People were positive about the meals provided. One person told us, "I like the food here, it is very nice." Another person told us, "Oh, the meals are fine." We found that in general the dining experience was satisfactory and the majority of people ate independently. People were supported to use suitable aids to eat and drink as independently as possible, for example, to eat their meal using a spoon and use of specialist beakers. This showed that people were enabled and empowered to maintain their independence and skills where appropriate. Where people required assistance from staff to eat and drink, this was provided in a sensitive and dignified manner, for example, people were not rushed to eat their meal and positive encouragement to eat and drink was provided by staff. Throughout the inspection people were provided with sufficient hot and cold drinks at regular intervals.

People's care records showed that their healthcare needs were recorded and this included evidence of staff interventions and the outcomes of healthcare appointments. Each person was noted to have access to local healthcare services and healthcare professionals so as to maintain their health and wellbeing, for example, to attend hospital and GP appointments and District Nurse.

Requires Improvement

Is the service caring?

Our findings

People's comments about the care and support they received were generally positive. One relative told us, "Everybody here is very nice; I think the staff are very good". Another relative told us, "I am very happy with the care and support my relative receives." However, where negative comments were provided, these had been brought to the provider's attention.

People's preferences and choices for their end of life care were not robust or as detailed as they should be. We found that the needs of people approaching the end of their life and associated records relating to their end of life care needs were either not recorded or contained minimal information. For example, the care plan for one person provided no information detailing the person's pain management arrangements and the care to be provided so as to provide comfort and dignity for the person nearing the end of their life. No information was recorded to identify who may have a few months, weeks or days to live; in order to aid care planning arrangements and discussions with the person and those acting on their behalf. In addition, no Preferred Priorities for Care [PPC] documents were in use. This is designed to help people prepare for the future and gives them an opportunity to think about, talk about and write down their preferences and priorities for care at the end of their life. This meant that people's 'end of life' wishes were not recorded, in line with new guidelines issued by the National Institute for Health and Care Excellence [NICE]. The latter places emphasis for a more individualised approach to 'end of life' care. We discussed this with the provider and they confirmed that they were aware of the Gold Standards Framework. This is a joint approach used by all professionals involved in a person's care that ensured they received appropriate and co-ordinated end of life care.

Prior to the inspection concerns were raised that one person who was on end of life care did not have their dignity respected. This referred specifically to an item of furniture being fitted in the person's room whilst they remained in bed and close to the end of their life. We were advised that the request for the furniture to be fitted came from the person's relatives, however consideration had not been well thought out by the provider or Customer Services Manager as to the person's comfort and dignity needs so as to ensure that they received care that was caring and compassionate.

However, this was in contrast to other observations during the inspection. People told us that their privacy was respected and they were treated with respect and dignity. Our observations showed that staff respected people's privacy, such as; people's modesty was upheld when personal care was provided as staff ensured that doors to bedrooms, bathrooms and toilets were closed. We regularly observed staff discreetly and sensitively reminding people about personal care needs. We saw that staff knocked on people's doors before entering and staff were observed to use the term of address favoured by the individual. In addition, we saw that people were supported to wear clothes they liked and that suited their individual needs so as to maintain their self-worth.

There was evidence to indicate that people using the service or those acting on their behalf had been involved in the care planning process or consulted. Four relatives confirmed that they had seen their member of family's care plan and had provided information as part of the pre-admission assessment

process.

People were supported to make day-to-day choices and their independence was promoted and encouraged where appropriate and according to their abilities. For example, several people at lunchtime were supported to maintain their independence to eat their meal and some people confirmed that they were able to manage some aspects of their personal care, for example, to wash their face and hands with a flannel.

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

Requires Improvement

Is the service responsive?

Our findings

Appropriate arrangements were in place to assess the needs of people prior to admission. This ensured that the service were able to meet the person's needs. Evidence showed that where able, people and those acting on their behalf had been involved in the development and review of their care plan.

Although some people's care plans provided sufficient detail to give staff the information they needed to provide personalised care and support that was consistent and responsive to their individual needs, others were not as fully reflective or accurate of people's care needs as they should be. This meant that there was a risk that relevant information was not captured for use by other care staff and professionals or provided sufficient evidence to show that appropriate care was being provided and delivered. For example, where people were assessed as living with dementia, information relating to how this affected all activities of their daily living was not clearly recorded.

No care plan had been developed for one person despite having been admitted to the service six days previous. We discussed this with the provider and they advised us that they thought they had two weeks to complete the person's care plan as this would enable staff to get to know the person and provide a more accurate care plan. However, on review of the person's pre-admission assessment, some key information was already known and documented about the person, particularly in relation to their manual handling needs, their dietary needs and the person's current skin integrity status. There was no obvious rationale as to why this information had not been used to inform the person's care plan or provide staff with specific information and guidance as to how the person's care should be delivered. This meant that a clear care plan detailing the person's care and support needs had not been developed. Not all staff was aware of the person's care and support needs. Staff confirmed that they had not had the opportunity to read the person's care records and therefore relied heavily on senior members of staff for information.

Staff told us that there were some people who could become anxious or distressed. Improvements were required to ensure that the care plans for these people considered the reasons for becoming anxious and the steps staff should take to reassure them. Guidance and directions on the best ways to support the person required reviewing so that staff had all of the information required to support the person appropriately and to reduce their anxiety. Where information was recorded detailing the behaviours observed, the events that precede and follow this and staff's interventions; improvements were required. There was little evidence to demonstrate staff's interventions and the outcome of incidents so as to ensure positive outcomes for people living at the service. For example, the incident record for one person stated that they had become very angry, were unsettled and wanted to kill themselves. No information was recorded detailing the actions by staff to respond to the incident, the steps to be taken to reduce the likelihood of this happening or recurring again and the outcome. This was not an isolated case. This meant that we could not be assured of the interventions carried out by staff or that there were positive outcomes for people.

People told us they had the choice as to whether or not they joined in with social activities at the service. Although the service employed a member of staff to provide social activities to people living at the service

for three hours per day Monday to Friday, our observations throughout the inspection showed that there were few opportunities provided for people to join in, particularly for people living with more advanced stages of dementia and who required more support to benefit from occupation and stimulation. On the first two days of inspection the activities person was seen to take a person out in their wheelchair to the local shops to purchase personal shopping and to enjoy some refreshments. Additionally on the second day in the morning an external entertainer visited the service. The latter was hugely popular as several people were able to participate by singing or dancing. However, at all other times, there was an over reliance on the use of the television or radio in communal areas and we observed long periods of inactivity where people with more complex needs or those who were unable to effectively communicate were either asleep or disengaged with their surroundings and the people they lived with.

Several people were very reliant on the care and support provided by staff as a result of them living with varying levels of dementia. Whilst we observed that some staff interactions with people were positive and staff had a good rapport with the people they supported, this was in contrast to other observations. These showed that some staff's practice when supporting people living with dementia required improvement and development. For example, some staff were observed to spend little time with the person living with dementia, particularly where people were not able to verbally communicate or who seemingly appeared asleep. Staff were seen to primarily focus solely on tasks and actions. Although staff primarily sat at a table in the main communal lounge area, staff did not always pick up on people's non-verbal communication, such as, gestures or facial expressions, where people spoke quietly or where people were unable to find the right words to communicate their needs. We discussed this with the provider and they confirmed that a review of where staff sat in the main communal lounge and staff observations would have to be undertaken.

Care plans relating to social activities were not robust. Although they provided information relating to people's personal preferences they did not provide the relevant detail about how this was to be delivered by staff and some of the information appeared uniform and generic.

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

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

Information on how to make a complaint was available for people to access. People and their relatives told us that if they had any worries or concerns they would discuss these with the management team and staff on duty. Relatives stated that they felt able to express their views about the service and in their opinion they would be listened to. However, not all relatives felt assured that where issues were raised, these would be addressed and sustained in the longer term.

Staff told us that they were aware of the complaints procedure and knew how to respond to people's concerns. Complaint records showed there had been three complaints in the preceding 12 months. A record had been maintained of each complaint and there was evidence to show that each one had been responded to and action taken by the provider. A record of compliments was available to evidence and capture the service's achievements.

Requires Improvement

Is the service well-led?

Our findings

The provider was able to demonstrate to us the arrangements in place to assess and monitor the quality of the service provided. This included the use of questionnaires for people who used the service and those acting on their behalf. In addition to this the provider monitored the quality of the service through the completion of a small number of audits, for example infection control, people's personal allowance and weekly air mattresses.

Although the above arrangements were in place, we found that the provider's quality assurance arrangements and processes which assessed, monitored or improved the quality of the service required significant improvement. Systems for improving the service through auditing and monitoring were not effective and had not identified the issues we found during our inspection, in particular where people were placed at risk of harm or where their health and wellbeing was compromised. There was evidence to show that because of this people did not always experience positive care outcomes and the lack of robust quality monitoring meant there was a lack of consistency in how well the service was managed and led.

Records relating to staff employed and people using the service were not properly maintained. Proper arrangements were not in place to ensure that effective staff recruitment and selection processes were in place for the protection of people living at the service and that staff received a robust induction. Suitable measures were not in place to ensure that staff were appropriately supervised. Supervisory support arrangements were poor and had not been monitored by the provider to ensure that these were being carried out. Several members of staff had not had an annual appraisal. Medication competency assessments had not been completed to ensure that staff who administered medication to people using the service remained competent to undertake this task safely and to an appropriate standard.

Records were not properly maintained, for example, in relation to risk assessments, care planning and end of life care. For example, although weekly air mattress audits were undertaken; records showed that these were last completed on 30 August 2016. Had this audit been completed each week and been up-to-date, this may have alerted the provider sooner to three pressure mattresses being incorrectly set in relation to people's weight. A periodic audit of care plans and associated records, such as, fluid monitoring for people at risk of dehydration and where people required their body to be repositioned at set intervals where they were at risk of developing pressure ulcers had not been considered or completed so as to ensure these were happening as they should and up-to-date. Additionally, an analysis of clinical information, for example, the incidence of accidents and incidents, pressure ulcers and weight gain and loss had not been considered or collated. The provider was unable to provide a rationale as to why this had not been picked up sooner.

It was evident that the absence of robust quality monitoring meant that the provider had failed to recognise any risk of harm to people or non-compliance with regulatory requirements sooner. Had there been a more effective quality assurance and governance process in place, this would have identified the issues we found during our inspection, identified where improvements were needed or applied learning across the service. However, an assurance was given by the provider that all of the issues raised as part of the inspection process would be addressed. On the third day of inspection, it was noted that various templates were in the

process of being devised to evidence better monitoring of the service. Additionally, the provider had sourced training relating to the use of oxygen.

Minutes of staff meetings were not available at the time of the inspection and were forwarded to us by the provider following the inspection. Staff meetings had been held so as to give staff the opportunity to express their views and opinions on the day-to-day running and quality of the service. Minutes of meetings were viewed for May 2016, July 2016 and September 2016. Although a record had been maintained, where matters were highlighted for action or monitoring, it was not possible to determine how these were to be monitored and the issues addressed. For example, the meeting minutes for the period May 2016 to September 2016 recorded that staff sickness at the service had been terrible and required significant improvement. No action plan was available to show how the provider was to monitor and address this for the future.

This is a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff felt that the overall culture across the service was open and inclusive. Staff told us that communication between staff and the provider was positive. Staff told us that 'staff morale' was good and that there was good team support. Staff's comments about communication were variable with some staff members feeling there was effective communication and others feeling that this required further improvement. Staff told us they received good support from the management team and they were always available should they need help and guidance. Staff confirmed that they were able to express their views to the management team and told us that they felt valued and supported. A copy of the last inspection report and the service's current rating were displayed in the service to provide people with information in an open and transparent way.

The provider confirmed that the views of people who used the service, those acting on their behalf, staff employed at the service and others had been sought on 30 September 2016. The provider confirmed that additional time would be given prior to the results of the questionnaires being collated and where appropriate actioned. The provider confirmed that the last questionnaires were completed in February 2016. The comments viewed were positive. One person recorded, 'Staff genuinely care about the residents.' A second person recorded, '[West House] feels like a genuine, caring place.'

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People who use services did not receive person-centred care and treatment that was appropriate to meet their needs. Assessments of people's care did not include all of their needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Improvements must be made to ensure that the provider acts in accordance with the Mental Capacity Act 2005.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance People who use services were not supported by the providers systems and processes to assess and monitor the quality of service provided. The arrangements in place were not effective in identifying where quality or safety were compromised.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Improvements were required to ensure that effective recruitment and selection procedures

were in place.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff did not receive ongoing or periodic supervision or an appraisal to ensure that their competence was maintained and their performance assessed. Not all staff had received a robust induction.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Not all care and treatment was provided in a safe way for people using the service. Risks were not always mitigated to ensure people's safety. Improvements were required in relation to medicines management.

The enforcement action we took:

We served a Warning Notice.