Willow Residential Care Limited

Willow House

Inspection report

2 Reading Road
Farnborough
Hampshire
GU14 6NA
Tel: 01252 522596
Website: www.willowhouse.org.uk

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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?	Requires Improvement
Is the service well-led?	Inadequate

Overall summary

The inspection took place on 30 December 2014, 5 and 13 January 2015.

Willow House is a care home providing accommodation and personal care for up to 18 older people. Most of the people in the home were living with dementia. When we visited there were 17 people living at the home. The home is a converted residential dwelling with accommodation over two floors. People live in single or shared rooms and bathroom facilities are shared. There is a dining room and sitting room which is also used as an activity room.

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

People living at the home, their visitors and visiting health professionals were complimentary about the quality of

Summary of findings

care and the support provided by the registered manager and staff. However, our own observations and the records we looked at did not always match the positive descriptions they had given us.

During this inspection we checked whether the provider had taken action to address the two regulatory breaches we found during our inspections in August 2014. We told the provider they needed to improve their record keeping by 14 October 2014. The provider sent an action plan in relation to care and welfare and stated they would achieve compliance in this area by 31 October 2014. At this inspection we found that the provider had not made improvements in the two areas where we had previously found breaches in legal requirements.

People's safety was not consistently promoted. Arrangements in place to protect people from harm were not always implemented. When safety incidents occurred these had not always been analysed so preventative action would be taken to keep people safe.

Staff recruitment processes were not robust to ensure people were supported by staff of good character. There were sufficient staff, however, staff did not always understand their roles and responsibilities to provide care that met people's health needs and wishes. Staff were not always responsive to people's individual needs and care was not tailored for each individual. This was especially the case for people living with dementia that could not direct staff to meet their needs. These people were not always given opportunities to retain their skills, remain involved in day to day tasks and live a stimulating life. Staff had received limited training and one to one supervision with the registered manager to support them to do their job effectively. Shortfalls in staff knowledge would not be readily identified and could lead to poor practice when supporting people.

We found the service was meeting the legal requirements relating to Deprivation of Liberty Safeguards (DoLS). Where people could not consent to living at Willow House arrangements were being put in place to ensure they were cared for without unlawful restrictions placed on their movement.

The registered manager aimed to promote a culture of openness and personalised care where people came first. However, their efforts did not always deliver a person focused service as people and staff were not actively involved in the delivery and improvement of the service. Especially people living with dementia, who could not communicate their wishes to staff, were not always full partners in their care and service planning.

Though the provider knew improvements to the service were required systems were not in place to deliver improvements in care.

We found several breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, including two continuous breaches from previous inspections. You can see what action we told the provider to take at the back of the full version of this report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Though staff understood the importance of keeping people safe they did not always protect people from avoidable harm. Risks were not always managed safely. Incidents were not reported and robustly investigated to ensure management plans were in place to minimise the risk of future occurrences.

There were sufficient staff to care for people. Staff suitability had not been robustly assessed at recruitment.

People's medicines were managed and administered safely.

Is the service effective?

Inadequate

The service was not effective.

People were supported by a staff team who did not receive the support they needed to provide care in line with best practice guidance. They did not always understand people's care needs.

The support people received to remain healthy were variable and professional support was not always sought promptly. People received suitable nutrition. Any changes were discussed with specialist healthcare professionals.

The service was meeting the legal requirements relating to Deprivation of Liberty Safeguards (DoLS). People were cared for without restrictions on their movement.

Is the service caring?

Requires Improvement

The service was not always caring.

People received care and support from kind and compassionate staff. Staff however, did not always know how to comfort and communicate with people living with dementia

People receive practical support in a respectful and sensitive way.

Staff respected people's privacy and dignity. People were encouraged to build relationships with staff.

Is the service responsive?

Requires Improvement

The service was not responsive.

Care was not personalised, based on people's wishes and preferences. People were not supported to maintain their appearance to their desired standard.

People living with dementia were not always given opportunities to retain their skills, remain involved in day to day tasks and live a stimulating life

Summary of findings

Relative's feedback were listened to, however, people with dementia were not routinely given the opportunity to share their views so improvements could be made to address their concerns.

Is the service well-led?

Inadequate 

The service was not well-led.

The registered manager aimed to promote a culture of openness and personalised care where people came first. However, their efforts did not always deliver a person focused service as people and staff were not actively involved in the delivery and improvement of the service.

Although there were some systems in place to look at the quality of the service these were ineffective and had not identified the areas for

improvement that were identified during our visit. Action had not been taken to make the improvements previously identified by specialist agencies.

The registered manager had access to best practice guidance and support from a variety of sources. This guidance was not always reflected in people's care planning, formally reviewed and shared with staff in a structured manner so people would be assured this guidance would be reflected in the care they received.

Willow 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 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 30 December 2014, 5 and 13 January 2015 and was unannounced. The inspection team consisted of two inspectors. Before the inspection we reviewed the information we held about the home including previous inspection reports and any concerns raised about the service. We also looked at notifications sent in to us by the registered manager, which gave us information about how incidents and accidents were managed. A notification is information about important events which the provider is required to tell us about by law.

During our inspection we observed how staff interacted with people using the service and used the Short Observational Framework for Inspection (SOFI) during lunch. The SOFI is a way of observing care to help us understand the experiences of people who could not talk with us.

We spoke with eight people living at the home and four relatives to obtain their reviews on the quality of care. In addition, we spoke with the registered manager and eight members of staff, including care and support staff. We reviewed ten people's care records. We looked at staff training records and recruitment files for eight staff. We also looked at records relating to the management of the home. These included maintenance reports and audits. We spoke with three health care professionals and a commissioner. We also spoke with the director of the provider company.

Inadequate

Is the service safe?

Our findings

People told us they felt safe living in the home and relatives said they had no safety concerns when visiting. However, our own observations and the records we looked at did not always match the positive descriptions people and relatives had given us.

Our inspection in August 2014 found people were at risk of harm because staff did not always have written guidance to know how to help people to stay safe, such as minimising the risk of falling. The registered manager had since reviewed some people's risk management plans. However, we remained concerned risks had not been managed and recorded to ensure people consistently received the support they needed to stay safe.

We observed people at risk of falls being supported to walk safely and staff knew what to do when people fell. The registered manager monitored people's falls monthly with the specialist community nurse for care homes in line with professional guidelines. The specialist community nurse told us the registered manager took account of their recommendations and had implemented their guidance promptly to reduce the risk of people falling. Falls had decreased across the home following the review of people's foot wear and medicine.

However, people's care plans had not always been updated to reflect their risk of falls and the support they required. One person had been discharged from hospital with an increased risk of falls and a walking aid. It had not been recorded how staff needed to support them to move safely or how they were to be supported to prevent falls when they refused to use their mobility aid. Staff did not have an up to date record of information detailing the care this person required. This put them at risk of not receiving appropriate care that could result in a fall and possible injury.

The above demonstrated that people were not protected from the risks of unsafe care because accurate information had not been documented to inform staff how to support people to stay safe. This was a continuous breach of Regulation 20 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider's infection prevention arrangements had not always been implemented and people were at risk of catching infections. Soiled materials were handled inappropriately and the kitchen environment was unhygienic. Staff did not always wear protective clothing to protect people or themselves from the spread of infection. Staff told us aprons were available and they knew they had to wear them, but we observed staff did not consistently use them. Appropriate bags had not been provided for staff to safely carry soiled linen and paper towels for disposal.

An appropriate standard of cleanliness had not been maintained in the kitchen and food was stored and prepared in an unhygienic environment. The shelves in the dry goods larder and freezer were dirty and cracked making them difficult to clean. Food debris and crumbs were left on surfaces. We checked whether cleaning had taken place. The kitchen cleaning scheduled had not been completed for 12 of the last 23 days. The registered manager told us they had not checked and could not confirm whether cleaning had taken place.

The lack of effective infection prevention and the inappropriate standards of cleanliness in the kitchen were a breach of Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People were not protected from the risk of abuse. The procedures in place to safeguard people had not always been implemented appropriately and consistently. Staff told us that it was the provider's policy to ask visitors to identify themselves to staff and record when and why they visited the home. This was to protect people from the risks posed by unauthorised strangers in the home. On the three occasions we visited we were not asked to identify ourselves or sign the visitors' book, neither was the district nurse nor two other visitors. People were at risk of strangers entering their home without arrangements put in place to supervise them, if required. Staff told us they would raise any concerns relating to abuse with the registered manager. Though staff had received training to enable them to identify abuse, they did not readily identify issues such as physical or financial abuse when we asked them. People experiencing abuse might not receive the support they required because staff would not be able to identify when they were at risk.

The registered provider had not made suitable arrangements to ensure that people were safeguarded against the risk of abuse. The provider and registered

manager had not taken reasonable steps to identify the possibility of abuse and prevent it from happening. This was breach of Regulation 11 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Recruitment procedures were not always robust to ensure people were supported by appropriate staff. A criminal offences check had been completed by the Disclosure and Barring Service (DBS) for all employees. However, a full employment history had not been obtained for one care worker. Evidence of conduct in previous employment was not available for two care workers although the registered manager told us they had received references. In the absence of robust recruitment information, the provider could not evidence that people were supported by staff of good character. Records of employment checks undertaken of previous employees were not readily available.

The registered manager was not able to demonstrate they had checked employees were suitable to work with people, prior to employing them. This was a breach of Regulation 21 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010

Following a safety incident a multi-agency safeguarding investigation concluded staff had not reported an incident appropriately. The registered manager had been told by the local authority to ensure staff knew how to report and record safety incidents. The local authority told us they were concerned about the quality of the investigation reports received from the registered manager and had asked them to undertake more robust internal investigations. The registered manager told us she had reinforced the accident and incident reporting procedure with staff and improved the quality of investigations.

We looked at a recent accident resulting in bruising to a person's face to see if the accident had been reported, recorded and investigated appropriately. An accident report had not been completed and no investigation or recommendations had been documented. We asked the registered manager to complete the provider's accidents procedure for this accident on 30 December 2014. On our third visit on 12 January 2015 this report had still not been completed.

Another person's fall and a possible injury whilst being transferred from an ambulance had also not been recorded as incidents. The fall had only been recorded in the person's daily notes and an incident report had not been completed. Though the registered manager had reinforced the provider's accident and incident procedure with staff, they still did not know how to implement it.

The registered manager could describe some action she took following these three incidents; however, the investigation and recommendations had not been documented to enable analysis of the impact on people so as to reduce harm in future. Apart from falls, the registered manager did not routinely review other incidents across the home to ensure learning was put into practice to minimise the risk of people experiencing repeat events.

Plans were not always in place to keep people safe from the risks of living in the home. There was a fire at the home in July 2014 and we looked at the arrangements the provider had in place to protect people from the risk of fire. The provider had recently installed a lift. A fire risk assessment was not in place to ensure staff and people knew what the safety arrangements were in relation to the new lift in case of a fire. Routine monthly fire checks had not been completed in December 2014. A general fire risk assessment was in place but the registered manager had not completed the improvement plan to address the risks identified by a specialist fire assessor in March 2014. When the provider instructed a specialist to undertake a fire safety audit they had ineffective systems in place to have regard to their report and guidance.

The above evidenced the registered manager and provider had not analysed all incidents that resulted in, or had the potential to result in, harm so preventative action would be taken to keep people safe. It also evidenced the provider did not implement an effective system to identify, assess and manage the risk of fire to people's safety. This was breach of Regulation 10 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

There were sufficient staff to meet people's needs. People told us they knew staff would come quickly when they called for help. This was confirmed by our observations. One person told us "There is always staff about". The provider had made some changes to the weekend staffing so that cleaning and cooking staff now worked seven days a week. Staff told us this had enabled them to focus primarily on caring tasks over weekends. Relatives and staff told us there were enough staff. One care worker said "There is enough staff so that we can spend time with people in the afternoon having a chat".

Inadequate

Is the service safe?

Though there were enough staff to keep people safe the current staffing was not clearly determined by people's individual support needs or risks. If people's needs changed there was a risk that staffing numbers might not be adjusted to meet their increased needs. We discussed this with the registered manager. She told us she adjusted staffing when people needed more support and was working with the provider to keep staffing levels flexible, especially when people returned from hospital.

Medicines were stored safely in a locked medicine trolley secured to the wall. Medicine Administration Records (MAR) were completed correctly and had been coded appropriately to show the reason why any medicines had not been given. We observed people being given their medicines at their own pace .There was clear communication between the home and the pharmacist. The registered manager spoke with the pharmacist monthly to confirm any changes in people's medicine before the next month's delivery was made. Staff administering medicine had received the necessary training to enable them to manage people's medicine safely. Only one member of the staff team had responsibility for managing medicines per shift including holding the drug cabinet keys. This limited the risk of people not receiving their medicines as prescribed.

Inadequate

Is the service effective?

Our findings

Staff did not always feel confident that they understood people's needs and could respond effectively to meet them. Staff did not receive routine support to be able to deliver people's care to an appropriate standard. Staff consistently told us the registered manager was supportive and would offer guidance when asked. Though some staff had received supervision, not all staff routinely received supervision, team meetings and appraisals. Four staff members had not been given the opportunity to routinely discuss their performance and concerns in order to improve their understanding of people's needs and the care they provided.

Staff received some training appropriate to their role and the needs of people. This included manual handling, dementia care and safeguarding. Whilst all staff had completed their mandatory training, limited focus had been given to people's needs and their health conditions. General guidance was available relating to diabetes and skin care. Staff told us they had not read all the staff's policies and guidance. They could not demonstrate their knowledge when we discussed people's diabetes and skin care needs.

Staff shared information between shifts. This was often limited to day to day information about people's appointments and visitors. This handover also did not provide an opportunity to develop their knowledge of people's specialist needs. Newer staff told us they had learned how to support people by observing experienced staff and did not feel people's care plans provided the level of detail they required to know how to support people. Some staff told us they did not feel confident they understood people's needs and had the knowledge to support them.

Staff did receive appropriate training, professional development, supervision and appraisal to support them in relation to their responsibilities. This was a breach of Regulation 23 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The support people received to manage their day to day health, was variable. We saw many examples of how staff identified when people had become unwell and involved the GP, paramedics and mental health specialists promptly. Relatives told us they were informed when people became unwell. However, at times the necessary action had not been taken to meet people's health needs and manage their pain. Following a hospital discharge one person refused to take their blood pressure medication for 28 days. Though the registered manager was aware of this she had not discussed it with the GP to ensure the person remained healthy. She took action when we asked her to do so. Another person had complained of pain for several days and the registered manager told us she were not aware what action, if any, had been taken to relieve this person's discomfort.

Some people in the home required support with continence management and as a result were at risk of their skin breaking down. Special care must be taken to check skin daily for any signs of redness and to keep the skin clean and dry. Staff we spoke with could identify the people that required support with their continence care and how they would support them to manage their personal care. However, they were not clear on how they needed to support people to protect their skin.

People with diabetes were not supported by staff who always understood their condition and the support they required to manage their health. The provider's diabetes guidance provided staff with information about diabetes and treatment of the condition. However, staff did not always understand the implications of this information for the people they supported. There were three people living in the home with diabetes. Care workers, including one cook, did not know who in the home required support to manage their diabetes. When these staff were asked about the support people might need they told us they should not be eating sugar. We were told one person struggled to understand they could not have sugar. A canister of sugar was put on the table for people to use if their dessert was not sweet enough during lunch time. This was not appropriate as people who may have dementia might not be aware of their condition and the precautions they needed to take.

Care plans did not provide information about people's diabetes management, such as how often they needed to visit the GP to review their condition. Staff could not describe how they would know if these three people became unwell due to their diabetes and when medical attention should be requested.

The above demonstrates staff were not able to implement the general guidance they had received and information

Is the service effective?

specific to individuals had not been sufficient for staff to understand how to meet people's needs and monitor their risks. They did not always know how to identify concerns so people could receive the specialist care and treatment they needed to ensure their welfare. This was a continuous breach of Regulation 9 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People told us that they enjoyed the food and that there was always enough. One relative said ''The food really looks good, fresh and homemade''. This was confirmed by our observations. Drinks were available to people throughout the day to ensure they remained hydrated.

Staff weighed people monthly and identified people at risk of weight loss. Significant weight loss was discussed with the specialist community nurse for care homes monthly to identify whether a person required additional support or specialist input to maintain a healthy weight. The registered manager told us and the specialist community nurse confirmed no one in the home was at risk of malnutrition. The community dietician recently met with the registered manager to discuss the support they provided. This resource was available to people if they were to require specialist nutritional support in the future.

The Care Quality Commission (CQC) is required by law to monitor the operation of Deprivation of Liberty Safeguards (DoLS). Care homes, in order to ensure people's rights are protected, must make a formal application and have authorisation to impose restrictions on people. Care homes have to apply for authorisation when restrictions are imposed on people to keep them safe when they do not have the capacity to consent to these restrictions.

The provider was meeting the requirements of the DoLS. The registered manager had been working with the Hampshire DoLS team and had identified three people who wanted to leave the home but did not have the capacity to make this decision. The registered manager had submitted these three DoLS applications for authorisation. They told us that most people in the home required a DoLS and they were working with relatives to submit these applications.

Staff recently completed training in Mental Capacity Act 005 (MCA) and DoLS. They were still developing their understanding of how this applied to their practice and people living in the home. Staff we spoke with were aware of the decisions that people were able to make. They could explain how they supported people who wanted to leave the home to access activities outside of the home with support. Staff understood their obligation to support people's freedom and independence.

The registered manager was awaiting the outcome of three DoLS applications for people who had repeatedly expressed the desire to leave the home. She was reviewing the decision making ability of the other 14 people to determine whether they could consent to living in the home. She told us ''About half of the people living in the home consented to being here some years ago when they still had the capacity to do so. I now need to check whether that has changed then do a mental capacity assessment''.

Requires Improvement

Is the service caring?

Our findings

Relatives and people told us staff were kind and caring in their approach to people. One person said ‘‘Staff are lovely and very friendly, nothing is too much trouble’’. Relatives told us they were always welcome to visit, staff were polite and the home felt relaxed and homely. One relative said ‘‘I always wanted my relative to live somewhere that felt like home and Willow House does’’. However, our own observations and the records we looked at did not always match the positive descriptions people and relatives had given us. Though staff had recently received training in dementia care we found that this was not always reflected in the care they provided to people living with dementia

Our inspection in August 2014, found staff did not have the information they needed to know how to comfort people living with dementia when they became confused and distressed. We still had concerns people living with dementia might not always receive comfort due to the lack of information available to staff.

We observed staff who knew people well using touch, clear communication and reassurance to comfort them. We saw people becoming calm and relaxed in response. However, we also observed staff leaving people without support when they became upset and saw their discomfort escalating. People’s support strategies had not always been recorded in their care plans so staff, who were less familiar with people, did not know how to comfort them. We were told one person was supported to write their appointments in a notebook so that they did not become upset if they forgot when their visitors were coming. This had not been recorded in their care plan. Less experienced staff told us they did not always know how to comfort people. Some people had support from mental health professionals but their care plans did not always include this professional guidance.

People might not receive consistent, caring support because records relating to their mental health conditions were not accurate or fit for purpose. This was a continuous breach of Regulation 20 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People living with dementia did not always receive the support they needed to understand information and communicate their decisions effectively. Communication with people was inconsistent. Some staff communicated well with people living with dementia; however, there were several instances where staff practice needed to be improved. We observed two staff members serving people drinks and snacks. One spoke clearly and gave people time to make a decision and, if needed, showed them the snack options so that they could make a choice. The other care worker spoke softly and became disengaged with people when they did not understand what they wanted. The staff member eventually gave them a cup of tea. It was still unclear whether this was what they wanted. People with communication needs were not supported with pictures or communication aids to understand the information they needed to make to exercise choice, and control over their daily life.

Care delivery for people who were living with dementia did not consistently meet their needs or protect their rights. This was a continuous breach of Regulation 9 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Relatives told us they had been involved in planning people’s care. The registered manager told us many people found it difficult to express their preferences and she observed people to see if they were ‘‘happy’’ and ‘‘content’’. This was done informally and not noted in people’s care plan reviews. The provider did not have a robust system in place to ensure people living with dementia were encouraged, with the appropriate support, to be involved in the planning and review of their care.

We also observed some good examples of staff supporting people in a caring way. Staff were calm and patient when they supported people to move around the building and they spoke to them in a pleasant and reassuring way. Some staff took time to chat with people and people enjoyed their company. We saw some people living with dementia found it difficult to initiate contact but would respond positively when staff spent time with them. Staff felt it was important to treat people with compassion and the more experienced staff told us they led by example so new staff would see how the provider expected people to be treated.

People were treated with respect and supported to maintain their dignity. Their personal care needs were met discreetly and with sensitivity. Staff responded quickly when people asked for assistance and staff who knew people well anticipated their needs and supported people

Requires Improvement

Is the service caring?

without the need for them to ask for assistance. People's privacy was respected and a health care assistant visiting the home told us they always attended to people in their bedroom without staff interruption.

Requires Improvement

Is the service responsive?

Our findings

At our inspection in August 2014, we found people living with dementia did not always part take in activities and tasks that were planned and tailored to meet their needs. At this inspection the registered manager told us they had arranged for some activities to take place in the home. This included a weekly music activity and guinea pigs visited the home monthly. Staff and relatives told us people had benefitted from these activities, especially people living with dementia enjoyed stroking the guinea pigs. Though action had been taken to make weekly activities available to people, further action was still required to make people's lives interesting and stimulating.

We observed people spending their day in the lounge sleeping in their chairs or watching TV. People gave us mixed feedback about the activities available. Some said they had enough to do while others told us they did not do much during the day. One care worker told us ''There is not much for people to do so some just go back to bed''. One person told us they read the newspaper daily. There were newspapers, magazines and games available; however, we did not observe staff supporting people to access these. Some people's care plans noted what they liked to do during the day. One person's care plan noted that she liked to remain involved with the housekeeping but we did not observe staff supporting her or other people to do so.

Staff told us they did not routinely do activities with people. People living with dementia did not have access to items which would aid stimulation or reminiscence. Some staff told us they did not know how to engage people in activities. Even when activities were available to people they did not receive the individual support based on their abilities and preferences to take advantage of an activity. People living with dementia were at risk of being left bored and isolated, without an opportunity to maintain their interests and skills especially if they found it difficult to initiate a task.

People living with dementia did not have their care planned and delivered in line with their needs and best practice guidance. They were at risk of receiving inappropriate care for their needs. This was a continuous breach of Regulation 9 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

There was an inconsistent approach by staff when supporting people living with dementia to maintain their independence in the home. Toilets downstairs and the kitchen were not clearly signposted and some people became disorientated and could not make their way independently. Some people got lost and had to rely on staff to find their way. People were not always provided with appropriate adjustments to maintain their independent eating skills. One person with dementia required the use of brightly coloured plates to support them to see their food during meals times. We saw these were not used for every dish and some people were spilling their drinks because the mugs they were given were too heavy. However, we also heard of many examples were people had been supported by staff to remain independent and manage their continence and mobility.

People's needs had been assessed before they moved into the home. The provider's needs assessment included the support people required to manage their personal hygiene and appearance. People were not supported to maintain their personal grooming skills and routines. We observed some people looked unkempt. Staff told us they asked people if they wanted a shower and assistance but they did not always know how people preferred all their grooming tasks to be completed. People's care plans identified they required support with personal care tasks but there was no detailed information about the practical assistance people would need and their preferences. Some people living with dementia might not be aware of the support they needed or remember when last they had a shower or bath. Staff did not keep a record of grooming task completed or if a person refused care so the registered manager could take action to ensure people maintained their appearance to their desired standard. This was a continuous breach of Regulation 9 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People we spoke with did not always know or understand how to raise their concerns. We asked the registered manager how they routinely listened to and learned from people and their relatives' experience. An annual relative satisfaction survey had been completed in February 2014. The registered manager told us relatives had been satisfied with the service but had raised some concerns regards the appearance of the home. Following this feedback the

Requires Improvement

Is the service responsive?

provider had replaced the garden fence and a new lift had been installed. They told us they spoke with people daily to hear if they were happy living in the home. This feedback was gained informally and not recorded.

The provider did not have a robust system in place to ensure people living with dementia were encouraged, with the appropriate support, to provide feedback about the service. We asked one of the cooks how they knew people were satisfied with the food. They told us ''It doesn't help asking people, they don't understand. I cook the food I think they would like and if they eat it I guess I got it right''. People were not routinely given the opportunity to share their views so improvements could be made to address their concerns about the service. This was a breach of Regulation 10 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People were asked about their religious needs and given support to practice their faith. One person received communion monthly in the home form the local church. Staff ensured this took place.

People were supported to stay in touch with people who were important to them. Staff informed each other of people's planned visits during each shift handover so they could be supported to receive their visitors.

The provider had a complaints policy. Relatives told us they felt confident to complain to the registered manager if they were unhappy about anything. One person told us ''Whenever I have had any concerns they put it right very quickly and I had no need to take it further''. Records showed and the registered manager confirmed they had not received any complaints in the past year.

Inadequate

Is the service well-led?

Our findings

Providing people with care that met their personal expectations was the main objective of the provider. Staff spoke about the importance of ensuring people were happy. The registered manager encouraged staff to listen to people and their relatives. However, this approach did not always deliver a person focused service as people and staff were not always actively involved in the delivery and improvement of the service. People living with dementia, who could not communicate their wishes to staff, were not always full partners in their care and service planning. Staff did not routinely receive feedback and were not always sure of their role and responsibilities in quality assurance and care delivery. Although the registered manager sought some informal feedback, it did not make for a shared understanding of concerns. Staff did not have a record to aid their understanding of improvements required. This made it difficult for the manager to review the culture of the service and ensure the service remained open and responsive to people and staff's experiences.

The provider did not have effective systems in place to monitor the quality and risks of the service. Few formal recorded checks had been completed to determine the accuracy of care and medicine records, whether infection prevention and incident reporting arrangements had been implemented appropriately and supervisions kept up to date. Where internal checks had been undertaken the current system had failed to identify a number of issues that were found during this inspection. Where checks had been undertaken by external agencies and concerns identified, the provider had failed to have regard to these reports and had not taken action to ensure improvements were made. Actions relating to the kitchen hygiene identified by the environmental health inspection in June 2013 had not been completed and an action plan was not in place to ensure these improvements would be made in timely manner.

The provider did not always effectively implement national guidance on dementia care to ensure people living with dementia received care in line with quality standards. People did not receive appropriate support to communicate their thoughts, manage their mental health and control their care. The registered manager had access to best practice guidance and support from a variety of sources. This guidance was not always reflected in people's care planning, formally reviewed and shared with staff in a structured manner so people would be assured this guidance would be reflected in the care they received. The lack of written guidance relating to people's care made it difficult for staff to know what was expected from them so they could be held accountable for their performance. Regular monitoring of staff's performance did not take place and the provider could not be assured people were receiving care from staff that met their needs and managed their risks.

The registered manager was also the nominated individual for the service. Nominated individual means the person whose name has been notified to CQC as being the person who is responsible for supervising the management of the service. She was responsible for running the home as well as undertaking quality assurance functions. She reported to the director of the provider company and met with him monthly. The registered manager kept the director informed of concerns. The director told us he was aware there had been concerns with staff not wearing protective clothing and care records needed to improve. However, a robust system was not in place to ensure these concerns were addressed by the provider so that the registered manager received the support, supervision and resources required to drive improvements and meet regulation requirements.

During this inspection we found numerous breaches of regulations which compromised the quality of care people received. We identified new concerns relating to cleanliness, infection control, safeguarding, accident management, staff training, supervision and recruitment. The provider also continued to breach regulations relating to people's care records and care delivery as identified in our previous inspection. Action required following our inspection in August 2014 had not been taken to ensure people received a safe person focused service. People could not be assured that the provider would take action to improve the service.

The above evidence demonstrates that the registered manager and registered provider did not have appropriate systems to regularly assess and monitor the quality and risks relating to the services. This meant people were at risk of receiving unsafe or inappropriate care and treatment. This was a breach of Regulation 10 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Inadequate

Is the service well-led?

There was a registered manager in post. They knew people well and had managed the service since 2010. People and staff told us the registered manager was open, fair and kind. We saw they spent time with people and staff and oversaw the day shift. The provider had recently employed a part time deputy manager to support the registered manager. The registered manager told us that she welcomed this support.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse The registered provider and registered manager had not made suitable arrangements to ensure that service users were safeguarded against the risk of abuse. The provider and registered manager had not taken reasonable steps to identify the possibility of abuse and prevent it from happening. Regulation 11 (1) (a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control The registered provider and registered manager did not ensure that service users and people employed were protected against identifiable risks of acquiring a health associated infection. They did not effectively operate systems designed to prevent the spread of infection. They did not maintain appropriate standards of cleanliness and hygiene in relation to premises. Regulation 12 (1) (a) (b) 2 (a) (c) (I)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010 Requirements relating to workers The registered provider and registered manager did not operate effective recruitment procedures to ensure people employed to undertake the regulated activity was of good character. Regulation 21 (a) (1)

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff The registered provider and registered manager did not have arrangements in place in order to ensure people employed for the purposes of carrying on the regulated activity were appropriately supported and received appropriate training, supervision and appraisal. Regulation 23 (1) (a)

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services **The registered provider and registered manager did not take proper steps to ensure each service user was protected against the risk of receiving care that is unsafe. They did not carry out an assessment of the needs of the service user and did not plan and deliver care in such a way to meet service user's individual needs and ensure the welfare and safety of the service user.** Regulation 9 (1) (a) (b) (i) (ii)

The enforcement action we took:
We issued the provider and registered manager with a Warning Notice telling them they are required to become compliant with regulation 9 (1)(a) (b) (i) (ii) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 by 30 March 2015.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records **The registered provider and registered manager did not ensure service users were protected against the risks of unsafe or inappropriate care arising from a lack of proper information about them by means of maintenance of an accurate record in relation to the care and treatment provided to each service user.** Regulation 20 (1)(a)

The enforcement action we took:
We issued the provider and registered manager with a Warning Notice telling them they are required to become compliant with regulation 20 (1)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 by 30 March 2015.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision

This section is primarily information for the provider

Enforcement actions

The provider failed to ensure that service users were protected against the risks of inappropriate or unsafe care and treatment by means of the effective operation of systems designed to identify, assess and manage risks relating to the health, welfare and safety of service users. Regulation 10(1)(a)(b)10(2)(b)(i)(iii)(iv)(c) and (i)

The enforcement action we took:

We issued the provider and registered manager with a Warning Notice telling them they are required to become compliant with regulation 10(1)(a)(b)10(2)(b)(i)(iii)(iv)(c) and (i) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 by 30 March 2015.