Lancam Nursing Care Limited

Lancam Nursing Home

Inspection report

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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

We carried out an unannounced comprehensive inspection of this service on 13 and 17 October 2014. Breaches of legal requirements were found. As a result, we undertook a focused inspection on 07 January 2015 to follow up on whether action had been taken to deal with the most significant breaches.

You can read a summary of our findings from both inspections below.

Comprehensive Inspection of 13 and 17 October 2014:

This unannounced inspection took place on 13 and 17 October 2014. Lancam Nursing Home provides accommodation and nursing care for up to 16 people. Its services focus mainly on caring for adults of all ages including those with physical disabilities and people with dementia. There were 12 people living in the service at the time of our inspection.

This inspection took place in response to concerns raised by a range of health and social care professionals about

Summary of findings

the standard of care and treatment provided to people at the service. The local authority informed us during the inspection visits that they had made the decision to restrict further admissions of people into the service.

We also took into account the service's inspection history, which included three inspections in the previous 12 months. We took enforcement action against the registered people as a result of the first of those inspections in November 2013. This took the form of three warning notices, in respect of concerns we found for the care and welfare of people, the management of medicines, and consent to care and treatment. These notices had been addressed at the subsequent inspection.

At this inspection, we found 11 breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of this report.

There was a registered manager in post at the time of our visit. 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.

Six people told us they were happy with the overall services provided. Comments included, "I'm very happy, I like it here" and "It's a home from home for me." However, two people were not happy with the overall service, and a relative told us, "It's a very ordinary care home." Despite the positive comments received, we found significant failing in the quality of care and treatment being provided.

We found that arrangements to keep people safe from the risk of abuse were not effective. Some staff had not been trained on abuse awareness, and when someone using the service experienced excessive control or restraint, it was not recognised as abuse. Plans to minimise the risk of abuse were not followed through, and the provider did not respond appropriately to allegations of abuse in how they worked with the local authority after safeguarding alerts had been raised.

We also found safety concerns in respect of equipment maintenance, recruitment practices, and the management of some medicines. People's individual risk assessments were not always kept up-to-date, and we were not assured that enough staff worked at the service at all times. We found that staff routines for providing medicines and breakfasts to people took priority over allowing people to sleep until they were ready to wake.

There had been no applications for Deprivation of Liberty Safeguards (DoLS) for people using the service at the time of our visits. This was despite the manager attending recent training, and our identification of people at the service who may be unlawfully deprived of their liberty.

The service had a care assessment and planning process that attempted to recognise people's individual needs and preferences. However, we found that care plans did not always adequately guide staff so that they could meet people's needs effectively. For example, two people's plans did not include a section on pain management despite identified needs in this area. Care plans were not always kept under review so that they reflected people's current needs.

We found that most people's healthcare and nutritional needs were attended to. However, the service had not identified and taken action to address the significant weight loss experienced by one person.

There was variation in how respectfully people were treated, despite some positive and friendly staff interactions. Some aspects of the environment also indicated a lack of care towards people. We noted that some staff could not always communicate effectively with people due to their limited English language skills, which meant that people were not always understood and responded to.

The service had a complaints procedure that was accessed by people at the service. However, we were not assured of the effectiveness of the procedure at resolving people's complaints to their satisfaction.

Whilst there were systems of providing staff with training and supervision, these were not adequate to equip them to meet people's needs consistently.

Records were not always accurate and well-maintained. We found contradictions in the information recorded about people, and records were not always up-to-date. Records about the management of the service were not

Summary of findings

always available to us on request, which did not assure us that they were maintained. This did not protect people from the risk of unsafe or inappropriate care and treatment.

The provider's system for assessing and monitoring the quality of services was not effective. This was because, despite a recent service audit, the provider's system had not identified the concerns that we found, and records of risk management decisions were not always available.

Focused Inspection of 07 January 2015:

We undertook this unannounced focused inspection to check if the provider had addressed the action plans they sent us following the last inspection, that the points we made within our enforcement warning notices arising from the previous inspection had been addressed, and to confirm that legal requirements in respect of the breaches of direct impact on people had been met. We inspected the service against four of the five questions we ask about services: Is the service safe, effective, caring and well-led?

Whilst we found evidence to demonstrate that a few aspects of the provider's action plans had been followed, we also found that a number of aspects of the action plans had not been addressed. We found that a number of breaches of legal requirements continued to occur, including breaches in relation to our warning notices. This put people using the service at significant risk of receiving inappropriate or unsafe care and treatment.

The provider's system for assessing and monitoring the quality of services remained ineffective. There had been no further documented service audits despite the concerns arising at our previous inspection. There continued to be no documented system of checking that people's call-bells worked. We found that in one person's room, there was no call bell for them to use despite it previously being available and that they could not otherwise easily summon staff support due to the use of bed-rails on their bed. Despite there being records of occasional incidents of behaviours by people that challenged the service, there continued to be no record of auditing incidents so that learning could take place with the aim of minimising the risk of harm to people using the service and staff.

There had been an audit of staff recruitment checks, however, documented action taken to address shortfalls could not be given to us on request. This meant that recruitment checks were still not effective at demonstrating that all current staff members were of good character.

Overall, we found that the majority of our concerns highlighted in the warning notice we served after the last inspection, in respect of assessing and monitoring the quality of services, had not been addressed. This continued inability to address the shortfalls identified and breaches of the regulations meant that the provider failed to protect people using the service and staff against the risks of inappropriate or unsafe care and treatment.

We found that the provider's arrangements to keep people safe from the risk of abuse had improved but these arrangements were not comprehensive. We found no instances of anyone using the service experiencing excessive control or restraint during personal care, and staff showed some awareness of listening to people's choices. However, we found that some staff still had no documented training on abuse awareness. We found that on some night shifts, none of the staff working had had this training, which put people using the service at unnecessary risk of abuse as it could be unrecognised.

We remained concerned that the service did not have enough staff working at all times. For example, none of three staff rostered to work the morning shift on the day of our visit arrived at the start of their shift. The two night staff continued working until cover had been arranged, two hours later. We found that cover arrangements could have been made sooner, and there was a consequent delay in supporting people to get up and have breakfast. We additionally found occasions in December 2014 when the provider's planned staffing levels were not met, and occasions when the levels were only met because staff who lacked sufficient skills and experience were used. This failed to safeguard the health, safety and welfare of people using the service.

We found that the care provided to four people was not always meeting their needs and ensuring their health, safety and welfare. For example, one person was supported to eat lunch in a way that did not follow healthcare professional guidance for them as the support failed to ensure the person's dignity, safety and welfare and put them at risk of choking. Another person had a health issue which we found the service was not treating appropriately.

Summary of findings

We still saw some ways in which people were not treated respectfully. Doors were not always knocked on before gaining permission for entry, and one aspect of the environment, the broken blinds in one person's bedroom, continued to indicate a lack of care towards them.

Where applicable, people's individual mental capacity assessments for specific care and treatment decisions, such as for the use of bed-rails, had still not been reviewed to act in accordance with the Mental Capacity Act 2005.

Staff had received some training and supervision since our last inspection. However, the system of providing staff with supervision was still not adequate to equip them to meet people's needs consistently. For example, there had been only one documented supervision of any nursing staff since our last inspection.

We also identified a new breach of regulations, for the safety and suitability of the premises. This was because one person's room had a strong smell of sewage but no action had been taken to permanently rectify this or move the person to a vacant room.

We found that some improvements had been made. Medicines cupboards were kept locked and there were records of audit of medicines to help minimise the risk of unsafe administration. There had now been applications for Deprivation of Liberty Safeguards (DoLS) for people using the service where appropriate, although none had been authorised at the time of our visit.

The registered manager continued to be in post at the time of our visit. Whilst we had been sent plans on changes to the management arrangements at the service, we found that current management arrangements were inadequate at consistently protecting people using the service against the risks of inappropriate or unsafe care and treatment.

We found overall that people using the service were at significant risk of receiving inappropriate or unsafe care and treatment. We found nine breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 amongst those regulations that we checked on. As a result of this inspection, we served notices proposing to cancel the registration of the provider and manager. 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 

Comprehensive Inspection of 13 and 17 October 2014:

The service was not safe. Arrangements to protect people from the risk of abuse, and the risk of excessive control or restraint, were not suitable.

People's individual risk assessments were not always comprehensive in relation to their needs, and reviews and updates did not always take place when appropriate. This put people at risk of receiving inappropriate or unsafe care and treatment.

Some safety certificates in place for equipment and premises maintenance were out-of-date, which may have compromised the safety and welfare of people.

Some aspects of the use and management of medicines were unsafe, which may have had an impact on people's health and welfare.

Staff recruitment checks were not effective at checking people's good character and language skills, which may have put people at risk of unsafe care and treatment.

We were not assured that there were enough staff at all times, to keep people safe.

Focused Inspection of 07 January 2015:

The service remained unsafe. We found that insufficient action had been taken to address the most significant concerns arising from our previous inspection.

Arrangements to protect people from the risk of excessive control or restraint during personal care had improved. However, arrangements to protect people from the risk of abuse remained inadequate because some staff working at the service still had not had documented training on safeguarding people from abuse. Sometimes, neither of the staff working during the night had had this training.

On the day of our visit, night staff worked beyond their planned 12-hour shift to uphold the provider's planned staffing levels. There were occasions when the provider's planned staffing levels were not met or were only met because staff who lacked sufficient skills and experience were working. This failed to safeguard the health, safety and welfare of people using the service.

Although there had been an audit of shortfalls with the recruitment checks of established staff members, there was no documented evidence to demonstrate that action had been taken as a result of the shortfalls. This continued to put people at risk of unsafe care and treatment.

Summary of findings

We found that one person's room had a strong smell of sewage but no action had been taken to permanently rectify this or move the person to a vacant room.

We found that some improvements had been made. For example, medicines cupboards were kept locked and there were records of audits of medicines to help minimise the risk of unsafe administration. However, our overall findings show that there continued to be unnecessary risk to people's health, safety and welfare.

Is the service effective?

Inadequate

Comprehensive Inspection of 13 and 17 October 2014:

The service was not effective. There had been no applications for Deprivation of Liberty Safeguards (DoLS) for people using the service at the time of our inspection, despite the manager attending recent training, and despite us identifying people at the service who may be unlawfully deprived of their liberty.

Whilst there were systems of providing staff with training and supervision, these were not adequate to equip them to meet people's needs consistently.

People were supported to attend routine health checks, and there was evidence of attention to people's healthcare and nutritional needs. However, the service had not identified and taken action to address the significant weight loss experienced by one person.

Focused Inspection of 07 January 2015:

The service remained ineffective. We found that insufficient action had been taken to address the most significant concerns arising from our previous inspection.

We found that some people continued to fail to have health concerns recognised and addressed. One person was supported to eat lunch in a way that did not follow healthcare professional guidance for them as the support failed to ensure the person's dignity, safety and welfare and put them at risk of choking. Another person had a health issue which we found the service was not treating appropriately. The care and treatment provided to people was not always meeting their needs and ensuring their health, safety and welfare.

There had now been applications for Deprivation of Liberty Safeguards (DoLS) for applicable people using the service, although none had been authorised at the time of our visit. However, applicable people's individual mental capacity assessments for specific care and treatment decisions had still not been reviewed to act in accordance with the Mental Capacity Act 2005.

Summary of findings

Staff had received some training and supervision since our last inspection. However, staff supervision was not being provided at the frequency set by the provider. For example, there had been only one documented supervision of any nursing staff since our last inspection. This was still not adequate to support staff to be equipped to meet people's needs consistently.

Our overall findings show that there continued to be unnecessary risk to people's health, safety and welfare.

Is the service caring?

Requires Improvement

Comprehensive Inspection of 13 and 17 October 2014:

The service was not consistently caring. There was some positive feedback about the approach of staff, and we saw a number of ways in which staff treated people well. However, we also saw some ways in which staff did not treat people respectfully, and some aspects of the environment indicated a lack of care towards people.

We found that some staff could not always communicate effectively with people. This meant that people were not always understood and responded to.

We also found that people could not always sleep until they were ready to wake, because staff routines for providing medicines and breakfasts were taking priority.

Focused Inspection of 07 January 2015:

The service continued to not be consistently caring. We found that insufficient action had been taken to address the most significant concerns arising from our previous inspection.

There was some positive feedback about the approach of some staff, and we saw some ways in which staff treated people well. However, we still saw some ways in which staff did not treat people respectfully. Doors were not always knocked on before gaining permission for entry. We saw one person being rushed to eat their meal which put them at risk of choking. The broken blinds in one person's bedroom that we found at the previous inspection, had still not been fixed which continued to indicate a lack of care towards them.

Our overall findings show that there continued to be unnecessary failures to ensure the dignity and privacy of people using the service, and to treat them with consideration and respect.

Is the service responsive?

Requires Improvement

Comprehensive Inspection of 13 and 17 October 2014:

Summary of findings

The service was not consistently responsive to people. Although people's needs and preferences had been assessed, and care plans developed, these did not always adequately guide staff so that they could meet people's needs effectively. For example, two people's plans did not include a section on pain management despite identified needs in this area.

Whilst the service had a complaints procedure that was accessible, and people experienced apologies for service shortfalls where appropriate, we were not assured of the effectiveness of the complaints process at resolving people's complaints to their satisfaction.

People were not consistently enabled to take part in activities of their choosing, however, we recognised that the service was trying to address this.

Focused Inspection of 07 January 2015:

This focused inspection was to follow up on whether action had been taken to deal with the breaches we found at our previous inspection that had most impact on people. Evidence for those breaches did not fall directly under the question of 'Is the service responsive?' and so we did not consider this question.

Is the service well-led?

Inadequate

Comprehensive Inspection of 13 and 17 October 2014:

The service was not well-led. Quality assurance and audit systems at the service were not effective at assessing and monitoring the risk of unsafe or inappropriate care and treatment of people. The provider had not identified the concerns that we found, despite a recent service audit.

We found that risk management processes were ineffective. For example, staff sometimes worked long hours without assessment and management of this risk, which may have compromised the safety and welfare of people using the service.

We found that records at the service were not always accurate in respect of people using the service, and were not always kept up-to-date. Records relating to the management of the service were not always kept, or could not be located when required. This did not protect people against the risk of unsafe or inappropriate care and treatment.

Focused Inspection of 07 January 2015:

The service continued to not be well-led. We found little evidence that effective action had been taken to address the most significant concerns arising from our previous inspection. The registered manager and provider had little understanding of what quality assurance meant. There had not been a whole-service audit since our previous inspection despite our previous concerns and enforcement work.

Summary of findings

Although we identified concerns that checks of call-bells were not effective at our last inspection, there was nothing documented to show call-bell checks at this inspection and we again found that someone did not have access to a call-bell in their room.

Despite there being records of occasional incidents of behaviours by people that challenged the service, there continued to be no record of auditing incidents so that learning could take place with the aim of minimising the risk of harm to people using the service and staff.

Overall, we found that the majority of our concerns highlighted in the warning notice we served after the last inspection, in respect of assessing and monitoring the quality of services, had not been addressed. This continued to fail to protect people using the service and staff against the risks of inappropriate or unsafe care and treatment.

Lancam Nursing Home

Detailed findings

Background to this inspection

This inspection report includes the findings of two inspections of Lancam Nursing Home.

We carried out both inspections under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The inspections checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, looked at the overall quality of the service, and provided a rating for the service under the Care Act 2014.

The first, a comprehensive inspection of all aspects of the service, was undertaken on 13 and 17 October 2014. That inspection identified 11 breaches of regulations. We took enforcement action, serving two warning notices on the registered provider and manager, in respect of two of the breaches.

The second inspection took place on 07 January 2015, and focused on whether action had been taken to deal with the most significant breaches we found on 13 and 17 October 2014. You can find full information about our findings in the detailed findings sections of this report.

Comprehensive Inspection of 13 and 17 October 2014:

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 13 and 17 October 2014. The first visit was unannounced. The inspection team included three inspectors and a specialist professional advisor on safeguarding and the Mental Capacity Act 2005.

Before the inspection, we attended a meeting called because of concerns raised by a range of health and social care professionals about the standard of care and treatment provided to people at the service. We also reviewed the information we held about the service.

We used a number of different methods to help us understand the experiences of people living in the service. We spent time observing care in the communal areas such as the lounge and dining area and met some people in their rooms. 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.

The manager told us that there were 12 people using the service at the time of our first visit. We spoke with 11 people who were using the service and three relatives, and interviewed the manager, the head of nursing and six other staff members. We also spoke with three health and social care professionals during and after the inspection.

We looked at nine people's care records, six staff files, duty rosters, accident and incident records, selected policies and procedures and medicine administration record sheets (MAR).

Focused Inspection of 07 January 2015:

We took enforcement action for some of the breaches identified at our inspection on 13 and 17 October 2014. We undertook an unannounced focused inspection of Lancam Nursing Home on 07 January 2015, to check that improvements required following our enforcement action had been implemented.

The team inspected the service against four of the five questions we ask about services: Is the service safe,

Detailed findings

effective, caring and well-led? This was because the service was not meeting some relevant legal requirements. The inspection team included three inspectors, and a specialist professional advisor on nursing care.

The registered manager told us that there were nine people using the service at the time of our visit. We spoke with six people using the service, seven staff members, the registered manager and the provider's nominated individual. We looked at care records of four people currently using the service along with various management records such as accident analysis records and staffing rosters.

Inadequate

Is the service safe?

Our findings

Findings from the comprehensive inspection of 13 and 17 October 2014:

People told us they felt safe, and a relative said, "There's no sign of neglect." However, our findings were in contrast to this when we looked at the arrangements in place to ensure that people were safeguarded against the risk of abuse.

We looked at the provider's records of investigation of two allegations of abuse reported to the local authority's safeguarding team that had occurred in the last five months. One investigation had statements from staff members that referred to a form of excessive control or restraint of a person using the service during personal care. The provider's investigation report also referred to this, but did not report that any actions needed to be taken as a result.

We checked the person's care plan, which specifically referred to giving them time for choices. The plan had no reference to any agreed form of control or restraint during personal care. The plan had not been signed by the person or their representative to show they had agreed to its content, and the file contained no information about whether the person could consent to being provided with support for personal care.

We checked the provider's safeguarding policy. It included statements such as, "We recognise that abuse of vulnerable adults may take place in any setting and in the following form (including) inappropriate or excessive restraint." It referred to an expectation on staff to report abuse, and for managers to encourage a culture that did not tolerate abuse.

The above evidence demonstrates that the person was excessively controlled or restrained during personal care, and that the provider's investigation failed to recognise this. Suitable arrangements were not in place to protect people using the service against the risk of any control or restraint being excessive.

The safeguarding policy also referred to ensuring that staff training took place and included refresher training. However, staff training records showed that 11 of the 21 staff listed had not received training on safeguarding people from abuse. Six of these 11 staff members had been working at the service for over eight months. This included two members of staff we spoke with, who confirmed that they had not received this training. Arrangements had not been made to ensure that these staff members attended safeguarding training, which would have helped ensure that they recognised potential abuse of people and responded accordingly.

We checked the records of the provider's investigation into another recent allegation of abuse. It included a five-point action plan, to minimise the risk of further allegations. We found that two of the actions had not been addressed within a reasonable timeframe. Specific safeguarding training had not taken place as planned, with no documented evidence available to show evidence of rescheduling. Guidance for respecting the choice of people using the service had not been followed according to other records we saw, and there was no recorded plan to address this. This was a failure to respond appropriately to allegations of abuse, which may have failed to safeguard people against the risk of abuse.

A health and social care professional told us that their requests for the provider to supply a copy of a completed investigation report into a safeguarding allegation, and their safeguarding policy, had not been addressed. We discussed with the management team their responses to requests from health and social care professionals involved in safeguarding cases. They were not able to show us that they had responded appropriately to the requests. These arrangements were not suitable to ensure that people were safeguarded against the risk of abuse.

The above issues were a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We saw some staff interactions that helped keep people safe, such as supporting someone to eat who was identified as being at risk of choking. Staff could promptly show us the sliding sheet identified for use with one person to help them manoeuvre in bed when we requested it. We saw some documents in support of keeping people safe, such as personal evacuation plans in the event of fire.

Individual risk assessments were in place for people to help protect them from harm. However, the assessments were not comprehensive. One person who used the service for a month did not have a risk assessment completed for nutrition or pressure care despite them using a wheelchair

so being at greater risk of pressure sores. Another person had pressure care equipment in place for them, and an updated risk assessment on pressure care which recorded them as at 'high' risk. However, they had no care plan relating to the management of pressure care. A third person who moved into the service more than two months before our visit did not have a general assessment of risk or specific risk assessments for nutrition, pressure care or manual handling. Care delivery records for them identified risks relating to their care and treatment, and specific nutritional risks.

Risk assessment reviews and updates were also inconsistent. One person's risk assessments for pressure care and nutrition were updated monthly from the start of the year, but there had been no updates in over three months before our visit. Their last pressure care risk assessment stated that the person was at 'high' risk, indicating that regular review was needed. Another person's risk assessment for pressure care had not been updated in over three months despite the last review scoring them at 'very high' risk and them using a wheelchair. The lack of ongoing assessment of risks to these people did not help to protect them against the risk of receiving inappropriate or unsafe care and treatment.

The above issues were a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We looked at the safety certificates in place for equipment and premises maintenance. We found that some of this was out-of-date. There was no service history available on request for fire extinguishers. When we looked at seven extinguishers around the service, their next test date was recorded as between 2011 and January 2014. The two electrical hoists used in the service had stickers indicating professional inspections that were valid until August 2014. We also saw records about the professional testing of water systems against Legionella which indicated that the annual test was due in August 2014. There was an avoidable risk, to people using the service and staff, that the equipment here would not have worked safely.

We saw recorded evidence indicating that some other equipment had been professionally assessed recently, such as for the gas supply in the service and the calibration of the weighing equipment. However, professional certificates confirming the safe and effective use of this equipment were not available on request. This did not assure us that people using the service and staff were protected from the risk of using unsafe equipment.

We checked the electronic pressure-relieving mattresses in use for two people. Whilst one was set to provide pressure relative to the person's weight, the other was set at almost twice the person's weight and so was not being used correctly. This put the person at risk of unsafe care and treatment.

The above issues were a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People told us they received their medicines on time. We audited two separately-boxed medicines and found that the number of remaining tablets corresponded with records, which showed us that these medicines had been administered as prescribed. We found no prescribed medicines had run out, and that there were records of medicines coming into the service and being returned to the pharmacist. The head of nursing showed us evidence of audit of medicines, and told us that checks of medicines coming into the home were made to ensure that they had been supplied correctly. She gave examples of actions taken when delivery errors had been made.

We checked medicines storage and handling. We found no out-of-date medicines. There were facilities for securely storing medicines requiring refrigeration. We saw medicines being given to people in a safe and respectful manner. However, when we checked the security of three medicines cupboards during the morning of our first visit, we found that they had been left unlocked, which increased the risk of misuse.

We checked the controlled drug record. One person was receiving a sedative prescribed for each night. However, records showed that it was not given every night. The head of nursing explained that it was not given if the person was already asleep. This may be appropriate in response to the person's circumstances, however, there had been no liaison with the prescriber to adjust the prescription to reflect the person's needs.

We checked the administration of a controlled medicine prescribed twice daily for pain relief of a person who used the service. We found one occasion when the medicine was not administered without reasonable explanation. The

stock-check records confirmed that the medicine had not been given. There was nothing in the records of care delivery for the person to indicate a reason for the medicine not being given. This omission failed to protect the person against the risks associated with the unsafe use of medicines

We also checked the administration records of other medicines for this person. We noted that the person was prescribed an inhaler twice a day. Their care plan and records indicated that they experienced breathing difficulties. The inhaler had been recorded as administered on five out of ten prescribed occasions. There was no recorded entry for the other five occasions to explain why the inhaler was not administered. These omissions indicated this person did not receive their medicine as prescribed.

The above issues were a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We looked at recruitment records of three staff members employed in the last six months. Although some recruitment checks such as for criminal records, identification, and the registration of nurses were in place in good time, we found that the provider's checks of good character in advance of employment were not effective. For example, there was a gap in employment history of one staff member for which there was no record of exploration despite there being records of interview.

None of the three files had satisfactory evidence of good character by the time each staff member started providing care and treatment to people. Records showed that one staff member was working with people before written references were in place, despite the interview records identifying possible concerns. One staff member's pre-supplied written references were accepted without a record of exploring conduct with those employers, and there was no record of attempting to explore their conduct in their last care employment. There was no record of exploring the last care employment for another staff member, or of their last employer despite that being an expectation within the provider's recruitment policy. There was only one written reference on file for that staff member, and we noted that the reference did not include the staff member's name, which failed to ensure that it related to the staff member.

The manager told us that phone calls had been made to address references where possible. She agreed that there was little evidence of documenting this. We were not assured that the provider's recruitment systems were effective at ensuring new employees were of good character.

One staff member's file included entries noting concern with their ability to communicate in English. They had been encouraged to attend training to improve their English, and it was noted as a reason why they had not completed the provider's online training. Our observations of the language abilities of three staff members raised concerns about how effectively they could communicate with people using the service. This did not assure us that recruitment procedures were effective at employing people with the necessary skills for the work they were to perform.

The above issues were a breach of Regulation 21 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Three people told us that there were times when it did not feel like there were enough staff working. One person said, "They're always short at night, if you need something, you can't get a nurse." Another person referred to night staffing and said, "They can get uptight with me, so I try not to bother them too much such as for a cup of tea." A relative told us that at weekends, there seemed to be "limited staff, about two on." The staff we spoke with told us there were enough staff, although one said they were very busy at night.

The manager told us that, along with 24-hour nursing cover, there were three care workers during the morning, two in the afternoon, and one at night, along with staff in other supporting roles such as a cook and a cleaner. We checked the October roster and staff attendance records, and found that these levels were kept to. However, there were occasions where staff worked a shift either before or after working at night. One staff member, for example, had worked a morning shift after a night shift on six out of 13 occasions in October. Similar practices occurred in September according to the roster for that period. Staff and the management team confirmed that this practice occurred. There was a foreseeable risk that staff would not always get sufficient rest to ensure they were able to safely and appropriately respond to people's needs.

Inadequate

Is the service safe?

The management team told us that night staffing levels had recently been reduced, to add an extra staff member in the morning, however, there was no recorded analysis of the needs of people using the service in coming to this decision. This meant that a 12-hour night shift had been replaced by a six-hour morning shift. We were also told of there being flexibility for a staff member to work from 6am or to 10pm to help meet people's needs, however, there was no recorded evidence of this occurring.

We also received an email from the manager before the inspection, stating that a staff member involved in a recent safeguarding case had been working, contrary to a previous statement that they would not be, due to staffing shortages. We were not assured that there were enough staff working at all times, to keep people safe.

The above issues were a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Findings from the focused inspection of 07 January 2015:

At this inspection, we looked at the actions taken by the provider in respect of the breaches of regulations 11, 13, 16, 21 and 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. We found that the provider remained in breach of regulations 11, 21 and 22, and was now in breach of regulation 15.

There had been one allegation of abuse reported to the local authority's safeguarding team since our last inspection. Checks we made at this inspection, and arising from communication about the allegation since it was made, indicated that the provider had worked in co-operation with health and social care professionals. We also found no evidence at this inspection of people using the service experiencing excessive control or restraint during personal care, and staff showed some awareness of listening to people's choices. This helped to ensure that people were safeguarded against the risk of abuse.

The registered manager told us that some staff had recently attended training on safeguarding provided by the local authority, and that all staff bar one had received training on safeguarding from a consultant since our last inspection. When we asked the registered manager for documentation in support of the training, such as names and dates of when staff had this training, we were given a staff training matrix and the dates of when the consultant visited the service. The consultant's document did not state that safeguarding training had taken place. The staff training matrix listed 11 of the 16 staff as having had Safeguarding Adults training, including evidence of some who had attended training since our previous inspection. However, five staff were not listed as having had this training. When we checked the certificates file and personnel file for these staff members, we did not find certificates for training on safeguarding. We established that all of these staff members were working at the time of our last inspection. We spoke with two of these staff members during our visit, and neither could confirm that they had received safeguarding training.

When we checked records of when staff had worked in January, we found three occasions when there was no-one working who had documented training on safeguarding. This occurred across three of the previous six night shifts. During these periods, the staff working did not have documented training on the awareness of what abuse can be, how to prevent it before it occurs, and how to respond appropriately to any allegation of abuse. These arrangements did not ensure that people were safeguarded against the risk of abuse.

The above evidence demonstrates a continued breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The registered manager told us that the planned staffing levels at the service were currently two care workers and one nurse working 8am to 8pm, and one care worker and one nurse working 8pm to 8am. Additionally, the Head of care worked 9am to 5pm weekdays but with authority to provide care support if needed, a chef worked 9am to 2pm seven days a week, and a cleaner worked 9am to 2pm on weekdays. The staff roster for January 2015 confirmed these staffing arrangements.

On the day of our visit, none of the three staff scheduled to work that morning arrived as planned. The two night staff worked until approximately 10am to provide cover. The provider's nominated individual was also present from 8:06am, although they did not explain that they were to take over as the nurse in charge and they did not have an explanation as to where the scheduled day staff were when asked.

At 8:44am, the Head of Care arrived and explained what had happened with two of the staff members scheduled to

work from 8am. One had called in sick, and the other had to attend a health appointment and so would be arriving late. By 8:58am, the registered manager had arrived, and initially told us that she was not aware of the absence of two of the scheduled staff members. She then recalled that the staff member arriving late had informed her of this the night before, but that she had forgotten to inform the Head of Care so that they could arrive at work earlier and provide cover.

The registered manager told us that the third scheduled staff member had phoned in sick the previous day, and so another nurse was scheduled to replace them. However, that person was also attending medicines training elsewhere on the morning of our visit and so the provider's nominated individual was covering the nursing duties until the staff member returned to the service. The registered manager confirmed that there was nothing recorded about the changes to the planned staffing arrangements on the January roster.

In summary, until the arrival at 9:25am of the staff member who had arranged to turn up late, the service had been reliant on night staff continuing to work beyond their planned 12-hour shift, which put the health, safety and welfare of people using the service at unnecessary risk. In particular, there was a disorganised approach to arranging adequate staffing cover from 8am. We noted the impact that the morning's staffing issues had on the nine people using the service. It took longer than usual for people to be supported to get up. We saw no activities taking place beyond people watching television and staff occasionally sitting with people. When we spoke with one of them when awake, they described their day as, "Just being wheeled from my bedroom to the TV lounge and back again." They noted that there were no regular activities. Another person said, "Staff are too busy doing their work to acknowledge me," adding they would not recommend the service as "they haven't enough good staff." We were not assured of appropriate staffing arrangements for safeguarding people's health, safety and welfare on the day of our visit.

We checked the staff roster for December 2014 against the staff signing in and out records for that period. We found instances when the provider's planned staffing levels were not kept to, which failed to safeguard the health, safety and welfare of people using the service.

On 26 December 2014, the records included a statement "one carer not came (sic)." The care workers recorded on the roster for that day shift were two staff members who had been rostered for a number of previous shifts that month but had not worked any previous shifts in practice. The registered manager had told us that one of them had been on sick leave. This meant that it was foreseeable in advance that these staff members needed replacing that day. The provider did not make suitable arrangements to replace them in practice. The staff signing in and out records showed that the service was one care worker short between 8:10am and 4:45pm that day. This failed to safeguard people's health, safety and welfare.

On 24 December 2014, the staff signing in and out register showed that the last member of the day staff team left the service at 8:15pm. However, there was no night care worker until 10pm. This meant that there was only a nurse working between 8:15pm and 10pm, without the support of the scheduled care worker. No-one requiring the support of two staff during that period would have received appropriate care and treatment. This failed to safeguard people's health, safety and welfare.

We were not able to talk much with one staff member, a bank care worker, during our visit due to their language difficulties. The registered manager told us that if a care worker called in sick, they had used this staff member as cover, with nursing staff demonstrating to them what was needed when they did not understand communication in English. The staff training matrix had no entries against this staff member, meaning they had not attended any training courses, which the registered manager confirmed. This failed to assure us that they were suitably skilled and experienced to work as a care worker. Records demonstrated that this staff member worked as a care worker on 15 occasions from 01 December 2014, to help maintain the provider's planned staffing levels. We found that if the provider had sufficient numbers of suitably qualified, skilled and experienced staff to safeguard the health, safety and welfare of people, reliance on this staff member, to work as a care worker on these 15 occasions, would not have been needed.

Of particular concern was that the above staff member worked a period of over 25 hours without a recorded break, from 6:45am on 25 December 2014 to 8:10am on 26 December 2014, then returned to work the same day at 4:45pm until 8:10am on 27 December 2014, then worked 1:55pm to 8:10pm on 27 December 2014. In conjunction

with there being a documented shortfall in the provider's planned staffing levels between 8:10am and 4:45pm on 26 December 2014, this all failed to safeguard the health, safety and welfare of people using the service.

Records demonstrated that there was no evidence of a replacement cleaner working on seven weekdays in December and January when the usual cleaner was not able to work in that role. The provider's planned staffing levels were not met on those occasions, which failed to safeguard people's health, safety and welfare.

Records demonstrated that another staff member had worked at least 17 night shifts since 01 December 2014. Records and feedback from that staff member showed they had been provided with fire safety training but no other formal training course since starting to work at the service over three months before our inspection. Their recruitment records did not demonstrate evidence of previous employment in care work nor training or qualifications in care. We additionally found no supervision records for them, which would have provided evidence of supporting them to become suitably skilled. We were not assured that the staff member was suitably skilled and experienced to work as a care worker, despite them frequently working in the service at night. This failed to safeguard people's health, safety and welfare.

The above evidence demonstrates a continued breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The registered manager told us that no new staff members had started working at the service since our last inspection. We were shown an undated personnel file audit which demonstrated checks of whether a number of key recruitment and employment documents were in place for each staff member. However, it lacked a plan in response to the shortfalls it identified, and there was no documented evidence of actions taken in response to the findings of the audit.

The audit identified two staff members to be missing a second employment reference. When we checked the personnel file of one of these staff members, there was only one reference available and it did not include that staff member's name, meaning it may not have related to them. Other documents showed that that staff member had undertaken voluntary work in care settings, however, there was no evidence of a reference from any such care setting.

The registered manager confirmed to us that they did not yet have a second reference for the other staff member. This did not demonstrate satisfactory evidence of conduct in previous care employment for these two staff members, which was continuing to put people using the service at unnecessary risk of unsafe care and treatment.

The above evidence demonstrates a continued breach of Regulation 21 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

When we went into one person's room, we immediately noted that there was a strong smell of sewage. Staff explained how there had been a leak in the en-suite bathroom that had been fixed, however, they confirmed that there was a prevailing smell. By failing to promptly recognise and eradicate the ongoing odour issue in the person's room, the person was not protected against the risks associated with unsafe or unsuitable premises. At the end of the inspection visit, at our suggestion, the registered manager agreed to close off the room and move the person to another room until the problem was investigated and solved. However, we had no confidence that these actions would have taken place without our intervention.

The above evidence demonstrates a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We noted that some improvements had been made to the service since our last inspection. Medicines cupboards were now kept locked and there were records of audits of medicines to help minimise the risk of unsafe administration. Antibiotics for people had been promptly acquired after being prescribed by a GP, and courses of antibiotics had been administered as prescribed. Nursing staff had attended medicines training. We also noted that forms were in use to document that information was handed over between outgoing and incoming nurses, which aimed to help ensure effective communication between nurses so as to ensure the safety and welfare of people using the service.

We found that professional safety certificates were now in place for equipment and premises maintenance. Some of these had been either out-of-date or unavailable at the time of our previous inspection. This included for the fire

Inadequate

Is the service safe?

extinguishers, the electrical hoists, and calibration of the weighing scales. This helped assure us that people using the service and staff were protected from the risk of using unsafe equipment.

Inadequate

Is the service effective?

Our findings

Findings from the comprehensive inspection of 13 and 17 October 2014:

At the time of our inspection the manager told us there were no Deprivation of Liberty Safeguard (DoLS) authorisations in place and no applications had been submitted for people currently using the service. The service had, however, applied for a DoLS authorisation for someone who had since stopped using the service.

We found that the provider had not yet fully considered the implications of a Supreme Court ruling that had significantly changed what would be regarded as a deprivation of someone's liberty, to ensure that the service remained within the law and considered what was in the best interests of all the people using the service. For example, the manager was not aware that applications would need to be considered for all people who were unable to leave the service as this was a restriction of their liberty. The manager said they had attended recent training on the Mental Capacity Act 2005 (MCA) and DoLS that included updates on the Supreme Court ruling, which had highlighted two people using the service that they needed to apply for. However, when we contacted the supervisory body at the local authority eleven days after the second day of our visit to the service, they informed us that they had not received DoLS applications for anyone using the service.

We additionally identified two other people using the service that would need to be considered for an Urgent DoLS Authorisation Application because both said they did not want to be at the service. For example, one person told us, "I am bored and fed up living here and I want to go and live with my friend at his flat." The manager confirmed that this person had on occasion expressed this view before. The person was not consistently consenting to their care and treatment arrangements but there was no assessment undertaken to establish whether or not they had capacity to consent to this. As they were subject to continuous supervision by staff, but were confirmed by the manager as not being free to leave the service, the provider may have been depriving the person of their liberty without the necessary authorisation to do so.

The manager told us that she was responsible for carrying out capacity assessments of people using the service when needed. When we checked the capacity assessments for two people, we found they had not been filled in correctly because the decision to be assessed referred to the person's best interests. This assumed a lack of capacity before the assessment of capacity had been made, contrary to MCA principles. We also found a consent form for the use of bed rails in one person's file, which had been signed by a member of the management team but not the person using the service. It was not stated whether the bed rails were being used with the person's consent or in their best interest.

We asked to see a copy of the codes of practice for MCA and DoLS but the manager told us that they did not have copies available. Two staff members told us they had not had training on MCA. A third staff member said they had been trained, and nobody living in the service needed it. When we checked training records, we saw that only two staff had received training on their responsibilities under MCA and DoLS, which the manager confirmed as correct.

We saw a record of a person resisting personal care but found no capacity assessment or best interest decision on the person's file in relation to this, which indicated that MCA principles were not being followed.

The above issues were a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Staff told us of receiving training through an online organisation and by the management team.

Training records showed that staff had attended training covering a range of topics. However, we identified that specific training had not been provided to enough staff to deliver care and treatment safely and to an appropriate standard. For example, of the 14 care staff listed, there had not been specific training on food hygiene for seven, on fire safety for six, on infection control for six, on conflict resolution for seven, and on manual handling for seven. Only two care staff were listed as having completed a National Vocational Qualification (NVQ) or diploma in care, although there was evidence of others having started it.

One of the service's stated specialisms is for dementia care, however, eight care staff and all nurses were not listed as having had dementia training. We also noted that of the three established nurses listed, two had not had training on percutaneous endoscopic gastrostomy (PEG) feeding despite at least one person being fed by this procedure,

and none had training on care planning. There was a training plan in place for the year which addressed some relevant areas such as safeguarding. However, it did not address manual handling or food hygiene despite the shortfalls evident from training records.

A new staff member told us they received a week of induction training before providing care and treatment to people. We saw that their induction record covered a range of relevant topics and had been signed off by a member of the management team as completed. We noted that the induction was not in line with the national training organisation Skills For Care, and that there was no training plan in place for the staff member. However, records showed that a staff member who started work a few months beforehand had been reminded to start and complete the online training courses. The induction records used were recorded as last reviewed in 2009, and so had not been reviewed in line with current guidance or the service's recent addition of dementia as a specialism. This put people at risk of receiving care and treatment which was not safe or to an appropriate standard.

Records showed that most care workers received regular supervision sessions. A programme of annual appraisal was in place to provide established staff with support. Staff said they found supervisions beneficial, and that they were provided with good support from the management team. However, we noted that of the five nurses listed on the supervision record for 2014, there had been only eight supervisions. This included two nurses who had been working for the previous nine months, and one new nurse who had received one supervision session in the five months they had worked at the service. The cleaner, who additionally worked some shifts as a care worker, had only one recorded supervision throughout 2014. The supervision matrix stated a supervision frequency of every two months, which was not being followed for some staff. We were not assured that there were suitable arrangements to ensure that staff were appropriately supervised, to enable them to deliver care and treatment to people safely and to an appropriate standard.

The above issues were a breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We reviewed the weight records of people using the service. Staff could demonstrate to us how they weighed dependent people using a hoist, which helped assure us that accurate records were made. Whilst most people's weights were stable across each month, and one person had gained weight as per their care plan, we noted that one person's weight dropped by 8% one month. We found no records indicating that this was planned, nor action taken in recognition of the potential risk to this person. The person had a plan specifically for food and drink, however, monthly evaluation did not identify the weight loss. The person's last Malnutrition Universal Screening Tool (MUST) assessment, which included consideration of weight loss, was dated 2013. Monthly nutritional assessments were recorded for the person. The last three scored 'very high risk – seek dietetic advice'. However, on discussion with the management team on our first day of visiting, we found that neither dietetic or GP advice had been sought. We were not assured that proper steps had been taken in the planning and delivery of care and treatment to this person so as to ensure their welfare and safety. This contributed to a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Seven people spoke positively of the food provided. Their comments included, "The food is really nice here" and, "They ask what I like and prepare it." People confirmed they got enough to drink. A relative spoke of how the service had helped their relative to eat more. Two people, however, gave negative comments about the food due to lack of variety.

Staff told us that people were asked what they wanted to eat, from the choices available, before lunch was prepared. We saw records of this that were passed on to the chef. Records of meetings for people using the service demonstrated that their views on the quality of meals and meal choices were sought. There was also recognition of individual food and drink preferences within people's care plans.

There was a stock of fresh foods available to prepare the meals from, which helped provide people with nutritious food. The chef demonstrated an understanding of people's particular dietary needs, for example, the pureed meal requested by one person. We saw a main meal being kept for someone for later in the day, as they did not want to eat it at lunch, which helped support their nutrition but respected their choice.

We saw that staff followed the health professional guidelines provided to one person in support of their eating. When we spoke with the staff member who had

assisted the person, they could demonstrate an understanding of the reasons for and the need to follow the guidelines. They told us that any new member of staff was given this same guidance during induction training. This helped ensure that the person received safe and appropriate care.

People had drinks easily available. These were regularly replenished, and people were encouraged and supported with fluid intake. Where people had greater support needs, their fluid intake was monitored. We checked five people's fluid intake and output charts. Two were not always totalled at the end of the day, to monitor the amount of fluid they had consumed. We also noted that the fluid output was greater than the intake on some days, which the manager explained would be due to staff making judgements on fluid output where people were using continence pads. These records did not consistently enable effective monitoring of people's hydration so that action could be taken where needed.

Recent records showed that people had access to healthcare professionals such as GPs, physiotherapists, and podiatrists. The service kept appropriate checks of people's blood sugar levels. The management team told us of how they had responded to people's health concerns, for example, taking GP advice to support someone to have weekly checks for an infection. We spoke with two healthcare professionals about their experience of the service. One told us that the service got in touch with them when appropriate, but the other had concerns about the service's ability to meet people's needs effectively.

Findings from the focused inspection of 07 January 2015:

At this inspection, we looked at the actions taken by the provider in respect of the breaches of regulations 9, 18 and 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. We found that the provider remained in breach of these regulations.

There was one person sitting in the lounge at the start of our visit. They were wearing hard outdoor shoes and had no socks on. We asked them why they were not wearing socks and they replied that they had a sore toe from a fall. We saw that the nail on the big toe on their left foot was blackened, and the second toe was weeping and possibly infected. There was no protection for the toes, and the inside of the shoe was dirty. The person told us that they had told staff about their toes, and that cream had been put on them. We were concerned that the care and treatment being delivered to this person in respect of the condition of the toes on their left foot was not meeting their individual needs or ensuring their safety and welfare.

When we spoke with staff members and the registered manager about the condition of the person's toes during the morning, we were not assured that they were aware of the concerns. When another staff member arrived during the afternoon, they were able to demonstrate some awareness of the person's condition. They showed us a record of a GP visiting the person in November 2014, in respect of concerns about the person's legs, although this did not specify feet or toes. We checked the daily records of care provided to the person in January, and the latest staff handover sheet, and found no reference to the condition of the person's toes.

We additionally noted that the person was assessed as 'high risk' on the Pressure Area Risk Assessment in their care file, but that there was no care plan in place for the management of pressure care risks for them or specifically for the care and treatment of their toes. The lack of documented planning and delivery of care and treatment of the condition of the person's toes did not demonstrate that their individual needs were being met or that their safety and welfare was being ensured.

We told the registered manager that she should ask the GP and podiatrist to visit and reassess the condition of the person's toes, and to provide the person with more appropriate footwear. Following the inspection, the registered manager informed us that she had followed this up. In particular, a GP visited the person the day after our inspection and prescribed antibiotics, which we understood to indicate a possible infection. Whilst this reassured us that better care and treatment was taking place for the person, we had no confidence that this would have occurred without our intervention.

During our inspection, we saw someone being supported by staff to eat lunch in the dining area. The staff member offered large pieces of burger to the person, and tried to give them more food when their mouth was already full. We also saw that no drinks were available to the person until much later during their lunch. We were concerned that the care and treatment being delivered to this person in supporting them to eat lunch was not meeting their individual needs or ensuring their safety and welfare.

Inadequate

Is the service effective?

We saw a Speech and Language Therapist letter dated July 2014 in the care file for the above person. It recommended for meal support to include "softer moister food options", "slow pace, small mouthfuls and sips", "constant supervision and prompts", and "normal fluids with care." The letter included a separate guidance document for mealtime information for the person, which we saw to be on the notice board in the dining room. The 'Eating and Drinking' care plan for this person was updated in August 2014 to reflect the recommendations of the Speech and Language Therapist. We noted that there was no evaluation of the effectiveness of the update to the care plan until December 2014, which noted that smaller pieces of food were enabling the person to eat more independently.

The support we saw the above person receiving at lunch was not following the recommendations of the Speech and Language Therapist's guidelines or their care plan. Parts of the meal were not soft and moist as it included chips, small mouthfuls were not being offered, and sips of drink were not available until later. It was of additional concern that the person was rushed because they were not able to finish mouthfuls before being supported with the next mouthful. This inappropriate and unsafe care and treatment of the person did not demonstrate that their individual needs were being met or that their safety and welfare was being ensured.

The registered manager told us that another person had not been eating for the last two or three days, but that they were being encouraged to. The weight records for this person showed that they were last weighed on 23 December 2014 and that they had lost weight since the previous check of their weight a month beforehand. The registered manager told us that the GP had checked the person and told them there was nothing that could be done. However, we were concerned that a request for the input of a community dietitian had not been made, nor had an increased frequency of checking the person's weight been implemented to help identify if they were continuing to lose weight. This planning and delivery of care and treatment to this person did not assure us that their individual needs were being met or that their safety and welfare was being ensured.

One person told us that they were putting on weight due to there being a lot of fried food and big portions. We checked their weight chart, which reflected what they told us.

However, when we checked their care plan, we found no evidence of planning to address their concerns around their increasing weight, or to take into account their diabetes. This planning and delivery of care and treatment to the person did not assure us that their individual needs were being met or that their safety and welfare was being ensured.

The above evidence demonstrates a continued breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We found that there had now been applications for Deprivation of Liberty Safeguards (DoLS) for people using the service where appropriate, although none had been authorised at the time of our visit. This showed us that the provider had made some arrangements for acting in accordance with regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Mental Capacity Act 2005 (MCA).

Following our last inspection, the provider sent us an action plan which told us that everyone's care plans would be checked by the end of December 2014 to ensure compliance with regulation 18, consent to care and treatment, and with training in that respect being provided to staff. When we asked the registered manager about reviews of people's care files to ensure compliance with regulation 18, she told us that this was to be done with the support of a consultant but that work had not been started as yet. This meant that the plan sent to us had not been addressed by the completion date that the provider set.

When we checked four people's care files, we found evidence in three of the mental capacity assessments that were in breach of regulation 18. The assessments had not been reviewed since our previous inspection. As at the previous inspection, they had not been filled in correctly because the decision to be assessed referred to the person's best interests. This assumed a lack of capacity before the assessment of capacity had been made, contrary to MCA principles.

For example, the assessment of mental capacity form in one person's file was dated 01 January 2014, over a year ago, and had no evidence of review or update on it. It had not been filled in correctly because it referred to a broad set of care and treatments in the assessment section rather

than a specific issue for assessment such as the bed rails that we saw that the person used. Section 3 of the form, for determination of best interests, had not been completed and signed off.

The mental capacity form in another person's file showed that the person was judged to have passed the four-stage assessment of capacity in relation to the assessment "most of the time." However, in contrast, it was ticked that they were unlikely to recover capacity and a process of determining their best interests in relation to the assessment was written albeit incompletely under section 3. These arrangements for acting in accordance with regulation 18 and the MCA in respect of people using the service were not suitable.

The staff training matrix showed that, as at our previous inspection, there were only two staff who were recorded as having received training on their responsibilities under the MCA. The registered manager told us that a consultant was training staff in this respect, however, the consultant had the list of staff they had provided this to and so we could not view this during the visit. When we spoke with two staff members, we found their understanding of the MCA to be limited. They did not know what 'the Mental Capacity Act' referred to, and one of them asked if it was about mental illness. The provider's plan for addressing staff training in respect of the MCA had not been effective. These arrangements for acting in accordance with regulation 18 and the MCA were not suitable.

The above evidence demonstrates a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The staff supervision and appraisal matrix for 2014 showed that one supervision had taken place for six of the 16 staff members since our last inspection. Checks of five staff personnel files corroborated this information. For example, the last supervision record in one staff member's personnel file was dated 26 June 2014, which matched their last date of supervision on the supervision and appraisal matrix. This indicated that the staff member had been working for over six months without a supervision meeting. Records for another staff member showed that they had been newly working at the service for over three months without a supervision meeting.

The supervision and appraisal matrix stated a supervision frequency of six to eight weeks, which the registered manager confirmed as correct. Twelve weeks had passed since our last inspection, so between 24 and 32 supervisions should have taken place overall based on the documented frequency. This failure to provide staff with supervision opportunities failed to support staff to deliver care and treatment to people safely and to an appropriate standard.

For nursing staff, the supervision and appraisal matrix documented that there had been only one supervision meeting for any nursing staff since our last inspection. The registered manager told us that she had left the supervision of nurses for the provider's nominated individual to attend to, as she was not a qualified nurse. However, she said she had just been told that she had to now provide supervisions to the nursing staff. This meant that the systems of providing nursing staff with supervision were not adequate to support them to deliver care and treatment to people safely and to an appropriate standard.

The above evidence demonstrates a continued breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Requires Improvement

Is the service caring?

Our findings

Findings from the comprehensive inspection of 13 and 17 October 2014:

Five people told us they were happy with the approach of staff. There was some very positive feedback such as, "They're very good to me" and "The carers couldn't be more helpful." Relatives' feedback was mainly positive too, such as, "Staff are so patient." However, one person told us that staff listened to them but none of them chatted with them. Two other people were not happy with the staff approach. One person said, "They don't talk to me, just come in and push things around." Another person spoke of the "rude" approach of a minority of staff, but added, "They're usually nice with dressing me."

A staff member told us that people using the service did not always understand them. Three of the five staff we spoke with did not always understand our questions. We saw people using the service having to repeat their requests until they were understood, for example, that they wanted toast for breakfast. We also saw a request for tablets not being responded to. A health and social care professional noted the limited communication skills of a member of staff they had been liaising with. The manager told us of support they had arranged for some staff to attend training on the English language. However, recruitment records for new staff did not assure us that there was proper consideration of applicants' abilities to communicate effectively with people using the service, nor of considering how caring the applicants were.

We saw a number of examples of people being treated respectfully at the service. For example, we saw staff being polite to people, taking the time to explain the support they wanted to offer, and encouraging people during lunch. We saw that people had been supported to dress well, and some people had had their nails varnished. We checked some people's wardrobes with their permission, and found the wardrobes tidy and only with clothing that belonged to the person. One person told us of new clothing that the service had recently arranged to buy for them.

However, we found that the relationships between staff and people did not consistently demonstrate dignity and respect at all times. We overheard a person being told they would receive no breakfast if they did not do as they were asked, which we informed the manager about shortly afterwards so that they could take appropriate action. The same person was supported into the lounge without shoes or socks on. Whilst we saw some staff knocking on people's doors before entering their bedrooms, we also saw some staff walking into people's rooms without first knocking, for example, when taking drinks to them.

One person was recorded as having Halal meals in the care file, however, staff informed us that this did not always occur when the person was provided with meals. We noted that only one of the 21 staff members listed on the service's training matrix had received diversity training. This did not assure us that people's care and treatment was being provided with due regard to cultural backgrounds.

The curtains in one person's room, facing onto the road, did not work properly. The windows also had blinds, but two of the three blinds did not shut. This compromised the person's privacy. We saw a record in the service's maintenance book dated 11 days before we started the inspection, requesting the matter be addressed, however, the person's privacy was still being compromised at our second visit. A broken drawer in another person's room, and a broken lock to a toilet door used by some people, were fixed during our second day of visiting after we pointed these out when we first visited.

One female had personal care instructions for a male on the wall in in her room. The management team explained that this was for the previous male occupant of the room, and removed the instructions. However, we were not assured that suitable arrangements were in place to ensure that the environment experienced by people consistently upheld their dignity.

We noted that there was no specific training recorded on the training matrix for dignity and respect, and none on the training plan, although this was part of the induction process for new staff. However, the head of nursing explained that they modelled and discussed dignity and respect matters with staff.

A staff member told us that most people woke early, and when they worked nights, breakfast was finished by 8am. Another staff member confirmed that night staff provided breakfast to people. We noticed that people's medicines records indicated that medicines were offered between 6 and 7am. A relative told us that their relative received medicines at 6am which they felt had an impact on their well-being. Whilst only one person was in the lounge or

dining area on our arrival at 7:45am, meaning that people were not rushed to get up, we were not assured that people could sleep until they were ready to wake, because staff routines were taking priority.

The above issues were a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Findings from the focused inspection of 07 January 2015:

At this inspection we looked at the actions taken by the provider in respect of the breach of regulation17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. We found that the provider remained in breach of this regulation.

Some people using the service fed-back positively about the approach of some staff members, for example, “They come immediately when I ring my call bell” and “The staff are alright.” We saw some ways in which staff treated people well, for example, in giving people time to make choices. However, the feedback and our observations did not demonstrate a consistently caring approach. The same person who praised some staff gave examples of how others did not treat them with respect, including, “They insist on closing the curtains, although I do not want them to do this.” Another person said, “I do not like all the staff here because they tell me different things.”

At our previous inspection, we saw some staff walking into people’s rooms without first knocking. At this inspection, we saw the provider’s nominated individual enter someone’s room without first knocking. The person was in their room at the time. The nominated individual also came into the room we were using to interview a staff member without first knocking, meaning what we saw in the morning was not an isolated instance. As the nominated individual representing the provider, and a role model to staff at the service, this failed to demonstrate suitable arrangements to ensure the dignity and privacy of people and treat them with consideration and respect.

At our previous inspection, we saw that two of the blinds across the windows in one person’s room did not shut. At this inspection, we found that the blinds were still not fixed. One blind was missing, and another was broken. This meant that the person’s privacy was compromised and their room would be illuminated by street lights at night. This failed to make suitable arrangements to ensure the dignity and privacy of the person and treat them with consideration and respect.

We received an action plan in response to the report of our last inspection that included a response to the breach of regulation 17. However, the specifics of the plan did not refer to the issues we highlighted about knocking on doors or the blinds in someone’s room.

During our visit, we saw someone being supported by staff to eat lunch in the dining area next to the kitchen. During this process, we saw how more food was being given to the person when their mouth was already full. We were concerned that the person was being rushed and not able to finish mouthfuls of food before being supported with the next mouthful and so could have choked. This was not a suitable arrangement to ensure the dignity of the person, and to treat them with consideration and respect.

The above evidence demonstrates a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Requires Improvement

Is the service responsive?

Our findings

Findings from the comprehensive inspection of 13 and 17 October 2014:

We checked nine people's care plans. Plans were based on pre-admission assessments by both members of the management team and community healthcare professionals. Some included appropriate detail on the person's individual needs and how staff should provide care and treatment. For example, plans considered the personal care, communication and health needs of people. There was some evidence of review and evaluation of specific parts of the care plans to reflect people's changing needs. One person's plan had been updated to reflect risks and support needs around smoking. Another person's plan had been updated a few days before our first visit to reflect a new aspect of a health condition they had.

However, we found that people's care plans did not always adequately guide staff so that they could meet people's needs effectively. For example, one person did not have care plans in place for most aspects of their care and treatment until almost four weeks after they moved in. There was no plan in place for behaviours of the person which challenged the service, despite evidence of the behaviours within care delivery records. These care planning delays and omissions put the person at risk of being provided with inappropriate or unsafe care.

Two people's care plans did not include a section on pain management, despite their assessments referring to them as experiencing pain on occasion. One of these people's records included a short period in hospital due to experiencing pain, however, their care plan was not reviewed on return from hospital, and continued to have no section on pain management. This may have compromised their safety and welfare.

The Head of Nursing told us that one person may not take medicines unless it was offered to them in a specific manner. Whilst it was positive that the person's routine was recognised, we noted that it was not documented within their care plan. One person's plan stated that they did not eat meat, however, feedback from staff indicated that they sometimes chose to, meaning their plan did not reflect their choices. These failures to address all of the individual care needs of people within their care plans put them at risk of being provided with inappropriate or unsafe care.

Care assessment and plan updates were also inconsistent. There were monthly evaluations of care plans in most people's files. However, parts of one person's care plan had not been reviewed since they moved in over three months before our visit. Two people's continence assessments had been started but not completed when they moved in, and had not been reviewed. We also found that the dependency assessment for three people who had used the service throughout the year had not been reviewed in over three months, contrary to a previous monthly frequency. This did not protect people from the risks of receiving inappropriate or unsafe care and treatment.

One person told us, "Staff chop and change, if they're here for six months, they get to know my ways." Staffing rosters demonstrated some degree of turnover of staff, which increased the risk of people receiving inappropriate or unsafe care of treatment where care plans did not accurately reflect people's current needs and preferences.

The above issues were a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Four people told us the service was responsive to their requests. Comments included, "They ask you if you want anything, you can have everything you want." A relative told us, "The manager is approachable, and improves things if I raise an issue." People reported that their call-bells worked and were responded to, and we saw that this occurred. However, three people told us of not always experiencing responsiveness. Their comments included, "They leave me to wait a long time if I need something, busy with someone else" and "I have reported things in the past, you get an apology, but there's no change."

We saw a complaints procedure on display at the entrance to the service, and in people's rooms. Training records showed that most staff had received specific training on handling complaints. Records demonstrated that complaints were documented and responded to. For example, a person using the service had complained about the food provided to them, for which an apology was provided with explanation of a misunderstanding occurring. Another person had complained about how a staff member spoke with them. The staff member had been issued with a letter informing them that their behaviour was not acceptable.

Requires Improvement

Is the service responsive?

However, there was some evidence of complaint resolution not being effective. The complaint file recorded a relative's complaint about clothes laundering, from which a more robust system had been set up for the specific person. A further record was then made noting that the relative remained unhappy despite the changes, with no record of additional actions then being taken. Another relative had made a number of recent complaints, which indicated that further action was needed to reasonably resolve matters to their satisfaction.

In conjunction with people's feedback about the responsiveness of the service, we were not assured that when people raise complaints or concerns about the care or treatment they received, the service investigated their views thoroughly and changed practice to improve where appropriate.

There was some evidence that the service responded to people's individual needs and preferences. We saw a handover of information between the outgoing and incoming nurse which covered each person's recent care and treatment, and advised on particular needs such as a health matter for one person for which further monitoring was needed. We saw a residents' meeting record which made arrangements for one person to be enabled to watch their favourite television programs without disruption. A health and social care professional told us that staff knew people's preferences.

People's comments about things to do in the service included, "There were two entertainers recently", "Sometimes I go to the shops, depends how I feel" and "I don't go out much." A relative told us, "There's not a lot of activities but it's hard to motivate people. More music might be nice." The manager booked a musical entertainer during the second day of our visit. A record of when this was provided in September showed that one person was much happier for the engagement it provided.

Staff told us how they supported people with activities. This usually occurred after lunch, for example, playing games, providing manicures, and having a chat. They told us that people were asked for activity preferences, and we saw some recorded evidence of this, both within people's care files and from residents' meetings. However, we also saw a blank activity assessment for one person who had been using the service for over two months. Staff also spoke of occasional trips out with people, such as the cinema or a pub lunch, however, this last occurred three months before our visit.

We saw that a record of activity was kept for each person which provided some evidence of individual preferences being addressed. We noted that for one person, 'weekend' was recorded at the weekend rather than the actual activity, which matched some staff feedback that people wanted to 'rest' at the weekend. We also noted that the provider's survey of people using the service found that three of the 12 people asked did not like the activities. In response, further efforts were recorded as being made to personalise the activities.

We were not assured that people were effectively enabled to take part in activities of their choosing within the service or in the community, however, we recognised that the service was trying to address this.

Findings from the focused inspection of 07 January 2015:

This focused inspection was to follow up on whether action had been taken to deal with the most significant breaches of regulations found at our previous inspection. Evidence for those breaches did not fall directly under the question of 'Is the service Responsive?' and so we did not consider this question on this occasion.

Inadequate

Is the service well-led?

Our findings

Findings from the comprehensive inspection of 13 and 17 October 2014:

The quality assurance and audit processes at the service were not effective. We were shown the 'Monthly Home Audit' that the manager had used the previous month to assess and monitor service quality. It ticked five out of a possible 374 audit boxes as 'standard partially met' with nothing ticked as 'standard not met'. There were no recorded plans or actions to address any concerns, although there were occasional additional explanations or comments on service quality. We found that the audit had not picked up on risks to people's safety and welfare that we had identified during our visit. For example, it was recorded as 'standard fully met' against 'all necessary documentation on file prior to commencement of work', 'firefighting equipment certificate' and 'hoists serviced.'

The provider sent us certificates following the inspection to demonstrate that they had taken action to address risks arising from safety certificates being out-of-date for fire extinguishers and mobile hoists. However, the system in place to identify, assess and manage risks relating to the health and safety of people using the service and staff was ineffective as it had not identified these issues, and the provider only acted when we pointed out our concerns about the maintenance of equipment.

When we checked that people's call-bells worked, we found one that did not. We discussed this with the management team, who found that the device was not pushed in correctly. We were told that there were no recorded checks made that call-bells were working correctly and left available for the person to use. This did not assure us that the provider had an effective system for identifying, assessing and managing risk in relation to call-bells so as to protect people using the service against the risks of inappropriate or unsafe care and treatment.

When we asked to see health and safety risk assessments in relation to the service, the management team were not able to supply us with anything. We then saw a general risk assessment document on the office wall that was undated and did not contain any evidence of taking action to minimise identified risks. There was, however, a fire safety risk assessment for the service dated from within the last year.

There was no record of audit of incidents that occurred at the service, so that learning took place with the aim of minimising the risk of harm to people using the service.

The ineffectiveness of the provider's system of quality and risk auditing was also demonstrated through the breaches of regulations we found during this inspection that had not been identified by the provider before our visit. For example, there were no specific care plan audits to monitor whether information in people's care files reflected their needs and was up to date, and that action had been taken where needed to protect people against the risks of inappropriate or unsafe care and treatment.

The above issues were a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We found that records kept at the service were not consistently accurate. There were occasions when there were gaps in the records of care and treatment delivered to people. There was no record of the dietary intake of a person who had used the service for respite. During our first visit, staff told us of a behaviour of one person that challenged the service. The management team told us this was a recognised behaviour of the person, and we saw reference to it in the person's care plan. However, during our second visit, when we asked to see the record documenting the person's behaviour that day, nothing could be supplied. This made it difficult to review the person's behaviour, and was not an accurate record of the care and treatment provided to the person. It did not protect them against the risk of unsafe or inappropriate care and treatment.

One person's pressure care risk assessment stated that they did not have a catheter in place, which contradicted their care plan and records of their care and treatment. The risk assessment was not accurately kept, from which risks to their pressure care treatment may not have been identified correctly.

One person's care file had a nutrition assessment for October 2014 stating that they were underweight. Their pressure care assessment of the same date stated they were not underweight. If they had been scored as underweight, the pressure care assessment would have scored a 'very high' risk rather than the 'high' risk result. There was also a dependency assessment for this person that was filled in monthly. It did not include an entry to

reflect when the person lost a significant amount of weight. Another person's latest pressure care risk assessment scored a 'high' risk, however, their dependency assessment of the same date scored them 'at risk' rather than 'high' risk for pressure care. As these records were not being accurately kept, there was an avoidable risk that these people were not being protected against unsafe or inappropriate care or treatment.

We noted that only four of the 21 staff members listed on the staff training matrix were recorded as having received record-keeping training. This training information did not assure us that staff had sufficient training on keeping accurate and appropriate records.

During the second day of our visit, we reviewed the risk and dependency assessments of one person whose file we checked at our first visit where assessments had been recorded until June. At the second visit, we found these had been updated by the manager for July, August and September. The manager did not have any explanation for this backdating of records. This did not protect the person using the service against the risk of unsafe or inappropriate care, because the three new records were not accurate.

When we discussed a recent safeguarding case with the manager, she informed us that a staff member had not been providing personal care to people on a particular day. However, a previous e-mail of hers in response to a requested explanation from a health and social care professional stated that the staff member had been working that day due to staffing shortages. The staffing roster for the day in question did not list the staff member as working. This contradiction in records and feedback from the manager did not assure us of appropriate records in relation to the management of the service, which failed to protect people using the service from the risks of unsafe or inappropriate care and treatment.

The manager gave us explanations of actions taken in response to some concerns we raised in relation to the management of the service, however, when we asked to see a record of this, none was supplied. For example, we identified that a nurse had arrived late at the service for one night shift recently, and had left early. This meant that there had twice been no nurse on duty, and only one staff member which may have compromised the care and treatment of people using the service. The manager stated that the nurse had been given a warning letter about their conduct, however, the letter was not available in the nurse's file or where we were told a copy should have been saved on the provider's computer system. This failure to maintain records, or locate them promptly when required, did not protect people against the risks of unsafe or inappropriate care and treatment.

The above issues were a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Two people and a relative commented positively on the manager's approach. Their comments included that she "pops in every day to say hello" and she "gets to know what I think." We saw records of meetings for people using the service, and a recent survey asking them their views. Whilst these raised no significant concerns, there was some evidence of planning to improve the service based on feedback, for example, around menu-planning. This helped assure us that people were involved in the service in a meaningful way.

Staff spoke positively about the management of the service. For example, one staff member told us they could discuss ways to improve practices, and felt there was good team work. Records showed that two team meetings had taken place in the last three months. These had been used to remind staff of expectations around service quality, to inform them of staffing changes, and for staff to raise concerns about how the service operated. This showed some evidence of appropriate support of staff. We saw a staff newsletter focussing on similar themes, for example, upcoming training dates. The management team also told us of informal meetings held during quieter periods of the day at which discussions could take place briefly, which we saw happening during our visit.

Findings from the focused inspection of 07 January 2015:

At this inspection we looked at the actions taken by the provider in respect of the breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. We found that the provider remained in breach of regulation 10.

The quality assurance and audit processes at the service remained ineffective. When we asked to see what audits had taken place since our last inspection, the registered manager showed us an audit that focussed on catering and food hygiene arrangements, and an undated personnel file audit. The registered manager confirmed that no other

audits had taken place. This meant that no documented assessment, of the quality of the overall care and treatment services being provided, had been undertaken since our last inspection despite us identifying 11 breaches of the regulations at that inspection. This failed to protect people against the risks of inappropriate or unsafe care and treatment.

The two audits completed since our last inspection were not effective. The audit that focussed on catering and food hygiene arrangements, dated November 2014, noted two points that were "not met": "Have kitchen staff had fire training in the last six months" and "CoSHH risk assessments are available and updated." There were additionally some points that were judged as "partially met," such as "All grades staff attended Food Hygiene Training within the last 12 months." There was no comment about the unmet points, and the action plan arising from the audit had only one action. The registered manager confirmed that no risk assessments were available, which would include CoSHH risk assessments. The staff training matrix had no entry under fire prevention training for the chef, and it showed seven out of 16 staff as not having had food hygiene training. Checks of the 'certificates' file, staff personnel files, and discussion with a staff member confirmed this. This demonstrated the ineffectiveness of the audit, as action to address concerns raised by the audit had not been taken.

The undated personnel file audit checked whether a number of key recruitment and employment documents were in place for each staff member. However, it lacked a plan in response to the shortfalls it identified, and there was no documented evidence of actions taken in response to the findings of the audit when we explored this with the registered manager.

The audit identified two staff members were missing a second employment reference. When we checked the personnel file of one of these staff members, there was only one reference available. The registered manager confirmed to us that they did not yet have a second reference for the other staff member. This demonstrated the ineffectiveness of the audit, as action to address concerns raised by the audit had not been taken.

When we checked that people's call-bells worked, we found one that did not, as we had found at our last inspection. On this occasion, it was because there was no call-bell connected to the socket in the person's room.

Discussion with staff found that the person had not had access to a working call-bell for a number of weeks. We asked how the person summoned staff, as they additionally had bed-rails in place and so could not get out of bed easily and safely. Staff answers included, "Staff call in to say hello and the service user is usually very good" and "The door is usually kept open." However, we observed that this bedroom door was closed for the duration of our inspection and the person was in their room until late morning. The registered manager told us that checks of call-bells were occurring, but there was no record of this. Our evidence demonstrates that an ineffective system for identifying, assessing and managing risk in relation to call-bells remained in place despite us raising the concern at our last inspection. This failed to protect people against the risks of inappropriate or unsafe care and treatment.

The registered manager told us that there were no health and safety risk assessments for the service, however, a consultant would be providing her with training on this within a few days. We received a similar explanation about there being no record of audit of incidents that occurred at the service, so that learning took place with the aim of minimising the risk of harm to people. This meant that action had not yet been taken to address the concerns we raised about risk assessments and incident analysis at our last inspection. Processes to identify, assess and manage risks to the health, safety and welfare of people remained ineffective.

We checked the incident, accident, and complaints records and found no entries since our last inspection. However, when we checked the recent behaviour review forms for two people using the service, we found records of incidents. For example, one person had on occasion been verbally and physically aggressive towards staff members. We noted that the person had been in their room on all three of these recorded occasions. This was the room that did not have a working call-bell, meaning the person may not have been able to summon staff. However, there had been no audit of these incidents from which learning could took place with the aim of minimising the risk of harm to people. This failed to protect people against the risks of inappropriate or unsafe care and treatment.

The registered manager told us that there had been no meeting for people using the service since our last inspection, or documented staff meetings. Staff and the registered manager told us that '11am' meetings took place

Inadequate

Is the service well-led?

each day to review care and treatment of people, however, these were not documented, and the meeting did not occur on the day of our inspection. This failed to demonstrate that the provider was regularly seeking the views of people at the service, so as to come to an informed view in relation to the standard of care and treatment provided to people.

The registered manager told us, in respect of failing to identify quality and risk concerns within audits, that she lacked experience and training for that role. The provider's nominated individual told us that there was a "lack of leadership now," and so a new manager, who had not started at the time of our inspection, had been appointed who was a qualified nurse unlike the registered manager. The nominated individual added that the registered manager's role was to change, to become the company's quality auditing manager and training lead. However, the evidence we found at this inspection does not give us confidence that the registered manager's impending new role will improve the provider's system of assessing and monitoring the quality of service provision so as to protect people against the risks of inappropriate or unsafe care and treatment. This failed to ensure decisions in relation to the provision of care and treatment of people are taken at the appropriate level and by the appropriate person.

The provider sent us an action plan in response to the report of our last inspection. However, it lacked sufficient detail overall and was not always timely in addressing concerns. We sent a letter to the provider requesting that that be addressed. At the time of drafting this report, we had not received a revised action plan. At this inspection we found evidence of ongoing breach of three regulations that did not have a specific plan within the plan supplied by the provider. This additionally demonstrated the ineffectiveness of the provider's system of assessing and monitoring the quality of service provision, as there was insufficient regard to our inspection report for the previous inspection or our subsequent letter pointing that out. This failed to protect people against the risks of inappropriate or unsafe care and treatment.

At this inspection, we overall found evidence of ongoing breaches of eight regulations, along with evidence of a breach of a different regulation. This provided further evidence of the ongoing ineffectiveness of the provider's system of assessing and monitoring the quality of service provision, as there was a lack of regard to the concerns we raised from the previous inspection.

The above evidence demonstrates a continued breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

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 Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services **13 and 17 October 2014** The registered person did not take proper steps, through individualised and up-to-date needs assessments and care plans, to ensure that each service user received care and treatment that was appropriate and safe. Regulation 9(1)(a)(b)(i)(ii) **07 January 2015** The provider continued to be in breach of this regulation. [Regulation 9(1)(a)(b)(i)(ii)(iii)]

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines **13 and 17 October 2014** The registered person did not protect service users against the risks associated with the unsafe use and management of medicines, by means of the making of appropriate arrangements for the recording, safe keeping, and safe administration of medicines. Regulation 13 **07 January 2015** The provider is now meeting this regulation.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 16 HSCA 2008 (Regulated Activities) Regulations 2010 Safety, availability and suitability of equipment **13 and 17 October 2014**

This section is primarily information for the provider

Action we have told the provider to take

The registered person did not make suitable arrangements to protect service users and others who may be at risk from the use of unsafe equipment by ensuring that equipment provided was properly maintained and suitable for its purpose, and used correctly. Regulation 16(1)(a)(b)

07 January 2015

The provider is now meeting this regulation.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services **13 and 17 October 2014** The registered person did not, so far as reasonably practicable, make suitable arrangements to ensure the dignity and privacy of service users; and enable service users to make, or participate in making, decisions relating to their care or treatment. This included failure to treat service users with respect, and failure to ensure that care was provided with due regard to cultural and linguistic background. Regulation 17(1)(a)(b)(2)(a)(h) **07 January 2015** The provider continued to be in breach of this regulation. [Regulation 17(1)(a)(b) (2)(a)]

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment **13 and 17 October 2014** The registered person did not have suitable arrangements in place, in relation to the care and treatment provided for service users in accordance with the Mental Capacity Act 2005, for obtaining, and acting in accordance with, the consent of service users or others

This section is primarily information for the provider

Action we have told the provider to take

lawfully able to consent on their behalf, or where applicable, establishing, and acting in accordance with, the best interests of the service user. Regulation 18(1)(a)(b)(2)

07 January 2015

The provider continued to be in breach of this regulation. [Regulation 18(1)(a)(b)(2)]

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records **13 and 17 October 2014** The registered person did not ensure that service users are protected against the risks of unsafe or inappropriate care and treatment arising from a lack of proper information about them by means of the maintenance of an accurate record in respect of each service user, appropriate records in relation employees and the management of the service; and by means of ensuring that records could be promptly located when required. Regulation 20(1)(a)(b)(2)(a) **07 January 2015** We did not assess this regulation on this occasion.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010 Requirements relating to workers **13 and 17 October 2014** The registered person did not operate effective recruitment procedures in order to ensure that no person is employed for the purposes of carrying on a regulated activity unless that person is of good character, and has the skills necessary for the work to be performed. Regulation 21(a)(i)(ii) schedule 3 part 3, 6 **07 January 2015**

This section is primarily information for the provider

Action we have told the provider to take

The provider continued to be in breach of this regulation. [Regulation 21(1)(a)(i)(ii)(b) schedule 3 part 3]

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing **13 and 17 October 2014** The registered person did not take appropriate steps to ensure that at all times, there were sufficient numbers of suitable qualified, skilled and experienced people employed to deliver care and treatment, so as to safeguard the health, safety and welfare of service users. Regulation 22 **07 January 2015** The provider continued to be in breach of this regulation. [Regulation 22]

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff **13 and 17 October 2014** The registered person did not have suitable arrangements in place to ensure that staff were appropriately trained and supervised to deliver care and treatment to service users safely and to an appropriate standard. Regulation 23(1)(a) **07 January 2015** The provider continued to be in breach of this regulation. [Regulation 23(1)(a)(b)(2)(3)]

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises **07 January 2015**

This section is primarily information for the provider

Action we have told the provider to take

Regulation 15 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The registered person failed to ensure that service users are protected against the risks associated with unsafe or unsuitable premises, by means of adequate maintenance and, where applicable, the proper operation of the premises. [Regulation 15(1)(c)(i)]

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 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse **13 and 17 October 2014** The registered person was failing to make suitable arrangements to ensure that people using the service are safeguarded against the risk of abuse, by means of taking reasonable steps to identify the possibility of abuse and prevent it before it occurs; and by means of responding appropriately to any allegation of abuse. Additionally, where a form of control or restraint was used in the carrying on of the regulated activity, the registered person did not have suitable arrangements in place to protect service users against the risk of such control or restraint being excessive. Regulation 11(1)(a)(b)(2)(b)(3) **07 January 2015** The provider continued to be in breach of this regulation. [Regulation 11(1)(a)(b)(3)(a)(b)(c)(d)]

The enforcement action we took:
We served a Warning Notice on the Registered Provider and the Registered Manager on 04 November 2014, to become compliant with the regulation by 01 December 2014.
We served a Notice of Proposal on the Registered Provider and the Registered Manager on 28 January 2015 to cancel their registrations in respect of the regulated activities that they are registered for.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers **13 and 17 October 2014** The registered person did protect service users against the risks of inappropriate or unsafe care, by means of the effective operation of systems designed to assess and monitor service quality, and identify, assess and manage risks. Regulation 10(1)(a)(b)(2)(a)(b)(iii)(c)(i) **07 January 2015**

This section is primarily information for the provider

Enforcement actions

The provider continued to be in breach of this regulation. [Regulation 10(1)(a)(b)(2)(b)(iii)(v)(c)(i)(d)(i)(ii)(e)]

The enforcement action we took:

We served a Warning Notice on the Registered Provider and the Registered Manager on 25 November 2014, to become compliant with the regulation by 30 December 2014.

We served a Notice of Proposal on the Registered Provider and the Registered Manager on 28 January 2015 to cancel their registrations in respect of the regulated activities that they are registered for.