Care Community Limited

Linden House

Inspection report

205 Linden Road,
Gloucester, GL1 5DU
Tel: 01452 524555
Website: www.carecommunity.co.uk

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Ratings

Overall rating for this service	Requires Improvement
Is the service safe?	Requires Improvement
Is the service effective?	Requires Improvement
Is the service caring?	Good
Is the service responsive?	Requires Improvement
Is the service well-led?	Inadequate

Overall summary

This inspection took place on 9 and 10 October 2014 and was unannounced.

Linden House is a detached house which provides personal care and accommodation for six adults aged 18 years and over with mental health disorders, physical and learning difficulties. The primary aim of Linden House is to help people maintain or increase their independence. Staff support people to take part in activities away from the home, help people to plan and complete tasks around their home and provide emotional and psychological support. Some people occasionally required the support of two staff whilst others only needed staff to be present some of the time. At the time of our visit there were six people living at the home and most had lived there for over two years.

At the time of our inspection the provider did not have a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run.

Summary of findings

There had been no registered manager at Linden House since 2011 although managers had been appointed and had applied for registration with CQC they had left before they were registered with us.

People were not kept safe at the home. At times there were not enough staff with the right skills, knowledge or training working in the home to keep people safe and to meet their individual needs. Staff did not have access to an effective system of support or annual reviews of their performance to reflect on their roles and responsibilities or training needs. When new staff were appointed robust recruitment processes had not been followed to make sure all the necessary checks had been completed.

People did not receive an effective service. Their health care needs were not responded to effectively so that they did not receive the care, support and treatment they needed to keep healthy and well.

People's care was not responsive to their individual needs. Their care plans did not reflect their changing needs. The care they received was inconsistent or they did not always receive the care and support they needed.

The leadership and management of the home failed to effectively monitor the care provided. Risks and concerns were not reacted to promptly. The provider had failed to notify the Care Quality Commission about incidents affecting the wellbeing of people living in the home.

People told us they enjoyed learning new skills so they could be more independent. They were supported to take part in activities of their choice which reflected their interests. People's cultural and religious beliefs were considered when planning their day. We observed people receiving visitors and choosing where to spend time with them. People made choices and decisions about their day to day lives and discussed with staff their wishes for the future. People told us they liked the food and helped to plan and prepare meals. We observed staff patiently and sensitively supporting people, reassuring them when needed and helping them to become calm. People, their relatives, staff and visitors were asked for their views about the home.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and of the Health and Social Care Act 2008 (Registration) Regulations 2009. The provider did not protect people from the risks of unsafe care, they did not notify CQC about incidents affecting people's wellbeing and they did not follow safe procedures to recruit new staff or make sure they were supported to develop in their roles. The provider did not have effective systems in place to monitor and review the quality of care provided. 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?

Requires Improvement

The service was not safe. There were not sufficient staff with the right skills and knowledge to meet people's needs. Recruitment checks were not fully completed before new staff were employed.

People and staff had raised concerns about alleged abuse but action to keep them safe had not always been taken promptly. The provider had taken action to address this.

People were involved in decision making about reducing risks in their day to day lives. Risk assessments however were not individualised to reflect the hazards each person faced.

The systems for the administration of medicines were managed safely.

Is the service effective?

Requires Improvement

The service was not effective. Staff did not always receive adequate support and training to make sure staff had the skills and knowledge needed to meet people's needs.

People's support to manage their health care was inconsistent. Most people's health needs were well managed but for people with specific conditions such as diabetes routine checks with the appropriate health services had not been arranged.

Staff understood the requirements of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards. People were protected when they could not make a decision independently or they had their freedom restricted by staff.

People had enough to eat and drink which reflected their individual cultural and religious beliefs. The nutritional needs of people with specific conditions such as diabetes were not well managed.

Is the service caring?

Good

The service was caring. We observed people being supported with patience and by staff who were sensitive to their needs. People told us staff encouraged them to be independent and to learn new skills.

People and their relatives had opportunities for expressing their views about the running of the home and the care provided.

People's cultural and religious beliefs and requirements were respected and promoted. People were treated respectfully and their privacy maintained.

Summary of findings

Is the service responsive?

Requires Improvement 

The service was not responsive. People were at the risk of receiving inappropriate or inconsistent care. Their care plans were not kept up to date to reflect their present needs.

People's views had been taken into account when developing their care plans. They reflected their likes, dislikes, wishes and preferences.

People raised concerns about the service and changes were made as a result to improve their experience.

Is the service well-led?

Inadequate 

The service was not well led because the management and leadership of the service was not effective. A manager had not completed registration with the Care Quality Commission to be the registered manager since 2011. Quality audits did not lead to improvements in the service. A lack of resources impacted on the quality of care provided.

Staff were not supported to carry out their roles. Risks to people were not analysed to improve their care and support.

The provider had failed to submit information required by the Care Quality Commission.

People, their relatives and staff had been asked for their views of the standard of service provided.

Linden House

Detailed findings

Background to this inspection

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

This inspection took place on 9 and 10 October 2014 and was unannounced. This inspection was carried out by one inspector. Before the inspection, the provider completed a provider information return (PIR) although we were unable to access some of the return (the contact list for professionals) which contained confidential information.

This information was requested again during our visits to the provider. The PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

As part of this inspection we spoke with the six people who use the service, three visitors, the manager, the registered provider, five care staff and five social or health care professionals. We also reviewed records relating to the management of the home which included three care plans, daily care records, ten staff records, medicines records and quality assurance systems. We spent time observing the care and support being provided and how people chose to spend their day. Following our visit we spoke with a health care professional and a commissioner of the service.

Requires Improvement

Is the service safe?

Our findings

We asked people if there were enough staff on duty to keep them safe. Comments included; "I would say there are enough staff, you could always do with more" and "You just need to be patient and staff will get to you." Minutes from a residents meeting in September recorded concerns raised by a person living in the home who was worried about missing activities due to staff shortages. We looked at the staff rotas for September and October 2014. Sign in records completed by staff indicated how many staff had worked each day. There were times when people had not been supported by sufficient numbers of staff. Timesheets recorded when there had been a shortage of staff in July, August and September 2014. These identified the hours staff had worked and the overall staff hours worked for each month. Each month there had been a shortage of between 40 and 100 hours when shifts had not been covered. We were told these might occasionally run short and would be covered by the manager. However as the manager worked Monday to Friday this had impacted on cover arrangements for weekends. The result was that people had to wait for staff to support them to participate in their day to day activities or to support them with their care.

A social care professional told us they had contracted for a person to have allocated hours with one member of staff each day to make sure they were able to go out into the local community and participate in a wide range of activities. They said the person had not been receiving this individualised support. This had led to an increasing number of safeguarding incidents for this person because they were not receiving the support they needed. As a result staff said they had to provide two staff when supporting this person in activities outside of the home to make sure they stayed safe. This in turn had impacted on other people living in the home on their personal safety and the activities they could then participate in. Staff confirmed the provider had said they could increase staffing levels to support people in a crisis but they were often unable to cover the additional shifts. They told us the provider had not given them permission to use agency staff to cover shifts. We observed staff trying to cover shifts during our visit to the home to make sure safe staffing levels were maintained. At the time of our inspection there were not sufficient numbers of appropriate staff to keep people safe and meet their needs. This is a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Staff recruitment practices at the home did not protect people from staff unsuitable to work with vulnerable people. Two staff had been appointed in 2014. There were gaps in their employment history. The provider had not been able to verify whether people had previously worked with vulnerable adults or children during this period of time. Checklists stated when information or checks had been obtained. There was evidence a satisfactory Disclosure and Baring Service check (DBS) had been obtained. The most recent employers listed in the application form had been contacted to find out why the staff had left their employment with vulnerable adults and children. People were put at risk because effective recruitment and selection procedures were not in place. This is a breach of Regulation 21 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Staff had completed safeguarding training and were able to explain the procedures for identifying and reporting abuse. They said they would record incidents, accidents and concerns in daily notes and other records as well as passing on information to management. They were aware of the whistle blowing policy and procedure. Staff said their concerns had not always been dealt with in a timely fashion and they had been unsure if safeguarding alerts had been raised with the local authority. At the time of our inspection the provider confirmed they had been aware of this and had taken the necessary disciplinary action with staff who had not raised the safeguarding alerts. One person told us a member of staff had inappropriately physically restrained them. The provider had suspended the member of staff pending disciplinary investigation and a safeguarding alert had been raised with the local authority.

People were supported to take risks to gain confidence and become more independent. Hazards were discussed with them and any known risks were minimised. For instance, one person went out for pre-agreed periods of time in the local community. This had increased from 30 minutes to two hours over the last six months as their confidence grew. The person told us, "I like to occasionally have staff supporting me when I go out but I like to be able to go into town on my own."

Requires Improvement

Is the service safe?

People's risk assessments for medicines, finances and personal safety had not been individualised. Each risk assessment provided exactly the same detail for managing risks to the person. They did not reflect the individual hazards each person faced and how the risks to them had been minimised. Staff discussed the strategies for keeping people safe and these strategies reflected an individualised approach which had not been recorded in their risk assessments. The manager said this had been pointed out to them at an inspection by a social and healthcare professional and they would be addressing this. However risk assessments in response to people's changing needs for instance where medicines had been prescribed to manage diabetes had been personalised.

We observed people being given their medicines at times appropriate to them. Staff told us how they made sure people had their medicines as prescribed for instance with food or before food. They also made sure people had their medicines at the right time so there were sufficient gaps between doses of medicines. They said this was important for people who chose to get up later in the mornings. We observed people being offered medicines which could be taken when necessary (PRN) if they were feeling unwell. Each person had a record stating what PRN or over the counter medicines they could take. These provided guidance about the correct procedure for administering these medicines. Where PRN medicines had been given to people when they were upset or anxious incident forms had been completed to evidence the reason for giving this medicine. Staff said they had to inform the out of hours manager when PRN medicines were given to people. This made sure people were protected from the inappropriate and unsafe use of medicines to sedate them. Staff confirmed they had completed medicines training. A member of staff talked through the administration of medicines, how medicine administration records were maintained and people's medicines care plans and risk assessments. A person discussed with us how they were being supported to manage their own medicines. They said staff had supervised them through each stage until they were confident to complete the process independently.

There was an emergency plan in place to deal with foreseeable emergencies such as fire or power failure. Staff said there was an out of hours emergency system in place for advice or support from management. Each person had an individual personal evacuation plan which described the support they needed to leave the home in an emergency.

Requires Improvement

Is the service effective?

Our findings

Staff had been scheduled to have individual meetings with the manager throughout 2014 to discuss their performance and training needs. New staff had been scheduled monthly meetings and existing staff were to have bi-monthly meetings. During 2014 two staff had received one to one support in April and seven out of the 13 staff had attended individual meetings in July. When it was identified a member of staff was struggling with a particular task such as administration of medicines support had been provided. For example, additional shadowing of other staff or training had been provided. This level of support was not consistent. Staff said they had not received annual reviews of their performance and did not have monthly or bi-monthly individual meetings as planned. The provider had recognised there was a problem in delivering one to one meetings and appraisals. They had allocated team leaders to take responsibility for providing these meetings but they had not completed the relevant training.

Staff said they kept up to date with their training and refresher training. Copies of certificates evidenced staff had completed training in the safeguarding of adults, first aid, medicines awareness and health and safety. Observations of staff practice had been introduced to make sure staff had put their knowledge into practice. The provider information return confirmed all staff had completed the Diploma in Health and Social Care. The provider sent a schedule of staff training after our visits. This confirmed when staff had completed training but did not identify when refresher training should be completed. Staff had been trained in the management of challenging behaviour and the use of physical intervention in April 2013. They needed to complete annual refresher training to make sure they maintained their skills when supporting people with behaviour which challenged them. The escalation of incidents in the home indicated that some staff were struggling to support people effectively when they were upset or anxious. We discussed with staff the support they provided to two people living in the home who had diabetes. They were unable to give a robust picture of their needs in relation to their diet or their health care. They confirmed they had not received any training in this area. This lack of awareness could impact on how the health needs of people living with diabetes were managed by staff. A new member of staff who had been in post for three weeks said they had not started their induction programme. The induction for new staff should have commenced on their first day of employment and completed within six months. Staff were not adequately supported to acquire and maintain the skills and knowledge to meet people's needs effectively. This is a breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The care plans for two people living with diabetes stated they were on a controlled diet but did not give specific information about the diet they should be following. A monthly review for September 2014 stated the diabetic nurse had told staff to monitor the sugar in another person's diet and to ensure they had at least two fish meals a week. This had not been recorded in their care plan and staff spoken with were not aware of this. Staff were also not aware of what action they needed to take should a person with diabetes become unwell or of the checks which needed to be carried out on their feet and eyes. People's care plans stated they looked after their foot care themselves. People's health care records had no evidence of appointments with podiatry to check on their feet or the optician to monitor the health of their eyes. This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Each person had a life plan which provided information about their health needs and any medicines they were taking. People were supported to arrange and attend appointments with a range of health care professionals. These included their GP, dentist, mental health professionals and a diabetic nurse. Records had been kept for all appointments to keep staff informed about the outcome of the consultation and of any follow up treatment or appointments. Each person also had a hospital assessment which provided information should they need to be admitted to hospital in an emergency.

Relatives of one person told us, "Staff look after him really well." A person told us, "(name) is really nice and other staff are to." Staff spoken with had a good understanding of people's assessed needs, their preferences and choices. They discussed with us the support they provided and reflected on people's routines and likes or dislikes. We observed a member of staff supporting people with skill and insight. At a staff handover we observed staff speaking professionally and respectfully about people. They passed on information to other staff highlighting any areas of concern and changes in people's needs.

Requires Improvement

Is the service effective?

Staff had completed training on the Mental Capacity Act 2005 (MCA) and understood the need to assess people's capacity to make decisions. The MCA is legislation that provides a legal framework for acting and making decisions on behalf of adults who lack the capacity to make particular decisions for themselves. The provider had been advised by a local authority representative to review their mental capacity assessments. New assessments had been completed with people where they had fluctuating capacity to make decisions about their finances or taking medicines due to occasional poor mental health. Staff discussed the rationale for restrictions such as a key pad on the front door. This was to comply with conditions imposed by the courts on one person living in the home. Other people needed the support of staff to go out. The manager was aware of recent developments (March 2014) in the case law around the Deprivation of Liberty Safeguards(DoLS) and that additional DoLS authorisations may need to be submitted as a result. The DoLS provide a lawful way to deprive someone of their liberty, provided it is in their own best interests or is necessary to keep them from harm.

The service was meeting the requirements of the Deprivation of Liberty Safeguards. Staff had been trained to understand when and how an application to deprive someone of their liberty should be made. Authorisations had been granted when needed and these had been reviewed with the supervisory body after six months. The manager discussed with us an urgent application they were about to make in response to the changing circumstances of a person living at the home. The appropriate health professionals had been involved in assessing the person's capacity to make decisions about their care and support and had concluded decisions needed to be made in their best interests. A decision or action taken on a person's behalf must be made in their best interests where a person had been assessed as lacking the capacity to make a decision.

People's care plans and risk assessments provided guidance for staff about how to support them when they were upset or anxious. Protocols prompted staff to pay attention to what might upset people. For instance a noisy environment and what action they should take to help people remain or become calm for example going out for a walk or to their room. Staff discussed how they supported people using distractions and diversions. They said they did not use physical intervention. People's care plans stated physical intervention would be used only as a last resort to keep them and others safe. We observed staff effectively and patiently reassuring and supporting people to become calmer. We also observed staff advising and prompting a person to consider the effect of their behaviour on others living in the home and to respect their personal space. This was done in such a way the person responded positively and engaged with other people in a less confrontational manner. In relation to this a person told us, "I talk to staff if I have a problem, they go and talk to the others and quietly talk to them."

We discussed with staff how they supported people who were living with diabetes. They said high energy drinks had to be avoided for one person. The person told us, "I like to have fizzy drinks but they are bad for me." Staff were unable to explain how they supported people to manage their diabetes through their diet. The provider information return stated people's dietary needs and religious beliefs had been considered with people when preparing menus. Menus were individualised to reflect each person's likes and dislikes and were displayed in the kitchen. One person told us, "They cook halal food for me." Staff explained how they stored meat separately in the freezer and fridge to make sure there was no cross contamination between halal meat and other meat products. The provider confirmed consideration was given to people when they fasted due to their religious requirements. We observed people having their meals when they wanted and choosing where to eat them. People had access to drinks and snacks when they wanted them. A person had been supported to bake cupcakes and these were offered to people during the afternoon. Another person said, "I like cooking my own lunch."

Good

Is the service caring?

Our findings

People were treated with kindness and concern. Relatives of two people told us, “They have really turned (name)’s life around” and “They look after him well, he is happy”. Three people commented, “I love it here, it’s a lovely home”, “I like living here” and “I love playing chess with staff”. We observed seven staff during our visits supporting people in their day to day activities. They treated people respectfully, calmly and patiently. They spent time listening to people but if they had to attend to someone or something else they apologised for having to leave them and explained what they were doing. Staff then returned to the person to continue the conversation. This reassured people and we observed them happily waiting for staff.

A person told us, “I do my prayers every day.” We observed staff making sure the person had could follow their religious beliefs when at home and also supported them to attend their place of worship. The staff team reflected the cultural and religious diversity of people living in the home. Staff said they were able to make sure people’s cultural and religious beliefs were recognised and celebrated. Staff understood people’s personal history, their background and their aspirations. One person told us, “Staff help me with my cooking and the next step is to help me with my medication. Being here helps me learn. I want to live independently.” People’s care records provided a snapshot of their life and their future aspirations.

We observed staff responding to a person who said they were in pain. They offered several options for them to choose from including taking a pain killer or going to their GP. An appointment was made to see their GP. Another person was becoming anxious due to a visit to their relatives. Staff responded by telling them when the visit would take place and keeping them occupied until the time had arrived.

People were observed discussing with staff their plans for the day and evening. They were involved in planning and arranging their time. Daily records evidenced when people had decided not to participate in an activity or go to an appointment and stated the reason why. We saw people receiving visitors and choosing where to talk with them. The relative of one person said, “We visit often” and the relative of another person said, “We are made to feel welcome”. One person showed us information about local advocates displayed on a notice board and told us “I will ask staff if I need one.” The provider information return stated people would be supported to access advocacy services if they wished. One person had an advocate who had said in a survey they completed, “Excellent service, lovely atmosphere”.

People were observed choosing where to spend their time either in the privacy of their room, an annexe in the garden, the lounge or the dining room. When a person wished to change their clothes in the dining room they were discreetly prompted to go to their room or the bathroom to do this. Staff respected people’s right to keep information about them confidential. People’s care records were stored securely and conversations with visiting health or social care professionals were conducted in private.

Requires Improvement

Is the service responsive?

Our findings

The care people received did not always fully reflect their assessed needs. Assessments and care plans did not always provide sufficient information so that staff could provide personalised care that was responsive to people's needs. Monthly reviews of care plans provided an up to date record of what people had been doing and any changes in their health or wellbeing. This information had not always been transferred to the appropriate care plan or risk assessment. These documents provided out of date information and staff unaware of the monthly reviews were at risk of providing inconsistent care. Poor documentation about the needs of people with diabetes or people who were having increasing incidents due to poor mental health increased the likliehood of people receiving inappropriate care or support. This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People's care plans described how they wished to be supported. They had a life plan which had been produced using pictures and plain English to aid people's understanding. People spoken with told us about their likes and dislikes which were recorded in these plans. They also described what they would like to do in the future. These included going on holiday, getting a job and living independently. One person showed us information about the type of job they would like and was heard discussing this with staff. Where people had preferences about the gender of staff providing their personal care this was highlighted in their care plans. People's religious and cultural requirements were recorded in their care plans. This was confirmed by a person who told us they went to their place of worship each week.

People were involved in planning and expressing views about their care. We observed staff talking with a person about what should be written in their daily records for the day. A person told us, "I talk with staff about my care. I have epilepsy and they come running if I have a fit." Care plans we read for one person with capacity to make decisions about their care and support had been signed by them. People told us staff supported them with their interests and hobbies. One person said, "I do lots of things going to the shop, we went to North Somerset and I like buying clothes. They keep me busy. I go to Kingfisher (a day centre)." Another person told us, "I get to go out. I went to the pub for my lunch." We observed one person doing some drawing. Staff discussed with them going to a local art class. People who wished to be more independent helped out around the home preparing meals, washing up and helping with the shopping. We observed a person talking with staff about how they wanted to live on their own and needed to learn skills to achieve this.

A person told us, "I talk to staff if I have any concerns." Relatives of one person said, "We have no complaints" and another relative told us, "I have no concerns, if I had any I would talk with the staff". A new easy read format of the complaints procedure had been produced using pictures and plain English. A copy had been given to one person and other people were due to be given their individual copies. The provider had not received any complaints. People could attend weekly house meetings where they talked about the menu, activities, future plans and whether they had any concerns. Minutes for meetings between June and September 2014 stated that people had raised concerns about the choice of meals and staffing shortages. The staff had responded by reviewing the menus with people. The provider was recruiting new staff at the time of our inspection.

Inadequate

Is the service well-led?

Our findings

The quality of care provided to people was not effectively monitored by the provider. Accidents and incidents had been recorded but there were no systems in place to analyse these or to assess whether any trends had developed. As a result changes in people's behaviour had not been responded to quickly enough resulting in the number of incidents increasing. This in turn had increased the number of safeguarding incidents which had the potential to harm people living in the home. There had been a delay in raising safeguarding alerts. Staff told us they had raised concerns but action had not been taken to address the situation promptly. People had not been protected against the risks of inappropriate care.

Although the provider had carried out some visits to the home to check on the quality of care provided we could find no evidence of any visits after February 2014. Quality audits had been scheduled to be completed each month. The provider sent copies of reports for visits in June and July 2014 carried out by a registered manager employed at another of the services managed by Care Community Limited. These had not been signed and there was no evidence the provider had seen these reports. Actions had been identified that weekly and monthly health and safety checks had not been carried out by staff. These included fire systems, fridge and freezer checks and water temperature checks. The audits did not follow up on actions identified in the previous month's audit to confirm that the necessary action had been taken. For example each audit stated health and safety checks had not been completed. It was not clear what improvements had resulted from actions identified in the quality assurance audits. Quality audits of care plans did not highlight the inconsistencies we found during the inspection. Care plans had not been updated to reflect people's changing needs. Risks to people were not being monitored. This is a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

There had been two incidents in September and October 2014 where people had not been safeguarded from potential harm. Staff had used physical intervention inappropriately. The local safeguarding authority and police had been notified of these incidents. The Care Quality Commission (CQC) had not been notified. CQC monitors events affecting the welfare, health and safety of people living in the home through the notifications sent to us by providers. We also found a Deprivation of Liberty Safeguard had been put in place for one person. We had not been notified about this. This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Registration) Regulations 2009.

The provider had no systems to make sure staff were aware of their roles and responsibilities or to check staff knew what was expected of them. A member of staff told us, "We do not have contracts of employment or job descriptions." The provider had failed to provide staff with adequate guidance and support in relation to best practice when supporting people with their health needs. People who were living with diabetes had not received the appropriate support to manage their condition.

At the time of our inspection the service did not have a registered manager. Although the provider had appointed two managers to the home during 2014 there had not been a registered manager for this service since 2011. The provider confirmed during the inspection they had appointed a new manager who would apply to become registered with the CQC. A registered manager is a person who has registered with CQC to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run. Due to the increasing numbers of serious incidents affecting people living at the service the registered person and a registered manager from another service owned by the provider had provided temporary management support.

Prior to our inspection we had asked the provider to complete a provider information return (PIR) containing information about the operation of the home. Although this had been returned the provider had been unable to give us a password to open a separate spreadsheet containing confidential information. Despite repeated requests by CQC this had not been provided. As a result we had been unable to contact professionals prior to the inspection to seek their views about the home. This information was requested and provided during our visit to the service.

People, their relatives and visitors had been asked for their views about the quality of the service provided. They had completed questionnaires in July 2014. A newsletter had been produced providing feedback about planned

Inadequate

Is the service well-led?

improvements to the service as a result of these surveys. For example, menus had been reviewed and people told us they had improved. Comments from the surveys included, "Very excellent care and staff", "Menu's need improving", "Everyone works well together" and "Service users well looked after".

People had raised concerns about their en suite facilities. Health and safety audits also identified leaks in a shower and bathroom. A new shower unit and bath had been installed. A tear to the floor in a person's bedroom had also been reported. We observed staff discussing with their relatives their choices for a replacement floor covering. The provider information return stated systems were in place to make sure a safe environment was maintained by completing annual and monthly safety checks.

The provider had clear procedures in place to investigate and take action where poor staff performance had been identified. The appropriate disciplinary action had been taken. A team meeting had been held to discuss recent incidents and another meeting had been planned. Staff and management had identified improvements which needed to take place including giving staff shared responsibility for key areas such as monitoring medicines, health and safety, training and activities. Other concerns and challenges discussed included appointing a manager and maintaining staffing levels.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services **The registered person had not taken proper steps to ensure that each service user was protected against the risks of receiving unsafe or inappropriate care as they had not taken action to ensure the welfare and safety of service users.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010 Requirements relating to workers **The registered person was not operating effective recruitment procedures because they did not ensure all information specified in Schedule 3 was available.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing **People who use services did not have sufficient numbers of suitably qualified, skilled and experienced persons employed for the purposes of carrying on the regulated activity.**

Regulated activity	Regulation
	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff **The registered person did not have suitable arrangements in place to ensure that persons employed for the purposes of carrying on the regulated activity received appropriate training, professional development, supervision and appraisal.**

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents The registered person had not notified the Commission without delay of incidents which occurred whilst services were being provided in the carrying on of a regulated activity. This included the outcome of a standard authorisation to deprive a service user of their liberty and abuse in relation to a service user.

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 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers The registered person had not protected service users and others who may be at risk, against the risks of inappropriate care. They did not have effective systems designed to regularly assess and monitor the quality of services. They had not identified, assessed and managed risks relating to the health, welfare and safety of service users. They had not made changes to the care provided relating to the analysis of incidents which had the potential or resulted in harm to a service user.