Mrs Margaret Yvonne Wrigley

Ismeer

Inspection report

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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 11 September 2015, the inspection was unannounced. The service was last inspected in April 2015, we had no concerns at that time.

Ismeer is a care home for up to 27 people who require accommodation and personal care. At the time of the inspection there were 20 people living at Ismeer. All of the people who lived at the home were older people. The majority of people had some form of dementia. Some people had physical or sensory disabilities. The home was spread over four floors and the original building had been extended. The extension was known as The Coach House.

There had been no registered manager in post since January 2015. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At the time of the inspection there was an acting manager in place, who had the day to day responsibility for running the service, but they had not applied to be registered manager. Due to ill-health the provider was not

Summary of findings

able to oversee the service. Family members had Lasting Power of Attorney (LPA), and had taken over responsibility for the business. The manager told us they were in regular telephone contact with one of the LPA's. However, the LPA did not live in the UK and had not visited Ismeer since the manager's appointment in May 2015. We were told the other LPA had; "backed off completely." There was no deputy manager or any administrative support in place. There was no hierarchy of staff within the home. For example there were no senior care worker posts or key workers who could take responsibility for people's care planning.

Some people occupied bedrooms on the upper floors which had fire doors that opened out onto steps down to the car park. These were not locked or alarmed and no risk assessments had been carried out to help minimise the risk. Following the inspection the manager had key pad locks fitted to the fire doors in order to help protect people from the potential risks they presented.

There was a call bell system installed so people could ring for assistance as required. This was a pull cord system and some people were not always able to reach the cord in order to operate it. In an attempt to overcome this problem for one person, string had been tied to the end of the pull cord, strung across the room at shoulder level, and attached to a chair. This posed a hazard for the person and others entering the room.

Parts of the building were in need of updating and redecorating. Some window latches were broken, string was being used in some rooms as window restrictors and the double glazing in some windows had deteriorated resulting in condensation between the glazing panels making it difficult to see out. There was no maintenance worker available to the service to help address issues such as these in a timely fashion.

Systems for the storage, administration and disposal of medicines were not robust. There were gaps in some peoples Medicine Administration Records (MAR). This meant we were unable to establish whether people always received their medicines as prescribed.

New employees were required to complete the Care Certificate in their first 12 weeks of joining the service. This contained various elements of training relevant to the service. Before working alone they spent some time shadowing more experienced staff. It was difficult to establish how often staff updated training following induction as there was no system in place to give an overview of the staff team position. The staff files we looked at showed refresher training in areas such as safeguarding and the Mental Capacity Act (2005) had not been done since 2012. Staff were not receiving regular formal supervision. This can be used as an opportunity for staff and managers to highlight any training needs or working practice issues. The manager told us they spoke with staff informally on a daily basis and had an understanding of the day to day issues affecting the service because they often supported care workers to provide care.

The manager was planning to update care plans to a new format. This was well laid out and the various sections covered all aspects of people's care needs. However only one care plan had been updated at the time of the inspection. The manager told us information in the remaining care plans was unreliable. Care reviews had not been carried out since May 2015. There was no evidence people, and/or their representatives, were involved in planning their care or consented to the plans.

Regular audits were not being carried out for all aspects of the service. For example, although falls were recorded in individual files, they were not analysed regularly to help identify any trends across the service. The Care Quality Commission (CQC) had not been informed of significant events such as accidents, as is required by law.

Staff were cheerful and friendly in their approach to people and we observed people and staff chatting and laughing together throughout the day. Although records of care provided were not always completed we found the standard of care was good. People who were confined to their beds due to their healthcare needs, were protected from the associated risks, demonstrating the appropriate care was being carried out.

We identified breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The actions we have asked the provider to take are detailed at the back of the full version of the 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. Arrangements for the administration, recording and storage of medicines were not robust.

People were not fully protected from risks associated with the premises.

New staff underwent pre-employment checks to help ensure they were suitable for the role.

Is the service effective?

Requires improvement 

The service was not effective. Staff did not receive regular training updates or formal supervision.

No mental capacity assessments or best interest meetings were held although applications to deprive people of their liberty in order to keep them safe had been made.

People had access to other healthcare professionals such as GP's and district nurses.

Is the service caring?

Good 

The service was caring. Staff treated people kindly and with compassion.

Information on how to communicate effectively with people was included in care plans.

People's cultural needs were recognised and respected.

Is the service responsive?

Requires improvement 

The service was not always responsive. Care plans required reviewing and updating.

Staff communicated well and were aware of people's changing needs.

Activities were held within the service. However these did not take account of the fact that many people were living with dementia.

Is the service well-led?

Inadequate 

The service was not well-led. There was no effective or accessible management structure in place.

Many aspects of the care provided were not regularly audited. Those audits that were taking place were not always effective.

Information available for staff within the service was out of date.

Ismeer

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 11 September 2015 and was unannounced. The inspection was carried out by two inspectors.

Before the inspection we reviewed previous inspection reports and other information we held about the home.

Due to people's health care needs we were not able to verbally communicate with everyone who lived at the service in order to find out their experience of the care and support they received. We used the Short Observational Framework for Inspection (SOFI) over the lunch time period. SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. We spoke with the manager, five people who were living at Ismeer, two relatives and five care workers, the cook, activity co-ordinator and a domestic assistant. Following the inspection we contacted two further relatives and an external health care professional to gather their views of the service.

We looked at detailed care records for five individuals, three staff files and other records relating to the running of the service.

Requires improvement

Is the service safe?

Our findings

Systems for the administration and recording of medicines were not robust. Handwritten records had been entered on the Medicine Administration Record (MAR) sheet. These were not consistently signed by two members of staff as required to help ensure the risk of errors was reduced. Creams had not been dated on opening. This meant staff could not be sure they were still effective and there was a risk they may have become contaminated.

A pot containing two tablets had been marked with a name and had 'refused' written on it. This was found at the bottom of the medicines trolley. The MAR sheet did not record any refused medicines for the person concerned and so we could not establish what medicine this was. The medicines policy stated; "Record if the medicine is refused." This was not being adhered to. An unmarked glyceryl trinitrate (GTN) spray used to treat chest pain was also at the bottom of the trolley. We were told this was waiting to be disposed as it had inadvertently been put in the washing machine. This demonstrated systems for the safe disposal of medicines were not robust.

Some people were using medicines which require stricter controls by law. We identified two errors in the recording of these medicines. A delivery of one drug had been made but not recorded. Another medicine was in the dedicated cupboard but there was no record of it in the medicines log. We discussed these errors with the manager who acknowledged the discrepancies.

MAR sheets contained gaps. For example one person received two medicines at night. There were gaps in the records for one on the 8 and 9 September 2015. For the other there were gaps on the 21 August and 5 and 9 September 2015. This meant we could not be sure the person had received their medicine as prescribed.

The manager had carried out a medicines audit on the trolley the week prior to the inspection. However they had not identified any of the problems found at the inspection.

One person was self-administering their medicine. Ismeers' medicines policy stated that in such circumstances a risk assessment should be in place to establish the person is able to self-medicate and a lockable space be allocated to them for safe storage of the medicine. However neither of these conditions were being followed.

The building was clean and the temperature comfortable. Some areas were in need of updating and redecoration. A relative commented; "It's clean but it could do with someone for maintenance." Shared bathrooms contained various items including personal toiletries, a razor, sponge, bars of soap and towelling towels. The manager told us the toiletries had been there for some time and they were not aware who most of them belonged to. We could not identify if items such as shampoo and shower gels were shared. This meant people were not adequately protected from the risks associated with cross contamination.

The above was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they felt safe living at Ismeer. One person commented; "I am safe here. There is never any unpleasantness." Staff told us they had no concerns regarding colleagues working practices and if they did they would report them to the manager. They were confident appropriate action would be taken but if not they would report concerns to the Care Quality Commission (CQC). No-one mentioned reporting concerns to the local authority as an option. Information regarding the process for reporting abuse was available in the managers' office. Some of the information referred to previous managers indicating it had not been updated for some time.

Care plans contained risk assessments for a range of circumstances such as moving and handling, falls and eating and drinking. Where a risk had been identified there was guidance for staff on action they could take to minimise this. For example the approach to take to support people if they became anxious. This helped ensure staff took a consistent approach to supporting people. There were also risk assessments specifically for those people who had multiple health conditions and were therefore potentially more vulnerable. We saw clear guidance for staff on how to move people who were confined to bed causing as little discomfort a possible. One relative told us; "They know what they're doing. I hold her hand and she might give a little moan but it's very quick." However risk assessments were not consistently dated or reviewed. Therefore it was sometimes difficult to ascertain whether the information was up to date.

The building was spread over four levels and had been extended to the side. We saw staff in all areas of the building supporting people in their rooms and in the

Requires improvement

Is the service safe?

lounge and dining areas. The manager told us they had one staffing vacancy for a night worker. People and their relatives did not express any concerns regarding staffing levels within the service. On the day of the inspection staff were available to support people throughout the building at all times apart from one occasion. During the afternoon we were talking to the manager in the office which was situated just off the lounge. We heard a resident call for assistance and the manager rang a call bell as there were no staff members in the lounge. Fifteen minutes later we heard the resident call out again as no-one had responded. The manager left our meeting to attend to the person themselves.

People were protected from the risks associated with the provision of care by unsuitable staff because staff recruitment practices were safe and robust. All of the appropriate background checks were completed before new employees began work. This included Disclosure and Barring Service (DBS) checks.

Requires improvement

Is the service effective?

Our findings

The service was not effective because staff did not receive regular training or support to provide them with the knowledge and skills to carry out their roles safely.

The manager told us staff received an induction which included a period of shadowing more experienced staff before working alone. They were also supporting new employees to complete the Care Certificate within a twelve week period. This is training recommended by Skills for Care which aims to give workers a basic theoretical knowledge of care work alongside observed practical work. However, new employees were not routinely receiving training before starting to give personal care. Some recent employees had previous experience in care and had received training from other providers. For example two new employees told us they had not received any moving and handling training at Ismeer but had done it in their previous jobs. However the manager had no system of checking new staff competencies.

We discussed with the manager how they identified when staff training required up dating. They told us there was no system in place such as a training matrix which would enable them to have oversight of the staff team training needs. In order to establish who needed training and in what area they would need to look at individual staff files. There was no evidence staff files were being regularly audited. The files we looked at showed staff had received First Aid training in May 2015 but there was no evidence of any recent training in other areas such as safeguarding, infection control or moving and handling. Of the five members of care staff we spoke with three told us they had completed training in dementia awareness and the Mental Capacity Act 2005. The activity co-ordinator and cook said they had not had any training.

The manager told us they spoke with staff often on an informal basis and worked alongside them. This meant they were able to observe working practices and identify any problems staff were having. However formal one to one supervisions were not taking place. These can give staff and managers opportunities to discuss any training requirements, career development and working practice issues. Records showed some staff had received formal supervision but this was not consistent. This meant staff did not receive effective support and any on-going training needs or personal development requests may not have been acted upon.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

We found there were insufficient adaptations to the premises to support people with dementia to orientate independently around the building. Although shared bathrooms and the dining room were marked with clear signs there was a lack of appropriate signage to help people with dementia identify their bedroom. Names were on doors but this was inadequate for people whose cognitive abilities may have deteriorated. Signs in the lounge area indicated there were drinks and fruit available at a particular table but this was not correct. An activity board with pictorial representations of various activities on offer throughout the week was displayed. We were told this was not followed. This meant signage was inaccurate and/or meaningless which could have been confusing for people.

This contributed to the breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 referred to in the 'safe' section of this report.

The Mental Capacity Act 2005 and associated Deprivation of Liberty Safeguards (DoLS), is a legal framework to protect people who are unable to make certain decisions themselves. Applications for DoLS had been made to the local authority for some people and the manager was waiting for the outcome. The legislation states it should be assumed that an adult has full capacity to make a decision for themselves unless it can be shown that they have an impairment that affects their decision making. DoLS provides a process by which a person can be deprived of their liberty when they do not have the capacity to make certain decisions and there is no other way to look after the person safely. However capacity assessments had not been carried out or best interest meetings held prior to these applications being made.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Due to their health care needs some people had their food and fluid intake monitored daily and records were completed by staff. The cook was aware of people's

Requires improvement

Is the service effective?

preferences and any dietary requirements. They regularly went into the lounge to talk with people about food choices and check people were still enjoying the menus on offer. Care plans contained specific information when people required a soft diet as well as information regarding peoples likes and dislikes.

People chose where to eat their lunch. Some ate in a dining room or in the lounge while others chose to eat in their bedrooms. Staff supported people who needed assistance to eat appropriately. We heard staff check with people how much help they required. For example we heard one member of staff ask if someone wanted help cutting up food. People were asked throughout the day if they needed drinks. Those who chose to stay in their rooms had access to drinks at all times.

People had regular access to external healthcare professionals according to their individual needs. Following the inspection we spoke with a District Nurse who told us people cared for at the service who were at risk from pressure damage were well looked after. They said all appropriate measures were taken to help ensure people were protected from risk. They went on to say staff cared for people effectively with minimum input from themselves.

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Good

Is the service caring?

Our findings

Staff treated people kindly and with compassion. One person told us; “They’re all wonderfully kind.” A relative commented; “[My relative] is very well looked after. They sit and speak with him.” Everyone agreed people were treated with dignity and respect.

Staff explained to people what was going to happen before supporting people to move and gave reassurance throughout. As well as supporting people with specific tasks such as moving around the building and eating and drinking we saw staff chatting to people and socialising throughout the day. When staff needed to leave people for any reason they explained where they were going. For example we saw one member of staff starting to support someone to eat a meal in the lounge area. We heard them tell the person; “Bear with me, I’m going to go and get someone to help me lift you up a bit. You’re a bit slanted aren’t you.” The care worker returned quickly with a colleague and supported the person to sit up appropriately and safely.

People were able to make choices about how they spent their time within the service during the day. People told us they chose what time to get up and go to bed. On our arrival at the service at 9:00am some people were eating their breakfast, others had already eaten and some were preparing for breakfast. This demonstrated there was a flexible approach to the organisation of breakfast time.

Some people spent the majority of their time in the lounge which was divided into an area for TV watching and a quieter sitting area. We saw some people preferred a more sociable environment and sat round chatting among themselves and to any visitors. Other people were reading newspapers and completing puzzles. People told us the previous day had been unexpectedly warm and they had sat outside enjoying the sunshine. Staff completed any paperwork at one end of the room and so were usually available when assistance was required.

Staff were aware of any communication difficulties people might have and respected these. Care plans recorded information on how best to talk with people. For example; “[Person’s name] has hearing difficulties so communicate with them from the right side.” And later in the same care plan; “[Person’s name] will require the subtitles to be on TV when watching.”

Some care plans had personal histories which contained information about the person’s life when they were younger, their likes and dislikes, and their current family life. The manager told us they considered this information important as it helped staff to get to know the person’s background and gain an understanding of who they were today. The activities co-ordinator told us one person had been a successful artist in the past and they tried to nurture this interest. Although they had not been successful they recognised the importance of identifying people’s past interests in order to engage with them.

People’s cultural needs were recognised and respected. One person had very clear religious beliefs. As well as this information being noted within the care plan there was information for staff outlining some of the basic beliefs associated with the religion. This meant staff were able to gain some understanding of the person’s beliefs and help ensure they were able to acknowledge and respect them.

Requires improvement

Is the service responsive?

Our findings

The manager told us they were updating care plans and showed us one which was almost complete. The format was well laid out and the information was relevant and guided staff clearly on the type and level of care to be provided. However most of the care plans were out of date and the manager told us they were a "big problem, a lot of wrong information." They said they intended to have all the care records reviewed and updated to the new format by the end of the year. No care plan reviews had been carried out since May 2015. There was no evidence that people, or their families where appropriate, had been involved in care planning or that they consented to the plan of care in place.

Monitoring charts were kept for some people who were at risk of pressure damage. These included charts to record when people had been turned in their beds in order to relieve pressure and minimise the risk of developing skin damage. The charts were not consistently completed. For example, one person required turning every two hours. On the 8 September we saw recorded they had been turned at 6:00, 8:00, 13:00, 22:00, 24:00, 2:00 and 4:00. On the 9 September at 6:00, 8:00, 13:00, 16:00 and then not until 21:00. This meant we were unable to evidence the person was receiving the care and support they required to keep them safe from the risk of pressure damage. We discussed this with the manager who told us the turns would have taken place as necessary but the carers had failed to complete the chart.

This contributed to the breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 referred to in the 'well-led' section of this report.

Staff were aware of people's changing needs. One person told us; "They notice the minute you are off colour." Daily record sheets were kept in care files which contained detailed bullet pointed information regarding key aspects of the persons care throughout the day. This helped prompt staff as to the kind of information they were required to document and gave a good overall picture of people's physical and emotional well-being.

An activities co-ordinator was employed three days a week between midday and four pm. Their role was to support people over the lunch time period and then spend time with people in the afternoon. The manager told us they would attempt to encourage people who preferred to stay in their rooms to socialise. If people were clear they preferred to spend most of their time in their rooms staff would spend time chatting with them to try and protect people from becoming isolated. In addition the kitchen assistant organised 'pampering sessions' helping people to have manicures and hand massages. During the inspection we saw the activities co-ordinator chatting with people on a one to one basis. We did not see any group activities taking place. The activities co-ordinator told us they had not had any training around working with people who had a diagnosis of dementia. People told us they were sometimes "bored." One person said they used to enjoy getting out but this was no longer possible. We discussed this with the activities co-ordinator who said they had relied on a community bus for outings but this had stopped running recently. Occasionally outside entertainers visited the service. For example in the week following the inspection a singer was booked to attend.

No-one had complained about the service in recent months. People told us if they did have any concerns they would be comfortable approaching the manager who everyone knew. There was a complaints policy on the wall in the managers' office. However this had not been updated and contained the names of previous managers.

We recommend that the service seek advice and guidance from a reputable source, about supporting people living with dementia to engage with meaningful activities.

Inadequate

Is the service well-led?

Our findings

Systems were not being operated effectively to assess and monitor the quality of the service provided. Audits were not completed for all aspects of the service, for example there was no system to audit falls. While any falls or other accidents were recorded in people's individual files there was no system in place to allow the manager to have an overview of incidents and audit them effectively. This meant they were unable to analyse information in order to identify trends and work towards improving the service.

Other audits were not effective; although a medicines audit had recently been carried out internally it had failed to identify shortfalls found at this inspection. A book to record medicines audits was kept in the medicines trolley. The last recorded audit in this book was in May 2015. We asked why the recent audit had not been recorded here and were told; "We don't use this book now."

During the inspection we found risks associated with the environment and equipment had not been assessed or action taken to mitigate risk. Two bedrooms on the upper floors had fire exits which opened on to fire escapes leading down to the car park. These were easily opened using a push bar. There was nothing to prevent the people using these rooms from exiting the building via these doors. There was no alarm system to alert staff if the doors were opened. The manager told us one of the rooms was occupied by someone with; "dubious capacity." The other room was occupied by someone who had poor eyesight. The fire door was directly adjacent to their bed. No risk assessments had been completed in regard to the fire exits. This meant people were not protected from risks associated with the environment. We discussed this with the manager and, following the inspection, the manager had key pad locks fitted to the fire doors to prevent them being opened inadvertently.

People were able to lock their doors using a privacy thumb turn lock typically used on bathroom doors. One person chose to lock their door when they were not using it. They used a table knife to operate the lock. The knife was left on a radiator in the corridor outside the room. Across the corridor was a bathroom used for storage. This was locked using the same kind of mechanism. Another knife was kept on top of the door frame for staff to access the room. A bedroom in the same corridor was occupied by someone who had a diagnosis of dementia. The manager told us they had a tendency to wander and take things from other people's rooms. The presence of knives in this area meant people were at risk of injury. Following the inspection we contacted the manager and they told us they had acquired a large washer which could be used to operate the bedroom door lock. This had been attached to a key chain and the person whose room it was had been given this to keep with them.

An unused laundry room in the Coach House was unlocked. On entering the room there was a steep concrete step almost immediately inside the door. This meant people entering the room who were unaware of the step were at risk of falling. The manager agreed this room would be kept locked in future.

The window in one bedroom, which was not occupied at the time of the inspection, had string around the handles which was being used in place of window restrictors to prevent the window being fully opened. This was not an effective method for keeping people safe. The windows in some bedrooms were cloudy which meant the occupant was unable to see out clearly. We discussed this with the manager who told us the windows were clean but the double glazing had 'blown.' There was no maintenance staff available to address issues such as this around the building.

Bedrooms had call bells fitted to enable people to summon assistance if required. This was an old pull cord system. In one room we saw the cord was positioned above the person's bed so they were able to use it during the night. However their mobility was restricted and during the day, when out of bed and sitting in the room, they could not easily or quickly, reach the cord. String had been tied to the pull cord, strung across the room at shoulder height, and attached to a chair to allow the person to access it. This meant there was a risk of walking into the string which could result in injury. Another person had coloured plastic protective aprons attached to their call bell cord which was above their bed. A relative told us this was because the person had poor vision and this aided their ability to locate and operate the call bell. This posed a suffocation hazard. We concluded there was not a robust or effective system in place to enable people to call for assistance when required. The measures taken to try and adapt the system had resulted in potential hazards in the environment. There was no risk assessment in place in respect of the use of the pull cord.

Inadequate

Is the service well-led?

There was no system in place to effectively monitor staff training needs. We were unable to establish how many staff members had completed all the training identified as required by the service without inspecting every staff file. The manager told us some staff had recently completed medicine training. However they were not able to tell us exactly who had completed this.

A file containing Personal Emergency Evacuation Plans for people living at Ismeer was kept in the managers' office. However information in the file was out of date. Some of the plans were in respect of people who no longer lived at the service. Other information was out of date and the manager told us that not everyone was included in the file. This meant the information could not be relied on in an emergency.

We identified concerns regarding the completion of people's records. As previously stated in this report the manager was planning to improve the format of care plans. Only one had been done at the time of the inspection and much of the information in the remaining care plans was out of date. As information was often not dated it was difficult to ascertain what was correct and what was out of date. The manager was aware information in people's care plans was out of date and therefore possibly incorrect. However, there was no clear plan of action in place to address this. For example, no specific time had been allocated to work on the care plans.

Information in the office regarding reporting safeguarding concerns and raising complaints was out of date and referred to managers who no longer worked at the service.

People living at the service and staff were not supported by a robust leadership culture or an effective management structure. The provider's representatives had not had a registered manager in post since January 2015. At the time of the inspection there was an acting manager in place but they had not applied to be registered manager. They told us they did not want to take legal responsibility for the service until; "All the ducks were in a row." The provider was unable to run the service due to ill-health and two of their family members had been appointed Lasting Power of Attorney (LPA) with responsibility to oversee the operation of Ismeer. The manager told us they had regular contact with one of these LPA representatives, who did not live in the UK, by telephone although they had not visited the service since May 2015. The manager told us the second LPA representative had; "backed off completely" and was no longer involved with the service. The manager was not receiving any supervision or training support. This meant there was inadequate oversight of the service by any responsible person(s) on behalf of the provider.

The provider is required by law to submit notifications to CQC of significant events such as injury or any safeguarding concerns. We found that the provider had failed to send in notifications which they should have sent us.

We found there was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The manager had taken up the role following the sudden departure of the previous manager. There was no deputy manager in place or any administration support. There were no clear lines of accountability or responsibility within the staff team. For example there was no key worker system whereby staff members are assigned to work closely with people and take responsibility for their plan of care. There were no senior staff roles. This meant that, in the event the manager was absent from work for a period of time, there would be no system to ensure people were supported by a well-managed staff team.

This contributed to the breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 referred to in the 'effective' section of this report.

In the week following the inspection the provider's representative visited the service as had previously been arranged. We spoke with the manager who told us they had discussed the management arrangements. Plans were being put in place to create a more structured management of the service with the recruitment of a deputy manager and administration worker. They were also planning to recruit a maintenance worker to help ensure any repairs were carried out in a timely fashion.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent How the regulation was not being met: The provider did not ensure the requirements of the Mental Capacity Act (2005) were adhered to when people were unable to give consent because they lacked capacity to do so.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met: Care and treatment was not provided in a safe way. There was not a safe or proper system in place to manage medicines. People were not adequately protected from the risk of infection. Regulation 12 (1)(2)(g)(h)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing How the regulation was not being met: There were not sufficient numbers of suitably qualified, competent, skilled and experienced persons deployed. Staff did not receive the appropriate support, training, professional development, supervision and appraisal as necessary to enable them to carry out the duties they were employed to perform. Regulation 18 (1) (2)(a)

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met: Systems and processes were not established or operated effectively in order to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity. Regulation 17 (1) (2)(a)

The enforcement action we took:
A Warning Notice was served. We have asked the provider to meet the requirements of the Warning Notice by 18 November 2015.