Mrs Michelle Roberts

Gadlas Hall Nursing Home

Inspection report

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Ratings

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

Overall summary

This inspection took place on 24 October, 18 and 19 November 2014 and was unannounced. At our previous inspection in January 2014, we found the service compliant with the regulations that we looked at.

On 22 October 2014, the local authority shared concerns about people's care and treatment. On 24 October 2014, we carried out a joint inspection with the local authority, continuing health care and the police. We found that people did not receive safe, appropriate care and treatment. The local authority has stopped further placements at the home until the provider makes improvements to ensure people receive the appropriate care, support and treatment.

Gadlas Hall provides accommodation, nursing and personal care for older people and people living with dementia. This home is registered to provide a service for 29 people; on the days of our inspection 26 people were living there.

The home had a registered manager in post who was present for our inspection. A registered manager is a

Summary of findings

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. The registered manager at this service was also the registered provider.

At our inspection on 18 and 19 November 2014, we found that the provider had not taken sufficient action to address the concerns identified during our inspection on 24 October 2014 and people's care, support and treatment needs were not being met.

During our inspection on 24 October 2014, we found that staff were not always available to assist people with their care and support needs. At our inspection on 18 and 19 November 2014, we found that the provider had not taken any action to ensure staff were always available to assist people when needed.

Staff were not always available to support people with their care needs. For example, people were not always supported each morning to get out of bed. This did not help people living with dementia to know the difference between night and day and increased the risk of people developing skin damage. Staff were not responsive to people's needs and we observed that this caused one person to become distressed. This was also acknowledged by a care staff and the provider.

On 22 October 2014, the local authority shared information about inadequate management of pressure sores. At our inspection on 18 and 19 November 2014, we found that the provider had taken the necessary action to ensure that people received the appropriate wound care.

During our inspection on 24 October 2014, we found that the management of people's prescribed medicines was not robust and placed people's health at risk. At our inspection on 18 and 19 November 2014, we found that the provider had not taken sufficient action to improve the management of medicines.

Risk assessments were in place to tell staff how to support people safely. However, we found that although accidents had been recorded the provider had not taken any action to reduce the risk of further accidents. This was of concern as the provider told us that seven people were receiving treatment for injuries after sustaining a fall.

At our inspection on 24 October 2014, we found that people were not provided with support to eat and drink enough. During our inspection on 18 and 19 November 2014, we found that the provider had not taken any action to ensure people were provided with support to eat sufficient amounts. However, people were complimentary about the food and choices available to them.

The staff we spoke with understood their responsibility of sharing concerns about abuse with the provider. However, we found that the provider had not maintained a record of safeguarding referrals or to show what action had been taken to protect people from further harm.

The provider told us that staff had access to on-going training and this was confirmed by the staff we spoke with. However, a number of people who used the service were living with dementia. We found that not all staff had received dementia awareness training. We saw that not all staff showed a caring approach or patience with people living with dementia.

During our inspection on 24 October 2014, we found that medical intervention was not obtained for people when required. At our inspection on 18 and 19 November 2014, the people we spoke with and the care records we looked at showed that people had access to other healthcare services. However, we found that people were not always involved in decisions about their care and treatment.

People told us that they were able to maintain contact with people important to them. One relative said they were able to visit the home at any time.

The provider told us that they had not received any complaints. However, we found that people were not provided with information about how and who to share their concerns with. The provider acknowledged that there were no arrangements in place to enable people to express their concerns.

On 22 October 2014, the local authority shared concerns about the home being cold. On the first day of our inspection on 18 November 2014, the home was cold. The provider had not taken any action to monitor the heating

Summary of findings

within the home. The provider said there were no quality monitoring audit systems in place to address the concerns identified at our inspection on 24 October 2014.

People remained at risk of receiving a service that was unsafe and ineffective. There was no clear leadership and we found that not everyone who used the service were aware of who the registered manager and provider was.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Staff were not always available to assist people with their care needs when required.

The management of people's prescribed medicines were not robust and placed people's health at risk.

The provider did not take action to ensure people were not placed at further risk of abuse.

Accidents and incidents within the home were not monitored or acted on to reduce further risks to people.

Is the service effective?

Requires Improvement

The service was not effective.

People were complimentary about the meals provided.

Staff were aware of people's care needs but confirmed that people's request for support was not always responded to.

The environment was unsuitable for people living with dementia and placed them at risk.

People were not involved in making important decisions about their care and treatment. Best interest meetings were not always carried out.

Staff were unaware of people who had a DoLS in place and this placed people at risk of receiving inadequate support.

People had access to other healthcare services when needed.

Is the service caring?

Requires Improvement

This service was not consistently caring.

People were not always provided with support in a friendly, caring and sympathetic manner.

People were not involved in the review of their care plan or asked how they would like to be cared for to ensure they received care and support the way they liked.

Is the service responsive?

Inadequate

The service was not responsive.

Staff were not responsive to information identified in care plans so individual care needs were not met.

Summary of findings

There were no arrangements in place to enable people to tell the provider about their experiences of using the service or to share their concerns.

People were not always provided with support to pursue their hobbies and interests.

Is the service well-led?

Inadequate

The service was not well-led.

The provider had not acted on concerns we had identified on 24 October 2014. On 18 and 19 November 2014, we continued to find these shortfalls.

There were no arrangements in place to monitor the care, support and treatment people received.

There was no clear leadership to ensure the effective running of the home.

The provider had not maintained accurate records of deaths within the home.

Gadlas Hall Nursing Home

Detailed findings

Background to this inspection

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

We carried out an inspection on 24 October 2014 and found that people's support, care and treatment needs were not being met. We carried out a further inspection on 18 and 19 November 2014. This inspection was unannounced.

The inspection team consisted of two inspectors, a pharmacist inspector, a specialist advisor and an expert by experience. The specialist advisor had experience and expertise in elderly care. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert by experience was experienced in caring for an elderly person and also lived in a residential home.

Before our inspection we spoke with the local authority to share information they held about the home. The local authority was closely monitoring the service because of concerns relating to people's care and welfare. We also looked at our own systems to see if we had received any concerns or compliments about the home. We analysed information on statutory notifications we had received from the provider. A statutory notification is information about important events which the provider is required to send us by law. We used this information to help us plan our inspection of the home.

On the day of our inspection we spoke with six people who used the service, one relative, four care staff, an activities coordinator, the cook, a kitchen assistant, one nurse, the deputy manager and the registered manager who was also the registered provider. We looked at three care plans, two risk assessments, nine medication administration records and accident reports.

During our inspection 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 live at the home. We used this because some people living at Gadlas Hall were unable to tell us in detail what it was like to live there. We also used it to record and analyse how people spent their time and how effective staff interactions were with people.

Inadequate

Is the service safe?

Our findings

During our inspection on 24 October 2014, we saw seven people in the lounge all with various care needs. There were no staff available to support people when needed and they did not have access to a call bell to ask for assistance. We heard one person calling for assistance but there were no staff available to assist them. On 18 and 19 November 2014, we continued to find that staff were not always available to assist people when needed. For example, we saw three people in the lounge. There were no staff nearby to provide supervision or assistance when needed. This was of concern because these people lacked mental capacity to ask for support and this placed their welfare at risk.

One staff member told us that there were not enough staff available to get everyone up in the morning. The deputy manager informed us that two people were cared for in bed due to their health condition. However, we saw six people in bed. The provider was unable to explain why these people were left in bed. This did not support people living with dementia to understand the difference between night and day. This also placed people at risk of developing pressure sores. However, the provider confirmed that no one had a pressure sore. Due to people's lack of mental capacity they were unable to tell us if it was their choice to stay in bed. The provider said that due to insufficient funds they were unable to increase the staffing levels. This placed people at risk of inadequate care and support.

At our inspection on 24 October 2014, we found that people were not provided with sufficient support to eat and drink. For example, we saw one person having difficulty eating their meal and the majority of their meal had dropped on the floor. This person was not provided with assistance to eat and drink enough. On 18 and 19 November 2014, we continued to find that staff were not always available to assist people with their meals. We saw that one person was not provided with support to eat their breakfast, although their care plan showed that they may need some support with their meal. We saw another person sat at the dining table, their breakfast was placed out of their reach, so they were unable to eat it. A member of the inspection team placed the person's plate in front of them so they could reach their food. The provider was unable to give an explanation why there were no staff present to assist people with their breakfast. We heard one person ask for a drink and this was not provided to them. Twenty five minutes later the person became agitated and told us that they were going to find someone to make them a drink. We shared this information with the provider who told us that this person constantly requested a drink.

This was a breach of Regulation 22 of the Health and social Care Act 2008 (Regulated Activities) Regulations 2010.

At our inspection on 24 October 2014, we found that the management of people's prescribed medicines was unsafe. At our inspection on 18 and 19 November 2014, we found that the provider had not taken sufficient action to improve the management of medicines.

We looked at nine medication administration records (MAR). A MAR is a record of people's prescribed treatment that staff signed to show when people had been given their medicines. We found that two people had not received their medicines because the provider had not obtained the necessary supply of medicines. The MAR showed that these two people had not received their prescribed treatment for three days. We found that three people had been prescribed medicines that needed to be inhaled. They were not provided with the necessary support to ensure they received these medicines at the intervals identified by the prescriber. This placed their health at risk.

We found that one person had been prescribed an analgesic patch. These were prescribed for the management of pain. Instructions from the prescriber showed that these patches should be changed every seven days. However, records showed and the supplies in stock indicated that the patch had not been changed for 11 days. The person had not received their planned treatment to manage their pain. Records showed that people's medicated patches were not being applied to the skin appropriately. The nurse responsible for the management of medicines was unable to confirm whether these medicated patches had been applied appropriately and that staff had failed to record this.

During our inspection on 24 October 2014, we found that 'when required' medicines were not managed safely. 'When required' medicines are prescribed to be given only when needed. For example, medicines prescribed to the treatment of pain relief. We found at our inspection on 18

Inadequate

Is the service safe?

and 19 November 2014, the provider had not taken any action to improve the safe management of these medicines. The nurse in charge would not provide us with information about how these medicines were managed.

We found that medicines stored in the fridge were not maintained at the correct temperature as recommended by the pharmaceutical manufacturers. This placed people at risk of receiving medicines that were unsuitable for use. Accurate records were not maintained of medicines that had been disposed of. The provider was unable to demonstrate that medicines were managed safely.

This was a breach of Regulation 13 of the Health and social Care Act 2008 (Regulated Activities) Regulations 2010.

One person who used the service said, "I feel safe here. There has never been any trouble." Another person told us, "I feel safe here; I am looked after incredibly well. The staff are like my family." The provider said that staff had received safeguarding training and this was confirmed by the staff we spoke with. The staff we spoke with confirmed their understanding about various forms of abuse. They told us that they would share any concerns of abuse with the nurse in charge or the manager to protect people from further harm. However, the provider told us that a record of safeguarding referrals was not maintained. For example, at our inspection on 24 October 2014, we shared concerns with the local authority about a person who had not received their prescribed treatment and the impact this had on their health. At our inspection on 18 and 19 November 2014, the provider had not recorded this information and was unable to tell us what action had been taken to safeguard the person from further harm. We looked at the person's medication administration record and found that they were receiving their prescribed treatment.

Risk assessments were in place to provide staff with information about how to support people in a safe manner and to reduce the risk of injury. For example, one care record contained a risk assessment to tell staff how to assist the person with their mobility. The risk assessment provided information about the appropriate equipment required to support the person. We also saw staff using this equipment. However, we found that accidents and incidents were not monitored to find out if there were any trends or to reduce the reoccurrence of accidents. This was of concern because the provider told us that seven people were receiving treatment for wounds sustained from falls.

The provider told us that the home's recruitment process ensured that all staff had the appropriate safety checks before they started to work at the home and this was confirmed by the staff we spoke with. This process ensured that staff were of suitable character to work at the home.

Requires Improvement

Is the service effective?

Our findings

We found that the environment was unsuitable for people living with dementia. For example, we saw an orientation board located in the lounge/dining room. This board was to assist people living with dementia to remember what day it was. We found that the date was incorrect and would not support people with a memory loss. We found that signs around the home were confusing. For example, one sign on a door was identified as the bathroom but this was a storage room. The flooring was patterned and one care staff told us that this confused one person living with dementia, who tried to pick the pattern off the carpet thinking they were flowers. This placed the person at risk of falls.

We saw a brown matter on the floor in the corridor and saw four care staff walk pass it. Discussions with two care staff confirmed that cat always defecated in the home. One care staff raised concerns that one person living with dementia often picked items off the floor and the cat defecating on the floor placed their health at risk. We found that paving stones leading to the home were slippery due to the growth of moss and placed people at risk of falls. The provider said that the person who maintained the property was on leave and this would be addressed when they returned. However, we saw that people frequently accessed the grounds and this placed them at immediate risk of harm. Prompt action had not been taken to reduce the risk to people.

This was a breach of Regulation 15 of the Health and social Care Act 2008 (Regulated Activities) Regulations 2010.

We found that some staff had a good understanding of the Mental Capacity Act 2005 (MCA) and the deprivation of Liberty Safeguards (DoLS). The MCA ensures that the human rights of people who may lack mental capacity to make a decision about their care and treatment are protected. DoLS are required when this includes depriving a person of their liberty to ensure they receive the appropriate care and treatment. The provider told us that DoLS were in place for four people and three applications had recently been sent to the local authority. The provider told us that staff were informed of people who had a DoLS in place during handover at the beginning of each working shift. However, we found that not all the staff were aware of what people had a DoLS in place. This placed people at risk of not receiving adequate care and support.

We found that there were a number of 'do not attempt resuscitation' (DNAR) forms in place. A DNAR tells staff and members of the emergency medical team that the person should not be resuscitated if they stopped breathing. The provider confirmed that the majority of people who used the service had a DNAR in place. We did not see any evidence of a best interest meeting to show that the decision made was in the person's best interest, where people did not have capacity to consent. The provider confirmed that best interest meetings had not been carried out. This meant people were not involved in decisions about their treatment.

This was a breach of Regulation 17 of the Health and social Care Act 2008 (Regulated Activities) Regulations 2010.

One person who used the service said, "The food is very good and we have a choice. The staff tell us what's on offer." Another person told us, "We are able to have a drink when we want one. The food is very good and there is a good choice." Staff were available to assist people with their lunch and we observed good practices where people were supported with their meal in a caring and dignified manner and people were not rushed.

We found that the cook in charge had a good understanding of what people required to eat and drink with regards to their health condition and their likes and dislikes. We saw that a record was maintained in the kitchen of meals suitable for the individual. For example, people who required a soft diet due to swallowing difficulties.

The provider told us that staff were provided with on-going training and this was confirmed by the staff we spoke with. One care staff told us that they had received training in safeguarding and moving and handling. The provider confirmed that a number of people who used the service were living with dementia. We found that not all care staff had received dementia awareness training to ensure they had the skills and competence to care for people with this health condition. One care staff said, "I have not had any training about dementia awareness or how to manage people's behaviours." We saw one person living with dementia was distressed and a care staff nearby did not offer them any reassurance. We saw very little interaction between people who used the service and staff.

The provider confirmed that formal supervision sessions were carried out with staff. The staff we spoke with also

Requires Improvement

Is the service effective?

confirmed this. One staff member told us that the provider was very supportive and that they found their supervision helped them to know more about people who used the service and the support they required. They said supervision also helped them to understand their role. Supervision is a process to support and guide staff in their role to ensure they have the skills to care for people properly. The provider confirmed that all new staff were provided with an induction and this was confirmed by the staff we spoke with. One staff said during their induction they worked with an experienced care staff which helped them to understand their role. Induction is a process to ensure that new staff are supported within their new role and to ensure they have the appropriate skills to do their job.

During our inspection on 24 October 2014, we found that a nurse manager from the clinical commissioning group (CCG) had asked the provider to arrange a GP to visit one person who used the service. However, no action had been taken by the provider and the required treatment was delayed. At our inspection on 18 and 19 November 2014, one person who used the service said that staff always called the GP when needed and they had access to other healthcare services for routine health screening. The provider told us that people did have access to other healthcare professionals when required to maintain good health. The care records we looked at confirmed this. For example, one care record showed the person had access to a GP and a community psychiatric nurse (CPN) when needed.

Requires Improvement

Is the service caring?

Our findings

One person who used the service said, “The staff are very caring and pleasant, they are more like your friends.” Another person told us, “I can’t fault the care here.” The people we spoke with were complimentary about the care and the support they had received. However, we found that not all staff interacted with people in a kind and caring manner.

During our inspection 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 use the service. We used this because some people were unable to tell us in detail what it was like to live at the home.

We found that not all staff showed a caring approach to people. For example, one person requested the attention of a care staff and the care staff replied, “I can’t talk now I have notes to write up.” We heard another person trying to talk to the same care staff several times and they were ignored.

There was very little staff presence in the lounge. We saw staff walk through the lounge without interacting with people. One person living with dementia was talking repetitively and was distressed. Although a care staff was present, this person was not provided with any reassurance. We found that some staff spoke to people in an unfriendly manner. However, we also saw some good practices, for example, one person sat at the table with a care staff. The care staff spoke with the person in a caring and kind manner. We saw that the cook was caring and compassionate when waking a person gently and asked them if they wanted a drink. We saw that each time the cook entered the lounge they took the time to respond to people when spoken to.

There were no arrangements in place to enable people to express their views or to be involved in making decisions about their care. The people we spoke with were unaware of their care plan but said they were happy with the care provided. People confirmed that they had never been asked how they would like to be cared for. One relative told us that they were informed of any changes to their relative’s care needs. They said, “The care is good but sometimes staff don’t seem organised and don’t work as a team but this doesn’t really affect the care provided to my relative.” They continued to say, “I would recommend the home although it is not perfect.”

A number of people who used the service lacked mental capacity due to their health condition. The provider told us that people did not have access to a self advocacy service; to represent the individual and ensure decisions made were in the person’s best interest. A self advocacy service helps people to have a say about their care, treatment and support and represents their interests. This placed people at risk of not having the relevant support or assistance to make important decisions.

The people we spoke with said that staff respected their privacy and dignity. One person said, “The staff always knock my door before entering my bedroom.” We saw two staff support a person with their mobility in a dignified manner. We heard a care staff ask a person’s permission for a member of the inspection team to be present whilst they were being assisted with their meal. We saw the same care staff giving a person a tissue in a discrete manner to enable them to clean their face and maintain their dignity. People were able to have visitors when they liked. One person said, “I am able to maintain contact with my family and friends and have access to a telephone when needed.” A relative told us that they were able to visit their relative at any time and there were no restrictions. This enabled people to maintain contact with people important to them.

Inadequate

Is the service responsive?

Our findings

We found that staff were not responsive to people's basic needs. For example, discussions with the provider and the care plan we looked at showed that one person was living with dementia. We heard this person tell a care staff that they needed support with their personal care needs. We heard the care staff say, "It's there" (they pointed towards the toilet) and the care staff walked away. The person became distressed and asked a member of the inspection team for support. One care staff raised concerns with the inspector for allowing the person to use the 'staff' toilet. No empathy was shown for the person or concerns that their care needs had not been met.

We saw two care staff assist a person into an armchair at 8.30am. The person looked uncomfortable and their feet were not touching the floor. We heard the person tell the staff that they disliked the chair and felt uncomfortable. The staff told the person that they would change the chair. Staff did not take any action to ensure the person's comfort. We saw that that person's request had not been carried out. We shared this information with the deputy manager who said the person had refused to be moved. However, the person had not been provided with a footstool to ensure their comfort. The deputy manager said the person often refused this. We found that there was no information in the person's care plan about the appropriate chair to be used or how to ensure the person's comfort.

We found that staff were not responsive to people assessed needs. For example, we heard one person ask for support to pursue an activity. A care staff told them that they would return in two minutes to assist them but the staff did not return. We heard the person ask a further two care staff for support. Both staff provided the person with a timeframe of when they would return to assist them. We saw the person get anxious and distressed because they had not been provided with the support they required. We looked at the person's care plan that showed that they responded well to timeframes. We spoke with two care staff who were aware of this and acknowledged that staff did not always follow the information contained in the care plan. The provider told us that the person would become distressed if these timeframes were not followed. One care staff had a good understanding of person centred care. They told us that this person's needs were not being met and this lead to behaviours that were challenging.

This was a breach of Regulation 9 of the Health and social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider told us that during the admission process an assessment of people's care needs was carried out and people were asked about their care and support needs. However, there was no evidence that people were involved in the review of their care and support needs. The people we spoke with told us that they had never been asked how they would like to be cared for. This placed people at risk of not receiving care and support the way they like. Further discussions with the provider confirmed that there were no systems in place to enable people to express their views about their care and treatment. People were not empowered to have a say about the service they received.

This was a breach of Regulation 17 of the Health and social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider said they had not received any complaints. However, we found that there were no arrangements in place to enable people to share their concerns. The provider told us that people did not have access to a complaints procedure. We spoke with a relative who said they had never made a complaint. They told us that they were unaware of the home's complaint procedure and was unsure who to share concerns with. One person who used the service told us that they had never made a complaint but they were confident that if they had any concerns the staff would address this.

This was a breach of Regulation 19 of the Health and social Care Act 2008 (Regulated Activities) Regulations 2010.

People were not provided with support to pursue their interests and hobbies. One person said, "There is not much to do. Occasionally I go for a stroll around the grounds. Sometimes I go to Oswestry for breakfast." We did not observe any social activities taking place during the inspection. Discussions with the activities coordinator confirmed that activities consisted of people watching films, listening to music, playing skittles and going for short walks. They told us that there were not enough staff to take people out and they were reliant on families and friends to do this.

The local authority shared concerns with us about inadequate management of pressure sores. We found that the provider had taken action to monitor and treat pressure sores. For example, one care record we looked at contained a wound assessment. This assessment provided

Inadequate

Is the service responsive?

staff with information about the size of the wound, the condition of the skin, medicines and dressings used to treat the wound. The healing process was recorded to show the decrease in the size of the wound. The provider said that no one in the home had a pressure sore. However, seven people were receiving treatment for skin damage sustained by falls. People could be confident that the appropriate measures had been taken to ensure that they received the appropriate wound care and treatment.

Inadequate

Is the service well-led?

Our findings

On 22 October 2014, the local authority had shared concerns about the home being cold. On 24 October 2014, when we inspected, the temperature of the home was appropriate. However, on 18 November 2014, when we returned to inspect, we found the home was cold. The provider told us that one person who used the service often turned the radiators off. However, we found that the provider had not taken any action to carry out routine monitoring of the temperatures in the home. This was of concern as a number of people who used the service did not have the mental capacity to say if they were feeling cold. This placed people's health at risk and showed a lack of action by the provider following the initial feedback provided.

We found other issues which had been highlighted to the provider had not been addressed promptly. For example, at our inspection on 24 October 2014, we found that the management of people's prescribed medicines was not robust and some people did not receive their prescribed treatment. During our inspection on 18 and 19 November 2014, we found that the provider had not taken sufficient measures to improve the management of medicines and some people were still not receiving their prescribed treatment.

The provider told us that they did not have any monitoring systems in place to ensure that sufficient staffing levels were provided to meet people's assessed needs at all times. We found that staff were not always available to assist people when needed and the provider acknowledged this. This placed people at risk of receiving inadequate care and support. Additionally, we found that the nurse call bells were not always accessible for people to ask for support. We found that action had not been taken to address this. The provider said that staff meetings were arranged but the attendance was poor. This was confirmed by the care staff with spoke with. A care staff said, "We have staff meetings quite often and discuss concerns. These concerns are usually about not having enough staff because staff keep going off sick, but nothing has been done about it."

One person who used the service was unaware of who the registered manager was. They told us that they had lived at the home for two years. They said, "We have a matron but I am not sure who that is. All the staff seem to be equal." We spoke with a relative who told us that they visited the home on a regular basis and they were unaware of who the registered manager was. One care staff told us, "I think the manager is great and approachable. I feel comfortable to raise any concerns with them." Although staff told us that the management team were supportive, the home did not have a clear, stable management and leadership structure that people who used the service understood.

The staff we spoke with were aware of the home's whistleblowing policy and told us that they would feel confident to share concerns of poor practices with the provider. Although we found shortfalls with the service provided to people. One care staff told us that the standard of care provided was 'brilliant' but was unable to provide us with examples of good care. We saw that not all the staff interacted with people in a caring manner. For example, we saw one staff ignore people who were distressed. This meant that staff may not recognise poor care.

This was a breach of Regulation 10 of the Health and social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider has a legal responsibility to inform us of deaths within the home. We looked the records that the provider had maintained with names and dates people had died. We found that for some people the date of the death had not been recorded. We shared this information with the provider who said they were unaware of who these people were. The provider was unable to demonstrate that records of deaths in the home were accurate or whether we had been notified of all of the deaths.

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 19 HSCA 2008 (Regulated Activities) Regulations 2010 Complaints How the regulation was not being met: There were no arrangements in place to enable people to share their concerns about the service they had received.

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 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises The home was unsuitable for people living with dementia. Inappropriate flooring in the home and slippery paving stones in the garden placed people at risk of falls.

The enforcement action we took:
We are considering further enforcement action and will report on this when it has been completed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing There were insufficient staffing provided to ensure that people's assessed needs were met.

The enforcement action we took:
We are considering further enforcement action and will report on this when it has been completed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines The management of medicines was not robust to ensure that people received their treatment as directed by the prescriber. The inappropriate storage of medicines meant that medicines may be unsuitable for use. The provider was unable to demonstrate that unwanted medicines had been disposed of safely.

The enforcement action we took:
We are considering further enforcement action and will report on this when it has been completed.

Regulated activity	Regulation

This section is primarily information for the provider

Enforcement actions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services People were not always involved in decisions about their care, support and treatment needs.

The enforcement action we took:
We are considering further enforcement action and will report on this when it has been completed.

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 People were not always provided with relevant support to ensure that their basic care, support and treatment needs were met.

The enforcement action we took:
We are considering further enforcement action and will report on this when it has been completed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision The provider had not addressed concerns identified at our inspection on 24 October 2014. There were no arrangements or systems in place to ensure that people received a safe and effective service.

The enforcement action we took:
We are considering further enforcement action and will report on this when it has been completed.