Elder Homes Bingley LLP

St Ives Disabled Care Centre

Inspection report

St Ives Estate
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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?	Requires Improvement
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Overall summary

The inspection was carried out over two days. It started on 26 November 2014 with an unannounced evening visit between the hours of 6.45pm and 10pm and resumed at 8am on 27 November 2014.

The last inspection was in March 2014 and the service was meeting the regulations we inspected.

St Ives provides nursing and personal care for people with physical disabilities; the majority of people using the service are under pension age. The home is a converted listed building and is located in the St Ives Estate close to Bingley. Accommodation is provided on four floors, there are single and shared rooms and many have en-suite facilities. There are three communal areas on the ground floor and there is also a lounge on the first floor.

The home has a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like

Summary of findings

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.

There were not always enough staff to meet people's needs. The system the provider used to decide how many staff they needed was not reliable and this created a risk people would not get the right care.

People who used the service told us they felt safe at St Ives. The required checks to make sure staff were suitable to work in a care home were done before new staff started work. Staff who had recently started working at the home told us they had been given induction training which prepared them to carry out their roles. After induction there was a planned programme of training for all staff. Although some staff were overdue for training we found this was being dealt with.

The home was clean and well maintained. Some staff were not aware of the correct evacuation procedures and there had been no fire drills for the night staff.

Medicines were managed safely and people told us they received their medicines correctly.

Some people said they did not always get enough to eat and the arrangements for providing people with snacks overnight were not adequate. We observed meal times and found there was a lack of consideration and respect in the way some people were supported to eat and drink.

The legal requirements relating to Deprivation of Liberty Safeguards (DoLS) were being met.

People were supported to meet their health care needs and had access to the full range of NHS services.

The majority of staff were kind and caring in their interactions with people, however, we found most interactions were linked to tasks such as supporting people with personal care. Activities were offered but they were not person centred and there was little evidence of people being supported to develop independent living skills. The location of the service made it difficult for people to become involved in the local community because the home did not have their own transport.

Most people were involved in planning and reviewing their care, however, people's care was not always planned and delivered in such a way as to meet their individual needs and preferences. Where it was appropriate people were supported to obtain the services of an advocate.

People knew how to make a complaint and complaints were recorded and dealt with. However, people living at the home said they did not feel the provider always listened to them or took their concerns seriously.

The systems in place for assessing and monitoring the quality of the services provided were not always effective in identifying shortfalls in the service and risks to people's health, safety and welfare.

We identified a number of areas where the provider was not meeting the requirements of the law. You can see what action we told the provider to take 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 always safe.

The service did not always have enough staff to meet the needs of people who lived there. The provider did not have an effective way of checking they had enough staff to meet people's assessed needs.

People who used the service told us they felt safe. The required checks were done before new staff started work.

The service was clean and well maintained. There had been no fire drills for the night staff and some staff were not aware of the correct evacuation procedures.

People received their medicines correctly.

Is the service effective?

Requires Improvement

The service was not always effective.

There was a planned programme of staff training and although some staff were overdue for training this was being dealt with.

People's nutritional needs were not always met. Some people said they did not always get enough to eat and the arrangements for providing people with snacks overnight were not adequate.

The legal requirements relating to Deprivation of Liberty Safeguards (DoLS) were being met.

People were supported to access health care services to meet their individual needs.

Is the service caring?

Requires Improvement

The service was not always caring.

During the morning we observed staff were kind and caring when they spoke with people who used the service. However, while observing meal service we saw some people were not treated with consideration and respect.

There were suitable arrangements in place to support people to have access to advocacy services when necessary.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Most people were involved in planning and reviewing their care, however, people's care was not always planned and delivered in such a way as to meet their individual needs and preferences.

Summary of findings

People were not always given the support they needed to develop independent living skills and follow their interests.

People knew how to make a complaint and complaints were recorded and dealt with.

Is the service well-led?

The service was not consistently well led.

People who used the service said they did not feel the provider always listened to them or took their concerns seriously. Staff told us the manager was approachable however they didn't always feel action was taken in response to their concerns.

The systems in place for assessing and monitoring the quality of the services provided were not always effective in identifying shortfalls in the service and risks to people's health, safety and welfare.

Requires Improvement

St Ives Disabled Care Centre

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.

The inspection started on 26 November 2014 with an unannounced visit which was carried out between 6.45pm and 10pm. The inspection resumed at 8am on 27 November 2014.

The inspection team was made up of four adult social care inspectors and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. On this occasion our expert's experience was in the area of physical disability.

Before the inspection we reviewed the information we held about the home. This included information from the provider, notifications and speaking with the local authority contracts and safeguarding teams. It also included information of concern which we received from relatives and/or friends of people who had used the service and concerns which had been raised through our whistle blowing processes.

In the course of the inspection we spoke with ten people who used the service, three relatives and one visiting health care professional. We spoke with five care staff, two nurses, the clinical lead nurse, a cook, one of the housekeeping staff, the maintenance man, the registered manager and one of the area managers.

We spent time observing how people were supported and cared for in in the lounges and observed the meal service in the dining room at breakfast and lunch time. We looked around the building including a random selection of people's bedrooms, communal bathrooms and toilets and the lounges and dining room. We looked at records which included three people's care plans, medication records, staff recruitment and training records, records relating to the management of the home and policies and procedures.

Before our inspections we usually ask the provider to send us a provider information return (PIR). This 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. We did not ask the provider to complete a PIR on this occasion because we planned the inspection at short notice.

Requires Improvement

Is the service safe?

Our findings

People living at St. Ives Disabled Care Centre had varying degrees of profound multiple disabilities which included impairments of vision and movement, epilepsy, schizophrenia and inherited neurological disorders. Before the inspection we received information of concern about the staffing levels, in particular that there were not always enough staff on night duty to meet people's needs.

We reviewed the staffing rota for the four week period immediately prior to our inspection. The manager told us there should be ten care staff on duty during the day, this included two registered nurses. In practice we found these staffing levels were regularly not met due to a combination of factors which included staff being absent at short notice. This meant there was a risk people's assessed care needs were not consistently being met. The registered manager confirmed that staff absence, particularly at short notice, caused disruption to the service. The registered manager told us they tried to minimise the disruption by asking existing staff to work extra hours and/or by using agency staff. They told us they were also developing a pool of bank staff that would be available to work at short notice to cover absence. This development was planned to coincide with the providers declared intention to reduce agency staff expenditure.

The registered manager told us there should be five staff on duty at night, four care staff and one registered nurse. In practice we found this did not always happen. For example, on the first evening of the inspection, 26 November 2014, we found there were four staff on duty in the home overnight, from 8pm to 8am. There were 34 people in the home that night and the clinical lead nurse told us 20 people needed a hoist to help them move/transfer which meant they needed two staff to support them.

The nurse in charge told us they would be kept busy with administering people's medication until nearly midnight. They explained at least seven people had their medications administered via a PEG (Percutaneous endoscopic gastrostomy) feeding tube which took more time. That meant there were three care staff available to provide people with the care and support they needed which included helping people to get ready and go to bed.

The registered manager told us the service was working with four night staff because nine people were away on holiday. We looked at the duty rota for the previous week when there were 43 people living in the home. We found on two occasions, 17 and 23 November 2014, there were three care staff on duty when there should have been four. Similarly the rota for the week commencing 10 November 2014 showed that on four of the seven nights the home did not have four care staff on duty. This showed us the service was consistently not ensuring there were enough staff on duty to meet people's needs.

When we looked at people's care plans we found some people needed a significant level of care during the night. This included people on 15 minute observations, and others on hourly observations. Actions recorded in care plans demonstrated that these observations commonly required a period of direct care such as supporting people with assessed tissue viability risks to change their position. Our observations of care plans coupled with the general lay-out of the building suggested that the provision of five staff for a night shift was inadequate.

We asked the registered manager what planning tool they used to determine the correct staffing levels. They told us the provider used a computerised staffing model based on the recorded dependency of each person living in the home. We asked the registered manager to demonstrate how the model worked and when the information was entered the result was that the service needed staff hours well in excess of the hours provided. The result was also well in excess of what the registered manager said they thought was necessary to meet people's needs. The planning tool demonstrated the need for around 2000 hours of care staff per week whilst in practice 1100 hours were budgeted for. We concluded that while the principles of the planning tool were sound it was, in practice, not fit for purpose. This meant the provider was not able to demonstrate that the numbers of staff on duty were sufficient to meet the care needs of people using the service.

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

We looked at a selection of maintenance and servicing records relating to gas, electricity, water, lifts and hoists and they were up to date.

The service was inspected by West Yorkshire Fire and Rescue Service in July 2014 and a number of

Is the service safe?

recommendations had been made. Areas identified for improvement included the fire risk assessment and staff training. The registered manager told us action was being taken to address the recommendations.

On the first day of the inspection we asked the nurse in charge on night duty about the fire safety procedures. They told us in the event of a fire they would evacuate people to an area outside the building. On the second day of the inspection we asked care staff and the registered manager the same question. They told us they would move people within the building to another fire compartment making sure they were two fire doors away from the area where the fire was. This is called horizontal evacuation and is recommended by the fire service as best practice. We looked at the fire drill records and could not find any record to show when the night staff had last taken part in a fire drill. We discussed this with the registered manager and they said they would arrange a night staff drill as a matter of urgency.

This showed the provider did not have suitable arrangements in place to protect people in the event of a fire. This was a breach of Regulation 9 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Following the inspection the registered manager confirmed fire drills had been carried out with the night staff.

People told us they felt safe living at St. Ives. They said the staff treated them well and were never rude or unpleasant. The training records showed staff had received safeguarding training and the staff we spoke with confirmed this. The staff we spoke with were aware of the different types of abuse and told us they would have no hesitation in reporting something if they suspected abuse. The registered manager was aware of the safeguarding procedures and the requirement to notify the Commission about any allegations or suspicions of abuse.

We looked at a random selection of staff files and they showed the relevant checks were carried out before an offer of employment was made. These included a full employment history, proof of identity and two references. The manager told us they obtained Disclosure and Barring Service certificates before new staff started work, this was confirmed by the records and the staff we spoke with. We found the service carried out checks to make sure nursing staff were registered with the Nursing and Midwifery Council (NMC) before they were employed. Once employed we saw there was a system in place to check that nurses kept their NMC registration up to date.

The manager told us they had recently asked people who used the service if they would like to be involved in the recruitment of new staff and three people had volunteered. On the day of the inspection we saw evidence of this in practice, one of the people who lived at the home was involved in interviewing a job applicant.

This showed the provider had suitable arrangements in place to make sure staff were properly checked before they started work in order to help protect people using the service.

One person told us the nurses gave them their medicines every day, they said, “They never forget; it’s important because I have epilepsy.”

One person who used the service administered their own medicines; everyone else had their medicines administered by trained nursing staff. People’s medicines were stored securely in suitable trolleys, cupboards and a medicine fridge. The temperatures of the medicines fridge and treatment room were checked and recorded to ensure that medicines were stored at the required temperatures. However, we found the room temperature was frequently not recorded and the fridge temperature chart had on occasions been used to record room temperatures. These matters had not been picked up during the service’s internal medicine audits. This was discussed with the manager who said they would deal with it.

Most medication was administered via a monitored dosage system supplied directly from a pharmacy. This meant that the medicines for each person for each time of day had been dispensed by the pharmacist into individual trays in separate compartments. Staff maintained records for medication which was not taken and the reasons why, for example, if the person had refused to take it, or had dropped it on the floor. A record was kept to show medicines which had been destroyed.

Creams and ointments were prescribed and dispensed on an individual basis. They were properly stored and dated upon opening. We checked the medication records, including the records for medicines classified as controlled drugs, and found they were accurate. Information about people’s allergies was recorded.

Requires Improvement

Is the service safe?

We saw that medicines prescribed to be given before food were clearly indicated and were given as directed. There were suitable arrangements in place for the safe administration of medicines prescribed to be taken as needed. We found people's medicines were available at the home to administer when they needed them.

This showed the provider had suitable arrangements in place to protect people from the risks associated with medicines.

When we looked around we found people were cared for in a clean and hygienic environment.

Requires Improvement

Is the service effective?

Our findings

One of the care staff we spoke with had recently started working at the service. They told us they had received induction training and had shadowed a more experienced carer until they felt confident to work on their own. They confirmed they had received moving and handling training and said the practical training had been very good.

We inspected the training matrix which demonstrated the service was planning training to ensure staff had the necessary skills to deliver basic care for people. The service cared for many people with rare neurological conditions which posed many challenges to staff to ensure appropriate care was given. We saw no evidence that staff had accessed training specific to the needs of some people at the service therefore there was a risk they would not receive appropriate care, support and treatment.

The records demonstrated that training was planned to ensure staff were trained in such matters as moving and handling, food hygiene, first aid, safeguarding vulnerable adults, Deprivation of Liberty Safeguards (DoLS) and the Mental Capacity Act 2005 (MCA). However, the records showed that some people were behind in attending planned training courses. The registered manager assured us this was being attended to. The staff we spoke confirmed they were receiving training on safe working practices. They said they had asked for more specialised training, for example on caring for people with epilepsy and Huntington's disease and understood this was being addressed.

We saw evidence of a structured approach to formal supervision with staff having supervision every two to three months. The staff we spoke with confirmed this. Whilst supervision was a feature of the service appraisal was not. The registered manager assured us they had identified this as an area of high priority for action.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. Whilst the service had not needed to submit any applications they had the proper policies and procedures in place. Relevant staff had been trained to understand when an application should be made, and how to submit one. We looked in detail at the records of five people whose diagnosis indicated they may lack capacity and may be subject to DoLS. Our scrutiny demonstrated that an application for DoLS would not be appropriate and we were therefore satisfied the service was acting within the legal framework provided by the Mental Capacity Act 2005.

We saw that care plans recorded whether someone had made an advanced decision on receiving care and treatment. The care files held 'Do not attempt cardio-pulmonary resuscitation' (DNACPR) decisions. The correct form had been used and was fully completed recording the person's name, an assessment of capacity, communication with relatives and the names and positions held of the healthcare professional completing the form. We spoke with staff that knew of the DNACPR decisions and were aware that these documents must accompany people if they were to be admitted to hospital.

Before the inspection we received information which suggested there was not enough food available for people during the night. On 26 November 2014 we arrived at the home at approximately 6.50pm. Staff told us the evening meal was served between 4.30pm and 5.30pm. Before the kitchen staff left at approximately 6.30pm they left out food for supper and overnight use and locked the store rooms and fridges. This meant staff had no access to any other food until the kitchen staff came back on duty in the morning. On the night of 26 November 2014 the food left out consisted of one tray of sandwiches, one and a half packets of biscuits, a loaf of bread, some cartons of juice, tea, coffee, milk, sugar and some homemade marmalade. Supper was served around 8.30pm and we observed that most of the food had been eaten. We asked one of the care staff what they would do if anyone wanted something to eat during the night, they said they would make them toast.

One person who used the service told us they had a big appetite and said they did not always get enough to eat. Another person said they were very rarely offered second helpings and could only get a second helping if someone else didn't want their meal. Another person said, "There is plenty of food but it's not too good."

On the 27 November 2014 we observed the meal service at breakfast and lunch time. We saw that some people had their breakfast between 10am and 11am and lunch was served at 12noon. There was no evidence that arrangements had been made to manage the gaps between meals for people who had a late breakfast.

Requires Improvement

Is the service effective?

At lunch time we observed the food was placed in the hot trolley at 11.20am and service started at 12noon. The lunch was corned beef hash and we saw people were offered alternatives such as sandwiches or omelettes. The portion sizes looked adequate and people said it was a good meal. We observed there was a lot of food left over; the chef said this was because some people were away on holiday. However, we did not see anyone being offered a second helping.

The service worked to a four weekly menu, copies of which were included in the Welcome Pack. At the time of the inspection the manager told us they were making changes to the menu in response to feedback from people who used the service.

We asked the cook about people's dietary needs. They told us a number of people had low sugar diets because of Diabetes and one person had a vegetarian diet. They said people were offered daily choices and whenever possible individual requests were catered for.

When we looked at people's care records we saw their nutritional needs were assessed. We saw people's weights were checked at monthly or weekly intervals depending on the degree of risk. However, in one person's records we saw a care plan review dated 25 June 2014 which stated their weight should be checked every week. There was no record that the person's weight was checked again until 26 September 2014. The next recorded weight was in October 2014. Following that we saw the person had been referred to a Speech and Language Therapist. At the time of the inspection the person had a PEG (Percutaneous endoscopic gastrostomy) feed in place and there was a dietician involved in monitoring their nutritional status. However, the delay may have been detrimental to the person's nutritional status and general health.

This was a breach of Regulation 14 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We saw people had access to the full range of NHS service and visits from external health care professionals were recorded in people's notes. This included GPs, tissue viability nurse specialists, dieticians, speech and language therapists and physiotherapists. During the inspection we spoke with one visiting health care professional. They told us they felt the staff were approachable and caring and did a good job of caring for people with complex needs.

Requires Improvement

Is the service caring?

Our findings

We observed the meal service at breakfast and lunchtime and found people were not always supported in a way that respected their dignity.

We saw one person started their breakfast at 10am, they were given porridge, the care worker who was supporting them stood beside them and between each mouthful of food they walked away to do something else; the person kept calling the care worker to come back. The person's breakfast was then interrupted by a nurse giving them their medicines. The person was taken out of the dining room at 10.15am with porridge down their face and with a blue paper towel, which was acting as an apron, still around their neck.

Another person came to the dining room for their breakfast at 10.20am. The care worker spooned what looked like porridge into the person's mouth, it went all over their face and dripped onto the paper towel which was acting as an apron. The care worker put another spoonful of food in the person's mouth and walked away. People were walking in and out of the dining room passing the person's chair. The care worker came back and gave the person another spoonful of food and more food spilled around the person's mouth and onto their chin. Another care worker then came and took over while the first care worker went to sign what looked like a greeting card. Having done that they came back and once again took over supporting the person. Initially the staff made no attempt to clean the person's face. When they noticed we were observing they started to clean the person's face between each mouthful. The person was in a recliner chair and was taken from the dining room by staff at 11.10am. Throughout the entire period of observation the care workers did not speak to the person

At lunch time we observed staff brought one person into the dining room and positioned them away from the main dining tables where other people were eating. A care worker was supporting the person to eat; they were standing over the person and not speaking to them. When the care worker saw we were observing they got a chair, sat beside the person and starting talking to them.

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

While observing care in the lounge areas we saw staff were kind and caring when they spoke with people who used the service. However, most of the interactions were prompted by a task, such as supporting someone with personal care. We did not observe staff sitting and chatting to people. Staff explained what they were going to do and asked people's permission before providing care and support. One person who lived at the home said, "Yes, staff are OK" and another said the "Staff are alright." A relative told us the staff understood their relative's needs and added "X [person's name] being here has given me peace of mind." We saw one person who used the service become upset and agitated. Staff responded with patience, they spoke with the person in a soothing way and tried to understand what they needed. We saw staff had a good knowledge of the person's needs and preferences as they offered different options to help alleviate the person's distress.

We found that some people who lived at the home had no relatives or friends to support them. The provider sought to make advocacy available for any person using the service who needed help in presenting their views. We saw that information was publicised on local advocacy schemes and one person was benefiting from the involvement of an advocacy service.

Requires Improvement

Is the service responsive?

Our findings

Several of the people we spoke said they were not happy about the lack of trips out. They said the home used to have a dedicated mini bus but this had changed and it was shared with other services. They said this limited their ability to get out and about. One person said, "I am bored, there is nothing to do." Another said, "I don't get out much." Two people told us they had regular weekly trips to a local pub but they had to pay for taxis.

There was no evidence of person centred activities and we saw people spent most of their time either watching TV or falling asleep in the lounges. It wasn't clear how people could be properly supported with Independent Living Skills such as involvement in the local community without readily available transport and staff available to support them.

At the time of the inspection nine people who used the service were away on holiday in Blackpool and the activities coordinator had gone with them. The planned activity on the day of the inspection was baking. Some people were able to take part in this but many could not because of the severity of their disabilities. The only other activity on offer was to watch TV.

We looked at three people's care records in detail. We found people's needs were assessed and care plans were in place in two of the care records reviewed. In the third person's notes we saw they had moved into the home ten days before the inspection. At the time of admission they had been assessed as needing support in a number of areas which included mobility, nutrition, sleeping and mental health due to confusion and cognitive impairment. There were no risk assessments or care/support plans in place to show how this person was to be supported to meet their assessed needs. We asked the registered manager about this and they said the person was still being assessed. However, they acknowledged risk assessments and initial care plans should have been in place within 72 hours of admission as stated in the provider's admission policy.

In the other two people's care records we saw evidence people were involved in assessments of their needs and care planning. Most of the people we spoke with said they received support they needed when they needed it. However, one person told us the night staff had taken their buzzer away. They said staff had propped the door open and told them to shout if they needed help. They said staff usually came when they shouted. Another person said the staff were very busy at night and it could take them half an hour to answer the buzzer. They said one night they had to wait an hour for a cup of tea. A relative told us that while they were generally satisfied with the care they were concerned that on occasions it was mid-day before their relative was helped to get up and dressed. They said they had discussed this with the registered manager. Staff told us they were not always able to give people the support they needed in a timely way. They said sometimes it was nearly lunchtime when people were up and dressed and this was not what people wanted. One staff member said, "Residents are not getting enough from us."

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

The provider had a complaints policy for ensuring complaints were recorded and fully investigated. The provider addressed verbal and written complaints in the same way. We looked at the home's complaints register. There had been three complaints in the past year. The register contained details of the complaint, the action taken to address identified shortfalls and the date resolved. We spoke with the registered manager about all three complaints and as a consequence we were satisfied that the service operated an open and transparent approach to complaints and used the outcomes to learn and make changes to improve the service. Furthermore we saw that the registered manager involved the local adult safeguarding service in complaints when appropriate. We saw that where staff had been found to be failing in their duties appropriate action was taken using the service's disciplinary policy and procedures. People living in the home told us they had no reason to complain and said they would not hesitate to speak to the registered manager if they had any concerns.

Requires Improvement

Is the service well-led?

Our findings

When we spoke with people who used the service they told us they had no major concerns or complaints but some expressed a sense of resignation that the service was not going to get any better and some said they didn't feel they were listened to by staff and management. The service held meetings for people who used the service to give them an opportunity to share their views about the day to day running of the home. We saw the minutes of meetings which had been held in April and May 2014. The notes from the May 2014 meeting showed that people living at the home had expressed the view that the provider did not listen to them or take their concerns seriously. We saw another meeting had been scheduled for August 2014 but it wasn't clear if this meeting had taken place as there was no record of the meeting. The registered manager, who joined the service in March 2014, told us they were trying to address these concerns. For example, they had planned a consultation about food and they had invited people living in the home to be involved in staff recruitment.

The records showed and staff confirmed staff meetings were held to discuss the day to day running of the home, the required standards and changes to working practices. However, there was some concern that matters discussed were not always followed up. For example, the notes of the April 2014 meeting stated additional equipment would be provided for the housekeeping staff but when we asked them they said it had not been provided. Staff said the registered manager was approachable but they had some reservations about how effective they were in taking action in response to issues raised by staff.

During the inspection we found confidential notes were not being disposed of appropriately. On arrival on the morning of 27 November 2014 we found confidential notes which belonged to people who used the service in a waste bin in the toilet adjoining the registered manager's office. This was raised with the registered manager who said they had placed them in the bin for shredding. However, they were in a black bin liner commonly used for household waste which meant there was a risk they would not be disposed of correctly.

This was a breach of Regulation 20 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We found the provider did not have effective systems in place to identify, assess and manage risk. For example, we found the tool used to determine staffing levels was not fit for purpose. The provider had not identified this until it was pointed out during the inspection. This meant there was a risk there were not sufficient staff to safeguard people's health, safety and well-being.

In one of the care plans we looked at we saw a risk of suicide had been identified. There had been one serious attempt of suicide prior to the person's admission to the home. We asked the registered manager whether it had been considered necessary to conduct a risk assessment to mitigate the risk of self-harm/suicide using ligature items or anchor points. They confirmed that no assessment had not been done but acknowledged that a risk was present and an assessment would be done.

The provider had systems in place for monitoring and auditing the quality of the services provided. This included regular visits by members of the senior management team whose responsibilities included carrying out audits and providing support to the registered manager. However, we had some concerns about the effectiveness of the monitoring systems. For example, when we looked at the management of medicines we found the checks on the temperatures of the treatment room and medicines fridge were not always recorded correctly. This had not been identified by the provider's medication audit.

In addition, the inspection identified a number of other areas where the provider was not meeting the legal requirements and regulations associated with the Health and Social Care Act 2008. These are detailed throughout this report and include concerns about people's care and welfare, nutrition and dignity and respect.

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

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing **The registered person did not have suitable arrangements in place to make sure that, at all times, there were sufficient numbers of suitably qualified and experienced staff to meet the needs of people who used the service.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services **The registered person did not have suitable arrangements in place to make sure people were protected against the risks of receiving care or treatment that was inappropriate or unsafe by ensuring the planning and delivery of care was done in such a way as to meet people's individual needs and ensure their safety and welfare.** **The registered person did not have suitable arrangements in place to protect people who used the service in the event of foreseeable emergencies.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010 Meeting nutritional needs **The registered person did not have suitable arrangements in place to make sure people were protected from the risks of inadequate nutrition and dehydration.**

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services **The registered person did not have suitable arrangements in place to make sure people who used the service were always treated with consideration and respect.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records **The registered person did not make sure records were securely destroyed.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision **The registered person did not have effective systems in place to assess and monitor the quality of the services provided and to identify, assess and manage risks to the health, welfare and safety of people using the service.**