M Hermon

Haven House Residential Home

Inspection report

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Ratings

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

Overall summary

We carried out an unannounced inspection at the service on 20 and 21 October 2015. The service provides accommodation and personal care for up to 28 older people who may be living with dementia. Fourteen people were living at the home at the time of our inspection.

There was not a registered manager in post. The previous registered manager had left the service in May 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. A new manager had been appointed, but they had not applied to register with us.

At our first ratings inspection in October 2014, the service had been rated as 'Inadequate'. We found six breaches in the legal requirements and regulations associated with the Health and Social Care Act 2008. The provider was failing to identify, assess and manage risks to people and to maintain appropriate standards of cleanliness. We

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issued Warning Notices for both of these breaches because people were at immediate risk. We told the provider they must take action to meet the regulations within four weeks of our serving the Warning Notices.

We undertook a focused inspection on the 5 January 2015 to check that the service had made improvements related to the Warning Notices. We found some improvements had been made. The service was re-rated as 'Requires Improvement'.

Because our inspection in January 2015 was focussed on checking whether the provider met the Warning Notices, there were still four breaches in the legal requirements and Regulations associated with the Health and Social Care Act 2008 that we did not check. We had identified failings in the requirements to maintain the premises, to maintain accurate records, to ensure suitable staff were recruited to deliver the service and to ensure people, or their legal representative, consented to care. We told the provider they should send us an action plan setting out the actions they would take to remedy these four breaches and the date the actions would be completed.

The previous registered manager had sent us an action plan in February 2015, explaining the actions they planned to take, but did not say when the actions would be completed by.

At the inspection in October 2015 we found there had been no progress in addressing the outstanding breaches. The provider had not acted in accordance with their action plan and we found that. The provider's quality assurance processes had not been maintained since the registered manager had left the service in May 2015.

Assessments to identify the potential risks within the building were not undertaken, or effectively delegated. We identified a risk to people's safety in relation to the building that the provider had been unaware of. The provider had not taken action required by the Fire and Rescue service in a timely manner. People were at avoidable risk of living in unsuitable premises.

The provider had not implemented a safe recruitment procedure. Staff were employed without appropriate assurance they had the necessary skills, experience or qualifications. Support staff were deployed in a care role without assurance they were trained or competent to deliver care. Two recorded accidents happened when there was an unqualified member of staff on duty.

The provider's policy and procedures for safeguarding people were not made known to all staff. The requirement to investigate concerns raised by staff was not understood or followed.

There were not always enough suitably skilled staff on duty, particularly during the evenings and weekends, which affected people's safety and the management of their individual risks. Incidents and accidents that occurred during these periods were not accurately recorded or investigated, which meant actions that could be taken to minimise risks were not always taken.

Improvements were still needed in staff's understanding and practice of safe medicines management, particularly about stock control.

Staff's understanding of the requirements and their responsibilities under the Mental Capacity Act (2005) was inconsistent. Mental capacity assessments were not completed in accordance with the legal requirements. Staff did not always obtain people's consent for care and support. People were not supported to make their own decisions. People living with dementia did not receive the support they needed to effectively minimise risks to themselves or others.

Training for staff to have the necessary skills to undertake their role was not monitored and no care related training had been delivered to staff since January 2015, although new staff had been recruited to work as care staff. Two staff had been recruited without appropriate evidence they had had the necessary knowledge or qualifications to undertake the role. A member of support staff, who had not been given appropriate training, was deployed to deliver care during the evenings and weekends. This was of particular concern because, there was minimal management oversight to ensure people received the care they needed.

Care plans had not been reviewed for five months, but were being updated during our inspection. They were not all sufficiently detailed for staff to know about people's preferences or how to support people to follow their

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interests. Care plans were not available for staff to read during the evenings or at weekends. People were not given the opportunities to engage in conversations or activities that reflected their interests.

People were supported to eat nutritionally balanced meals of their choice and which met their dietary needs. People were supported to maintain their health and were referred to other health professionals appropriately. Care staff understood people's moods and behaviours and were kind and compassionate in their interactions. Care staff understood people who were not able to communicate verbally.

A CCTV monitoring system was in use in the communal areas of the home, but the provider had not sought to obtain people's views or consent about the use of CCTV before this had been installed. People were being filmed in the communal areas of their own home without their knowledge.

The provider was not able to explain or show us evidence of how they monitored the quality of the service. They had not kept up the system of management checks of the premises or of staff's practice since May 2015. People did not have the opportunity to voice their opinions about the quality of the service.

The culture of the service was not open, transparent or empowering. The provider had not displayed the rating they were awarded in January 2015. Staff were treated differently in relation to their supervision, support and benefits. The provider did not maintain accurate records in accordance with the regulations. The provider did not respect staff's confidentiality. Staff were not well led and did not always act as a team, which affected understanding of how their actions might impact on people's well-being.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

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. The provider did not make sure the premises were maintained to provide a suitable and safe environment for people. The provider did not check staff's suitability and character before they started working as care staff. The provider's safeguarding and whistleblowing policies and procedures were not known to all staff, and were not followed to protect people from the risks of abuse. There were not always enough care staff to deliver care and support safely according to people's needs.

Is the service effective?

Inadequate 

The service was not effective. Not all care staff were trained in the Mental Capacity Act 2005 and some staff did not understand the purpose of the Act or their responsibilities under it. People were not supported to make their own decisions and people living with dementia did not receive the support they needed. People were given a choice of meals that met their dietary and nutritional needs and were supported to maintain their health.

Is the service caring?

Requires improvement 

The service was not always caring. The provider did not respect people's rights to privacy and had not consulted them or their visitors before installing a CCTV system in the communal areas of the home. Care staff were compassionate and treated people with kindness. They understood and responded reassuringly to people who were not able to communicate verbally.

Is the service responsive?

Requires improvement 

The service was not always responsive. Complaints were not recorded, and the investigation and outcome of complaints investigations were not recorded or shared effectively with complainants. The provider did not use complaints to learn about and improve the service. People and their relatives were involved in identifying and reviewing their physical and health needs. However, improvements were needed so that people's individual interests were identified and information with staff to enable them to respond according to people's interests.

Is the service well-led?

Inadequate 

The service was not well led. The provider did not seek people's views on the quality of the service. There was no identifiable quality monitoring system in operation to identify when improvements needed to be made. Staff were not all supported, supervised, empowered or treated equally, which caused divisions in the staff team. The provider did not maintain accurate and

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appropriate records of people's care, staff's employment or of records relating to the management of the service. The provider had not displayed the most recent rating of the service where people and visitors could see our assessment of their performance.

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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 took place on 20 and 21 October 2015 and was unannounced. The inspection was undertaken by two inspectors.

We had not asked the provider to complete a provider information return (PIR) because we had already inspected the service in January 2015. The PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. The previous registered manager had sent us an action plan setting out how they would make the required improvements that were identified at our previous inspections in October 2014 and January 2015.

We reviewed the information we held about the service. We looked at information received from relatives, the local authority commissioners and the statutory notifications the previous registered manager had sent us. A statutory notification is information about important events which the provider is required to send to us by law. Commissioners are people who work to find appropriate care and support services which are paid for by the local authority.

We spoke with five people who lived at the home and two relatives. We spoke with the provider, the manager, the deputy manager, three care staff and the cook. We observed care and support being delivered in communal areas and we observed how people were supported at lunch time.

Many of the people living at the home were not able to tell us, in detail, about how they were cared for and supported because of their complex needs. However, we spent time in the communal areas observing care to help us understand the experiences of people who could not talk with us.

We reviewed three people's care plans and daily records to see how their care and treatment was planned and delivered. We checked whether staff were recruited safely and trained to deliver care and support appropriate to each person's needs. We asked to review the results of the provider's quality monitoring systems to see what actions were planned to improve the quality of the service, but relevant and up to date records were not made available to us.

Inadequate

Is the service safe?

Our findings

During our inspection in October 2014, we found the provider did not identify and manage risks to people's safety related to the premises. The provider sent us an action plan setting out how they would improve.

The provider had taken some immediate actions after our inspection in October 2014 to repair and refurbish some areas of the home where risks had been identified during the inspection. For example, they had made repairs to the kitchen hand wash basin and a damaged skylight. In addition, the provider had redecorated some upstairs areas of the home. However, at this inspection in October 2015, we found the provider had still not implemented an effective system of continuously identifying and managing risks to the premises. They did not regularly check the building to identify whether repairs or refurbishments were needed.

We saw a window on the first floor window was wide open, because the window restrictor did not work properly, which meant people were at risk of falling from the open window. We found the window frame shook when the window was closed, because it was not fixed securely in place. The provider told us they did not know about the window frame or window restrictor needing repair because the maintenance person had not told them. The provider told us they had delegated the responsibility for risk assessing the premises to the maintenance person and they expected the maintenance person to identify any issues and make appropriate repairs. The provider was not able to show how they instructed, or guided the maintenance person or a task list for them to follow so they understood what they were expected to check or report on. Without clear instructions from the provider, the maintenance person could not reasonably be expected to know what to check or how to recognise risks. The provider told us the window would be repaired within 24 hours, but that did not give us assurance that the whole premises would be checked or any other issues identified.

A member of care staff told us they reported any maintenance issues to the manager or the maintenance person. The member of care staff told us the maintenance person was, "Very good, they work very hard." However, the provider was not able to show us any evidence that maintenance issues affecting the safety of the premises were logged when they were identified or when they were repaired. There were no current certificates to demonstrate they regularly checked the safety of gas or water supplies. A schedule for regularly testing the temperature of the water in people's rooms was last signed as 'completed and no issues' on 18 September 2015 and the schedule for weekly flushing of unused water outlets had not been signed as 'completed' since May 2015. The provider was not able to provide assurance they understood their responsibilities to ensure the premises were safe.

A fire safety audit undertaken by the fire service in January 2015 had identified a number of areas where work was required and an action plan was given to the provider. One required action was to enclose a staircase and install a fire door at the bottom of the stairs. The work had not been started at the time of our inspection, which was a risk to people's safety in the event of a fire. The provider told us the original deadline of July 2015 had been extended until November 2015 by the fire and rescue service. They told us they planned to start the work the week after our inspection. However, the provider had failed to take action to comply with fire safety recommendations for over three months.

This was a continuing breach of Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2014 Premises and equipment since October 2014.

At our inspection in October 2014, we found the provider did not follow safe recruitment procedures for staff. Following that inspection, the registered manager sent us an action plan explaining how they would make improvements to recruitment procedures.

During this inspection we found the provider had not taken the action they said they would take. Suitable arrangements to recruit staff safely were still not understood or followed. Three care staff had been recruited since our previous inspection in January 2015. The provider did not check the new staff's suitability for their roles and did not ensure they were suitably skilled or understood their role and responsibilities. There was no documentary evidence that the checks on their suitably had been made in accordance with Schedule 3 of the Health and Social Care Act 2008. There was no documentary evidence the duties and responsibilities of each role were understood and agreed by the staff.

The provider had not assured themselves that newly recruited staff understood their role or responsibilities. A

recently recruited member of care staff told us they had completed an application form, attended an interview and were verbally offered a post. They told us they had not discussed a probationary period, but had already been confirmed in post verbally by the provider. They did not have a contract or a job description and had not signed any terms and conditions of employment. Records in the staff's employment folder included an induction programme, a copy of a recent check with the Disclosure and Barring Service (DBS), and a reference from one previous employer, but no job description or contract. The DBS is a national agency that keeps records of criminal convictions.

The manager told us that no training had been planned or delivered to staff since our previous inspection in January 2015, so newly recruited staff had to rely on training from previous employers. The manager had asked the previous employer for copies of the staff's training certificates, but the copies had still not been received at the time the provider had confirmed the new staff in post. The provider had employed staff without assurance they had were appropriately skilled or experienced.

The staff rota showed that one person who had been recruited and employed as a cleaner and maintenance person, was currently working as care staff after 5pm in the evenings and at weekends. We asked the provider how they had ensured this person had the appropriate behaviours, skills, experience and training to deliver care, when their original interview had been for the post of a cleaner and maintenance role. The provider did not explain. There was no recorded evidence that the provider had checked staff's suitability, understanding or competence for the role or provided appropriate training.

This was a continuing breach of Regulation 19 HSCA 2008 (Regulated Activities) Regulations 2014 Fit and proper persons employed.

The provider had not taken reasonable measures to minimise risks to people's individual safety. The provider had not ensured that all staff understood their responsibilities to keep people safe from harm. This was because some staff had not received training in how to safeguard people from abuse. Although one member of care staff told us the signs of abuse included "Staff shouldn't argue in front of residents", we had been told by a concerned member of the public that one member of staff was verbally abusive to other staff. The staff that had argued in front of people did not recognise this was a form of abuse.

One relative told us they were worried their relation might be at risk of harm, because they had seen another person 'hit out' at other people. We asked people whether they felt safe at the home, but they were not able to articulate a response. One person who was not able to communicate verbally showed us bruises on their arm. Records showed care staff had raised their concerns about how the bruises had been sustained. Staff had recorded the bruising in the person's daily records and reported their concerns about how it happened it to senior staff during handover. The manager told us they had spoken with staff about how and when the bruises might have occurred, but had not documented their discussions. From the discussions with staff and reviewing the daily records, the manager was confident the bruises had not been made during the day, but had occurred while the person had been supported to go to bed.

However, the manager had not identified whether they were the result of abuse, neglect, poor practice or an accident, which meant there were outstanding concerns about their safety which should have been referred to the local safeguarding team. No action had been taken to ensure the person was protected from the risk of abuse in the manager's absence. The deputy manager told us, "I would report a safeguarding in the manager's absence", but they had not done so. The manager told us they would make a referral to the safeguarding team immediately following our inspection.

This was a breach of Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2014 Safeguarding service users from abuse and improper treatment.

A relative told us they worried about their relation because they were not confident there were always enough staff on duty. They knew [Name], who lived at the home, was unpredictable in their behaviour and could put other their relative and other people at risk. They told us, "If there are only three staff on shift and two take someone (out of the room), there is only one carer, which means staff aren't always around to keep an eye on [Name]."

The manager told us they arranged staffing numbers on the rota to ensure there were at least four care staff and a

senior on duty from 7am until 9:30pm and two waking night staff. They told us they knew this was an appropriate number of staff to support the 14 people who lived at the home because of their knowledge of people's needs and dependencies and their experience in delivering care. They told us they intended to implement the use of a dependency tool to support their staffing decisions, because the provider challenged their experience and sometimes decided there were more staff then necessary and sent staff home early.

We found that there were less staff on duty than the number the manager had identified as being adequate to meet the needs of people at the home. According to the staff rotas, for the week beginning 12 September 2015, there was sometimes only one senior and two care staff on duty. On Tuesday 15 September 2015 there were only three care staff and no senior in the afternoon and early evening. One of those care staff was the person who had been recruited and employed as a cleaner and maintenance person, and had not received any training in how to support people with their health and care needs. Staff told us this level and deployment of staff was a regular occurrence during the evenings and weekends.

Prior to our inspection a relative had raised concerns about the number of staff on duty at weekends. When they visited on Saturday 3 of October, they were concerned their relative had not been assisted with personal care. During the evening of Saturday 3 October, their relation had fallen and injured their head. The relative felt this was because there were not enough staff on duty to support them safely.

The rota for that week had been amended while the manager was away from work. The amendments showed that a member of care staff and a senior care staff had left at 2:30pm, seven hours earlier than planned. They had been replaced by one live-in care staff. The replacement care staff was the member of staff who had been employed as a cleaner and maintenance person, not care staff, and had not received any training appropriate to the role. One person who was at high risk of falls had fallen on 3 October 2015 when there were only two care staff on duty.

The manager told us a senior member of care staff usually 'stepped up' to become an acting manager, to provide day-to-day management in their absence. However, the senior member of staff had stopped working at the service on the first day of our inspection and had not yet been replaced by the provider. The provider told us they planned to arrange cover for the manager's forthcoming holiday, booked for the following week, for the deputy manager to increase their working hours and to step in as the acting manager.

We found this plan had not been discussed with the deputy manager until the day of our inspection and did not take into account the availability of the deputy manager, who only usually worked three mornings per week. The provider had not acted to resource management support for the home in a timely way, and plans were not confirmed for the following week. This did not ensure the safety of people at the home.

The deputy manager told us they had not had any training for, "Two to three years" and no longer felt qualified to deliver care. They told us they supported people's social needs and did administrative work only. The deputy manager was not trained, skilled or sufficiently experienced to cover the manager's holidays or sickness leave and was not available to work the necessary hours. The staffing plan was inadequate to ensure people's care and social needs would be met effectively.

People told us there were enough staff to support them with their needs. One person who spent time in their own room told us they just called out and staff came. We saw staff came promptly when they rang the bell. During our two day inspection we saw there were enough staff to support people according to their physical care and support needs and to spend some time with people one-to-one. However, records showed there were less staff on duty in the evenings and at weekends than the number of staff the manager had identified as needed.

This was a breach of Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2014 Staffing.

Accidents and incidents were not always recorded and were not analysed to make sure appropriate actions were taken to minimise the risks of a reoccurrence. A relative told us their relation had fallen in the past, but staff had not told them about this and they found out when they visited the home. The relative told us on a previous visit to the home their relation had red marks on their hands and face. They told us, "I had to ask what happened."

In the daily records for the person who had shown us some bruises on their arm, evening care staff had reported bruising to the person's right arm on 15 October 2015. This information was shared and recorded during staff

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handover, but was not recorded in the accidents or incidents log. We saw bruises on the arm of a second person at the home, but the bruising was not documented in their daily records or in the handover notes. We saw a third person had signs of a recent injury to their head. This was not recorded in the accidents and incidents book.

The most recent record for the person who showed us their bruises was dated 23 February 2015. The accompanying body map showed where the person had bruises, grazes and cuts. The record explained the immediate treatment the person had received. The most recent record for the second person who had bruises on their arm was dated 14 August 2015. The accompanying body map showed where they had sustained grazes and bruises. Neither incident record included details of an investigation into how the accidents happened, how the bruises were sustained or the outcome of an investigation. There were no instructions for staff about how to minimise the risks of the person being bruised in the future. There was no possibility that accident and incident records could be used to inform care plan reviews to minimise people's individual risks or risks within the premises.

Risks to people's health and wellbeing had been identified when they moved into the home by the previous registered manager. People's care plans included guidance for staff to minimise the identified risks. However, staff did not consistently support the person as their care plan described. For example, one care plan for a person at risk of progression of Alzheimer's disease described the person's requirements as, "Needs on-going reassurance at all times by staff involved in doing things around the home." During the two days of our inspection, this person stayed in their room apart from meal times. The person told us they liked to spend time in their room, but we did not see staff actively encouraging the person in 'doing things' around the home as their care plan stated. Either their care plan was not up to date, or the person had not been effectively consulted when it was written.

A member of care staff told us they had not read any care plans, but had learnt about people's needs during their induction by working with experienced staff. The care plans were kept in the office and were not available to staff in the evenings or at weekends. Care staff were not enabled to understand the underlying causes of people's individual risks or how to best support them, because information was not readily available. The provider and manager told us the care plans were not up to date, and had not been updated since the previous registered manager had left in May 2015, which meant changes in people's needs had not been recorded when they were identified.

An external consultant had been engaged to support the manager to update everyone's care plan. At the time of our inspection, the manager told us three plans out of 14 had been updated and an interim care plan had been completed for one person who had recently moved into the home. The person's care plan recorded that there were risks to their health and wellbeing, but the guidance for staff to support the person was not detailed or specific. For example, the care plan identified that staff, "Need to support [Name] with emotional needs", but there was no guidance for staff about how to do this. The risk assessments were brief and did not include any form of dependency score. The risk assessments and actions for staff were not detailed enough to inform the manager of how many staff might be needed to care for the person safely.

The manager told us they did not know whether people had personal emergency evacuation plans (PEEPS) in place. A PEEP is a plan that is unique to an individual, to ensure they can be supported to evacuate a building in an emergency according their needs and dependencies. When we found a folder marked 'PEEPS' in the dining room and showed it to the manager, they said they had not seen it before. As the manager had been in post for five months, this meant the manager, and other recently recruited staff, might not know how about people's specific support needs in an event of an emergency.

The pharmacist had delivered training to staff in the management and administration of medicines. Medicines were delivered from the pharmacy and kept in a locked room. The pharmacist supplied a medicines administration record (MAR) for each person that described the frequency and amount of medicine that should be administered. The three MARs records we looked at were signed and up to date.

The manager told us if anyone declined to take their medicines, staff would explain the risks of not taking them and ask the person again later. If the person continued to decline, they would destroy the medicine, record it and ask the GP's advice. The manager told us one person had

declined to take their medicines at the prescribed time, but had agreed to take them later in the day. The manager had checked with the person's doctor that this would not have a detrimental effect on their health.

One person's care plan said they should have one of their medicines as and when required, but their MAR showed this medicine was administered at each medicines round. The manager told us the care plan was wrong and needed to be updated, because the person now had the medicine regularly. The two records related to this person's medicines gave contradictory instructions to staff, creating a risk they would not be administered safely

The manager told us they conducted a weekly stock check, but did not record this. One person's prescription said the person should have one or two tablets as required. Staff had signed to say when they had administered the medicine, but did not always state whether one or two tablets had been given. It was not possible to know how much medicine the person had been given. This did not support accurate monitoring of the person's level of pain. It did not support accurate stock control, as it was not possible to check the amount that should have been available against the actual amount in stock.

We had previously identified stock control of medicines as requiring improvements during our inspection in October 2014. The provider's plan to improve in this area had not been implemented effectively. Improvements were still needed in staff's understanding and practice of safe medicines management.

Inadequate

Is the service effective?

Our findings

At our inspection in October 2014, we found the provider did not ensure consent to care was legally obtained. Following that inspection, the registered manager sent us an action plan explaining how they would make improvements in obtaining people's consent to care, and in staff's understanding of the Mental Capacity Act 2005. During this inspection we found these improvements had not been made.

The provider demonstrated they did not understand their responsibilities or the requirements of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS). The Act and DoLS set out the requirements that ensure, where appropriate, decisions are made in people's best interests when they are unable to do this for themselves.

Records showed only five of the current 17 staff had received training in the MCA. We saw this led to different understanding of the requirements of the Act. Most care staff asked people if they consented to care before they supported people. For example, staff asked people where they would like to spend time and whether they were ready to be moved. However, we saw one member of care staff, who had not received training in the MCA, made a decision for one person against their wishes and without considering whether they should have a best interest meeting.

On the first day of our inspection, 20 October 2015, one person told us they preferred to spend their day and have lunch in their own room. On the second day of our inspection, 21 October 2015, we saw this person was crying as staff brought them into the lounge. The person told us they did not want to sit downstairs. Staff told us a health professional had advised staff to encourage the person to mobilise more frequently to reduce the risks associated with a sedentary lifestyle. The health professional had suggested the person came downstairs so staff could encourage them to move around throughout the day. The member of care staff told us they would encourage the person to walk to the dining room and back and then they would, "Be allowed" to go back to their room. Staff had not understood the person's right to decline to follow the health professional's advice.

The member of care staff demonstrated no understanding of the person's capacity to make their own decisions or the requirement for best interest meetings if they felt the person did not understand the information presented to them. The member of care staff had persuaded one person to do something they clearly did not want to do, on the promise of being able to do as they wished at a later point in the day. Care staff did not recognise this as coercion and had acted unilaterally in the person's 'best interests.' This showed a lack of understanding of the requirements of and their responsibilities under the MCA.

During our inspection on October 2014, the registered manager had told us they assessed people's capacity in accordance with the MCA before they moved into the home. However, there were no completed mental capacity assessments in the care plans we looked at during that inspection, because they had been archived. We had seen mental capacity assessments in people's files during our inspections in 2012 and 2013.

At this inspection we saw the deputy manager had completed a mental capacity assessment for one person in February 2015. The deputy manager had assessed the person was able to understand information relevant to the decision, but not able to retain that information and not able to use or weigh that information, but was nevertheless, able to communicate their decision. The outcome of the assessment was that the person had capacity, "To make this particular decision at this time", but the assessor had added, "To a degree". The assessment did not specify what the decision was in relation to and the outcome was not clear. The assessment did not include any further information about which decisions the person could make for themselves, which decisions staff could make for them or when or why a best interest meeting should be held. This demonstrated staff's lack of understanding of the requirements of and their responsibilities under the MCA. The deputy manager told us their training was not 'up to date' so it was not clear why they had the task of completing an MCA.

The MCA and DoLS require providers to submit applications to a Supervisory Body for authority to deprive a person of their liberty if they have been assessed as not having capacity. The manager had recognised that one person could not see sufficiently well to climb three steps safely. They decided to keep an interconnecting door shut and key coded to discourage the person from using the steps. The

manager had recognised that this could amount to a deprivation of the person's liberty and had applied to the supervisory body for the authority to take this action. However, there was no documentary evidence that the manager had completed a mental capacity assessment to explain why they had taken this decision on the person's behalf.

This was a continuing breach of Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2014 Need for consent.

During our previous inspection in October 2014, we identified improvements were needed to in support staff and ensure they were appropriately skilled to care for people effectively and safely. During this inspection we found improvements had not been made in how the provider supported staff. Support for staff was not planned and we saw that staff did not always demonstrate appropriate skills or knowledge, which impacted on people's care and support.

Training was not monitored by the provider and staff's training needs had not been identified by the provider. The provider's training record had not been updated since January 2015 and included staff who no longer worked at the service, but did not include new staff. The manager told us that no training had been delivered since they started at the service in May 2015, apart from medicines training for senior carer workers. The deputy manager and a member of care staff told us they had not discussed their training needs at their most recent one-to-one supervision meetings.

Although most of the longer term staff had achieved a nationally recognised qualification in health and social care, at our inspection in January 2015 we identified one member of staff who had worked at the home for many years had not received appropriate training. At this inspection we found where staff lacked training in safeguarding people from abuse and food hygiene, for example, this had still not taken place.

Two care staff had been recruited since May 2015, and one person, who was recruited as a cleaner and maintenance person, was working as a member of care staff. One new member of care staff told us they had already completed all the relevant training to deliver care safely with a previous employer, but they were not able to show the provider certificates to evidence exactly what training they had received. They had not been offered any training in this post. There was no record of the cleaner and maintenance person's training for and induction into a caring role, or of how the provider had assessed their interest in the role. There was no evidence the provider had ensured the two newly recruited staff or the maintenance and cleaning staff had received appropriate training to deliver care effectively.

Two people who lived at the home told us staff supported them as they needed. One person told us, "They are good at the job." A relative told us, "I feel they are looking after [Name]", but they told us they had concerns about some staff recognising and responding effectively to people who lived with dementia.

All the staff who had been in post before May 2015 had received training in dementia awareness, but not all staff demonstrated awareness of how to support people living with dementia. The manager told us one person who was known to be unpredictable in their mood, and presented risks to themselves and others. We found this person was not always within staff's sight as they moved around the home. Records showed the person was liable to injure themselves or others because they did not recognise risks and we saw this person bump into a doorframe during our inspection. On the second day of our inspection we saw the cook brought the person into the dining room after they had made their way to the kitchen unobserved by care staff. A review of the person's needs had been arranged with the local authority commissioners, but staff did not seem to recognise the person needed continuous observation and staff were not always in the same place as the person.

Two people with a diagnosis of dementia spent the entire day sitting in wheelchairs in the dining room, which can have a detrimental effect on fragile skin leading to skin breakdown. Staff told us people chose to spend their day in this way but did not demonstrate an understanding of how dementia can affect people's decision making. Staff did not use appropriate techniques to encourage these two people to vary where they sat, or to actively engage them in a way that would include changing where they sat. Two other people spent time in the front lounge without staff. Apart from one of those people taking a walk around the garden with staff during the first morning of our inspection, there were no discernible efforts to engage their interest.

Staff's skills and understanding of their role were not monitored. One of the three new care staff told us they had

not been shown any written polices or procedures and had not been offered any training. Their induction included fire safety, being introduced to people and working alongside experienced staff. Records showed they had been assessed as competent by a senior member of staff. The manager told us they planned to introduce training in the Care Certificate for new staff, but this had not been started.

A member of care staff told us they had a one-to-one meeting with the manager. They said, "I have a supervision with [Name]. They asked if I was happy in my role, if I had any concerns." The manager told us they had held one-to-one supervision meetings with staff, apart from three staff who had been recruited by the provider prior to the manager's appointment. The manager told us these staff did not recognise their authority. The manager told us the three staff were supervised directly by the provider. The provider had not kept any records of conversations, observations, supervision or training requirements for these three staff. There was insufficient evidence to demonstrate all staff had been observed in practice and assessed as competent. The provider could not explain, and had not kept any records to show, how they assured themselves these three staff understood their roles and responsibilities.

This was a breach of Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2014 Staffing.

People told us the meals were, "Okay" and "Alright", but were not able to explain whether they might like to change anything about the meals or mealtimes. Two people told us they had cereal for breakfast and one person told us they had bread and jam, because this was what they wanted. At lunchtime people who were able to eat independently were supported to move to a dining table and away from the television so that lunch time was an opportunity to socialise. Staff ensured people were offered a drink with their meal. There were enough staff to support everyone who needed assistance, either with cutting up their meal, or with eating their meal at lunchtime. Staff described the meal to people and gave them time to savour each mouthful, checking they had finished each mouthful before offering the next.

A relative told us staff supported their relative to eat and drink according to their needs and preferences. The relative knew their relation needed a soft diet and preferred sweet to savoury foods. We saw the person was assisted by staff at lunch time to ensure they were offered a balanced diet. The relative told us they were pleased that staff supported their relation to eat their main meal because they knew their relation would only eat sweet foods independently.

Risks to people's nutrition were known and managed. There was a white board in the kitchen that identified people's dietary needs, for example, the names of people who needed a soft diet and the names of people who needed a diabetic diet. The cook, who had recently been appointed, told us care staff had shared information about people's likes, dislikes and preferences. They showed us their menu plans for the next two weeks, which was based on the information care staff had shared and their previous experience of working as a cook at this service. One person could not remember what was for lunch, but was confident staff would bring something they liked. The cook told us they spoke with each person who lived at the home every day to tell them about the planned menu and check whether they would like it, or whether would prefer something different. They told us the alternatives included eggs, cheese, baked potato, beans or any combination people suggested.

The cook told us care staff told them if people did not eat all of their lunch and they were offered a more substantial supper, such as eggs on toast, or fish fingers and chips. We saw staff recorded whether people ate all or some of their meals, but the records were not detailed enough to know whether people had eaten a balance of protein, carbohydrate and vitamins. The cook told us the visiting dietician had given them advice about preparing nourishing, high calorie meals three times a day, to minimise the risks of poor nutrition. The cook had suggested to the manager that people were weighed weekly and their weights made known to the cook, so they could monitor the impact of their planned improvements to people's dietary intake.

People were supported to maintain their health. Records showed people were referred to other health professionals when their health needs changed. One person told us, "You just tell them when you want a doctor" and a relative told us their relation had been referred to the district nurse and occupational therapist. One person's daily records showed staff had asked one person's GP to visit because the person

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Is the service effective?

was frequently in a low mood and regularly declined to take their medicines. The GP had referred the person to the community mental health team for an updated assessment of their medical needs.

A visiting dietician told us staff asked their advice appropriately, for example, when one person was losing weight. They told us they had referred the person to their GP and requested that supplements were prescribed at the end of last year. The supplements had not been prescribed, and they had repeated the request. The dietician had been concerned that care staff at the time had not let them know promptly that the supplements had not been prescribed, but current care staff were clearer about their responsibilities to support people with their health needs. The dietician told us the current care staff team, "Appear keen to turn things around."

Requires improvement

Is the service caring?

Our findings

The provider had not ensured people were treated with dignity and respect and had not respected people's right to privacy. They had installed a CCTV system in the communal areas of the home, but had not put up signs to warn people, visitors or staff that they were being filmed, as required under the Data Protection Act 1998 and the Protection of Freedoms Act 2002. The provider was not able to show us any evidence that they had consulted with people who lived, worked or visited the home before they installed the system or that people or their representatives had consented to being filmed in their own home. We shared our concerns about this with the provider on the first day of our inspection, but the CCTV was still in operation on the second day of our inspection and there were still no warning signs.

The provider told us that two staff lived on the second floor of the house, which was not registered for use by people who used the service. We saw that one room on the first floor where people at the home had their bedrooms, was being used by a member of staff. The manager told us another member of care staff used a second room on the first floor. The staff rota showed that two staff were on night duty, but they were on waking night duty, not sleeping night duty. There was no clear reason for staff to sleep in these two rooms unless they were also living at the home, or sleeping during their shift.

The provider was not able to show us any evidence that people or their representatives were consulted about sharing their home and facilities with staff. Their bedroom doors were not marked, 'staff' or 'private'. The door to one room staff were living in was marked, 'Fire door, keep locked shut', which indicated the provider did not want people to know that staff were living in their home. The provider had not supported people's autonomy, independence and involvement in deciding how they wished to live.

This was a breach of Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2014 Dignity and respect.

People told us they thought the care staff cared about them. People told us, "Most of them are good" and "It's nice here. I am happy to be here." A relative told us, "The staff are really caring. They are kind." One member of care staff came in to work early. They told us, "I love these people."

We saw some staff treated people with kindness and compassion. People appeared relaxed in staff's company and staff chatted to people as they carried out their care tasks. Care staff understood people's moods and supported them with their practical needs. When one person decided they wanted to move to another room, we saw a member of care staff offered the person both hands while they stood up independently. They reassured the person they could walk around independently. The person moved confidently across the room with this encouragement.

We saw staff understood people who were not able to communicate verbally and supported them with kindness and compassion. For example, the manager told us, "[Name] becomes more animated with food." At lunchtime we saw this person react as the manager had told us.

Care staff told us they understood people's preferences for care and respected their right to make decisions about how their care was delivered. A member of care staff told us the staff rota was worked out to ensure one person always had a male care staff, as that was their preference. Another person told us they always had female care staff to support them because they had expressed this preference. Three people told us they preferred to spend time alone in their rooms and staff respected their decisions.

A relative told us they had explained their relation's preferences for how they were addressed, but not all staff knew, or, some staff did not always remember. They told us their relation would prefer to be known by their full name, but some care staff used a shortened version of their name. Daily handover records showed staff referred to the person by their full name. People's care plans included their preferences, but not all care staff had read them. One member of care staff told us they had not been shown any care plans, but had been told about people's preferences by experienced care staff.

Everyone was able to state their preferences or had relatives to represent their interests. One member of care staff told us they understood advocacy, because care staff were assigned as keyworkers for named people. The

Requires improvement

Is the service caring?

keyworker role gave people continuity of care and enabled them to develop a strong relationship with the person and their representatives. They told us keyworkers took responsibility for people's rooms, clothes and toiletries and communicating with their families. The manager told us that due to changes in staffing and the number of people who lived at the home, they needed to update the keyworker system to make sure it worked equally well for everyone.

Most staff respected people's dignity and privacy. Staff spoke discretely to people when offering personal care and adjusted people's clothes to maintain their dignity when supporting them to mobilise. However, we did hear one new member of support staff asking care staff in a loud voice to support one person because they judged the person needed to use the bathroom, which was indiscreet. We were told that no training had been delivered since January 2015, and this new member of support staff had not received training in dignity and respect.

Requires improvement

Is the service responsive?

Our findings

The provider did not operate an effective complaints system and staff were not given clear guidance for handling complaints. None of the people who lived at the home told us of any complaints about the service. One relative told us when they had raised concerns previously with the manager they responded appropriately, but when they raised concerns with staff the concerns, "Were not always passed on."

The manager told us they had received a verbal complaint personally and a second complaint had been made while they were away on sick leave. A member of care staff told us they had made a note of the second complaint and put it in the desk drawer for the manager's attention when they returned to work. The manager told us there was no note in the drawer when they returned to work. No-one was able to explain this discrepancy.

We asked the provider whether they knew about the second complaint. They told us they had reviewed the complaint in the manager's absence and believed there was no substance to it. They had asked three care staff for their opinion of the evidence the complainant had presented and the care staff reported the evidence did not support the complaint. The provider had not responded to the original complainant personally, but had spoken with other members of the person's family. The provider told us they believed there were no grounds for the complaint. They did not tell us whether the other family members were satisfied with the investigation or the outcome of their investigation. The provider had not responded to the actual complainant, but had shared their findings verbally with a third party. They did not confirm whether they had spoken with the actual complainant since.

Prior to our inspection another relative told us they had complained about the number of staff on duty at weekends. The provider did not tell us about this complaint and there was no documentary evidence that the complaint had been received, investigated or resolved.

The provider had not recorded any complaints, investigations or proposed resolutions to complaints. The provider had not taken the two complaints we knew about as an opportunity to learn and make improvements to the service. If staff and relatives had not told us about the complaint, there would have been no evidence of the complaints having been made.

This was a breach of Regulation 16 HSCA 2008 (Regulated Activities) Regulations 2014 Receiving and acting on complaints

Three people told us they were involved in planning their care and staff responded to their needs. A relative told us "I am involved in care plans and reviews."

Records did not clearly demonstrate that people were involved in care planning. One of the newly implemented care plans we looked at was not signed or dated by the person or their representative. There was no record the person had consented to their care. Another care plan we looked at had been signed and dated by the person, which demonstrated they had seen it. However, the care plan included a front sheet which was entitled, "I am writing this on [Name's] behalf", but it referred to the person as 'he' not 'I'. The person's individual risks and actions for staff were described from care staff's point of view, not from the person's point of view. There were no specific details about people's histories, hobbies or interests in their care plans. The deputy manager told us, "We get to know them [people] and understand what they want and don't want. I'm not sure it's written in the care plans."

It was not clear whether care staff did not have time, or did not have sufficient knowledge of people's previous lives and histories, to engage them in one-to-one time. On both days of our inspection, we saw two people in the front lounge where the television was on, but they did not show any interest in the programme. Care staff came in and out of the room, but did not stay in the room to keep people company. A member of care staff came in to support one person to go to the bathroom when they called out, but no further engagement was offered apart from casual conversation while moving from room to room.

Several people sat in the dining room during both days of our inspection with nothing to engage them apart from looking out of the window and casual conversation with staff in passing. On the second day of our inspection the deputy manager played cards with one person and a member of care staff played a table top game with another

Requires improvement

Is the service responsive?

person. But these activities took place at the same table and the two people who were sat in wheelchairs during our two day inspection were sat at a different table with no active involvement in the games.

The provider had not responded to the complex needs of people who live with dementia. People had personal effects around their own rooms, but there were no pictures, signs, colours or artefacts around the communal areas to interest and engage people living with dementia. During our inspection care staff responded to people's immediate needs with kindness, but we did not see or hear staff engaging in appropriate activities dependant on each person's preferences. One member of care staff told us, "There's not a lot to do. There are no reminiscence tools here, no memory boxes. I miss the opportunity for fun (with people)." Another member of care staff told us, "We need more activities. We need more trips out. We used to go to Weston-Super-Mare."

Three people told us they preferred to spend time in their own room, watching television or reading. A relative told us their relation liked to watch television in the lounge, or to look out of the window. They told us staff knew this and supported their relation to do this. Two people who spent time in the top lounge told us they, "Used to have exercises but not lately." They did not know when or if exercise sessions would take place in the future. On the second day of our inspection, the deputy manager did engage both people in a half hour exercise session with a big ball. We did not see an events or activities planner, so it was not clear whether this was a planned or spontaneous exercise session.

The manager and care staff told us various visiting entertainers came to the home and people enjoyed these occasions. They told us a 1940s style singer and another group of singers in costume had entertained people within the previous month. The manager told us they had taken photos of people enjoying the entertainment, which could be used to remind people of 'good times'. The manager told us they could not display them around the home as they needed to obtain consent from people before they could display them publicly.

There was no clearly documented evidence that people's care plans were regularly reviewed, or updated when people's needs changed. The manager told us people's care plans had not been updated since they started work at the service in May 2015, because they had been busy delivering hands-on care. The provider had engaged an external consultant at the beginning of October 2015 to support the manager to review and update everyone's care plan. It was too soon for us to know whether the new care plans would include a section that accurately identified people's preferences for how they spent their time.

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Is the service well-led?

Our findings

When we inspected the service in October 2014, we found the provider did not assess and monitor the quality of the service. We issued a Warning Notice which told the provider when they must take action by. When we inspected the service in January 2015, they had implemented a quality assurance system to ensure they knew when improvements were needed. Records showed the previous manager had implemented a system of management checks which had been undertaken in November and December 2014.

However, during this inspection we found the provider had stopped monitoring and assessing the quality of the service. The provider did not ensure the safety of the premises were maintained, and there was no documented or agreed policy, procedure or schedule for assessing risks to the premises. The records available gave no assurance the provider assessed and took action to minimise risks, as prescribed by the Health and Social Care Act 2008. There were no schedules, guidance or instructions for how to conduct premises risk assessments and no records to demonstrate premises risk assessments were undertaken.

The cook showed us records of checks they made on fridge, freezer and hot food temperatures. The records were up to date and gave the cook reassurance that food was stored and served safely. However, certificates of safety checks the provider was obliged to make by law were out of date. The last recorded date of staff checking that mattresses were in good condition and fit for purpose was January 2015 and the last recorded date of wheelchairs being checked was 2014. The last recorded date of water safety being managed by regular flushing of taps in unused rooms was May 2015.

During our inspection in October 2014, we found the provider had failed to maintain accurate records of each person, member of staff and of the management of the service. Following that inspection, the registered manager sent us an action plan explaining how they would make improvements. During this inspection we found the improvements had not been made.

The provider did not keep accurate and complete records for each person who lived at the home or for each member of staff. The provider and manager told us people's care plans were not up to date, because there had been changes in the management team. Staff files did not contain all the evidence required to demonstrate staff were recruited safely and appropriately skilled and experienced for their role.

Some recent accidents and incidents had not been recorded and no analysis had been undertaken to identify trends or patterns in the accidents that had been recorded. Complaints were not recorded, so there was no opportunity to analyse the causes, identify preventative measures or make improvements. The provider did not use information that was available to them to minimise risks to people's safety or to improve the quality of the service.

People were not able to explain whether they were involved in developing the service, so we asked the manager and provider how they involved people. We knew the provider had previously undertaken surveys of people and relatives, but they had not done this since our inspection in October 2014. The manager told us they had not held meetings for people or relatives since they were appointed in May 2015. The deputy manager told us they 'chatted' with people for feedback, but nothing was written down. The deputy manager did not tell us of any improvements that had been made as a result of their chats. Neither the manager nor provider could recall any instances of actively seeking out people's opinions of the service or show us documentary evidence of involving people in developing the service.

We asked the provider how they were assured they delivered a quality service, but they were not able to explain. The provider was not able to show us evidence that they monitored the quality of the service.

This was a continuing breach of the requirement to keep accurate records of each service user, of staff and of the management of the service

And

This was a repeat breach of Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2014 Good Governance

The provider did not promote a culture that encouraged candour, openness or honesty at all levels. We asked care staff about their views on the culture, vision and values of the organisation and how they were understood and demonstrated across the team. Although one care staff told

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us, "It's a good job, I do like it", care staff's accounts of how the service and staff were managed differed. The only value the whole staff team agreed on was that the focus of their role was 'good outcomes' for people.

The manager told us they had attended two staff meetings since May 2015, but only three staff had attended the first one. They told us they had not felt respected or supported at the second staff meeting. In the absence of further evidence from staff, and a lack of written records of the meetings, we were not able to understand whether staff were supported to share concerns, discuss grievances and suggest improvements, in the interests of promoting an open, empowering culture.

The provider did not promote good, consistent or fair staff management. There was not a registered manager in post. The previous registered manager had retired and a new manager had been in post since May 2015. They told us they had not been told how long their probationary period would be before they could be confirmed in post. The manager told us they had not had a one-to-one supervision meeting with the provider to discuss their role, responsibilities or how to develop their skills, since their appointment. At least four staff did not have contracts, or job descriptions, so the provider had no assurance those staff understood their role and responsibilities.

Staff were not all treated the same. Two of the staff that worked only under the direction of the provider had been invited to live-in at the home, but the provider told us it would not be alright for other care staff to sleep at the home overnight. The lack of leadership and consistency in how staff were managed led to divisions between different groups of staff. A member of care staff told us staff argued with each other in front of people. Another member of staff told us they liked working at the home, but they didn't like the, "Atmospheres and back stabbing."

Care staff were not supported or encouraged to work as a team, which had a direct impact on staff's behaviour. For example, we heard a member of staff offer lunch to one member of care staff, but not to a second member of care staff sitting just two chairs away. The provider had assured us that all staff were able to have a meal whether they worked a standard or long shift. The member of staff remarked on this unfairness to us while they assisted one person, which did promoted an uncomfortable atmosphere.

One member of care staff told us, "I would report any concerns under the whistleblowing policy to the manager. They would be taken seriously." Another member of care staff told us they had recently challenged one care staff's poor practice, but the provider had not investigated this as a whistleblowing. Records showed the whistleblowing report had not been recorded as such or referred to the safeguarding team, but had been recorded as an accident. There was no supporting documentation to show how the accident was investigated or whether any changes in staffing, training or staff supervision had resulted from this event.

The provider had told the manager about our previous inspection in October 2014, but had not shared the report in full and had not told the manager about the local authority placement stop. A placement stop is when the commissioners decide they will not ask the provider to accommodate any more people until specific actions have been taken as agreed in their contract. The provider had not shown the manager the action plan the previous manager had drawn up after our previous inspection. In the absence of specific instruction, the manager had created a list of 'things to do' in response to our previous report. The provider told us they were not pleased the manager had taken it upon themselves to write the list without telling them, but the provider had not given the manager appropriate guidance about improving the service.

The provider did not demonstrate good leadership. Most of the staff were supervised by the manager, but three staff had declined and would only accept supervision by the provider. There was no evidence the provider had held one-to-one supervision meetings with the three staff since the registered manager left in May 2015. There was no evidence that one of those staff was sufficiently trained, skilled and experienced to work as care staff as they had been recruited as a cleaner and maintenance person.

Care staff had varying understanding and different experiences of how they were managed, trained and supervised. They had different understanding and experience of the management teams' responsibilities and authority. Staff were not all treated with respect and their confidentiality was breached. For example, when a member of care staff handed in their notice in writing, the

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provider had not discussed this with the member of staff themselves, but had a conversation with the member of staff's partner, who also worked in the home, about the length of their notice period.

The manager told us some staff did not recognise their authority and would not accept instruction, guidance or supervision from them. They told us some staff would only report directly to the provider. The provider did not support the manager and we saw examples of where they overruled their decision making. For example, the manager had organised the rotas to ensure a safe level of suitably skilled staff appropriate to meet people's needs. In the manager's absence the provider had reduced the number of staff on duty at weekends and afternoons and substituted untrained and untested care staff in place of experienced staff.

The manager told us they had tried to implement a new on-call duty rota to give senior staff a fairer proportion of duty, to promote a better work-life balance. They told us one member of staff did not like the changes, but had not discussed their objections with them as a manager. The member of staff had taken the new on-call rota down and directly to the provider. The provider had re-issued the original rota without discussion with the manager. The manager told us they felt the provider had undermined their authority, without constructive feedback. The provider had failed to understand the impact of their actions on staff's confidence in their role.

Improvements were needed in in supporting staff to understand what was expected of them and in the processes for staff to account for their decisions, actions, performance and behaviours.

The provider did not recognise their responsibilities under the Health and Social Care Act Regulations 2014 to display their rating or to direct people to our website, where anyone can find out about the performance of the service.

The service had previously been awarded a rating of Inadequate following our inspection in October 2014 and of Requires Improvement following our inspection in January 2015, but this was not shown on their website. Their website had been recently updated by hibu (UK) Limited for 2015, but did not include the most recent rating for the premises and activities, or our website address or direct people to the place on our website where the most recent assessment of their overall performance can be accessed.

A visitor told us, "I didn't know about the bad CQC report." There was no sign at the premises to tell service users or visitors about the latest rating for the service. The latest report, or a summary of the report, had not been made accessible to service users and visitors. The provider told us they did not want to share the report more widely because people, "See too much anyway." The provider had not displayed the service rating in a conspicuous place which was accessible to service users or others.

Improvements were needed to enable and encourage open communication with people who use the service, those that matter to them and staff.

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 10 HSCA (RA) Regulations 2014 Dignity and respect People who use services were not treated with dignity and respect. The provider did not ensure the privacy of the service users and did not support their autonomy, independence and involvement in the community. Regulation 10 (1) (2)(a)(b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent Care and treatment was not always provided with the consent of the service user or relevant person. For service users 16 or over who were unable to give such consent because they lacked capacity to do so, the registered person did not act in accordance with the 2005 Act. Regulation 11 (1) (3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment Systems and processes had not been established or operated effectively to prevent abuse of service users. Systems and processes had not been established and operated effectively to investigate, immediately upon becoming aware of, any allegation or evidence of such abuse. Care or treatment for service users was sometimes provided in a way that significantly disregarded the needs of the service user for care or treatment, which might amount to neglect of a service user. Regulation 13 (2), (3), (4)(c) and (6)(d)

Regulated activity	Regulation

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment The provider did not ensure premises and equipment used by the service provider were suitable for the purpose for which they were being used and were properly maintained. Regulation 15 (1) (a)(c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints The provider did not receive, investigate and take and necessary and proportionate action in response to any failure identified by a complaint or investigation. The provider did not establish and operate effectively an accessible system for identifying, receiving, recording, handling and responding to complaints by service users and other persons in relation to the carrying on of the regulated activity. The provider did not provide to the Commission, when requested to do so and by no later than 28 days beginning on the day after receipt of the request, provide a summary of complaints made under such complaints system and responses made by the provider to such complaints and any further correspondence with the complainants in relation to such complaints, or any other relevant information in relation to such complaints as the Commission requested. Regulation 16 (1)(2)(3)(a)(b)(c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider had not established or operated effective systems or processes to ensure compliance with the requirements of this Part. Regulation 17(a), (b), (c), (d) (i) and (ii), (e) and (f)

Regulated activity	Regulation

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing The provider had not ensured sufficient numbers of suitably qualified, competent, skilled and experienced persons must be deployed in order to meet the requirements of this Part.The provider had not ensured persons employed by them in the provision of a regulated activity received such appropriate support, training, professional development, supervision and appraisal as was necessary to enable them to carry out the duties they were employed to perform. Regulation 18 (1) (2)(a)
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed The provider did not ensure persons employed for the purposes of carrying on a regulated activity had the qualifications, competence, skills and experience which were necessary for the work to be performed by them and did not ensure recruitment procedures were established and operated effectively to ensure that persons employed met the conditions in- (a) paragraph (1) The provider did not ensure the required information specified in Schedule 3 or other information required under any enactment to be kept by them in relation to such persons employed was available. Regulation 19 (1)(2)(3)(a)(b)