Care Quality Commission

Marray House Care Services

Marray House

Inspection report

12-14 Essa Road
Saltash
Cornwall
PL12 4ED
Tel: 01752 844488
Website:

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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?	Inadequate
Is the service well-led?	Inadequate

Overall summary

This was an unannounced inspection on 10 December and 12 December 2014. Marray House provides accommodation for up to 20 older people who require support in their later life or are living with dementia. There were seven people living at the home because the service was subject to safeguarding processes, and the local authority were not commissioning with the service at the time of our inspection. The home is comprised of two separate houses which are joined together by a kitchen. Accommodation is arranged over two floors, and there is a stair lift to assist people to get to the upper floor. The home has 20 single bedrooms. There are shared toilets, bathroom and shower facilities.

After our last inspection in September 2014 we told the provider to take action to make improvements to how the quality of the service was monitored. The provider sent us an action plan on 7 November 2014 confirming all the improvements had been made. During this inspection we looked to see if these improvements had been made, but they had not all been completed.

Summary of findings

The service has not had a registered manager since September 2011. 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.

Staff did not understand how the Mental Capacity Act (MCA) and deprivation of liberty safeguards (DoLS) protected people to ensure their freedom was supported and respected. The MCA provides the legal framework to assess people's capacity to make certain decisions, at a certain time. When people are assessed as not having the capacity to make a decision, a best interest decision is made involving people who know the person well and other professionals, where relevant. DoLS provide legal protection for those vulnerable people who are, or may become, deprived of their liberty.

People's comments about the staff were variable; some people told us staff were kind and caring, whilst others felt differently. Relatives told us they were happy with the care their loved ones received, and like people who lived at Marray House, were complimentary of the provider. Relatives and professionals told us they always received a warm welcome when visiting. However,

people were not supported by sufficient numbers of staff who had the knowledge, skills, experience and training to carry out their role.

Staff were not aware of people's individual nutritional needs and people were not always supported to drink enough. People had access to health care services however services were not always contacted in a timely manner. The provider did not have effective systems in place to ensure information about people's health care needs were shared. This poor communication affected the ability of staff to meet people's individual needs.

The provider did not always embrace feedback from health and social care professionals to enable learning and improvement to take place. For example, the provider had chosen not to implement changes as suggested by social care professionals to improve the care planning documents for people.

People did not receive care which was personalised to their needs because staff did not always follow advice from health professionals. Care plans and risk assessments were not individualised and did not give clear direction to staff about how to meet a person's needs. This meant the care being provided was inconsistent between staff. People were not involved in creating and reviewing their own care plan. This meant people's care plans were not reflective of their own choices.

People's independence and social life were not promoted. People had requested trips outside of the home but no opportunities were provided.

People's medicines were not managed well which meant people did not receive them at the correct time and documentation was inaccurate. People's end of life wishes were not understood by staff and people's care planning documentation was not reflective of their wishes. This meant people were not well supported at the end of their life and did not always receive consistent and compassionate care.

The quality monitoring systems in place did not help to identify concerns and ensure continuous improvement.

Staff were able to explain what action they would take if they suspected abuse was taking place. People were protected by safe recruitment procedures as all employees were subject to necessary checks which determined they were suitable to work with vulnerable people. People told us, if they had any concerns or complaints, they felt confident to speak with the staff or provider.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of this report.<Summary here>

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?

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Aspects of the service were not safe.

Staffing numbers were not adequate to meet people's individual needs.

People were not protected from risks associated with their care and documentation relating to this was not reflective of people's individual needs.

People did not receive their medicines at the prescribed time, and documentation relating to medicines was inaccurate.

People told us they felt safe. Staff knew what action they would take if they suspected abuse was taking place. Safe recruitment practices were in place.

Inadequate

Is the service effective?

The service was not effective.

People did not receive support from staff who had the necessary knowledge, skills and training to meet their needs.

People's changing care needs were not always referred to relevant health services in a timely manner. People's care needs were not always properly met as staff did not always follow the advice from health professionals.

People were not supported to eat and drink enough and maintain a balanced diet.

People were not protected by the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) as staff had poor knowledge of the legislative framework.

Inadequate

Is the service caring?

Aspects of the service were not caring.

People told us staff were sometimes caring and meant well. However, there were times when people did not feel well cared for. Staff did not always speak with people in a respectful manner.

People's confidentiality, privacy and dignity were not always respected.

People's end of life wishes were not understood by staff. People did not always experience compassionate care at the end of their life.

Requires Improvement

Is the service responsive?

The service was not responsive.

Inadequate

Summary of findings

People were not involved in the design and implementation of their own care plans which meant care planning documentation was not reflective of their wishes. People's care plans were not individualised and did not provide guidance and direction to staff about how to meet people's care needs.

People's needs were not always met in line with professional advice.

People's independence and social life were not promoted, which meant people had very little to occupy their time.

Concerns which were raised by people were not always used as an opportunity to make improvements.

Is the service well-led?

Inadequate

The service was not well-led.

The service did not have a registered manager in place.

People and staff were not empowered to be involved in the running of the home. Lack of leadership meant staff did not know what action they needed to take to meet people's needs.

People did not receive a high standard of quality care because the provider's systems and processes for quality monitoring were ineffective in ensuring people's needs were met and the environment was safe.

Relationships with external professionals were not always positive which meant advice was not always implemented to the detriment of people and staff.

Marray House

Detailed findings

Background to this inspection

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

We visited the home unannounced on 10 December 2014 and 12 December 2014. The inspection team consisted of two adult social care inspectors. On the first day we focused on speaking with people, their visitors, and with staff. We observed how people were cared for, and examined care and recruitment records. On the second day we reviewed staffing levels and looked in more detail at care and management records, and spoke with staff and the registered provider.

During our inspection we spoke with five people living at the home, one relative, four care staff, and the registered provider. Following our inspection two relatives provided us with written feedback. We observed care and support. We looked at four care plans, medicine records, policies and procedures, and five personnel and training files. We also looked at quality assurance and monitoring paperwork which the registered provider had in place.

Before our inspection we reviewed the information we held about the home. We reviewed information provided to us by health and social care professionals and notifications sent to us by the provider. Notifications are information about important events which the service is required to send us by law.

After the inspection we contacted local commissioners of the service who funded people who lived at Marray House to obtain their views and the local authority service improvement team. We made contact with one GP, one social worker, one mental health nurse, and the community district nursing team.

Inadequate

Is the service safe?

Our findings

People's feedback regarding whether there were sufficient numbers of staff varied. Whilst some people told us there were enough staff, two people told us, "I am not one for calling them unnecessarily", and "I don't like to trouble them, they give the impression they are busy". When asked if staff assisted them promptly, one person told us, "depends how busy they are… in about a minute, sometimes 20… hard to say".

Care staff had responsibility for caring for people, as well as cooking meals and doing the laundry. Staff felt there were not always enough staff to meet people's personal care needs because of the other domestic tasks they had to undertake. External social care professionals had also shared concerns with us regarding staffing levels at the care home and the impact this was having on the ability to meet people's health and social care needs.

People did not receive their medicines at the prescribed time, for example, one person who should have been given their medicine at 8am was given it at 10am and another person was given a controlled drug at 9.10am when it was prescribed for 8am. This was because staff were busy doing other things. One person told us, "they give it to me [medicine] and I drink it on time, sometimes a little late because they're caring for someone else". We observed this person to receive their medicine at 10.45am when they should have received it at 8am.

Staffing was not adjusted to take into account people's changing needs. For example, one person's care needs had increased significantly since our last inspection however the staffing level had not been reviewed to reflect this. People were not always supported promptly. For example one person who had been assisted to the toilet was waiting for staff to support them back to the lounge. The person was shouting, "How long, how long?" As no staff responded we went to find a member of staff who was in the office and unaware the person needed assistance as they could not hear the person calling them.

People's care records showed at night time they required the support of two members of staff however the night staffing levels had not been reviewed to take this into consideration. We were concerned documentation relating to the care people received at night unlike during the day, was signed by one member of staff, which raised concerns whether people were being supported in a safe and correct way by two members of staff. At a meeting following our inspection it was confirmed that there were not always two members of staff working during the night. This meant people were not receiving safe care in line with their care plan.

We found people's needs were not being met because there were not sufficient numbers of staff.

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

People were not protected from risks related to their care and documentation was not always in place and reflective of people's individual needs. For example, one person who was at risk of choking did not have a risk assessment in place. All staff who supported this person had not read the care plan and, when asked what action they would take if the person choked, staff explained they would find the provider for help. The staff did not know what else they should do to meet this person's needs or how to respond in the event of the person choking.

Risk assessments were not in place to support one person who had been referred to a mental health nurse due to behaviour which was perceived by staff as challenging. Staff had been requested to record the behaviours to assist with the person's ongoing assessment. However, there were no clear guidelines or directions in place about how to support the person when their behaviour changed. This meant staff would not know how to minimise associated risks to the person, staff and others.

We found risk assessments were not always in place as necessary and were not always reflective of people's individual needs. This was a breach of Regulation 10 of the Social Care Act 2008 (Regulated Activities) Regulations 2010.

Staff did not have a clear understanding of what action to take in the event of an unexpected death. For example, we asked a member of staff whether they would ring the emergency services, they replied, "yes you could, but if they have gone it's not an emergency", and confirmed they were not sure what the policy said.

People told us their call bell did not work in their bedrooms. When we checked the call bell system we found this to be correct. This meant people were not always able to call for assistance when they required it.

Inadequate

Is the service safe?

People may be at risk in the event of a fire as we found the lounge door was propped open with items other than appropriate fire protection devices. We identified concerns relating to this at our last inspection and spoke with the Cornwall and Fire Rescue Service, who inspected and found additional concerns. The provider has been requested by the Cornwall and Fire Rescue Service to become compliant by April 2015.

The recording of when medicine was administered was inaccurate as staff did not distinguish a change of time on the medicines administration records (MARS). This could lead to a person being given too much or too little medicine in one day. People should be given their medicines at the prescribed time otherwise the medicine may not be effective.

For one person who was having difficulties swallowing their medicine, the GP had given permission for staff to crush their medicine. The person's care plan did not give staff clear guidelines about this. For example, the GP's request had become misinterpreted and we read staff had been crushing dispersible tablets which should have been dissolved in water. This indicated staff who administered medicines did not always have basic knowledge about the medicines they were handling. A health professional also raised concerns, and told us they felt staff did not always have a good understanding of medical conditions and of the medicines they were administering to people.

People were not always receiving their medicine, for example, we were told by a community nurse that a person had not received their medicine because staff were having difficulties in getting the person to take it, however no action had been taken to speak with the person's GP.

People's care plans did not provide guidance and direction to staff about how to meet people's care needs. For example, one person had been prescribed a cream. We saw from medicines administration records (MARS) the person was having the cream applied every two hours. Staff explained that it had been on the request of community nursing staff. When we read the person's care plan there was no guidance for staff about this. We spoke with a community nurse who told us this was incorrect and was related to the person's continence management. This meant the person was having cream applied every two hours when it was not necessary.

Staff who administered medicines received training; however, medicines were not always administered in line with the correct practice. For example, we saw a member of staff break tablets in half with their hands and then pass them to the person to take; this did not take into consideration the risk of cross infection. People's medicine was stored securely.

We found people were not always receiving their medicine when it was prescribed. Documentation relating to medicine management (MARS) was not being completed accurately. This was a breach of Regulation 13 of the Social Care Act 2008 (Regulated Activities) Regulations 2010.

Staff explained what action they would take if they suspected abuse was taking place. This meant people were protected as staff were able to recognise signs of potential abuse and knew what to do.

People were protected by safe recruitment procedures as all employees were subject to necessary checks which determined that they were suitable to work with vulnerable people.

Inadequate

Is the service effective?

Our findings

People did not receive support from staff who had the required knowledge and skills to carry out their role. For example, at the time of our inspection one person required end of life care, however, only one member of staff had undertaken training, and from speaking with staff they confirmed they had limited knowledge. This meant all staff did not have the necessary skills or knowledge about what care people needed when they were at the end of their lives.

Staff received training in manual handling; however a member of staff told us they had not had any training of how to use equipment such as hoists as the training had been theoretical and not practical. This was a concern as this member of staff was required to assist people using such equipment.

The provider did not ensure staff received the training they needed to do their job well unless it was identified by someone else. For example, a community nurse identified staff required first aid training, so the provider implemented the training. Another example of this was, following our concerns regarding end of life care, the provider responded by finding out about available training courses for all staff to attend. However the provider had not considered staff needed this training before our inspection.

The provider's training plan showed staff had not completed all of the training identified as mandatory by the provider, such as first aid and fire. This meant staff had not undertaken all of the training necessary for them to carry out their role. Community nurses told us they did not feel staff were well trained and lacked basic knowledge and skills. Health professionals felt staff were caring, however did not always understand the appropriate way to support people due to lack of training.

Staff were not given adequate support and supervision. Staff supervision records were in place but did not always identify training and development needs. Staff did not receive appraisals which meant staff were not given the opportunity to discuss their ongoing working practices and development.

People did not receive care and support from staff who had the right knowledge, experience and skills to support people. This was a breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Staff had a poor understanding of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) even though the provider's training records identified staff had undertaken training. The MCA provides the legal framework to assess people's capacity to make certain decisions, at a certain time. When people are assessed as not having the capacity to make a decision, a best interest decision is made involving people who know the person well and other professionals, where relevant. DoLS provide legal protection for those vulnerable people who are, or may become, deprived of their liberty.

The provider had not made all of the necessary DoLS applications in line with the legislation when a person's liberty may be restricted. The provider explained that, for one person, he had been waiting on advice from a mental health nurse. This demonstrated the provider was not aware of the recent changes to legislation and the new responsibilities which had been placed on registered providers.

People's advance directives were not always understood by staff. For example, a member of staff confirmed they did not know who had advance directives in place, and another member of staff did not know what an advance directive was. A member of staff told us there was only one person who wanted resuscitation, however when we read this person's care plan they had an advance directive in place which stated that they did not wish resuscitating. This meant, in the event of death, people's wishes may not be carried out.

People's consent to care had not always been obtained, for example staff were carrying out night checks, bowel and urine checks without the consent of the person and with no rationale as to why.

We found the legislative framework of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards was not always being followed. People's consent was not always obtained in relation to the care and treatment provided to them. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Inadequate

Is the service effective?

People were not supported to eat and drink enough and maintain a balanced diet. For example, one person had food charts which had been put into place by the community nurses to monitor the amount of food they ate and how much they had drunk within one day. This was because the person was at risk of not eating or drinking enough. At the end of our first day of inspection, the documentation for this person had not been completed, so there was no record of how much this person had eaten or drunk. This was of particular concern as the person was very unwell. We asked a member of care staff how much the person had eaten and drunk during the day. The member of care staff attempted to guess the amount and amend the documentation. We were concerned about the care and support this person was receiving and the competence of staff, so we informed the community nursing team and the local authority safeguarding team.

Staff were provided with specialist knowledge and support from the community nursing team. However, when advice was given, staff did not always put into practice what they had been told. For example, a community nurse told us that, after they had shown staff how to support a person with their eating and drinking, they were observed to be supporting the person incorrectly, placing the person at risk of choking because the person was not sitting in the correct position.

This same person was not always getting enough to drink at night. The night staff were unable to confirm exactly how much the person had drunk during the night and said they thought the person had "about five teaspoons, but not overly full"; however another member of staff said the person "should be having 1000mls a day". The person's care plan did not detail how much the person should be expected to drink and staff were not aware of what was expected.

People's nutritional risks were not always monitored. For example, one person told us, "sometimes the food is a bit scarce" and "I'm always hungry". We looked at the person's care records to find out if they had lost weight but the records had not been completed. The provider explained they did not have the right equipment to weigh people who were unable to stand on scales, and they had been waiting for a company to supply one. However, in the meantime, the provider had not considered other weighing alternatives such as the Malnutrition Universal Screening Tool (MUST).

People's care plans did not detail the risks associated with eating and drinking. For example, a visit from a speech and language therapist meant staff had been requested to support a person in a different way; however the care plan had not been updated and, from observations and information from health professionals, the person's care needs were not being met consistently by staff.

On the second day of our inspection we arrived at approximately 7.50am. People did not receive their breakfast promptly, for example one person was assisted with their breakfast at 10.55am having been awake since approximately 8am. Documentation showed this person last ate before staff had finished their shift at 8pm the previous day, which meant the person had not eaten anything for approximately 15 hours.

People were not always supported to have enough to eat and drink. Documentation relating to the recording of nutrition and hydration was inaccurate. This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People were able to see their GP or a community nurse when they chose to. One person told us, "I had conjunctivitis a few weeks ago; they called the doctor and sorted it out with drops". Another person told us, if they were unwell, the staff contacted a nurse quickly.

Health care professionals visited the home frequently. Community nurses told us they did not feel staff always followed the care plans which they had written specifically for a person and information between the staff was not always shared. This meant the care people received was not consistent and advice and guidance was not always followed.

People's health concerns were not always shared quickly and staff did not always contact community nurses promptly when a concern was identified. For example, when staff were discussing the condition of one person's skin it was clear that the person's skin had been a concern for a few days, however advice had not been sought.

There was not always an understanding from staff about the recognition of a person's changing health care needs and the necessary action which may be required. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Requires Improvement

Is the service caring?

Our findings

People's comments about staff were variable. One person told us, "they're not unkind, they just don't care". Another person told us they would like staff to "speak to you as a human being and treat you as an equal". Other comments included, "they're all nice here", "very kind", "some are better than others", "it depends who it is, some of them are very good, others not so", and "nothing is too much trouble for them, they are very helpful" and "all the girls are nice.

People were not always supported when requested, for example, a member of staff asked the provider to assist them in taking a person to the toilet. The provider told the member of staff they were busy in a meeting. We asked the provider to assist the member of staff straightaway to ensure the person did not have to wait.

People were not always spoken with in a respectful manner. For example, one person shared with a member of staff that they had experienced an embarrassing situation and needed assistance. The member of care staff said she was busy and replied, "are you going to do my shift for me, you know how to do med's [medicines] and everything?". Although this was said in a relaxed, humorous way, the response was disrespectful, inappropriate, and the person did not receive the care they needed.

People's confidentiality was not always respected. We were told by a health care professional they preferred to discuss medical matters in private. However this was not always possible as the person was sitting in the lounge, so consultations were carried out in communal areas. Another example was for one person who was receiving a visit from a speech and language therapist, their bedroom door had been left open. We heard a member of staff acknowledge that the door should have been closed but had not closed it. This meant their privacy was compromised.

People did not always experience compassionate care at the end of their life. For example, when a person was dozing, their bed was raised up without the person being told what was happening. Staff had not considered how this may have made the person feel. We read in this person's care plan that they wore glasses; however, when this person was supported they did not have their glasses on. This meant the person was unable to see clearly.

People were complimentary of the provider, one person told us, "even the boss is alright...he comes round and says morning and night…I think it is nice". Another person said, "he goes around checking everyone is alright, he's lovely. I like pulling his leg". The provider was seen to interact in a kind way towards people, took time to stop and have a chat, and showed an interest in how people were and what they were doing.

Relatives told us they thought staff were kind and caring. Comments included, "They are all kindness itself and nothing is too much trouble for them in the care of the residents", "treat people as individuals…they give a very personal level of care" and " an environment that reflects their own homes, warm, comfortable and friendly". One of the relatives told us the provider was "very caring". People's relatives and friends were able to visit at any time and they were welcomed warmly into the care home by staff and the provider. One relative told us, "Lovely….they [staff] are just relaxed".

Inadequate

Is the service responsive?

Our findings

People's care plans did not guide and direct staff to deliver consistent care to people. For example, one member of staff was heard to say, "I don't know what the other girls do, but I do…". For one person who was very unwell, a member of staff was brushing their hair and the person responded positively to this. The member of staff told us the person "loves" having their hair brushed however the person's care plan did not detail this individualised and important information.

People with specific care needs had care plans in place that had been devised by health professionals, such as ensuring people's skin was properly cared for. But staff were not always following these. For example, the specialist equipment put in place to minimise skin damage was not always being used. On the first day of our inspection we observed the equipment was not being used and the provider and staff told us it was not required and they were not aware of the instructions from the community nurse. A community nurse who had visited this person told us they were unhappy about how a member of staff had been supporting the person, were concerned about the consistency of care being delivered, the knowledge of staff and the accurate completion of care records and care plan documentation.

People who were at risk of skin damage had turn charts in place for staff to record when they had repositioned the person. However turns were not being carried out as requested. For example, for one person, the turn chart showed they should be turned every two hours, however at times we saw there had been delays in turns of three and a half and four and a half hours. This meant the person was at risk of tissue damage and developing pressure ulcers.

For one person, who had recently experienced hallucinations, the care plan gave no direction to staff about what to do in the event of this occurring. The lack of information meant staff may not know how to respond to the person in line with the professional advice which had been given.

One relative told us they were kept informed and had seen a copy of their relative's care plan. However it was not clear how people were involved in their own care plans and there was no evidence of care reviews with people and or their relatives. This meant people's care plans were not reflective of their own choices.

The community nurses told us they had not been made aware of the serious deterioration of one of the people who lived at the care home. The community nursing team were not given an opportunity to bring forward their visit to review the person's health condition and increase the support which may have been required.

A health care professional told us communication was not good. For example, at times the staff had asked them to visit someone but were not clear about the issues they wanted the professional to address. The health care professional said there were occasions when they arrived at the home, following a request to call, to find the member of staff who had made the call was not on duty and had not passed on the information to their colleague. At times the person had got better and a visit was no longer necessary. The health care professional also said that, when they had requested the staff carry out a specific action, it had not always been done or the message had become confused amongst staff.

People's independence and social life was not promoted. Minutes of residents meeting showed people had expressed their preferences for more social activities. However, on the day of our inspection people spent the day either on their own in their bedroom or sitting in the main lounge watching the TV, sleeping, or entertaining themselves, such as knitting. People were not given opportunities to go outside of the care home. One person told us, "I'd like to go out… a treat for me, would be a trip to Marks and Spencer's".

Community nurses told us lessons were not always learnt from previous concerns which had been raised. For example, the management of people's continence was not always being met correctly. We were told one person's skin had become very sore as they had been wearing the incorrect size of continence aids. Community nurses had previously discussed continence management with the provider and with staff. The concern about meeting people's continence needs had also been identified by us at previous inspections.

There was not always an understanding from staff about the recognition of a person's changing care needs and the

Inadequate

Is the service responsive?

necessary action which may be required. Care plans did not reflect the care being delivered. Staff did not always follow the advice of external professionals. The care being delivered by staff was not always consistent. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider had a complaints procedure in place which was displayed for people and visitors. People told us if they had concerns they would speak with the provider and with staff. One person described the registered provider, “as a nice man, when he says anything he means it”.

Inadequate

Is the service well-led?

Our findings

The provider has not had a registered manager in place since September 2011. We wrote to the provider in November 2014 requesting that an application to register a manager be made however none has been received.

This was a breach of Regulation 5 of the Care Quality Commission (Registration) Regulations 2009.

People did not receive a high standard of quality care because the provider's systems and processes were ineffective in ensuring people's needs were met. Staffing levels within the home were not reviewed and assessed which meant the system was ineffective in identifying staffing requirements. Staff were not appropriately supervised to ensure people received enough food and drink. There were no checks in place to help ensure people who were at immediate risk of developing unnecessary pressure ulcers were being supported as required. The community nurses told us they felt there was a lack of leadership and communication which at times had resulted in concerns about people's health not being shared in a timely way.

Concerns which were raised were not always used as an opportunity to make improvements. For example, the local authority service improvement team had an action plan with the provider for improvement since December 2012 but this had not been completed. The provider told us he did not agree with the entire action plan and of the professional opinions regarding care planning documentation.

The provider had no systems in place to review the environment to ensure it was safe for people. For example, moving and handling equipment for one person had not been serviced since 1999 and had not been identified by the provider. The provider was unaware that the call bell system was not working for everyone.

When speaking with the provider about our concerns, he placed blame and criticism on the staff team and consideration was not given to reviewing the leadership or management of the home.

People's care plans had been reviewed, however, the provider's auditing system had failed to identify the concerns we found. Medicines were being monitored, however the provider's auditing had also failed to identify the concerns we found.

We found the systems in place to monitor the quality of service people received to identify, monitor and manage risks and to obtain feedback from people were not effective. This was a breach of Regulation 10 of the 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.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 5 HSCA 2008 (Regulated Activities) Regulation 2010 Requirement where the service provider is a body other than a partnership The service did not have a registered manager in place, and has not had a registered manager in place since September 2011.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services The registered provider had not taken proper steps to ensure that people were protected against the risks of receiving care or treatment that was inappropriate or unsafe by not carrying out an assessment of people's needs or ensuring the planning and delivering of care met people's needs and ensured their welfare and safety. Care plans did not reflect the care being delivered. Staff did not always follow appropriate professional advice in relation to providing care. The provider did not have appropriate emergency procedures in place.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers The systems in place to monitor the quality of service people received; and to identify, assess and manage risks; and to obtain feedback from people were not effective.

Regulated activity	Regulation

This section is primarily information for the provider

Enforcement actions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines People were not protected by the risks associated with the recording, handling, and administration of medicines.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010 Meeting nutritional needs People were not always supported to have adequate nutrition and hydration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment The legislative framework of the Mental Capacity Act and Deprivation of Liberty Safeguards were not always being followed. People's consent was not always obtained in relation to the care and treatment provided to them.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing The registered provider had not taken appropriate steps to ensure that at all times, there were sufficient numbers of suitably qualified, skilled and experienced staff to safeguard the health, safety and welfare of people.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff Staff were not supported in their role to enable them to deliver care, treatment and support to people safely and to an appropriate standard.

This section is primarily information for the provider

Enforcement actions

The enforcement action we took:
<Insert description of action together with any timescales as relevant>