Care Quality Commission

Stanwell Rest Home Limited

Stanwell Rest Home

Inspection report

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Ratings

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

Overall summary

This inspection took place on 27 &29 January 2015 and was unannounced. The home provides accommodation and care for a maximum of 38 older people. Some people may be living with dementia or mental health illness. There were 34 people living at the home when we carried out our inspection. Accommodation is provided in the main building with an “apartment” in the same ground where eight people were living.

At the last inspection on 24 July 2014, we issued compliance actions for care and welfare of people using the service, medicines management, staffing, records and assessing and monitoring the quality of the service provision. The provider sent us an action plan to become compliant by 30 December 2014.

At this inspection we found some improvements had been made, such as the process for returning unused medicines was in place. However there were insufficient actions taken to meet the regulations in a number of areas which we assessed. Although the action plan had been developed, this had not been followed and people remained at risk to their care and welfare.

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

Summary of findings

People were not protected against the risks associated with unsafe care. Where risks had been identified; care plans had not been developed to inform the staff's practices and protect people from unsafe care.

People were not receiving their medicines at the correct times or in a safe way placing them at risk. The medicines administration records (MARs) showed people had received their medicines, however we identified additional stock levels that could not be accounted for.

People were put at risk to their health through poor infection control processes. Staff did not follow the guidance on the prevention and control of infections and the associated risk of cross infection.

Where people lacked the mental capacity to make decisions, the provider did not always follow the principles of the Mental Capacity Act 2005. Mental capacity assessments were not conducted and the provider could not evidence how best interests decisions had been made to protect people.

Staff were not supported through regular supervision, in order to monitor their practice and identify training and development needs. Staff's training and updates were not up to date.

The provider was failing to inform CQC of incidents which affected the health and welfare of people using the service.

Quality assurance systems were not effective. Audits had not been completed, incidents and accidents were not investigated through lack of reporting in order to ensure lessons were learnt to prevent further incidents and inform practice.

Records were not managed safely and records we requested relating to the management of the service were not available to us.

There was a complaint process, however the registered person was not able to show us the records of how complaints were managed and responses made to deal with complaints and concerns.

People were provided with a balance diet and were satisfied with the meals and choices offered. A variety of meals were available to suit people's individual needs. Pureed diets were not well managed.

People were treated with care and their privacy and dignity respected when receiving care.

Recruitment procedures were followed and necessary checks were completed prior to staff starting work.

We have made a number of recommendations for the provider to consider when providing care to people.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to the regulations 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 this report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Staff had had received up to date training in safeguarding people. However, they were not aware of their role in reporting appropriately to the different agencies.

Medicines were not always managed and administered in a safe way. People did not receive their medicines in a timely manner.

Infection control practices and procedures did not protect people from the risk of cross infection.

Appropriate assessments were in place to identify risks when meeting people's needs. However, there was no procedure to follow up or monitor incidents to reduce the risk of subsequent events.

There were enough staff to meet people's needs in a timely manner.

Recruitment procedures were followed and necessary checks were completed prior to staff commencing work.

Is the service effective?

Requires Improvement

Not all aspects of the service were effective.

Staff were not appropriately supported through regular supervision, training updates were not up to date and staff practices were not monitored.

Staff had not undertaken Mental Capacity Act (2005) and Deprivations of Liberty Safeguards (DoLS) training, to make sure that they understood how to protect people's rights.

People were offered choices with meals and supported appropriately. However people's weights were not monitored and pureed diets were not managed appropriately.

People were supported to access appropriate healthcare advice from health professionals as required.

Is the service caring?

Requires Improvement

The staff were caring and people were treated with care, compassion and staff respected their wishes.

Staff respected people's privacy and dignity when providing care and support to people.

There were no restrictions on visiting the home and relatives were always made to feel welcome and kept informed of changes.

People were not involved in planning their care at the end of their lives.

Summary of findings

Is the service responsive?

Inadequate

The service was not responsive to people's needs.

Risk assessments and care plans were not fully completed which put people at risk of receiving inconsistent care.

Information about how complaints were managed and responded to were not available. People however, felt able to raise concerns with the staff.

Incidents and accidents were monitored; however as these were not all reported, actions could not be developed to improve practice and safeguard people.

Is the service well-led?

Inadequate

The service was not well led.

The quality monitoring system was not effective in order to effect necessary changes and learning.

There was a lack of monitoring at provider level such as regular review of the service provision.

Care records were not adequately maintained and records relating to the management of the service were not available when we requested them.

Notifications were not always sent as required to the Commission.

People were asked for their views as part of the quality monitoring process.

Stanwell Rest Home

Detailed findings

Background to this inspection

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

This inspection, which took place on 27 and 29 January 2015 and was unannounced. The inspection was carried out by two inspectors. We reviewed information we held about the service including previous inspection reports and notifications. A notification is information about important events which the service is required to send to the Care Quality Commission (CQC) by law.

We spoke with 11 people who lived at the home, observed care and support people received in the communal lounges and dining rooms. We also spoke with two visitors, eight staff and four healthcare professionals. We reviewed nine care plans and associated records as part the inspection. We also looked at records relating to the management of the service, five staff recruitment records, training records, duty rotas, some of the provider's policies and procedures, minutes of meetings and quality assurance audits. We also spent time observing the lunchtime meals and people receiving their medicines over two days and reviewed medicines' management.

Inadequate

Is the service safe?

Our findings

At the last inspection in July 2014, we issued compliance actions for care and welfare of people using the service, medicines management and staffing. There were shortfalls in the way prescribed creams and ointments were being used and medicines for disposal were not recorded and disposed of appropriately. The provider sent us an action plan stating they intended to become compliant by 30 December 2014.

At this inspection we found medicines were not managed safely. Staff confirmed the medicines round could take up to two and a half hours to complete. The medicines administration record (MAR) charts did not record the time medicines, such as pain control medicines, were administered. One person had not received a prescribed tablet for the month of January. Although the registered manager had initially enquired with the GP about continuing this medicine, this was not followed up when they did not receive a response. Another example was the timing of some medicines that should be given before food. People were put at risk of receiving medicines too close together and not as prescribed which may be detrimental to their health.

The medicines administration records (MARs) showed people had received their medicines; however we identified additional stock levels that could not be accounted for. A number of medicines did not match the stock when compared to the amount received and administered. This included pain control and blood thinning medicines. One person had run out of their eye drops and did not receive these for a couple of days before the end of the cycle which should have lasted 28 days. The systems used to manage stock levels of medicines were not effective.

In a number of bedrooms there were prescribed topical creams and ointments. These did not contain dates when the creams and ointments were opened to ensure they were used and discarded as per manufacturer's guidance.

One person showed us a number of medicines they were self- administering. The manager was not aware of all the other medicines this person was taking. Medicines, such as those brought over the counter were not recorded and advice sought to ensure they do not interact with other prescribed medicines. These medicines were not stored in a locked cabinet therefore there was a risk of other people especially people living with dementia inadvertently having access to these. The national institute of clinical excellence (NICE) guidance on management of medicines in social care recommends that all care home providers have a policy and processes in place for safe and effective use of medicines in the care home. There was no policy and procedure in place for the management of self-administration of medicines.

The examples above showed that medicines had not been appropriately managed this failure put people at risk. This is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

A process for returned medicines had been developed, a detailed list to be returned to the pharmacy was maintained and the staff followed their procedure for discarding medicines safely.

Although the medicines trolley was locked this was left in the dining room unattended and not secure for some time following the medicines round which may pose a security risk.

The infection control process was not adequate and put people at risk to their health and welfare. Equipment such as mattresses were not cleaned and some contained brown stains which staff said was an "old urine stain". A number of bedrooms had a pungent smell of urine. Soiled and infected laundry was not managed safely, because staff did not always follow good infection control procedures. There were red plastic bags with soiled and contaminated linen piled up on top of laundry trolleys. Clean laundry was also stored close to the soiled and contaminated laundry; increasing the risk of cross contamination of the clean laundry. The floor and walls of the laundry room were not visibly clean. Carpets were stained, in poor conditions and the bathrooms and shower facilities were not maintained appropriately. This included the ground floor bathroom where the sealants around the bath were damaged and stained, which would make cleaning difficult to maintain and increases the risk of infection.

Inadequate

Is the service safe?

The process for maintaining the cleaning mops was not safe. The mops were stored in the laundry room in dirty fluid within a mop bucket. The drain outside contained debris and was not working effectively with stagnant water which over spilled the outside drain.

There were no infection control risk assessments in order to identify and manage risks relating to infection control and the spread of infections and protect people and others from these risks. The registered manager confirmed risk assessments had not been undertaken. As part of infection control process, registered persons are required to take account of the Department of Health's publication, 'Code of Practice on the prevention and control of infections'. This provides guidance about control measures in order to reduce the spread of infection. We found these measures had not been followed regarding the provision of a clean and safe environment, equipment in use and the staff practices.

The examples above meant people were living in unclean conditions which increased their risk of acquiring infections or of infections being spread. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Care plans for people who had been identified as at risk of falling contained measures to minimise the risks such as pressure alarm mats to alert staff. Action was taken when people had a fall and appropriate treatment given at the time. However, care records showed where staff had noted bruising or injuries of unknown cause this was not reported or an action plan or risk assessment put in place. There was no procedure to follow up or monitor incidents to reduce the risk of subsequent events. In people's care records other possible risks had been identified including the risks of falls, malnutrition and choking. Although some care plans were developed, this was not consistent in order to inform the staff's practices.

Risks were not always assessed and plans developed to minimise risks. A person was seen wheeling themselves; using their feet to propel the chair. This was not safe as they were not aware of the danger and on two occasions got in the path of other people who were walking with their frames. Their care plan and risk assessments were not fully completed and put people at risk of receiving care that may be unsafe and not according to their needs. There was no physiotherapy assessment to ensure the chair and the lap strap was appropriate and safe for this person. The Medicines and Healthcare products Regulatory Agency (MHRA) has reported that most hazardous incidents have been caused by inappropriate use of such equipment and inadequate information or instruction. Healthcare professionals had also raised concerns about people not having their pressure cushions when out in their chair. People were put at risk of falls and pressure injury through the use of inappropriate equipment and the lack of risk assessments and action plans for staff to follow to maintain people's safety.

The staff did not always respond appropriately to incidents of potential abuse. The care records contained a number of incidents where people had displayed inappropriate behaviour towards other people. These were recorded in the daily records by staff, however, they failed to report to management and follow their internal safeguarding procedures. Records contained some alerts, which had been raised with the safeguarding team at the local authority but and these had not been reported to the Commission. People were put at risk of abuse because procedures to safeguard them were not always followed.

People and their relatives said they felt safe living at the home. A person told us "There is no reason not to feel safe". Comments included, "The staff are very kind and my relative can wander safely around the home and go out into the garden in the better weather". Another family member said, "It seems very nice here and the staff are kind and helpful".

There was a current safeguarding policy and procedure available to staff and they were able to raise their concerns with external agencies. Training in safeguarding adults was undertaken by staff and new staff had been booked on this training as part of their induction. The staff demonstrated an awareness of different forms of abuse and how they might relate to the people they looked after. Although staff members were aware of how to report concerns, they had not always done so and this could impact on people and their care.

People said they received the support they needed; one person said "They (the staff) are very busy, but they come soon as they can". People said there were busy times such as morning and evenings and the staff "Do their best". Relatives told us the staff were very nice; however there were "Not enough staff to motivate people". People living in

Inadequate

Is the service safe?

the “apartment” told us they received appropriate care and support, comments included “The staff are very helpful “. They said there were no restrictions about when they got up or retired to bed and “The staff are really lovely”.

Following the last inspection the provider had started to use system for assessing whether there were enough staff to meet people’s needs. As part of their action plan a staff member was now working a twilight shift between 8 and 10 pm to support people with the bedtime routine. We reviewed the duty roster for three weeks in January 2015. There were five care staff in the morning, four care staff in the afternoon and three staff on night duty. Staff also had the support of a chef and kitchen assistant. Staff told us they were “Very busy but managed” the care. On night duty there were three staff, one of which worked alone in the “apartment” which is in a separate building from the main home. The manager told us they were available on call for any emergency at night. The staffing ratio on night duty may not be adequate when a staff member had to go across to the apartment which would leave one staff member to care for about 25 people with varying degrees of dementia.

The provider had a process for recruiting staff which was followed. Each staff file contained evidence of satisfactory pre-employment checks such as disclosure and barring service (DBS) check, the right to work in the UK documentation and references. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services. There were copies of their appropriate identification and information about their qualifications. This showed that the provider had and used effective recruitment and selection processes.

Equipment was provided and maintained appropriately, such as regular servicing of these to help ensure people’s safety. The manager confirmed there was an on-going programme for servicing of fire equipment, hoists, assisted bath hoists and chair lifts. An emergency plan had been developed including safe evacuation procedures if needed.

Requires Improvement

Is the service effective?

Our findings

A staff's supervision programme was in place. Supervision is a process which offers staff support, assess learning needs and help in their development. Staff were not able to tell us whether they had received any supervision of their work and the frequency that this occurred. Staff supervision and appraisal records could not be located when we asked for them. The registered manager told us that they were all out of date as staff had not received supervision. The lack of staff supervision and engagement meant opportunities for identifying learning and development were missed.

There was an induction programme which staff completed when they started working in the home. The training record showed some staff had completed training in health and safety, infection control, first aid and moving and handling. There were eight staff who had completed medicines training, although the training record had recently been put in place and did not include all of the staff administering medication. We could not determine when all staff had received this training or update.

The training records also showed gaps in "essential" training for some staff. The minibus driver had not completed safeguarding or moving and handling training which is part of the provider's mandatory training. The registered manager told us they had been booked to attend training in February. The manager also confirmed all staff should have yearly updates. The lack of training updates may impact on the delivery of care to meet the needs of people safely and effectively.

The examples above show staff were not supported effectively which may impact on care people receive. These matters were a breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Staff had not completed training in mental capacity act (MCA) 2005. There was no evidence in any of the care files that mental capacity assessments had been carried out or that best interests meetings were held. The manager understood their responsibility under MCA and Deprivation of Liberty Safeguards (DoLS) and who to involve in the event of having to deprive someone of their liberty. However, there was no one accommodated who was under this safeguard. There was one person who was placed in a wheelchair with a lap strap in place. The person's care plan did not contain any risk assessment or a deprivation of liberty safeguard (DoLS) consent for them to be restrained in this way.

Another person was a smoker which staff told us they were keeping the cigarettes for this person. There had been no capacity assessment undertaken and it was not clear how best interests' decisions were taken to restrict their cigarettes which were kept by staff. Their care plans did not contain information about how staff would be supporting this person to enable them to smoke and ensuring this was managed in the person's best interest and without infringing on their rights.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards, which apply to care homes. These required providers to submit applications to a 'supervisory body' for authority to deprive someone of their liberty. Following a Supreme Court judgement earlier in 2014 which widened and clarified the definition of a deprivation of liberty.

The examples above show restrictions were put on people without appropriate consultation to safeguard people's best interests. These matters were a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

A pre-assessment was completed prior to people moving into the service in order to identify people's individual needs, preferences and any equipment as needed. One person told us the registered manager came to see them in another home prior to moving in and asked them some questions. This would enable the staff to develop care plans to meet the assessed needs of people as required. Staff also sought information from other professionals such as placing authority to gather as much information prior to people moving into the service.

People had access to healthcare professionals. People and their relatives told us staff supported them to access healthcare as needed. A person said "the staff are good and will get the doctor to see you" when required. Healthcare professionals provided good support to people. There were a number of people who were regularly assessed by the district nursing team. These included assessment with maintaining people's skin integrity, their weights and nutrition monitoring and support.

Requires Improvement

Is the service effective?

The staff used a nutritional screening tool to assess people's nutrition status on admission. The Malnutrition Universal Screening Tool (MUST) is a five-step screening tool developed to identify adults who may be at risk of malnutrition. The registered manager said these were meant to be completed for all the people on admission. However, we found not everyone had an assessment completed. This may put them at risk of not receiving the appropriate support to meet their dietary needs.

People's weights were monitored; however a person who had lost 4Kg in weight over one month and no action had been taken. This person was seen by the district nurse two weeks later; when weekly weight, food and fluids charts were initiated to monitor this person for any further deterioration. Records of dietary needs, including food and fluids were not always complete or updated. Staff could not be confident that people had received adequate food and fluids and were not at risk of malnutrition without closer monitoring and review of people's weight.

People were complimentary about the meals they received. Comments included "Meals are quite good, we have a choice of two main courses". People told us they were offered a varied diet including cooked breakfast which they enjoyed. They said "food is very good and plentiful".

Another person said "we have lovely dinners and I always enjoy what's given". People chose where they sat and were offered a choice of two meals, which was nicely presented and wholesome. However for people who were receiving pureed diets, this was not well managed. The meals were not pureed separately as recommended but all mixed up together which may not look appetising, have the correct textures and consistency.

There were a number of people who were living with dementia and adequate measures were not used to assist people to choose their meals such as pictorial menus of "sample plates". This could mean that people living with dementia may be at risk of not receiving an informed choice regarding the meals available.

People were supported to eat in a calm and caring way and encouraged to eat at mealtimes. The staff interacted positively with people while providing support. One person told us they liked ice cream and this was available to them. Another person did not like the main meal provided and was provided with an alternative which they ate and told us "It is very nice". The kitchen had a list of people's likes and dislikes and identified if people required special diets such as diabetic, vegetarian, soft or pureed meals.

Requires Improvement

Is the service caring?

Our findings

People were positive about the care and support they received. They stated they were well cared for. People said “this is a good place to live” and the staff were “wonderful, very good girls all of them”. Other comments included “I have been here for over six years and it is as good as it can be, the carers are very good and they do their best for you”. Another person said, “The staff are all nice, very kind”.

People also told us that they were treated with dignity and respect, and staff respected their wishes with day to day activities. A person said “we usually go to bed at about 10 or 10:30” which suited them and the staff respected their wishes. People in the" apartment" said they spent their time as they wished and had a routine the staff respected.

There were no restrictions on visiting and visitors and relatives were made welcome. The majority of people using the service were not able to participate in decisions about their care due to their mental frailty; however, people’s families were kept informed of changes or new treatment. People told us they enjoyed the monthly visits from the church and the regular service. Comments were “we do like the hymns”.

Observations demonstrated the staff were caring and treated people with respect and in a kind and compassionate way. Staff interacted in a friendly way with people and had developed relationship with them and we saw lots of smiles and laughter. Staff were knowledgeable about people they cared for and used people’s preferred names and were respectful when providing care to them. The induction training for all staff included dignity and respect and care practices observed reflected these. They spoke to people calmly and allowed them time to express themselves. They calmed a person when they became agitated during lunchtime and encouraged them to finish their meal.

The service had appropriate policies in place to ensure people’s privacy and dignity was respected. Staff described how they did this in practice. For example by making sure doors were closed when people received personal care. The care records contained little evidence of people being supported to be involved in the planning of their care. In some care plans people had signed ‘permission to share’ forms for the administration of medication, for the use of their photograph but was not consistent in other people’s records which had not been completed.

There were no end of life plans completed with people and their families. One relative told us that this had been done independently of the home with the person by their family. The manager told us that they were just starting to address this. This could mean that people were at risk of not having their individual wishes respected at the end of their life.

Inadequate

Is the service responsive?

Our findings

At the last inspection in July 2014, we issued compliance actions for care and welfare of people using the service. The care plans were not updated and did not reflect people's current individual needs and how these would be met. The provider sent us an action plan to become compliant by 30 December 2014.

At this inspection care plans were not fully developed to ensure people received care in a person centred way. A person was receiving a pureed diet, however their care plans, which was last updated in August 2014, showed they were 'on normal size meals, cut up'. This person had been seen by a speech and language therapist (SALT) and was on a purred diet. This person was put at risk of receiving inappropriate care, such as choking on their food, and not according to their needs.

A person who was diabetic had a concern regarding their feet. Cream had been prescribed to be applied each day. According to their care records the last recorded cream application was dated mid-December 2014. A staff member told us this person should have this cream applied daily as their skin was vulnerable. This would then be recorded on the cream charts. However we were not assured this was occurring as planned placing the person at risk of not receiving the care and treatment to treat their feet problem.

Another person diagnosed with diabetes. There was no diabetes management plan in place to guide staff about this person's care needs. Care record stated 'monitor and report any concerns'. There was no guidance of how this should be achieved or what staff should be aware of. This person had also been identified as having sight problems and had undergone an operation on their eyes. The sensory care plan had not been completed to guide staff as to how to support them effectively.

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

There were arrangements for responding to complaints which was aligned with provider's policy and procedures. We were not able to assess how complaints and concerns were dealt with as this information could not be accessed when we requested it. We were unable to assess how complaints were dealt with and responded to. Such as if these were analysed and action taken to improve practices and learning from them. Staff told us they would report any concerns raised with them with the registered manager. They were not aware of the process of recording complaints and would not follow these up to ensure actions had been taken.

The above issues were a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People said they would talk to their family if they had any "worries". Other people told us they did not have any complaints and were happy with the care they were receiving. Staff said they would report any concerns with the registered manager and were confident they would be addressed.

There was a lack of activities in order to offer people interest and mental stimulation. In the lounges we observed people sitting, asleep in their chairs for most of the day with the television on and no other activities. People could be at risk from lack of stimulation and from risk of social isolation. In one lounge for all of the day 10.30am - 4.45pm there was age appropriate music being played loudly. In the morning people were enjoying the music and singing along but were tired of it by late afternoon. A person commented to us "I have asked them to turn the music down, as to be honest it is now getting on our nerves".

The registered manager told us they had recently employed an activity coordinator. People went out on minibus trips and staff told us four to five people went out on those trips. We tracked the records for ten people and found that since October 2014; only one of the ten people had been recorded as going on a minibus trip.

Records of accidents and incidents were available. There was a monthly review stating what actions were taken and what follow up was needed. However this was not consistent and effective, as all the incidents had not been recorded or analysed. Staff had recorded these in the daily records and the registered manager said these had not been reported to her. These incidents which had caused harm or had the potential to result in harm were not analysed and reviewed. An action plan could not be developed to make necessary changes and lessons learnt from such incidents.

Inadequate

Is the service well-led?

Our findings

Following our last inspection in July 2014, we issued the provider with a compliance action as the internal auditing system was not effective and did not identify shortfalls in care in order for appropriate action to be taken. The provider sent us an action plan to become compliant by 30 December 2014.

Although an action plan had been developed since the last inspection, this had not been followed and people remained at risk to their health and welfare. The provider had not implemented a system to carry out regular checks to see if their procedures were followed and standards were maintained or needed to improve. The registered manager said there was no environmental audit carried out by the provider on a regular basis in order to ensure safety and identify areas needing improvement. Health and safety checks were not carried out, such as on portable heaters which were in use in a number of people's bedrooms. We asked to see the risk assessment regarding these and the registered manager said there was none in place. There was a lack of systems for monitoring the quality of service provided which meant actions could not be taken and improvements made.

The registered manager had started an audit of care plans and three had been audited with a number of actions points identified. An action plan was being developed to address these. However, the concerns relating to care planning, infection control, medicines had not been identified as part of the provider's audits.

Staff said they felt supported and were able to discuss any concerns with the manager. Staff meetings were occurring. Staff were able to tell us about the visions and values such as providing the "best care for people". They were not aware of quality assurance and how improvement could be achieved.

The examples above show the audits were not effective which may impact on people's health and welfare. This is a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The records management was not effective and records relating to the management of the service were not available when we requested to see them such as audits, risk assessments and care plans. The care records were not up to date, some were incomplete and information was not readily accessible when required. Records relating to complaints management were not available to us.

The above issues were a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The registered person is required by law to send the Care Quality Commission (CQC) notifications of events at the home. A notification is information about incidents which affect the welfare of people living at the home including incidents of abuse. The registered person was not able to provide evidence of notifications which had been sent to the Commission. On a number of occasions incidents had occurred at the service which the registered person had failed to notify CQC.

The above issues were a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

Policies and procedures were appropriate for the type of service, reviewed regularly taking into account current legislation and accessible to staff. There was a whistle blowing policy in place. Whistle blowing where staff can report their concerns about things that are not right, are illegal or if anyone at work is neglecting their duties, including someone's health and safety is in danger. Although these policies and procedures were in place, it was not clear that responsibility and accountability was understood at all levels such as lack of reporting where people welfare may be compromised. The manager promoted an open door policy and staff said they were able to raise any issue with management.

There was a system to seek the views of people using the service. Surveys had been sent to service users, families and staff in December 2014. The manager was in the process of collating these with an action plan to follow.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents How the regulation was not being met: The registered person was failing to send notifications which affected the welfare of people using the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision How the regulation was not being met: People were not protected for the risk of inappropriate care as the audits did not effectively identify risks to health, safety and welfare.

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 How the regulation was not being met: The registered person does not have suitable arrangements in place for obtaining and acting in accordance with the consent of service users. People's legal rights have not been upheld.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA 2008 (Regulated Activities) Regulations 2010 Complaints How the regulation was not being met:

This section is primarily information for the provider

Action we have told the provider to take

The registered person was unable to provide when requested information about complaints management.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records How the regulation was not being met: People were not protected from the risks of unsafe care and treatment and records relating to the management of the service were not available.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff How the regulation was not being met: Staff were not appropriately supported and supervised, training updates were not up to date and may impact on care people receive.

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 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services How the regulation was not being met: People who use services and others were not protected against the risks of unsafe care. Care and support plans were not developed and relevant to people's current needs. Regulation 9 (1) (b) (i) (ii)

The enforcement action we took:
Warning notice issued for Regulation 9 to be met by 17 April 2015.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control How the regulation was not being met: People and others were not protected against the identifiable risks of infection. Infection control practices were poor. Regulation 12(1), (2)(a)(b) and (2)(c)

The enforcement action we took:
Warning notice issued for Regulation12 to be met by 17 April 2015.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines How the regulation was not being met: Medicines were not managed safely and people were at risk of not receiving their medicines as prescribed. Regulation 13.

The enforcement action we took:
Warning notice issued for Regulation 13 to be met by 17 April 2015.