Mrs M Newland

Welcome Care Home Limited

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?	Inadequate
Is the service well-led?	Inadequate

Overall summary

The inspection took place on 15 May 2015 and was unannounced. Welcome Care Home Limited is a residential care home that provides personal care and support for up to 15 people, some of whom were frail or had dementia. At the time of the inspection there were 14 people using the service.

There was a registered manager in post. 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.

At the last inspection on 30 September 2014 the service was not meeting the regulations we inspected. The service did not provide safe care and meeting nutritional and hydration needs for people.

At this inspection we found ten breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not protected against the risk of abuse because the procedures in place did not identify risks to people. They were at risk of receiving unsafe care because the registered manager and staff had not updated people's care plans, risk assessments and did not have plans in place to monitor and manage risks.

Summary of findings

People's medicines were not managed safely and staff did not follow the provider's medicines policy. People were at risk of infection because the cleaning of the service was ineffective.

The recruitment process used by the service was not robust; staff were employed at the service without criminal records checks in place. We saw that staff were busy but this did not impact on the care people received. Staff did not have effective support, induction, supervision, appraisal and training to support them in their caring roles.

People were not consistently supported to access health care when required and were not involved in making decisions in planning their own care. People were not provided with meals which were balanced and met their nutritional or health care needs. The registered manager did not understand the requirements and their responsibilities under the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). People's records were not stored securely.

People did not receive a service which was responsive to their needs. Staff did not respond to people's changing care needs and the way care and support was delivered was not tailored to meet their individual needs. People were not always treated with dignity and respect and did not have privacy when they wished.

People and their relatives were encouraged to formally feedback to staff and the registered manager regarding the quality of care for people. The registered manager analysed these responses however they had not identified any areas for improvement for the quality of care for people. Concerns raised by people and their relatives were not always followed up promptly. The service held meetings with staff were to gather their suggestions about how to improve the service but these were not always acted upon.

The day to day operation of the service was not effectively led, coordinated and managed by the registered manager as they did not understand their responsibilities and did not provide clear leadership and support to other managers to deliver their roles effectively.

People were treated with kindness and compassion by staff. People and staff engaged well with each other.

The overall rating for this provider is 'Inadequate'. This means that it has been placed into 'Special measures' by CQC. The purpose of special measures is to:

Ensure that providers found to be providing inadequate care significantly improve.

Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.

Services placed in special measures will be inspected again within six months. The service will be kept under review and if needed could be escalated to urgent enforcement action.

You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

This service was not safe. Risk assessments were not accurate and up to date and effective management plans had not been developed to meet people's needs.

People did not receive their medicines safely.

Recruitment processes used by the service were not safe and the service had inadequate staffing levels to ensure people were kept safe.

Standards of cleanliness were not maintained which put people at risk of infection.

Is the service effective?

Inadequate

The service was not effective. Staff were not supported with regular induction, training, supervision and appraisal to support them in their caring roles.

People did not always have access to healthcare when required.

People were not provided with meals which met their healthcare needs and requirements.

Staff were not aware of their roles and responsibilities within the framework of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS).

Is the service caring?

Requires improvement

The service was not caring. People were not treated with dignity and respect by staff.

Staff did not act to relieve people of distress.

People were not always cared for in line with their care plan.

We observed good interactions between staff and people.

Is the service responsive?

Inadequate

The service was not responsive. People and their family were not always involved or contributed in the development and review of care records.

Staff did not act on people's changing needs.

Is the service well-led?

Inadequate

The service was not well led. There were effective processes in place to monitor the quality of the service.

There was a registered manager in post who was not managing the service daily.

Summary of findings

People and their relatives were encouraged to provide staff with feedback on the service; people's responses were not acted on.	

Welcome Care Home Limited

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 took place on 15 May 2015 and was unannounced.

The inspection was carried out by two inspectors and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. Their area of expertise is in care homes for older people.

Before the inspection we looked at information we held about the service, including notifications sent. During the inspection we spoke with seven people using the service, two relatives, we interviewed five care staff and spoke with the registered manager, administrator and the care consultant. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We reviewed eight care records, five staff records, resident and relative satisfaction survey, health and safety records, records for the maintenance of the service, audits, team meeting minutes, staff rota, menus and 14 medicine administration records. We looked at policies in place at the service.

After the inspection we spoke with a safeguarding manager from the local authority.

Inadequate

Is the service safe?

Our findings

People told us that they felt safe living at the service. One person told us, "Yes, I feel safe here." However, our findings during the inspection did not support what people told us.

Staff could not provide people access to their money. We asked staff to provide financial records for people. We were told that no staff on duty had access to the safe which held people's money and financial records. Only the deputy manager and the registered manager could provide access. The deputy manager and registered manager were not at the service during the inspection.

The registered manager did not manage people's money safely. There was a system in place for two members of staff to check the income, expenditure and balance of money available for people; and sign people's financial records. The registered manager told us that the records were checked during each financial transaction. The system for managing people's money had not identified that three of the four financial records we looked at were incorrect. People were at risk of financial abuse because the registered manager did not have effective processes in place to reduce the risk of abuse and manage this risk. This was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were at risk from harm. Staff told us that they were aware of people who were at risk and how to manage those risks. We looked at eight care records and found that risk assessments were not updated to reflect people's needs. For example, one person was identified as being at risk of wandering. Staff had not identified the risk to the person and had not put plans in place to keep them safe from harm.

People were at risk from harm in the event of an emergency. Six out of 14 people did not have a personal emergency evacuation in place in the event of a fire. When we checked these plans for people the evacuation instructions for two people were recorded incorrectly and these were not personalised. For example, they did not take into account people's individual mobility needs, their health needs, or support people would require in the event of a fire.

People were unable to call for help and support because the call bell system was not available in all cases. Staff carried out checks on alarm call bells. The last check of these was in March 2015 and it showed that all call bells were tested and available for people. We checked all rooms occupied by people and found that one room did not have a call bell available. Staff told us that the person living in this room needed assistance and support when walking, and unable to seek help from staff without assistance. The person was at risk of not receiving help in an emergency because they did not have access to a call bell to alert staff when needed. The checks carried out by staff had not identified that people did not have the facilities to call for help in an emergency. The service did not ensure that there were methods in place to keep people safe in the event of an emergency.

These issues were in breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service did not have a safe recruitment practice and important checks had not been carried out on staff's suitability to work at the service. We spoke with staff who told us that they had completed an application process and had an interview with criminal records check and references taken before they came to work at the service. Records showed that six out of 19 members of staff did not have current criminal records checks: one criminal records check had expired with no current application made and four criminal records checks had been applied for. Of these four were scheduled to work on the rota.

These issues were in breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were three care staff on duty on each shift to provide care for people. However, there were times during the day were the level of staff did not meet the care and support needs for people. For example during a shift, one carer completed the medicines round and another completed the cooking of meals and one carer cared for 14 people. People were at risk of receiving unsafe care because of insufficient levels of staff and staff did not have appropriate criminal records checks in place so people were kept safe.

People's medicines were not managed safely. Medicines were checked when they came into the service, however, there was no procedure for staff to monitor medicines used or disposed of. For example, an audit of medicines was not carried out and the registered manager could not identify errors in administration. We checked the medicines stored

Inadequate

Is the service safe?

for people and we found that medicines for one person were missing and not accounted for. Staff looked for them in the medicine cupboard and were unable to find them. The person was at risk of deteriorating health because they had not received twelve doses of their medicines to maintain their health. The registered manager provided no explanation for this and took no action to minimise the risk of recurrence.

People were not given their medicines as prescribed. We checked the medicine administration records (MAR) for 14 people using the service. We saw one person's MAR showed that there were 12 gaps in these records. Staff had not signed that the medicine had been given to the person. We spoke to staff and we checked through the MARs with the registered manager who told us that they did not know why there were gaps in these records. We checked the person's medicines and found that the medicines were not given to the person because the registered manager had not made arrangements for the re-ordering medicines when they ran out. People were are risk of poor and deteriorating health because the provider did not have processes in place to re-order medicines for people. The registered manager called the pharmacist to request medicines for the person. We reported this incident as a safeguarding alert to the local authority.

People were not given their medicines in a safe way. There were no capacity assessments or support in place for people who refused their medicines. We saw records and checked blister packs of two people who had refused their medicines. We asked staff what action they took to support these people they told us they did not give the medicine. The GP was not informed and advice not sought by staff if people refused their medicines. People were at risk of poor health because staff had not sought specialist advice to meet their health needs.

The registered manager told us that there was no process in place to dispose of expired or unused medicines. We looked in the cupboard where the medicines were stored and found that there were expired medicines for two people. People were at risk of receiving medicines which were ineffective.

These issues were in breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at the 15 rooms available to people. We found two toilet bowls visibly dirty in and all around the outside and, toilet waste leaking onto floor. We noticed a person's toothbrush and paste were in a cup placed on top of the dirty toilet cistern. The walls were dirty and in need of redecoration. We saw leaking shower heads and dirty shower cubicles.

People lived in a service that was not cleaned effectively. The service employed two cleaners to maintain the cleanliness and hygiene of the service. However we found that the cleaner did not follow local infection control guidance. One mop and bucket was used to clean all the communal areas including people's bedrooms, toilets and bathrooms. The lift floor and doors were dirty and dusty and had not been cleaned on the day of the inspection. Staff were not protected when carrying out their roles within the service. The cleaner did not wear personal protective equipment and was wearing open toed flip flops when cleaning and mopping the floors.

Staff identified that there was a need for cleaning in the communal areas and in people's bedrooms. This had not been implemented. People were at risk of infection due to the ineffective cleaning and hygiene of the service.

These issues were in breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We noted the ceilings in two people's bedrooms and in two areas of the hallway that needed repairs following a water leak and damage. No action was taken by the provider to make those repairs. People were at risk of injury from an unsafe living environment. This was a breach in regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us that they were aware of the signs of abuse and how they would protect people they cared for from harm. They described how they would raise an allegation of abuse first to their manager and to the local authority if required. Staff we spoke with were aware of the whistle-blowing policy and procedures of the service. Staff told us that they would be confident to raise a concern with their line manager or whistle blow if necessary.

Inadequate

Is the service safe?

There were fire evacuation procedures, fire alarm testing and personal fire evacuation plans is place at this service. Staff told us that they had training of fire safety training records reflected the same. There were records of fire alarm testing which was competed on a monthly basis.

Inadequate

Is the service effective?

Our findings

Staff were not adequately supported in their caring role. We spoke with staff about the support they received from their manager and identified some concerns.

Staff had not received supervision on a regular basis. Staff told us that they had supervision from their line manager; however what staff told us, what the registered manager told us and what staff records showed was inconsistent. One member of staff said, "I have supervision every six months." The registered manager told us that staff had supervision every six weeks. We spoke with staff about their supervision and they could not provide us with dates for when they last had their supervision. Records showed that staff did not receive supervision every six weeks in accordance to the service's policy. Staff supervision records showed one member of staff had not had supervision for 47 weeks, one member of staff had no supervision in 42 weeks, four members of staff had no supervision in 40 weeks, five members of staff had no supervision in 39 weeks and another member of staff had no supervision in 37 weeks.

People were supported by staff who did not have the opportunity to identify their training and professional development needs to enhance their caring role. The provider's policy stated that staff would receive an annual appraisal. However no staff had received an annual appraisal in 2014 or 2015.

Staff had not completed training necessary for their role. For example, the staff training records dated January 2015 showed that no member of staff had completed training in basic life support in 2013, 2014 or 2015. Eighteen out of 19 staff did not attend safeguarding adults training in 2013, 2014 and 2015, the administrator told us they had made arrangements for staff to attend this training, and there were no records to confirm this. No staff had completed training in risk assessment, privacy and dignity and MCA in 2013, 2014 and 2015. People were cared for by staff who did not gain knowledge and skills equip them to provide care for them.

These issues were in breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

The provider did not have an understanding of their responsibilities of how to support people within the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). The MCA provides protection for people who may not have the capacity or ability to make some decisions for themselves. The DoLS gives protection to people from unlawful restriction of their freedom without the authorisation to do so. Staff we spoke with were unaware of the role of an advocate when the person had been assessed as lacking decision making capacity.

The registered manager managed people's finances and there were no records that showed that people's capacity to make this decision had been assessed. People were not supported to consent to or make decisions regarding the management of their money. We did not see records to support the service managing people's money and there was no evidence this decision was made the person's best interests.

The registered manager had not identified people who could benefit from an assessment of their capacity to make specific decisions. Staff were not seeking consent from people to receive care and there were no best interests decisions recorded for them. The service had a policy on the Deprivation of Liberty Safeguards (DoLS), but not on MCA. Staff did not seek consent from people because staff did not have training in MCA to enable them to support people to consent to receive care. People were at risk of receiving care which they did not consent to.

These issues were in breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last inspection the service was in breach in meeting nutrition and hydration needs for people. The provider failed to ensure people had access to a balanced diet with sufficient food and drinks to meet their nutrition and hydration needs. At this inspection we found that improvements had not been made to improve the quality to meet the nutrition and hydration needs for people.

People were not offered meal choices to meet their personal preferences. For example, a person who had specific dietary requirements relating to their health needs told us, "I'm only allowed one type of cereal for breakfast which doesn't taste too good." We spoke to staff about this and they confirmed that only one cereal was available to the person. The person told us that they would like to have a choice of breakfast cereals, we told this to staff who said that the registered manager ordered the food for people.

Inadequate

Is the service effective?

Staff told us that stocks of food were ordered and some kept at the registered manager's home and staff would go there to collect food items they had run out of. The registered manager confirmed this.

People did not have access to a balanced diet to meet their health care needs or to maintain health. People did not have access to fresh fruit or sufficient fresh vegetables. People were asked for their feedback on the quality and choice of meals. People made suggestions to improve the quality of food provided. For example, the use of pictures for meals so that people could choose their meals based on how meals were presented. People did not have their comments implemented and the provider did not act on people's food choices.

People did not have access to foods to manage their health conditions. There were people living at the service who had health conditions which meant that they had to follow specified diets. The service did not have fruit juice, glucose or fizzy drinks available to people, in line with guidance for staff on how to manage specific medical emergencies. Staff told us that these drinks were unavailable. We found that the registered person had not protected people against the risk of poor nutrition and hydration.

These issues were in breach of regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A diabetic specialist was involved in the care of two people with diabetes and requested that staff record the blood sugar levels twice daily and show these results to the district nurse. Staff completed twice a day diabetes monitoring checks and recorded the results. However, we found on one person's record that staff had not followed this guidance. We checked these records and saw on the 14 May 2015, staff had not taken appropriate action to inform the nursing service or the GP of the deterioration in health for the person.

We discussed the results with the district nurse who told us that staff should have contacted the emergency district nursing service or the out of hour's doctors' service for advice due to the high blood sugar levels. This action was not taken. People were at risk of not receiving appropriate health care to maintain their health when required. Staff had not taken action to mitigate risks. This is a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were supported to attend hospital appointments where necessary. Appointments letters were kept on people's care records and staff had access to this information, so that they could support the person to their appointment.

Requires improvement

Is the service caring?

Our findings

At the last inspection the provider was in breach of our regulations. The provider failed to support people to access appropriate advice and support from a health professional when needed. People were unable call for help in an emergency because call bells in the communal areas did not work.

People did not make decisions in planning their own care. In the staff office there was a list of advocacy services which were available to people in the local area. It listed services which could help people with supporting them to make decisions. We spoke to people about whether they were aware of any services which could provide them with support with advocacy if they wished. People told us that they were unaware of an advocacy service.

People did not have the privacy that they needed. For example, a person's bathroom door had a hole in it, so their privacy was not maintained when they were using their bathroom. A person's bedroom door could not be shut or locked for privacy because the lock was broken. The person told us, "it has been like that for a long while, I told them about it."

People were not treated with dignity and respect at all times. We spoke to staff about the care and support that was received by one person and a member of staff told us, "They are a very difficult person to deal with." People were not treated with dignity and respect when they received care and support by staff.

At the inspection we saw some examples of caring interactions; however we observed where staff did not understand people's cultural needs when providing care and support for them. For example, staff had not developed links with local organisations that could provide activities and support to meet people's cultural needs. People were at risk of social isolation impacting on their well-being.

One person living at the home did not have English as their first language. We checked their care records and found that the person was unable to speak or understand English. There were no carers employed at the service who spoke the person's language. We observed that this person was socially isolated and remained in their room throughout our inspection; there were no books, or television in their room. This person was at risk of isolation and staff did not support them to take part in activities which met their needs.

These issues were in breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We observed interactions between staff and people in the conservatory were people were sitting and relaxing, eating or participating in activities. It was clear from the conversations taking place that people were relaxed.

People were encouraged to attend various activities; some people went to the daycentre. While others were supported to attend religious meetings when they wished. We observed that carers asked whether people wanted to hear music, most people responded and said yes carers encouraged people to dance to the music. Some people joined in this activity and those who did not want to join in were able to sit and enjoy the music. Other people who were not in the conservatory, did not want to participate in the activities, went to their room.

Relatives were encouraged to visit when they wished. One relative told us, "I think my relative is looked after very well in here and they know him well". Another relative said, "I can visit anytime I wish, staff make me feel welcome here." Relatives were encouraged to participate in social events carried out at the home, such as barbeques and birthday celebrations. However, people were not encouraged to participate in the planning of these events. One person told us, "nothing much happens here that interests me, I prefer to stay in my room." Another person said, "I have never been asked my opinion on planning any events here."

Inadequate

Is the service responsive?

Our findings

People's support needs were not always responded to. We saw records where staff had failed to take action to relieve discomfort for people. A person told us, "I felt unwell in the night and I knew that it was my diabetes." They added, "sometimes at night I go downstairs for help and the staff don't want to help me. They don't like calling an ambulance for me anymore." We spoke with their relative who confirmed that the person was concerned about help during the night.

We also saw examples where people were acutely unwell and staff had not taken appropriate action. For example, records showed when a person had chest pains during the night their health was monitored but medical advice was not sought. It would have been appropriate for staff to seek medical advice to effectively support this person due to the pain they were experiencing.

People's concerns were not managed effectively. We found where people had raised a concern about their health with staff; this was not always followed up appropriately. For example, a person told us, "I spoke with the deputy manager a couple of days ago about feeling dizzy and I am still feeling dizzy, but nothing has happened since then." We spoke to a member of staff about this concern and they told us that deputy manager was not on duty so they were unable to find out what actions had been taken for the person.

These issues were in breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were at risk of receiving poor care because the service did not take into account professional recommendations and guidance to improve the quality of care for them. A social work review had recommended one person's care plan be reviewed taking into account recent health deterioration. However we found the recommendation had not been implemented.

People had risk assessments that were not updated, reviewed or managed by staff. For example where a person's mobility needs had changed this was not updated to reflect this. Another example we saw when a person's health needs had deteriorated their management plan was not update to reflect this or the change in care the person required. People were at risk of harm because their changed care needs were not managed to keep them safe.

People were at risk of receiving inappropriate care because care records and care plans were not updated to reflect their current care and health needs. We looked at eight care records and found the majority of care records had not been updated monthly as advised by the registered manager. The majority of care records were last updated in 2013 and one care record had not been reviewed and updated since 2011. We saw examples of documents for four people whose care needs had changed. For example, where people had gained and lost weight, where their mental health needs deteriorated or when their mobility needs had changed. Their care records had not been updated with this information and their care plans and risk assessments had not been updated to manage these changes. People were at risk of receiving care which did not meet their changed needs effectively not taking preferences into account

These issues were in breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were supported to take part in activities they enjoyed. One member of staff said, "This person really enjoys dancing to music." The conservatory was the main activity area. There was a large activities notice board with weekly timetable, and we were provided with a copy of the activities provided in the home. There were books and magazines available to people. During the morning some people were playing cards, connect 4, bingo, a person was reading a newspaper, matching up 'snap' tiles and a game of floor rings was being played. A person told us, "I really feel comfortable here, and the staff are all OK with us all." They told us that their family visits when they wished and they preferred to have their own activities rather than join in the main events "I keep myself to myself really, I look after my goldfish and I can get outside for a smoke – I have my TV and radio".

We told the registered manager about the concerns people raised with us during our inspection. They told us that they would look into the concerns raised and respond to the complainant following their investigations.

Inadequate

Is the service well-led?

Our findings

People did not receive a service that was well-led. The registered manager was not managing the day to day operation of the service. The deputy manager was fulfilling this role. We asked people if they knew who the registered manager was and one person told us, "I've been here for a long time and she used to come up quite regularly to see me, but not now."

There were no effective quality assurance systems in place. The registered manager and the deputy manager undertook internal audits on the quality of care and support, food, activities and the home environment. These had not identified the concerns that we found in each of those areas. For example, the last audit for the home's cleaning was completed in April 2013. There was a home maintenance record with 27 requests for repair from 5 December 2014 to 11 April 2015, and of these only, seven actions had been completed.

An audit was completed in 2014 and reviewed in May 2015. The audit identified areas for improvement for the service. There were 88 areas of improvement identified from November 2014 to May 2015. Of these 88 actions required only 23 actions had been completed but several had not been completed by the due date. The quality of care people received was poorly monitored and actions to improve the service were not completed

People were at risk of receiving an unsafe service. Staff did not complete medicine audit so were unable to identify areas of risk in regards to the management of medicines. Staff did not have a plan in place to monitor the quality of the management of medicine increasing the risk to people.

These issues were in breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and their relatives were encouraged to feedback to staff and the registered manager regarding the quality of care for people. The registered manager analysed the response people and their relatives made. The analysis showed that the majority of people were satisfied with the quality of care, cleanliness, meals, and environment. The registered manager did not develop an action plan for the improvement in the quality of service. This was in contrast to what people and their relatives told us and the observations and evidence we found regarding the quality of service and of care delivery. This was a breach in regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's records were not stored securely. We asked staff for people's care records and saw that they were kept in an unlocked cupboard in the communal dining room. We asked the registered manager about the storage of records and we were told that staff needed access to them as necessary. People were at risk of their personal and private information being accessed by people using the service and visitors. This was a breach in regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was a lack of transparency in the service from all levels of management. People were employed in the service to completed specific tasks, for example the administrator's role was to maintain staff records. When we asked the registered manager for clarity on other staff roles at the service we were told that they was a care consultant who supported staff in the daily management of the service. Information was difficult for staff to access as there was no central place where information was stored.

We noted that some staff were responsible for some tasks in the service while others did not. For example, only three members of staff were provided access to the safe which stored petty cash for people. If one of these members of staff was not on duty staff had to wait for the deputy manager or the registered manager to provide access to this. The registered manager and the deputy manager had access to people's money whilst on duty. During our inspection neither manager was onsite meaning people did not have access to their money when they wished.

Staff working on individual tasks had the information kept and was not shared with other staff. Information regarding the quality of care and improvement was not collated in one place. The registered manager did not have insight or an overview of the service and could not identify areas of risk, concerns and therefore these issues could not be addressed and plans in place to make improvements to the care people received.

Staff were encouraged to participate in team meetings and offered their opinions and suggested changes to improve the quality of the service. We saw that suggestions made were not acted on. For example, staff highlighted the need

Inadequate

Is the service well-led?

for a deep clean of the service, with particular attention for the communal bathrooms and people's bedrooms. We saw that the registered manager had not taken action on the feedback offered by staff.

The registered manager was not onsite every day so was not aware of staff attitude and was unable to monitor and act on staff attitudes. There was little opportunity for staff to have a working knowledge of the organisations values because the registered manager had not reviewed this so was not able to identify areas of concern therefore a plan of action could not be developed with staff to ensure staff improved their attitudes, values and behaviour whilst delivering care and support to people.