Sycamore Lodge

Sycamore Lodge

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

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 and to pilot a new inspection process being introduced by the Care Quality Commission (CQC) which looks at the overall quality of the service.

Sycamore Lodge provides care and nursing support for up to 77 older people. At the time of our inspection there were 76 people using the service. The service is split into five units over three floors. Two of the units provide nursing care and the service also provides care for people with dementia care needs.

The last inspection of this service took place on 18 June 2013. During this inspection we found that the service was meeting regulations related to respect and involvement, care and welfare, nutrition, supporting workers and complaints.

This inspection was an unannounced inspection. At the time of our inspection there was not a registered

Summary of findings

manager in post. A registered manager is a person who has registered with CQC to manage the service and has the legal responsibility for meeting the requirements of the law; as does the provider.

People were not kept safe at the service. Not all staff were aware of their responsibilities or felt confident raising concerns about the welfare of people using the service. In addition there were not always enough staff to meet people's needs. Staff recruitment processes did not protect people from staff unsuitable to work with vulnerable adults and there were inadequate plans in place to manage risks to people's welfare.

We found the service did not fully consider people's mental capacity, their right to make decisions for themselves or the impact of any restrictive practices to ensure that people's rights were respected.

People's health and wellbeing were not suitably monitored and taken care of. For example, people's individual needs were not fully assessed and care plans did not always consider people's preference, likes or dislikes. Staff did not always adequately monitor people's weight or ensure that general eye, foot and dental care needs were addressed. In addition people had mixed views about the food provided and people were not always offered foods that met their individual dietary needs, including their religious and cultural needs.

Staff received an induction to the service and mandatory training, however, they did not always receive training to equip them with the skills to meet people's individual needs.

People using the service and their relatives gave varied accounts about the staff and how caring they found the service. We saw some positive interactions between staff and people using the service but we also saw staff acting in ways that were not respectful.

People's spiritual needs were met. An activities co-ordinator organised activities for people and some people were supported to go out into the community. However, there was limited one to one interaction with people on a day to day basis or activities that supported people to maintain their interests and hobbies.

We found that the home was not managed in a way that ensured people's safety and there were not systems in place that encouraged openness and learning from incidents. The operation of the service was not adequately monitored to ensure that any issues were addressed and improvements made.

Following our inspection we spoke with a local authority representative who stated that they had identified similar concerns to those found during our inspection.

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 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. Systems for protecting people from abuse were not robust.

There were not always enough staff on duty to meet people's needs and staffing levels were not effectively monitored or managed.

Staff recruitment checks were not fully completed and therefore did not protect people from staff unsuitable to work with vulnerable people.

We found that the service did not fully consider people's mental capacity and the impact of any restrictive practices that required Deprivation of Liberty Safeguards (DoLS) to ensure that people's rights were respected.

Is the service effective?

Inadequate

The service was not effective. People had mixed views about the food provided by the service and people's individual nutritional needs were not always met.

Health concerns were referred to the appropriate health professionals. However, staff did not always monitor people's general wellbeing by checking their weight or arranging dental, eye and foot care check-ups in a timely way.

Staff received an induction, management support and general training. However, they did not always receive training to equip them with the skills and knowledge to meet people's individual needs.

Is the service caring?

Requires Improvement

Aspects of the service were not caring. People using the service and their relatives gave varied accounts about the staff and how caring they found the service.

We saw some positive interactions between staff and people using the service but people's dignity and independence were not always promoted

People's diverse needs were not always met, in particular their communication needs and information about people's ethnic and religious identities was not always included in their care records.

Systems in place to provide information to people and involve them in their care were not effectively used

Is the service responsive?

Inadequate

The service was not responsive. People's needs had been assessed but care plans did not always reflect people's preferences or contain enough detail about the person as an individual. People were not always involved in planning their care.

Summary of findings

Activities were arranged, however, there was limited one to one interaction with people or activities that reflected people's individual interests.

People were given information about how to make a complaint. However, there was no information displayed in the home about how to make a complaint and we saw that the acting manager did not always appropriately respond to complaints.

Is the service well-led?

Inadequate

The service was not well led. Systems were in place to monitor the service but these were not effective as they were not always fully completed or followed up to ensure action was taken to address any issues.

Staff did not feel supported by the management team and were not involved in the operation of the service. They did not feel confident about raising concerns.

Records were not kept up to date or in order and were not always easily accessed when required.

Sycamore Lodge

Detailed findings

Background to this inspection

This inspection took place over two days on the 29 and 30 July 2014. The inspection team consisted of two inspectors and an expert by experience. This is a person who has personal experience of using or caring for someone who uses this type of service.

Before the inspection we reviewed information we held about the service and sent the provider a Provider Information Return (PIR). A PIR is a document that we ask providers to complete that tells us about the operation of the service, what they do to meet people's needs and any proposed improvement plans. The acting manager told us that this document had been submitted online but inspectors had not received a copy prior to the inspection. However, the acting manager gave us a copy on the first day of the inspection.

We used a number of different methods to help us understand the experiences of people living in the service. We spent time observing care in the communal areas such as the lounge and dining area and used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We spoke with 24 people who were using the service, five relatives and a total of 22 staff members. These included the regional manager, the acting manager, four nurses, 11 care staff, three domestic staff, the assistant catering manager and the activities co-ordinator for the service. We also spoke with a GP who had patients at the service.

We looked at records relating to people's care and the management of the service. These included 11 care records, staff duty rosters, five staff recruitment files, quality monitoring records, accident, incident and complaints records.

Following the inspection we spoke with local authority representatives and the local authority safeguarding adults' team.

This report was written during the testing phase of our new approach to regulating adult social care services. After this testing phase, inspection of consent to care and treatment, restraint, and practice under the Mental Capacity Act 2005 (MCA) was moved from the key question 'Is the service safe?' to 'Is the service effective?

The ratings for this location were awarded in October 2014. They can be directly compared with any other service we have rated since then, including in relation to consent, restraint, and the MCA under the 'Effective' section. Our written findings in relation to these topics, however, can be read in the 'Is the service safe' sections of this report.

Inadequate

Is the service safe?

Our findings

People generally told us that they felt safe when being cared for by staff. However, we found significant shortfalls in the operation of the service that placed people using the service at risk of harm and one person told us they did not feel safe when supported by a particular staff member.

We asked staff about their responsibilities in relation to safeguarding people who used the service. Most staff were able to demonstrate their ability to identify and respond to safeguarding concerns. However, two members of staff told us that if they witnessed another member of staff abusing someone they would tell the person to stop but would only report it if they saw them do it again. All staff have a duty to immediately report any safeguarding concerns to protect people who use the service. In addition, we found that some staff did not understand what whistle blowing meant and many of the staff we spoke with were unaware of external agencies they could contact if they had safeguarding concerns. Whistleblowing is when a worker reports suspected wrongdoing at work. A worker can report things that aren't right, are illegal or if anyone at work is neglecting their duties, including if someone's health and safety is in danger.

During the inspection a person using the service and a member of staff disclosed two separate safeguarding concerns to an inspector. The member of staff told us that they had raised concerns with the acting manager but said they were not aware of any action that had been taken. We discussed this with the acting manager who told us she had not been given all of the information relating to the incident and therefore had not treated the incident as a safeguarding concern or investigated the matter further. Following the inspection we referred both incidents to the local safeguarding adults' team.

There was a central record of safeguarding incidents maintained for the service. However, this was not up to date and the acting manager was unable to demonstrate how safeguarding concerns were being addressed and monitored. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People using the service and their relatives told us that there were not always enough staff on duty to attend to their individual needs. One relative told us, "There have definitely not been enough staff around this week" and another commented "There aren't many male carers; it would be nice to have a man, from the personal care point of view." Some people told us that they had to wait a long time for their call bell to be answered because staff were busy. They said that staff were kind and caring when they did attend to them but that they often "rushed." One person said, "The staff are lovely, but there's not enough of them" and another told us, "You have to wait a long time, during the night when you need support."

On the first day of our inspection we observed morning medicines being administered on one unit at 09:45. When we asked the nurse why medicines were being administered that late in the morning they told us they had been busy attending to an emergency on another floor. This was not in accordance with good practice.

We found that the service had significant recruitment and staffing issues. There had been a large turnover of staff and staff retention was poor at the time of our inspection. The acting manager told us there were three nurse vacancies out of a total of 10 nurses and said that a fourth nurse was leaving the following week. The regional manager also told us that a head of nursing had been recruited but had left after a few weeks working at the service. Staff confirmed that the service was often short staffed and one staff member told us that at times they had to work alone on a unit that had a minimum staffing level of two members of staff.

We requested duty rosters for the week beginning 4th August 2014 and the rest of the month to check staffing levels. However, these were not available as they had not yet been written. Therefore staff had not yet been told what shifts they would be working the following week and the management team was unable to demonstrate that they were forward planning to ensure that there were enough staff at all times.

The duty rosters we viewed were not easy to read and it was not always clear where there were gaps in staffing or how these had been covered. For example, on the first day of the inspection we found that there was no nurse on duty on one unit for the evening shift and the following morning shift. The acting manager was not aware of this issue and we raised the issue with the regional manager who then

covered the shift herself. The following day there was a nurse on duty and she told us she had been moved that morning from another home run by the same provider to cover the shift.

We also noted that there was no night nurse on the nursing unit for three nights during the week prior to our inspection. When we asked the day nurse about the impact of this, they told us it meant that the night nurse from the dementia unit then had to also cover the general nursing unit. This was a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Staff recruitment practices at the home did not protect people from staff unsuitable to work with vulnerable people. We looked at recruitment records and found that information was incomplete. For example, one file only contained one reference and in two other files references had not been verified to ensure they were authentic. In two of the files there were gaps in the staff member's employment history that had not been explored and in another there was no record of a criminal record check. We also noted that the staff records for a nurse recently employed by the service did not contain up to date information about their registration with the Nursing and Midwifery Council (NMC) to confirm that they were registered to practice as a qualified nurse. This was a breach of Regulation 21 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Staff told us they had not received any training relating to the Mental Capacity Act 2005 (MCA) or Deprivation of Liberty Safeguards (DoLS) and the acting manager confirmed this. Staff had a general lack of understanding about mental capacity and decision making and care records did not include capacity assessments. This was despite a clear indication that many people using the service lacked the mental capacity to make some decisions for themselves such as whether they wanted their bedroom door left open or wanted to stay in bed.

The acting manager told us that there was a DoLS authorisation in place for one person using the service and that another application was in the process of being submitted. We looked at the records relating to both of these and found that the authorisation had conditions attached. We discussed these with the acting manager and found that the service had not taken action to ensure that these conditions were met to reduce the impact of the restrictions on the person using the service.

In addition, we found that the service had not been proactive in considering the implications of a Supreme Court ruling that had significantly changed what would be regarded as a deprivation of someone's liberty, to ensure that the service remained within the law and considered what was in the best interests of all the people using the service. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We saw behaviour log sheets that were used to record incidents where people's behaviour had challenged the service. We found that details of the incidents were recorded but there was no information about what action staff had taken and therefore no evidence that the behaviour had been managed safely. Records lacked guidance for staff about how to manage behaviour that challenged the service in a way that minimised any risks to themselves or others.

People's care records contained individual risk assessments that covered areas such as moving and handling, nutrition, falls and skin integrity. However, we found that many of these had not been reviewed for over a year and therefore may not have contained accurate information about the risk posed and how this should be managed by staff to keep the person safe. In one person's records we saw that they were at high risk of developing pressure ulcers. Staff told us that the risk assessment was reviewed monthly but when we checked it had not been reviewed for over two months. In another person's records we found contradictory information about the level of assistance they required with their mobility and therefore staff did not have clear guidance about the support the person needed to keep them safe.

We noted other risks that had not been identified by staff. For example, we saw worn furniture with foam exposed on two units that were a potential infection control risk and a Formica strip on a height adjustable bed frame that had come away, exposing wood underneath that was a potential hazard.

We saw the contingency planning document for foreseeable emergencies that could adversely affect the

Inadequate

Is the service safe?

operation of the service such as a flood or loss of power. This did not contain clear guidance for staff about the action they should take in the event of such an incident to protect the welfare of people using the service. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Inadequate

Is the service effective?

Our findings

People using the service and their relatives had mixed views about how people's healthcare needs were managed. One person told us that they had requested to see a chiropodist and it was evident that the person required some support with their foot care. They said they had been waiting a long time and that an appointment had not yet been arranged for them. A relative also expressed concerns about having to get involved with their relatives dental care as staff had not realised that their family member required dental treatment. Records relating to routine healthcare checks such as eye tests, dental and foot care were not kept up to date and it was difficult to tell if people's needs were being met.

The home had a policy of monitoring people's weight on a monthly basis as any significant changes could indicate ill health. However, we found gaps in people's weight monitoring records. In one record there was a 10 month gap and in another there was a nine month gap. In another record we saw that someone had lost two kilograms in one month, however, this had not been followed up. In another person's records we saw that they were underweight, however, their weight had not been monitored for the last two months and their nutritional risk assessment had not been reviewed since February 2014. Therefore staff were not adequately monitoring people's nutritional and health needs. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We saw that GP visits had been arranged to explore health concerns that were identified and we spoke with a visiting GP who told us that staff did carry out checks that she requested and provided clear verbal information about the condition of each person she saw. We also saw that staff had referred people to specialist healthcare professionals such as speech and language therapists, diabetic nurses and dieticians.

Comments people made about the food varied. For example, one person said "it's very nice" and another said "it's lovely". However, someone else told us, "The food is not very good, it's not interesting enough, it's not very tasty. The chef probably tries his best." One person also commented, "Vegetarians get a really raw deal; they could do more interesting things with vegetables."

We observed lunch on three of the units. It was noted that staff had limited interactions with people during the meal. Staff did not chat with people or ask them if they had enjoyed their meal and didn't offer sufficient encouragement to people who were not eating.

People were supported to choose their meals a day before the meal was served. This system did not work very well as many people had forgotten what they had chosen by the following day and no longer wanted that choice. One person told us they had ordered an omelette as they didn't like the choices on offer and this had not been prepared but once we told staff they arranged for the omelette to be made. For another person the dietician had recommended in her assessment that they be provided with finger foods throughout the day to support their nutrition. We saw no evidence of this other than biscuits that were provided at afternoon tea.

The assistant catering manager showed us the four weekly menus that were changed every few months to take account of the changing seasons and to provide variety. He told us that staff from the units provided a list of people who had special dietary requirements such as soft foods and said a vegetarian option was always available. He told us that individual cultural needs were not catered for but that 'ethnic' meals were included in the four weekly menus. This meant that people's religious needs were not always met as we found that people were not always provided with culturally appropriate meals. This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The weather was very warm at the time of our inspection. We observed staff regularly offering people drinks on each of the units and drinks were available for people to help themselves.

Staff confirmed that they received an induction and mandatory training in topics such as fire safety, moving and handling, health and safety, food safety, infection control and safeguarding. This training was then repeated annually so that staff knowledge remained up to date. The acting manager told us that staff received training on dementia awareness and that working with behaviour that challenged the service was included in this training. However, there was no training provided in other topics such as epilepsy, nutrition and skin integrity to ensure that

Inadequate

Is the service effective?

staff were equipped will the skills and knowledge to meet people's individual needs. This was a breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Staff told us they had one to one meetings with their manager about every three months. The acting manager showed us a matrix that had been introduced to monitor when one to one meetings were taking place. However, this was not up to date at the time of our inspection. The acting manager told us that almost all staff had recently taken part in an annual appraisal of their performance. However, she was unable to provide documentation to evidence this as she said that the paperwork had been sent to the provider's head office.

Requires Improvement

Is the service caring?

Our findings

People using the service and their relatives gave varied accounts about the staff and how caring they found the service. Comments ranged from, "excellent, very pleasant" and "The staff are unbelievable, very kind, nothing is too much trouble" to "There's no sense of empathy or warmth, it is so business like here" and "There are so many people here with dementia, staff treat everyone as though they have it."

We saw some positive interactions between staff and the people using the service such as staff talking to people kindly. However, we found that staff did not always assist people in a way that promoted their dignity and independence. For example, during lunch we observed a member of staff standing over someone while they were supporting them to eat and also heard a member of staff respond abruptly to a person who stood up several times during their meal. On another occasion we saw a member of staff place someone's cup of tea in a position where they could not reach it, rather than take the time to put a side table close to them. We also observed two occasions where people attempted to carry out tasks such as washing a cup and sweeping the floor independently but were stopped from doing so by staff with no explanation.

We noted in two people's rooms that half full urine bottles had been left in view next to their drinks on the bedside table. We also noted that staff did not always take time to interact with individuals in the communal areas and observed staff watching television and not always responding when people spoke to them. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People told us their privacy was respected. However, we saw that several bedroom doors were left open where people were in bed during the day. Staff had not considered if people wished to have their doors closed and these preferences were not recorded in people's care records.

People's diverse needs were not always considered. For example, there was very little information available about some people's individual communication needs to ensure that they were able to communicate their preferences and needs to staff. Arrangements had not always been made to ensure there was someone available who spoke a person's first language so that they could communicate with staff and there was very little information recorded in people's care records about their cultural and religious identities and what this meant to them. In some files we saw that people's gender preference in relation to support with personal care had been recorded but this was inconsistent.

The service did arrange religious services to take place at the home. There was a Catholic church service that took place on the first Wednesday of every month and a Church of England service that took place on the second Tuesday of every month. There was also a Korean choir that visited the service once a month.

People were provided with information about the service prior to moving in and there were systems in place to provide people with information about what was happening in the home on a daily basis. For example, there were white boards in the communal areas to inform people about the staff on duty, activities taking place and there were picture boards to tell people what was being served at mealtimes. However, staff were not keeping these up to date and therefore the information was inaccurate and did not support people's understanding of what was happening in their environment.

Some staff did understand the importance of involving people in their care and taking into account their wishes. One staff member said, "We have to listen to them, we have to look after them as we would our mum and dad."

Inadequate

Is the service responsive?

Our findings

One relative commented, "I have observed staff being nice to people, but they lack an understanding of people's individual needs. There is no laughing or joking with people here."

Pre-admission assessments were in place but they were not always fully completed. Care plans were developed for each person that outlined their needs and guided staff about what action they should take to meet these. In one record we saw that staff had recorded what time the person liked to get up in the morning and in another a person's food preferences were recorded. However, in most of the care plans we viewed there was no reference to people's personal preferences about how they liked to be cared for and supported. We also found that people's preferences were not always considered by staff. For example, one person's care plan stated that they liked to have a weekly shower. The person told us that they were not offered a shower every week and there was no evidence in the records that this was taking place. We saw that pain assessments were not always completed for people with wounds and one person told us that staff did not always change their wound dressing at the required intervals due to staff shortages. When we checked this, the wound progress form indicated that the dressing on one occasion had not been changed for four days when the care plan stated it should be done every three days.

There was a lack of detail in the care plans that meant staff were not given sufficient information to ensure they met people's needs effectively. For example, there was limited information about how to safely manage people's medical conditions and carry out tasks to ensure people remained free of infection.

Care plans stated that people should be encouraged to do things for themselves but there was no additional information recorded detailing what tasks people could do for themselves or guidance for staff about the support people required to maintain their independence. We saw evidence that people using the service or their relatives had signed their agreement with the care and support to be provided initially on their admission to the service. However, many of the care plans viewed were not signed by the person using the service or a relative and there was very little evidence that people had been involved in developing their care plans and making decisions about the use of equipment such as bed rails. We also saw that several people were nursed in bed in their rooms. However, there was no record of why this was or if people had chosen to remain in their rooms.

There was a system in place to review people's care plans on a monthly basis. However, we found that some people's care plans had not been reviewed for several months. We also found that people's care plans had not always been updated or reviewed following discharge from hospital which is important as their needs may have significantly changed. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Most people told us they had not felt the need to make a complaint about the service and one person said, "I'm well pleased, no complaints at all." However, a relative felt that communication was poor because they didn't know who to raise concerns with. They said, "Communication could be better, there are always different staff, we don't know who to speak to."

People were given information about the complaints procedure as part of the guide to the service when they were admitted. However, there was no information clearly displayed in the units to inform people and their visitors about how to raise any concerns or provide feedback about the service.

We looked at the complaints record. Details of complaints were clearly recorded, however we could not always see how the manager had responded to the complainant to reassure them that their concerns had been listened to and action taken to resolve any issues. This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

During our inspection we saw limited evidence of any one to one activities taking place with people using the service. We saw some people reading newspapers and in the afternoon on the first day of our inspection an external music entertainer provided a group activity in one of the units. Staff told us they were unable to sit down and carry out activities as they had other tasks to complete but said they did sometimes take people to the garden and offer hand massages and manicures. We saw no evidence that

Inadequate

Is the service responsive?

people were supported to use the garden even though the weather was warm. A relative commented, “They don’t encourage people to take part in things, they [staff] just accept the first refusal and move on.”

The activity co-ordinator showed us the cinema room that people could access and the service also had a reminiscence room, a sensory room and pampering room. However, there was only one activity co-ordinator for the service and many of the other staff were unable to support activities as they did not have the time to do this. There were some external organisations that visited the service on a regular basis to provide activities such as music and Japanese Origami and 12 people had recently been supported to learn how to use a computer. The activities co-ordinator said the service was also involved in a project to support people with dementia care needs to use computer tablets to improve their wellbeing.

The activities co-ordinator told us that she had completed activity profiles for each person and was in the process of developing life history documents for people. However, these were not kept in people’s files where staff on the units could access them.

Inadequate

Is the service well-led?

Our findings

There was no registered manager in post at the time of our inspection. The previous manager had been in post for 18 months and left shortly before our inspection. They had submitted an application for registration but had left before this was assessed. The regional manager had submitted an application to be registered in the interim whilst a new permanent manager was recruited. There was an acting manager in post at the time of our inspection.

Prior to the inspection a Provider Information Return was sent to the provider. A PIR is a document that we ask providers to complete that tells us about the operation of the service, what they do to meet people's needs and any proposed improvement plans. We did not receive the completed document before the inspection, however, the acting manager gave us a copy on the first day of the inspection as she said she had difficulty submitting the form electronically.

On the first day of the inspection we asked the acting manager about any challenges that the service was facing. She told us that the service was not facing any particular difficulties. Throughout our inspection we found evidence of several issues impacting on people using the service and staff, including staff recruitment and retention, inadequate care planning and some poor staff practice. We found that the management team was not adequately monitoring the operation of the service as poor practice had not been identified or addressed.

Staff told us that the culture within the service was not open and transparent and there was a lack of leadership at the service. They told us the acting manager had little or no contact with them and people we spoke with were not aware of who the manager was when we asked them. Staff told us they did not feel respected, valued or supported and two members of staff we spoke with said they did not want to report concerns they had about poor staff practice because they were worried about the response they would receive.

We observed that the management and nurses on duty tended to complete administrative tasks and did not support staff with personal care of people. There was little support offered when staff were busy such as during mealtimes to assist people with their meals.

There was only one staff meeting recorded for 2014 that took place in April. The minutes showed evidence of the management sharing information but there was no evidence of staff involvement in this meeting. Relatives meetings were supposed to be arranged quarterly, however, the last meeting was held in February 2014 and the one before that in April 2013. These meetings were used for information sharing and to keep relatives informed about what was happening at the service. We asked the acting manager if she was aware of any other meetings that had taken place and any available minutes and she told us that no other meetings had been held with staff or relatives. Some meetings had been held with people on the units, however, again this was inconsistent.

Throughout the inspection, the information we requested was not easily accessible and the acting manager was often unaware of where information was held. Records were generally not up to date and were not well organised so that information could be found promptly when required. People's care records also contained insufficient detail and were not kept up to date. This was a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The regional manager informed us that all information about accidents and incidents was reported to the provider centrally so that these could be analysed. She told us that a meeting was then held to discuss any concerns or patterns that were identified. We asked the regional manager to forward details of the last meeting following our inspection but this information was not provided.

We asked to see the quality assurance systems in place for monitoring the operation of the service. The acting manager told us that medicine and care plan audits were completed monthly. The records for these were incomplete. For example, the care plan audits had been completed in June 2014 but there was no evidence that any had been completed before that. In addition the record was a tick list that identified whether a section of the care plan was completed but did not comment on the quality of the content.

The medicines audits identified several issues in January and February 2014. However, there was no information recorded to demonstrate how these issues had been addressed. Following the medicines audits in February, there were no further records until July 2014 and the acting

Inadequate

Is the service well-led?

manager could not tell us if any further audits had taken place. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

There were no systems in place to analyse complaints that were made about the service. The regional manager told us that this was done by the provider for the organisation as a whole and not by individual services.

We saw that health and safety audits were taking place every two months and that issues were addressed to ensure the safety of people using the service.

The acting manager told us that satisfaction surveys were given to people using the service, their relatives and health and social care professionals on an annual basis usually in August or September. She said that the results of these were analysed and then an action plan developed that was shared with the local authority. The acting manager was unable to find the action plan to evidence this at the time of our inspection.

We asked if there were any action plans in place identifying any plans to develop and improve the service. The regional manager told us that there was nothing currently in place. There was very little evidence that the service learned from incidents to drive the improvement of the service and the acting manager could not demonstrate how the service used best practice guidance to ensure that people's needs were met effectively.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse **The registered person had not made suitable arrangements to ensure service users were safeguarded against the risk of abuse. Regulation 11(1)(a)(b)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing **The registered person must take appropriate steps to ensure that, at all times, there are sufficient numbers of suitably qualified, skilled and experienced persons employed for the purposes of carrying on the regulated activity. Regulation 22**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010 Requirements relating to workers **The registered person was not operating effective recruitment procedures as they did not ensure all information specified in Schedule 3 was available. Regulation 21(a) and (b)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment **The registered person did not have suitable arrangements in place for obtaining, and acting in accordance with, the consent of service users in relation to the care and treatment provided for them. Regulation 18**

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Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services The registered person had not taken proper steps to ensure that each service user was protected against the risks of receiving unsafe or inappropriate care as they had not taken action to meet the service user's individual needs and ensure the welfare and safety of service users. Regulation 9(1)(b)(i) and (ii)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010 Meeting nutritional needs The registered person had not ensured that service users were protected from the risks of inadequate nutrition as there was not always sufficient choice of suitable food, food did not always meet any reasonable requirements arising from service user's religious or cultural backgrounds and support was not always available to ensure service users ate and drank sufficient amounts. Regulation 14(1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff The registered person did not have suitable arrangements in place to ensure that persons employed for the purposes of carrying on the regulated activity received adequate training. Regulation 23(1)(a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services The registered person had not made suitable arrangements to ensure the privacy and independence of service users. Regulation 17(1)(a)

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Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 19 HSCA 2008 (Regulated Activities) Regulations 2010 Complaints The registered person had not brought the complaints system to the attention of service users and persons acting on their behalf in a suitable manner and format and had not taken steps to co-ordinate a response to complaints that related to care or treatment provided to a service user where such care or treatment had been shared with others. Regulation 19(2)(a) and (d)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records The registered person had not ensured that service users were protected against the risks of unsafe or inappropriate care and treatment arising from a lack of proper information about them as there was not an accurate record in respect of each service user and other records relating to persons employed and the management of the regulated activity were not maintained and could not be located promptly when required. Regulation 20(1)(a)(b)(i) and (ii)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers People who use services were not protected from unsafe or inappropriate care as the registered person did not regularly assess and monitor the quality of services provided and did not adequately identify, assess and manage risks relating to the health, welfare and safety of service users and others. Regulation 10(1)(a) and (b)