Care Quality Commission

Sudera Care Associates Limited

Grindley House Residential Care Home

Inspection report

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Date of inspection visit: 28 October 2014
Date of publication: 05/02/2015

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?	Requires Improvement
Is the service well-led?	Inadequate

Overall summary

We inspected this service on 28 October 2014. The service was registered to provide accommodation and personal care for up to 22 people. People who use the service have physical health and/or mental health needs, such as dementia.

At the time of our inspection accommodation and care was provided to 17 people.

The service had 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 and associated Regulations about how the service is run.

Summary of findings

At the last inspection on 14 April 2014 we asked the provider to make improvements. These were in relation to the content and accuracy of the information contained in people's care records, how the quality of care was assessed and monitored and how the staff's professional development needs were monitored and managed.

During this inspection we found that the registered manager and provider had failed to make the required improvements. This meant the provider had continued to not meet the standards required to meet people's care and welfare needs.

We also identified additional areas of unsafe, ineffective and unresponsive care. This was because the service was not well led. We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and The Care Quality Commission (Registration) Regulations 2009. You can see what action we told the provider to take at the back of the full version of the report.

Risks to people's health and wellbeing were not consistently identified, managed and reviewed and people did not always receive their planned care. This meant people were not always kept safe and their welfare and wellbeing was not consistently promoted.

There were insufficient numbers of staff to keep people safe and provide the right care at the right time. This also meant that people's individual care preferences and needs were not always met.

Records relating to people's care were not always accurate, up to date or readily accessible in the event of an emergency situation. This meant people were at risk of receiving unsuitable or unsafe care. Records in relation to the management of the home did not always contain information relating to criminal checks completed on the staff. This meant people could not be assured they were being cared for by suitable staff.

The provider did not monitor the staff's performance or learning needs. This meant people could not be assured that they were receiving care from staff who were appropriately skilled.

People were at risk of dehydration and malnutrition were not always monitored to ensure they ate and drank sufficiently. When people lost significant amounts of weight the registered manager could not show us that professional advice had been sought. This meant that people's risks of malnutrition and dehydration were not always managed.

Some people who used the service were unable to make certain decisions about their care. The registered manager and provider could not show us that under these circumstances the legal requirements of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS) were being followed. The Mental Capacity Act 2005 and the DoLS set out the requirements that ensure where appropriate, decisions are made in people's best interests when they are unable to do this for themselves. This meant people could not be assured that decisions were being made in their best interests when they were unable to make decisions for themselves.

When staff had the time they supported people with care and compassion and respect. However, we saw that sometimes people were not treated with the care, compassion and respect they should have received.

People's feedback about the care was sought, but the systems in place to analyse feedback needed to be improved so that feedback could be consistently listened to and acted upon.

The provider did not have effective systems in place to assess, monitor and improve the quality of care. This meant that poor care was not being identified and rectified by the provider.

The registered manager did not inform us of incidents that occurred at the service and pre-inspection information was not completed at our request. This meant we were unaware of incidents that had occurred within the home.

Medicines were given to people in a safe manner. People's privacy was promoted and people understood the complaints process and the deputy and registered manager's told us how they would respond to a complaint in accordance with the provider's policy.

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. Risks to people's health and wellbeing were not consistently identified, managed and reviewed. This meant people's safety and welfare was not always promoted.

There were insufficient numbers of staff to meet people's individual needs and keep people safe.

Care records relating to care provision and the management of the home were not always accurate or readily available. This meant people were at risk of receiving unsuitable and unsafe care.

Suspected abuse was not always reported in accordance with the agreed local safeguarding procedures. This meant that appropriate action was not always taken to protect the people's safety and welfare.

Medicines were managed safely by the staff. This meant people were protected from the risks associated with medicines.

Is the service effective?

Requires Improvement 

The service was not effective. Care records and staff discussions did not show that consent to care was sought in line with legislation and guidance. This meant people could not be assured that the requirements of the Mental Capacity Act 2005 were being followed when decisions were being made in their best interests.

The legal requirements to ensure people were lawfully restricted to the confines of the service were not followed. This meant people could not be assured that they were being prevented from leaving the home in a lawful manner.

People's risks of dehydration and malnutrition were not consistently identified and appropriately managed. This meant people could not be assured they were eating and drinking sufficient amounts to maintain their health and wellbeing.

The provider did not monitor the staff's performance or learning needs. This meant people could not be assured that they were receiving care from staff who were appropriately skilled.

Is the service caring?

Requires Improvement 

The service was not consistently caring. People gave mixed feedback about their interactions with staff and we saw that people were not always treated with care, compassion and respect.

People were given choices about their care, but people's feedback showed that they were not assured that their choices were always respected.

Summary of findings

People's independence was not always promoted and some of the staff's actions disabled and restricted people.

People privacy was promoted and respected.

Is the service responsive?

Requires Improvement

The service was not consistently responsive. There were insufficient numbers of staff to meet people's care preferences and people were not consistently enabled to participate in their preferred leisure and social based activities.

People's care preferences were not always recorded. Information about people's likes and dislikes was not always available for the staff to follow. This meant people were at risk of receiving inconsistent or unsuitable care.

Feedback about the care was sought. However feedback was not always analysed and acted upon. People understood how to complain if they needed to share concerns about care.

Is the service well-led?

Inadequate

The service was not well led. The required improvements from our last inspection had not been made. This meant the provider had continued to not achieve the standards required to meet people's care and welfare needs.

Effective systems were not in place to assess, monitor and improve the quality of care. This meant that poor care was not being identified and rectified by the registered manager and the provider.

The registered manager did not inform us of reportable incidents that occurred at the service and they failed to submit information about care at our request.

Staff morale was low and people who used and visited the service were aware of this. This meant that atmosphere at the home was not always positive.

Grindley House Residential Care 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 was 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 28 October 2014 and was unannounced.

Our inspection team consisted of 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. The expert by experience had experience of older people and people living with dementia.

Before the inspection, the provider was sent a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. The provider did not submit a completed PIR to us despite confirming they had received the request.

We checked the information we held about the service and the provider. This included the notifications that the provider had sent to us about incidents at the service and information we had received from the public and the local authority. We used this information to formulate our inspection plan.

We spoke with six people who used the service and two relatives. We did this to gain people's views about the care. We also spoke with three members of care staff, the activity coordinator, the deputy manager and the registered manager. This was to check that standards of care were being met.

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 looked at 11 people's care records to see if their records were accurate and up to date. We also looked at records relating to the management of the service. These included audits, health and safety checks, staff rotas, training records, three staff recruitment files and minutes of meetings.

Inadequate

Is the service safe?

Our findings

At our last inspection we found that effective systems were not in place to keep people safe. People's care records did not always show that action had been taken to address risks to their health and wellbeing and people's risks were not always reviewed following safety incidents. The information in people's care records was not always accurate and up to date. We told the provider that they needed to make improvements to ensure people received safe care.

At this inspection, we found that the required improvements had not been made and people were not protected from receiving unsafe or unsuitable care.

The risks of harm to people who used the service were not consistently identified or managed to promote their safety. For example, one person had a medical condition that increased their risk of pressure damage to their skin. We saw that an assessment of their risk of pressure damage had not been completed. Another person's completed pressure damage risk assessment showed they were at risk of skin damage. However, no risk management plan was in place to manage or reduce this risk. This meant that suitable management plans to manage their risk of pressure damage were not in place and staff did not have the information required to keep these people safe.

Infection risks had not been identified by the staff. We saw that two bins located in toileting areas were broken. One of the bins had a broken foot pedal and the other had no lid. This meant there was a risk that people would touch the bins with their hands to open them. This could increase the potential spread of infection.

The failure to identify and manage risks to people meant there was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We found that where risks had been identified the provider could not show that people consistently received their care in accordance with their care plans. For example, care records showed that one person was not supported in accordance with their care plan to change their position to manage their risk of skin damage. This meant that the provider could not show that some people received their planned care in a manner that ensured their welfare and safety.

Staff told us and two people's care records showed they needed to use mobility frames to walk safely. We saw that their mobility frames were unsafe and ineffective. This was because the staff had not maintained the frames or checked their safety. This meant that these people's welfare and safety were not consistently promoted.

People were also at risk of receiving unsuitable care that did not promote their welfare or safety. For example, some people who used the service had a 'Do not attempt resuscitation' order (DNAR) in place. These were in place at people's individual requests or in people's best interests due to their medical condition and general health. Staff could not accurately tell us which people had a DNAR in place. This meant that people were at risk of receiving resuscitation against their wishes or were at risk of not receiving resuscitation when they required it.

The failure to provide care in a manner that promotes people's welfare and safety meant there was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Without exception people and staff told us there were not always enough staff to meet people's needs and keep people safe. One person who used the service said, "The staff tell us, 'we're short of staff at the moment'". Another person said, "They are short staffed, but it doesn't really affect me as I do a lot for myself". A staff member said, "People have to wait to go to the toilet and for us to answer buzzers. We just have to tell them we can't come straight away". The registered manager also told us there were not enough staff to keep people safe. They said, "The staffing numbers concern me and I've told the provider there are not enough staff for this size home. I've been trying to get three staff on at night as two is not safe with the lay out of the building".

On the day of our inspection, there were insufficient numbers of suitably skilled staff to meet people's needs and keep people safe. For example, we saw that one person was not supported with their mobility needs safely or in accordance with their planned care. This person was left unsupervised and unsupported whilst they requested assistance because care staff were busy supporting other people. This meant the person was at risk of harm because staff could not offer support when it was required.

We saw that sufficient numbers of staff were not always available at mealtimes to meet people's needs. Our

Inadequate

Is the service safe?

breakfast observation showed that the kitchen staff served people's breakfast as soon as they arrived into the dining room, but people then had to wait to receive the support they required to eat and drink. For example, one person who required assistance to eat waited 33 minutes before they received the support they needed from a member of staff to help them to eat their breakfast.

The registered manager told us what the provider's minimum staffing numbers were. The staffing rotas for a 21 day period between 5 October 2014 to 25 October 2014 showed that the provider's minimum staffing levels were not consistently met.

The lack of sufficient numbers of staff meant that people's individual needs were not met and people's safety and welfare were compromised. Therefore this was a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Records relating to people's care were not always readily available in the event of an urgent situation. For example, two members of care staff did not know where DNAR's were located. Upon our request, the registered manager could only locate one of the three DNAR orders that were in place at the service. This meant that people were at risk of receiving unsuitable care.

Records relating to the management of the home were not always available. We looked at three staff records to check that the required criminal history checks had been completed. This is known as the Disclosure and Barring Service (DBS) check. The registered manager and staff told us that the DBS checks had been completed, but two of the three records showed no evidence of this check. This meant that accurate management records were not kept and people could not be assured that the staff were suitable to work with them.

The failure to maintain and keep accessible records in relation to care provision and the management of the home was a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The staff we spoke with explained how they would recognise and report abuse. However, we found that suspected abuse was not reported in accordance with the local reporting procedures. A significant safeguarding concern had been identified by the staff, but the concern was not reported in accordance with local safeguarding procedures. This meant that appropriate action was not taken to protect the person's safety and welfare. Therefore this was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Medicines were managed safely by the staff. Medicines were correctly stored to protect people who used the service and to ensure that the medicines would be effective when used. We observed a staff member administering people's medicines in a safe and consistent manner. An accurate record of the types and frequency of medicines administered were maintained. This showed that systems were in place to ensure people received their medicines safely.

Requires Improvement

Is the service effective?

Our findings

At our last inspection we found that effective systems were not in place to support the professional development of the staff. We told the provider that they needed to make improvements to ensure that the staff received regular professional development and support.

At this inspection, we found that the required improvements had not been made. The registered manager told us she had scheduled staff supervision sessions (supervision enables managers to monitor staff development and offer staff support). However staff told us they had not yet received supervision. We asked three staff members if they received regular supervision. All three told us they had not received supervision. One staff member said, "I haven't had supervision since last December". This meant that the staff's professional development continued to not be monitored.

The failure to provide staff with appropriate training and development opportunities was a breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Care records and discussions with staff did not show that consent to care was sought in line with legislation and guidance. The Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS) set out requirements to ensure that decisions are made in people's best interests when they lack sufficient capacity to be able to do this for themselves.

We looked at four people's care records to see if mental capacity assessments had been completed. We did this because care staff told us that these four people were unable to retain information. This indicated that these people may have had limited mental capacity to make decisions about their care. All four records showed people's mental capacity status. However, only one record showed that the principles and requirements of the Mental Capacity Act 2005 had been followed during the assessment process. This meant that we could not be assured that the five statutory principles of the Act and the two stage mental capacity assessment were consistently adhered to in accordance with the Act.

The staff we spoke with were unable to tell us how they complied with the requirements of the Mental Capacity Act 2005. Staff told us they had not received training in the Act and the staff training records confirmed this. This meant that the staff did not have the knowledge required to work in accordance with the Act. Therefore this was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We saw that access to and from the building was restricted by a key coded lock. Staff told us this was to keep people safe by preventing them from leaving the home. We asked the registered manager if any people who used the service were being restricted to the home's environment in their best interests under the deprivation of liberty safeguards (DoLS). The registered manager told us that no DoLS authorisations were in place, but she named five people who used the service who were being restricted in their best interests. This meant that the legal requirements of the Mental Capacity Act 2005 and DoLS had not been met for the five people who had been identified as requiring DoLS referrals. Therefore this was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider could not always show that people were supported to sufficiently eat and drink. Staff told us that two people required the amount of drinks they consumed to be monitored because they were at risk of dehydration. Their care records showed that the amounts of drinks they consumed were not being monitored as the staff were not calculating the overall amounts that people drank each day. As a result of this the staff had not identified that both people were regularly consuming low amounts of drinks. This meant effective systems were not in place to ensure people's risk of dehydration was being appropriately monitored.

We saw that two people had lost a significant amount of weight since January 2014. Their care records did not show that their weight loss had been reported to a health care professional, despite the registered manager stating, "If weight loss is over a long period of time it is handed over during GP visits". This meant people could not be assured that their weight loss was being appropriately monitored and acted upon. One of these people's care records did not contain a nutritional risk assessment to reflect their weight loss and risk of malnutrition. This meant there was no plan in place to ensure their nutritional risks were being managed to ensure their safety and welfare.

Requires Improvement

Is the service effective?

The failure to identify and manage risks relating to dehydration and malnutrition was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People were complimentary about the food. One person said, “The meals are very good”. Another said, “They seem to go out of their way to make it a nice meal for us”. People told us and we saw that meal choices were offered and meals were provided in accordance with people’s choices. One person said, “There’s a board that tells you what’s on the menu that day and you just tell them what you want”. This meant that people were satisfied with the food at the service.

Requires Improvement

Is the service caring?

Our findings

People gave mixed feedback about their interactions with staff at the home. Positive feedback included, "All the ladies [The staff] here make you feel content and comfortable" and, "These girls [The staff] all work so hard and they're all so friendly". Negative feedback included, "The staff are very good, mostly. One or two of them are a bit snappy sometimes, I think they know they are in charge" and, "Some of them [The staff] show their authority but it's necessary". This meant that some people felt that the interactions between people who used the service and the staff were not always positive.

We saw that when the staff had the time to interact with people this was done with care, compassion and respect. For example, we saw staff kneel and bend down to talk with people at their level. However, we saw that the staff did not always support people with care, compassion and respect. For example, we saw staff remove one person's empty cereal bowl and replace it with a plate of toast without communicating. This person was visually impaired and was unaware their toast was in front of them. This meant people were not consistently treated with care, compassion and respect.

Some of the staff were aware that people were not receiving their care in a positive manner. One staff member said, "I can't interact with people the way I used to. I get upset that I have to rush with people". Another said, "It's the people that need to come first. We try and put everything in front of them even if staff do not get breaks". This showed that some staff put people's needs before their own.

We saw that staff involved people in making day to day choices about their care. For example, people were given choices about the food they ate and the staff respected these choices. However people gave us mixed feedback about their involvement in making decisions about when to get up and go to bed. One person said, "You can get up when you like, there's no set time". Another person said, "They don't like you hanging about, we have to go to bed before 10pm". Staff told us people could get up and go to bed at a time that suited them. Despite the staff telling us this, people were not assured that they could consistently go to bed at a time of their choosing.

People's independence was not consistently promoted. At meal times people's mobility aids were removed from the dining room. We observed one person ask staff for their mobility aid so they could leave the room independently by using their mobility aid. This person waited five minutes for staff to bring their mobility aid back to them. Another person asked for their glasses so they could see and eat their breakfast. This person waited 10 minutes before they received their glasses from the staff. A staff member said, "They shouldn't have been bought down without them". This meant that at times people were restricted and disabled by the actions of the staff.

We saw that people's privacy was respected. For example staff supported one person to move from a communal area to a private area in the home so they could receive treatment from a visiting health care professional. We also saw that people's private information contained in their care records was kept secure. This showed that people's right to privacy was respected.

Requires Improvement

Is the service responsive?

Our findings

People who used and visited the service and the staff told us there were not enough staff to meet people's care preferences. One person who used the service said, "I used to like to have a bath every day when I lived at home. I only have one once a week here, but I have to be content with that as there are lots of people here". Staff told us that people were assisted to bathe on a weekly basis. Care records did not always show that people were supported to bathe once a week. We found that two people's care records did not show they had received regular weekly baths. A staff member confirmed this by saying, "We try our best to get things done, but we're not able to always give people baths as we are overworked". We spoke with the registered manager about this. They said, "I think it's a staffing issue".

Staff told us that the activities coordinator was employed for four hours a day, five days a week and that they did not have the time to facilitate activities in their absence. People and staff told us that the activities coordinator had recently been absent from work for a six week period. The registered manager confirmed there had been no cover provided for this role.

The failure to provide sufficient numbers of suitably skilled staff to meet people's care needs and preferences was a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People told us they were not always able to participate in their preferred leisure and social based activities. One person said, "The lady over there [Activity coordinator] does quizzes and that fella came yesterday and twanged on a guitar, it's the first time' and, "We need something to get our attention". Another person said, "The activity lady only works certain days, not every day" and, "Yesterday morning we had Bingo but I can't do it very well because of my fingers you know". This meant that people were not consistently supported to participate in activities that were meaningful or suitable to meet their needs and preferences.

We saw that the provider was using temporary staff alongside permanent staff due to reduced staffing levels. People told us and our observations showed that when permanent staff provided care it was done in accordance with people's care preferences. This was because the permanent staff knew people well as they had worked with them over long periods of time.

However some people told us that they believed the temporary staff did not understand their care preferences and needs. One person said, "There are a lot of new staff [Temporary staff]" and, "You have to accept what they do, sometimes they don't do enough, I think they ought to do more". We found that people's care records did not always record people's care preferences so this information was not readily available for temporary staff to use. As a result of this people were at risk of receiving inconsistent or unsuitable care.

People's care records were not always accurate and up to date. Changes in people's care needs were not always recorded. For example staff told us that one person required assistance to eat and drink due to a deterioration in their condition. The increased support this person required and received had not been recorded in their care record as their care needs had not been formally reviewed. This meant that this person's care records were not accurate or up to date and information about their current care needs was not recorded. This placed them at risk of receiving inconsistent and unsuitable care, particularly from temporary staff who may not have worked with the person before.

The failure to keep accurate and up to date records detailing people's care preferences and needs was a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We saw that systems were in place to gain people's feedback about the care. For example regular meetings were held with people and their relatives to discuss the care, food and environment. One person had chosen not to attend this meeting, therefore the registered manager met with them on an individual basis to gain feedback about the care. We saw that action had been taken to address issues raised during these meetings. For example, it was identified through one of these meetings that people did not know who their keyworker's (staff member responsible for coordinating their care) were. We saw that action had been taken to address this. This showed that people's views about the care were sought and acted upon.

Requires Improvement

Is the service responsive?

However, we saw that a satisfaction survey had been completed in July 2014. The registered manager confirmed they had not analysed the results of the survey which meant any negative feedback about the care had not been acknowledged or acted upon. This showed that the systems in place to gain and act upon people's feedback were not always effective.

People told us they would tell the registered manager or deputy manager if they had a complaint. One person said, "I would tell [The deputy manager], but I've never had to do that". A relative said, "I would go to the office" and, [The deputy manager] is pretty good". There were no complaints for us to review since out last inspection but the registered manager and deputy manager demonstrated they understood the complaints process.

Inadequate

Is the service well-led?

Our findings

At our last inspection we found that effective systems were not in place to assess and monitor the quality of care. We told the provider they needed to make improvements to ensure that the quality of care provision was regularly assessed and monitored.

The provider submitted an action plan that recorded the actions they had agreed to take to make the improvements required. However, we found that the actions they told us they would complete had not been completed. This meant that the registered manager and provider had failed to make the required improvements.

Effective systems were still not in place to assess and monitor the quality of care. For example, no audit systems were in place to assess and monitor the quality of the information contained in people's care records or the frequency of baths people were supported to receive. This had meant the registered manager and provider were unaware of the failings in care we had identified at this inspection. The registered manager told us, "I don't have the time to do this [Assess and monitor quality] and I don't have any support from the provider" and, "I've had to work on the shop floor to cover shifts". This meant the registered manager was not regularly assessing and monitoring the quality of care provision.

Risks to people were not being consistently identified, managed and reviewed by the registered manager and provider. For example, one person who had lost a significant amount of weight did not have an assessment of their risk of malnutrition and their weight loss had not been reported to a health care professional. This meant the registered manager and provider did not consistently promote this person's welfare and safety.

The registered manager had not analysed the results of a satisfaction questionnaire that had been sent to people who used the service in July 2014. They told us this was because they had not had the time to evaluate it. We saw that six of the seven people who responded had stated that access to the community for trips was poor. The registered manager had not identified this as a concern and action had not been taken to improve people's access to the community.

The registered manager failed to return their provider information return (PIR) as requested by the Commission. During the inspection the registered manager found the email that contained the PIR document from us. They confirmed they had missed this email and had failed to submit the pre-inspection information we requested.

The failure to regularly assess, monitor and improve quality was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The registered manager had not informed us of a serious injury and a safeguarding incident that had occurred at the service. Informing the Commission of incidents such as alleged abuse and serious injuries is a legal requirement. This meant there was a breach of Regulation 18 of The Care Quality Commission (Registration) Regulations 2009.

People told us the atmosphere at the service was not always positive. One person said, "The staff are browned off". A relative said, "I can tell the staff are unhappy. I've heard the unrest amongst the staff". Staff confirmed that their morale was low. One staff member said, "I don't feel valued or that I matter to the provider all". Another said, "I just wish I could be there for people and not keep putting them off". This meant that staff morale was low and people who used the service were aware of this.

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 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment Effective arrangements were not in place to show that consent to care was gained in accordance with the legal requirements of the Mental Capacity Act 2005.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing There were insufficient numbers of suitably experienced staff to keep people safe and meet people's care preferences and needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff Staff's professional development needs were not being regularly monitored and managed.

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 People did not always receive assessments of need. Care was not always planned and delivered in a manner that met their needs or promoted their welfare and safety

The enforcement action we took:
We served the registered manager and provider with a warning notice telling them to make the required improvements by 18 December 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers Effective systems were not in place to regularly assess, monitor and improve care provision. Risks to people were not always identified, managed and reviewed. People's feedback was not always acted upon to improve care.

The enforcement action we took:
We served the registered manager and provider with a warning notice telling them to make the required improvements by 18 December 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse Allegations of abuse were not reported in accordance with local safeguarding procedures. People could not be assured that they were being lawfully restricted within the service.

The enforcement action we took:
We served the registered manager and provider with a warning notice telling them to make the required improvements by 18 December 2014.

This section is primarily information for the provider

Enforcement actions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records Accurate and up to date records were not being maintained in relation to care provision and the management of the service. Important information about people's care needs was not always readily available for the staff to use in the event of an emergency.

The enforcement action we took:
We served the registered manager and provider with a warning notice telling them to make the required improvements by 18 December 2014.