Ismeer

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	Inadequate
Is the service effective?	Requires Improvement
Is the service caring?	Requires Improvement
Is the service responsive?	Requires Improvement
Is the service well-led?	Inadequate

Summary of findings

Overall summary

We inspected Ismeer on 07 June 2016, the inspection was unannounced. Ismeer was last inspected in January 2016 when we identified breaches of the regulations. These were in respect of: Care plans being out of date with no evidence people had consented to their plan of care. Monitoring records not being in place or not consistently completed. Issues regarding the environment. A lack of effective oversight of the service. At this inspection we checked to see if improvements had been made and found the service remained in breach of these regulations.

Ismeer is a residential home for up to 27 older people. At the time of the inspection 17 people were living at the service, some of whom were living with dementia.

Ismeer is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. There had been no registered manager in post since January 2015.

The provider had passed away in April 2016 and the service was being overseen by the provider's representative who was one of two executors of the estate. The provider's representative lived overseas and was unable to monitor the service on a day to day basis. The provider's representative had appointed an agent who was based at the service two or three days a week and they communicated regularly. There were also two full time acting managers in post who had responsibility for the day to day running of the service.

There was a lack of risk management for people living at Ismeer. Risk assessments were either out of date or had not been put in place despite people being identified as at risk. Systems to ensure staff were aware of people's changing needs were not robust. For example, the day before the inspection a visiting GP had identified one person was dehydrated and had associated low blood pressure. They had advised the person be encouraged to drink six glasses of water a day. This had been recorded in the person's notes by the GP but staff on duty were unaware and were therefore not acting on this advice.

Recruitment processes were not robust, one new member of staff was working unsupervised. They had not had a completed Disclosure and Barring check and only one telephone reference had been received. This was contrary to the service policy.

Records showed shortfalls in staff training identified as necessary for the service. For example, no staff had undertaken recent refresher safeguarding training. There had not been any training to meet people's specific needs.

The provider was not working in accordance with the processes set out in the Mental Capacity Act (2005) or associated Deprivation of Liberty Safeguards (DoLS). Only one DoLS application had been made to the local

authority. The local management team acknowledged several people were not free to leave and therefore should have had DoLS authorisations should have been applied for. There was no evidence of any mental capacity assessments or best interest meetings taking place. One person with capacity was being kept from going out of the home, which was against their legal rights.

The service was based in an old property and there were structural problems with the building which had resulted in considerable damp forming. Bedrooms showed signs of damp and mould, the décor was in need of updating and furnishings were of a poor quality. There was a general air of neglect throughout the property. Systems for reporting faults and defects were not robust and repairs were not always happening.

Information in care plans was out of date and was at times inaccurate. There was no evidence of regular reviews taking place. People and/or their representatives had not signed to indicate they were in agreement with their plan of care.

There was a lack of organised activities taking place and one person told us they were bored. On the day of the inspection we did not observe anyone being supported to take part in activities. One person we met chose to stay in their room but only had access to one channel on the television. They were unable to operate the radio.

There was a lack of oversight of the service from the provider's representatives. There was no effective leadership to support the prioritisation of tasks necessary to make improvements to the service. There were no systems in place to help ensure stakeholders opinions were sought to help drive improvement. For example, no staff meetings were taking place, there were no residents meetings or ways of gathering their views and families were not asked for their experiences of the service.

There was no system to ensure regular audits took place in order to monitor the quality of the service. For example, while falls were recorded as required they were not audited in order to highlight any patterns or trends.

We identified several breaches of the regulations. You can see these listed at the back of the full version of the report.

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. Action was not taken to protect people from identified risk.

The recruitment process was not robust. Pre-employment checks had not been completed before a member of staff started working unsupervised.

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

Is the service effective?

Requires Improvement

The service was not effective. Legislation laid down in the MCA and associated DoLS was not being followed. This meant people's liberty was being unlawfully restricted.

Staff training was not regularly updated.

Action to address problems in the environment were not adequate and had not been carried out in a timely manner.

Is the service caring?

Requires Improvement

The service was not entirely caring. People's dignity was not consistently respected.

People's bedrooms were not arranged in a way which supported their emotional well-being.

Staff worked with families to establish how people preferred to be supported.

Is the service responsive?

Requires Improvement

The service was not responsive. Care plans had not been updated and did not reflect people's current needs.

Handovers between staff did not ensure staff were aware of any changes to people's health.

There was no organised programme of events in place. People

who chose to stay in their room had little to occupy them.

Is the service well-led?

Inadequate

The service was not effective. Although arrangements for the day to day running of the service had been put in place there was no clear oversight or guidance from the providers representative.

Efforts to improve the delivery of the service had been ineffective.

Audits to monitor service delivery were not in place. Staff, people and their families were not asked for their views of the service.

Ismeer

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 7 June 2016 and was unannounced. The inspection was carried out by two adult social care inspectors.

Before the inspection we reviewed previous inspection reports and other information we held about the service including any notifications. A notification is information about important events which the service is required to send us by law.

During the inspection we looked at seven people's care plans, Medicine Administration Records (MAR), three staff records and other records in relation to the running of the home. We spoke with the agent acting on behalf of the provider's representative, the two acting managers and three other members of staff. We also spoke with six people who were living at Ismeer.

Due to people's health needs we were not able to communicate verbally with everyone to find out their experience of the service. We spent some time observing people at lunch time using the Short Observational Framework Inspection (SOFI) tool. SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. We also observed staff interactions with people.

Inadequate

Is the service safe?

Our findings

At our inspection in January 2016 we had concerns that, where people had been identified as being at risk appropriate action was not taken to protect people from the risk. For example, one person was confined to bed and therefore at risk of developing pressure ulcers. There was no recording sheet in place for staff to record when the person had been moved to alleviate any pressure. Night logs indicated the person had not been moved.

At this inspection staff told us one person had fallen on several occasions during the previous two months. Accident and incident forms were in place which documented six falls in April and three in May. We checked the persons care documentation and found there was no risk assessment in place in respect of falls. When the falls had occurred during the night, accident forms recorded that the person had been reminded to use the call bell if they wanted to get up in the night. However, this had not prevented the falls occurring. One of the acting managers told us they were considering using pressure mats so staff would be alerted when the person got out of bed but no further action had been taken. At the front of the persons care file it was recorded; "[Person's name] has a history of falls and needs to be assisted at all times when mobilising." However the accident forms showed this was not happening. For example, one stated; "[Person's name] was moving around the home, lost his footing and fell." A request had been made to the GP to refer this person and one other to the falls clinic but no other action had been taken to attempt to minimise the risk in the meantime.

One person had a dog living with them in their room. We saw records which stated the dog had defecated on the floor of the person's room. Staff had taken responsibility for feeding and exercising the dog in the grounds of the service. They told us the dog had sometimes growled at them when they approached the person to carry out any procedures and could be "snappy." There were no risk assessments in place to guide staff as to how to approach the person and what action they could take to minimise any risk. There was no sign on the door to alert visitors to the fact that there was a dog in the room.

Some care plans contained risk assessments for a range of areas including falls, manual handling and skin integrity. However, these were all dated early 2015. There was no evidence of any recent reviews of risk assessments or indication they were reconsidered following any incident. One care plan contained no risk assessments at all.

Some people required assistance from staff to move around the building or transfer from standing to sitting or vice versa. We observed one person being helped from his chair to a walking frame using a handling belt. The handling belt was used inappropriately to pull the person to their feet. Staff did not give the appropriate verbal assistance or position the person's wheelchair behind them correctly. The person was not wearing any footwear and so was at increased risk of slipping. Later in the day we witnessed the same person being supported to their feet by staff lifting them by pulling them up under their arms. This is not in accordance with current guidance.

One person was identified as being dehydrated with associated low blood pressure on 6 June 2016. The GP

had advised the person should be encouraged to drink; "at least six cups of water a day." The GP's advice had not been recorded in the person's daily notes. Staff told us they were unaware of the advice which indicated the information had not been shared with staff during the shift handover. No fluid charts had been put in place to ensure the person received the fluids they required. No entries had been made into the staff communication book since 31 May 2016. This demonstrated systems set up to ensure staff were aware of increased risks to people's health were not effective.

Staff told us one person could sometimes behave in a way which was challenging for staff. The persons care plan contained no information on what the likely triggers for this behaviour were and what staff could do to avoid the person becoming distressed or how they might alleviate any anxieties.

We found there were risks associated with the premises. For example, signs by hot water taps warned "Caution hot water." The water temperature was not regulated and ran very hot. This meant people with limited or decreased cognitive abilities could have been at risk of scalding. Radiators in some rooms and corridors did not have radiator covers on them. This meant people could have fallen against them and sustained burns.

Furniture had been arranged in one bedroom in such a way that the person could not reach the call bell should they need assistance. In order to mitigate this problem a long piece of string had been attached to the fitting of the call bell and draped across the room to reach the person. The operation of this arrangement was not easy or safe.

We found a bar of soap and a flannel in a shared bathroom. This did not protect people from the risk of cross infection.

We concluded that action was not taken effectively, or in a timely manner, in order to protect people from identified risks.

We found there was a continuing breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The recruitment process was not robust. We were told a new member of staff had been taken on to cover waking night shifts. This member of staff was still in their induction period and their Disclosure and Barring (DBS) checks, to ensure they were suitable to work with people, had not been completed. They were already included on the rota and working unsupervised. The local management team told us the employee had a DBS from their previous employment which they were able to evidence. This had been issued in September 2015. It is important that new DBS checks are completed when employees are recruited to ensure the information is up to date. The new employee only had one reference on file which had been obtained by telephone. This was not in line with the providers policy which stated; "Two written references are obtained before an appointment is confirmed."

We found there was breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and a relative told us they considered Ismeer to be a safe environment. The relative said; "I have no concerns I can't fault them." Staff were confident about the action they should take if they believed anyone was at risk from abuse. They told us they would report any concerns to the manager and were confident appropriate action would be taken, but if not they would report concerns to the Care Quality Commission (CQC) or local authority. Up to date information regarding the process for reporting abuse was available in

the managers' office.

We checked a sample of Medicine Administration Records (MAR) and saw there were no gaps in the records. This indicated people were receiving their medicines as prescribed. MARs had people's photograph at the front of the chart to protect people from the risk of receiving the wrong medicine. Handwritten entries on MARs were countersigned to minimise the risk of errors. Medicines were stored in a trolley which was secured to the wall. There was evidence the trolley was checked on a regular basis.

There were systems in place to help ensure the safe ordering, receipting, checking, administration, storage and disposal of medicines which require stricter controls by law known as controlled drugs (CD's). At the time of the inspection only one person was having CD's administered. Medicines in stock tallied with the records.

People were supported by sufficient numbers of staff. People's needs were met quickly. Staff told us they rarely needed to use agency staff but could access this resource if necessary. The staff team was relatively stable and some had worked at the service for several years. In addition to care staff there were two kitchen employees and a cleaner. A maintenance worker and a gardener were contracted to work at the service as required.

People were having their personal monies kept and managed by the service. Arrangements in place were satisfactory to protect people from the risk of financial abuse. We checked records for people's monies against the amount of cash being held and found these tallied.

Checks were completed on a weekly or monthly basis as appropriate for fire doors and alarms. Hoists, slings and stair lifts were regularly serviced to ensure they were fit for purpose.

Requires Improvement

Is the service effective?

Our findings

Newly employed staff were required to complete an induction before starting work. This included familiarising themselves with the service's policies and procedures and completing the Care Certificate. This replaced the Common Induction Standards and is designed to help ensure care staff have a wide theoretical knowledge of good working practice within the care sector.

Training in areas identified as necessary for the service was organised by one of the acting managers. Training records showed there were shortfalls in this training. For example, only four members of staff out of 17 had up to date food hygiene training. On the day of the inspection a kitchen worker was absent from work and a care worker was covering the kitchen duties. The training records showed this Care worker did not have up to date food hygiene training. According to the training records no-one had up to date safeguarding training, eight had not received refresher moving and handling training and five had not had recent first aid training. One member of staff told us they had received refresher moving and handling training but added; "Honestly? It wasn't the best. Before we've got involved, sat in slings to see what it felt like. This was just talking, a bit boring." This indicated the training provided was not effective or meaningful.

It is important staff have access to training specific to individual's needs. Arrangements had been made for a specialist dementia nurse to visit the service to speak with staff about the challenges facing people living with dementia. Other training was limited. For example, some people living at the service could become anxious or distressed due to their health condition. This sometimes resulted in behaviour which was difficult for staff to manage. No-one had received training to enable them to deal with this effectively. There were no arrangements for training in areas such as end of life care.

We found there was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff received regular supervisions which they told us were; "Useful." They said they felt well supported by the local management team and were able to ask for additional support as needed.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

People's liberty was restricted in order to keep them safe. For example, the front door was locked and people did not have access to the keypad code to allow them to leave the building if they wished. We asked how many people were not free to leave and the agent told us; "Quite a lot." A DoLS application had been submitted to the local authority for one person. No other applications had been made or were in the process of being made. There was no evidence of any mental capacity assessments taking place or any best interest meetings. There was no evidence people had consented to the restrictions. One person told us they would like to go out; "But there's a combination lock on the door." We discussed this with the local management team who told us they were concerned the person might purchase items that were not good for their health and they did not want them to do this. No capacity assessment had been carried out to decide if the person was not able to make the decision for themselves. This demonstrated a lack of understanding of the principles underpinning the legislation and the right people have to make unwise decisions. There was a MCA policy in place but this had not been updated to include the most recent legislation. There was no DoLS policy in place. Only five members of staff had completed training in this area. People's liberty was being unlawfully restricted as the provider was not working in accordance with the processes set out in the Mental Capacity Act (2005).

Care plans had not been signed by people or their representatives to show they had been involved in the care planning process. This meant we could not be sure whether people or their representatives where appropriate, had agreed to the care plan.
We spoke with staff about the need to gain people's consent before giving personal care. One care worker said; "I always tell them what I'm about to do but I don't ask their permission, I just do it."

We found there was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last two inspections in September 2015 and January 2016 we had raised concerns in respect of the environment. Several double glazed window units in people's bedrooms had 'blown' resulting in them becoming cloudy and difficult to see out of. Some bedrooms were showing signs of damp and mould, the décor was in need of updating and there were several examples of bedroom furniture which was broken and/or shabby and in need of replacing.

At this inspection we looked round the building and found that, while some action had been taken to address the problems, this was not sufficient to address the problems. Bedroom furniture was often scuffed and shabby. For example, in one room we saw a set of drawers with a missing handle and the trim on a wardrobe door had broken away and was hanging loose. We discussed this with the agent who told us they would ensure the repairs were prioritised by the maintenance worker.

Damp patches were still evident in people's bedrooms. The agent told us some of the damp had been caused by problems to do with guttering and repairs had been carried out to address this. We were told redecorating would be scheduled in the near future to improve the décor. In other parts of the building extensive work to the roof was needed to address causes of damp. There was no definite date for this work to be done.

The 'blown' windows were still in place. The agent told us they had arranged for the purchase of replacement glass and frames and these would be replaced the following week. However, there were numerous such windows in bedrooms and communal areas, not all of which would be dealt with by this action.

There were other examples of the deterioration of the building and its fittings. For example the surface of a

bath in a shared bathroom was chipped and stained. There were holes in the walls where old fittings had been and the bathroom was dark and badly lit. A large bunch of artificial flowers were lying on a high shelf, these were grubby and obviously had been there some time.

A maintenance book was in place for staff to record any identified problems within the building. Staff told us when they identified a defect they; "Either tell [names of acting managers] or put it in the book." Identified issues such as broken light bulbs had not been signed as completed. The agent told us they were not aware of the book. During the inspection they checked all the recorded problems. Some of them had already been addressed and they attended to those that hadn't immediately or made arrangements for maintenance to look at them. This demonstrated the system for reporting faults in the premises was not robust. The agent told us they would take steps to ensure the book was used to report any faults and that it was checked regularly by a member of the local management team.

We concluded the actions taken to record and address the problems within the environment were not adequate and had not been carried out in a timely manner.

We found there was a continuing breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Signage throughout the building had been designed to help people orientate themselves through the building independently. Bedroom doors were clearly marked with people's names. Communal areas such as the lounge and dining room were also clearly signed.

We observed the lunch time period in the dining room using SOFI. This was a social occasion, the atmosphere was relaxed and people chatted together. People told us the food was usually of a good standard and the portions were generous. One person commented; "I can't knock it!" They said there was always a choice of meals and if anyone wanted something other than that offered it could be provided.

People had access to external healthcare professionals such as chiropodists and GP's. District nurses, GP's and a dementia liaison nurse all visited regularly.

Requires Improvement

Is the service caring?

Our findings

Not everybody was able to verbally communicate with us about their experience of care and support at Ismeer. Most were complimentary about the care they received. A relative was also happy with the care provided.

People had their weight monitored and this was done in the open lounge area. Although a screen was available staff told us they did not routinely use it. This was not respectful of people's dignity. We discussed this with the local management team who told us they would move the weighing scales to a more private part of the service and ensure staff used the screen.

People had photographs on display and personal ornaments in their room. Staff knocked on people's doors before entering and introduced us to people. However, as outlined in 'Effective' the furnishings in people's rooms were of a poor quality. In some rooms curtains had come away from the curtain rails. Pictures were leaning up against the wall. In one bedroom we saw a black bin bag on the floor next to the person's bed which they were using to put rubbish in. There was no sense that any thought had been put into the furnishings or arrangements for people's private spaces.

Some people required equipment to move them safely such as hoists and slings. These were assigned to individuals and kept for their specific use. People had access to continence products which had been specifically prescribed for them.

Staff were friendly and affectionate in their approach to people. We saw examples where people were showing signs of distress or agitation. Staff were calm and reassuring in their response. They were able to describe how they approached people in these circumstances and spoke about people fondly.

Families were encouraged to be involved in the care planning process although this had not been formalised. For example, the manager had spoken with one person's family about what they could do to improve the person's daily life. They had suggested she be encouraged to eat in the dining room more often and explained her preferences in terms of who she was seated next to. They had also asked that a chair which had been purchased for the person, be used on a regular basis. All these suggestions had been acted upon demonstrating a willingness to work with families in order to improve people's experiences.

Care plans contained information about people's personal histories. This is important as it helps staff gain an understanding of the person and enables them to engage with people more effectively.

Requires Improvement

Is the service responsive?

Our findings

At the two previous inspections we found care plans were out of date. Monitoring charts for people were not always completed so we were unable to be sure people were receiving the care and support they required to maintain their health and well-being.

At this inspection we found a new format was being introduced for the organisation of care files. However, information within the care plans was out of date and had been simply moved from the old format to the new one. For example one person had their dog living with them but the care plan stated the dog was; "With a foster family." Another care plan stated; "[Person's name] has full capacity to discuss her care plan and sign her care plan." However, a DoLS application had been submitted in respect of this person indicating they did not have capacity to agree to their plan of care. Information was not dated and so it was impossible to establish how recent it was. We discussed this with the local management team who agreed they would prioritise this to ensure it was completed quickly. They told us key workers would be supported to help achieve this.

Handovers took place at 8:00 am and 9:00pm to help ensure staff were up to date with people's changing needs. However, shifts were staggered with some care workers starting at 1:00pm and 2:00pm. This meant staff might not be aware of the most current information. A communication book was available and the local management team told us staff recorded any relevant information in it. No entries had been made in the book since 31 May 2016 showing that not all information that needed to be communicated had been put into this book.

This contributed to the continuing breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The local management team told us people were supported to take part in individual activities and small group activities within the service. For example, crosswords, dominoes and reading. There was a piano in the lounge and one person told us they sometimes played this to entertain people. We did not see any activities taking place on the day of the inspection. The local management team told us activities were not planned or scheduled but were arranged by staff on duty when they had the opportunity. It was a sunny and warm day but we did not see anyone being supported to access the gardens. One person chose to spend time in their room. This meant they were at risk of becoming socially isolated. The television in their room could only receive one channel and the sound quality was poor. They were unable to operate the radio which was either broken or difficult to use. They told us; "I get a bit fed up. I'm very much abandoned." We discussed this with the local management team who were unaware of the problems and assured us they would address them.

We found there was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Monitoring charts were in place in people's bedrooms to enable staff to maintain a clear picture of any

changes in people's health. These were usually completed as required although we did note gaps in two people's charts. People had their weight monitored regularly.

Care files were being updated and the local management team told us they were hoping to complete this process by the end of the month. We looked at files where the process had started. The files had been reorganised into clearly defined sections. Flash cards had been developed which contained brief pertinent information which could be given to ambulance crew in an emergency situation. Pre admission information was thorough and relevant. A new tool for keeping daily records had been developed and this supported staff to maintain complete and relevant records of what activities people had done, their general well-being and evidenced night checks. These had been filled in appropriately. Staff told us the improvements were positive and information was more detailed.

There was a complaints policy in place which outlined the timescales within which people could expect to have any concerns addressed. The policy was included in the service user hand book which people had access to. There were no complaints on-going at the time of the inspection. People told us they would approach a member of the local management team if they had any worries.

Inadequate

Is the service well-led?

Our findings

At our previous inspection we were concerned that arrangements for the oversight of the service were inadequate. The manager in post at the time of that inspection was not receiving supervision and there was no system in place for regular provider checks and audits.

Since the previous inspection in January 2016 the registered provider had passed away and the service was being overseen by a relative who was one of the executors of the will. They were acting as the provider's representative. The service is required to have a registered manager. There had been no registered manager in post since January 2015.

The provider's representative lived overseas and was unable to monitor the service on a day to day basis. Arrangements had been put in place to manage the service. An agent was based at the service two or three days a week and we were told they communicated regularly with the provider's representative. There were two full time acting managers in post who had responsibility for the day to day running of the service. They were supported by senior carers. A system of key workers was in the process of being introduced. Key workers have responsibility for overseeing individuals care planning and any appointments. We spoke with one member of staff who told us they were going to be a key worker but couldn't remember who for. This demonstrated the arrangements had not been embedded.

In our conversations with the local management team they demonstrated a commitment and enthusiasm to improving the service and bringing the inspection ratings up. However, the systems in place were not sufficiently embedded or established to support this. There was no evidence to suggest work to improve the delivery of the service had been prioritised effectively. For example both CQC and the local authority had highlighted the need to update care plans. Efforts to do this had concentrated on how the information would be organised with no evidence the actual information had been reviewed or checked for accuracy. No action was taken to review assessments following any changes in people's needs, accidents or incidents.

While there had been improvements in terms of the support care workers received there remained a lack of oversight at provider level. The local management team told us they felt the arrangements were sufficient. However, they were unable to tell us when the provider's representative would be back in the country. Arrangements for the local management team to access funds had not been established before the relative left the country. This had meant they had been unable to set up new payments which needed to be made. They told us this had impacted on their ability to update existing staff DBS's or obtain new ones. The local management team had since managed to get an agreement with the bank so they could withdraw cash but they were still not able to set up any new BACS payments. (A system for making payments directly from one bank account to another).

Staff told us things had improved and staff morale was good. No staff meetings were being held. The local management team told us they aimed to reintroduce these soon.
The provider has a legal responsibility to displaying inspection reports. The report for the last inspection in January 2016 was not displayed in the service for people and visitors to see. This was addressed on the day

of the inspection.

There were few systems in place to monitor the quality of the service provided. Audits were not being carried out to monitor accidents and incidents such as falls. This meant any patterns or trends might be missed. Systems to ensure staff received regular training relevant to people's needs were not robust and staff had fallen behind with their training. Observations of poor moving and handling techniques demonstrated this was directly putting people at risk.

There were no systems in place to gather the views of people or relatives regarding the running of the service. For example, residents meetings were not held, care plan reviews had not taken place recently and families views were not sought out formally by means of a survey or questionnaire.

As outlined earlier in the report, systems for staff to communicate were not adequate. A communication book was not used on a daily basis, a maintenance book was used sporadically and not checked to establish if repairs had been completed.

We found there was a continuing breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked the local management team to provide us with details for people's families following the inspection. This was to enable us to talk to relatives about their experience of the service. They agreed to do this at the time but we were not subsequently supplied with this information.

The local management team had worked hard to manage the day to day running of the service. One told us that about half of their time was spent providing care to people living at the service and supporting staff. The management team had not received sufficient leadership and support to help them prioritise their efforts to improve the service. This meant that important actions had not always been taken in a timely manner.

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 9 HSCA RA Regulations 2014 Person-centred care Care and treatment did not consistently meet people's needs. Regulation 9(1)(b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Care and treatment of service users was not provided with the consent of the relevant person. Where people lacked capacity the service did not act in accordance with the 2005 Act. Regulation 11(1)(3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Care and treatment was not provided in a safe way. Action was not taken to assess the risk to the health and safety of service users. Action was not taken to all that was reasonable practicable to mitigate any such risk. Persons providing care and treatment to service users did not have the qualifications, competence, skills and experience to do so safely. The premises used by the service provider were not safe for such use. Regulation 12(1)(2)(a)(b)(c)(d)

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment Premises used by the service provider were not properly maintained. Regulation 15(1)(e)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes were not established or operated effectively to ensure compliance with the requirements. Regulation 17 (1)(2)(a)(b)(c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Recruitment procedures were not established or operated effectively. Information specified in Schedule 3 was not available. Regulation 19(2)(3)(a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Persons employed did not appropriate support or training to enable them to carry out their duties they are employed to perform. Regulation 18 (2)(a)