Accord Housing Association Limited

Carpenter Place

Inspection report

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Date of inspection visit: 28 and 29 January 2015.
Date of publication: 15/06/2015

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?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Overall summary

This inspection took place on 28 and 29 January 2015. The inspection was unannounced.

We had found breaches in the Health and Social Act 2008 at the past two inspections of this service. We last inspected this service in April 2014. At that time we found improvements had been made but that the service remained in breach of the Health and Social Care Act 2008 and we found evidence that people's needs were not consistently being met. We did not find that people's care and welfare needs were being met, people were not being safe guarded from the risk of abuse, medicines were not being well managed, staff were not being adequately supported and the systems in place to assess and monitor the quality of the service were not effective.

Carpenter Place provides personal care and accommodation to up to 32 older people who may also have a learning disability, dementia or a physical disability. At the time of our inspection 32 people were living at the home. All of the people had small self-contained flats within the home and had access to shared lounges, dining rooms, and assisted bathrooms.

The service should have a registered manager in post. At the time of our inspection a manager had been recruited but was not on duty during the inspection. Following the inspection we were informed that the person had resigned from this position. The provider informed us of the interim management arrangements in place to cover this vacancy. A registered manager is a person who has

Summary of findings

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.

We did not find that people were being adequately protected from the risk of abuse and the risk of harm. Our observations and feedback from people living and working at Carpenter Place did not provide evidence that people always had access to the staff support they needed to meet their needs or to stay safe.

People needed staff to manage their medicines. We found that the medicines were not always being administered as prescribed. One person whose care we followed in detail had not received the medicines they needed for four days as the supply had run out. This had resulted in the person experiencing an unpleasant symptom which could have been reduced or avoided if action had been taken by the provider.

People had been supported to see the doctor when they experienced ill health. Changes in people's health and support needs were not always well documented and did not always result in a review of the person's needs. People had not been offered opportunities to meet their wider healthcare needs such as eye care, dental care and foot care. People had not been supported to maintain their personal hygiene and care needs.

The Mental Capacity Act 2005 (MCA) sets out what must be done to make sure that the human rights of people who may lack mental capacity to make decisions are protected. The MCA Deprivation of Liberty Safeguards (DoLS) requires providers to submit applications to a 'Supervisory Body' for authority to deprive someone of their liberty. We looked at the work undertaken by the service to ensure people had been assessed and the necessary applications made to the supervisory body. We found that numerous people were experiencing restrictions to their liberty but that these had not been identified as such and no applications had been made. Two applications had been made and neither staff, manager's nor records were able to identify who these were for or what restrictions had been agreed for people. This showed the service was not complying with the requirements of the MCA 2005.

People told us that in recent months the food had improved, however we did not find that people always had a pleasant meal time experience. People were not always given the support they needed to eat. The organisation of the meal times meant people did not always get to enjoy hot food, and on occasions cutlery or comfortable seating was not available.

We saw many interactions between staff and people living at the home which were compassionate and caring. People gave us mixed feedback about the staff, some people told us staff were kind and did all they could to help them, others told us staff made them feel worthless and did not support them to meet their needs.

We found that some arrangements had been made to provide people with interesting things to do each day. Some people liked the arrangements and some people told us the activities were not suited to their interests and needs. People were encouraged to maintain their independence and to access the local community if they were able, and to maintain relationships with their family and friends.

There was a system to respond to concerns and complaints and we found this varied in effectiveness. Some people had raised concerns that had been investigated well, recorded and the matter of concern had been addressed and changes made. Other people had not experienced this and were frustrated that issues of concern had not been resolved.

The management and leadership of the home had not been effective and people did not consistently experience a safe, good quality service. There were audits and checks in place but these had failed to identify all of the issues of concern. The provider's action planning in response to audits had failed to drive up standards and to secure the level of service that people needed or should have been able to expect.

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

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was not safe.

People were not protected from the risks associated with medicine management.

There were not always enough staff to support people to meet their needs.

Needs that may impact on the safety and well-being of the person, staff or other people living at Carpenter Place had not all been identified, assessed and action taken to reduce the risk or likelihood of harm.

Inadequate

Is the service effective?
The service was not effective.

The support provided to meet people's daily care needs was not reliable or consistent.

The home was not complying with the requirements of the Mental Capacity Act 2005.

People were not always enjoying a pleasant meal time experience or receiving the support they needed at meal times.

Inadequate

Is the service caring?
The service was not consistently caring.

Our observations and feedback from people gave mixed feedback about the support and care people received from staff.

Risks to people's dignity were not always identified. Staff practice and support provided to people failed to maintain people's dignity.

Requires Improvement

Is the service responsive?
The service was not consistently responsive.

There were activities provided for people to take part in. These were not to the satisfaction or expectation of everyone in the home.

People had been encouraged to maintain relationships with their friends, family and local community groups.

People reported a varied level of satisfaction with the way complaints and concerns had been investigated.

Requires Improvement

Is the service well-led?
The service was not well led.

Inadequate

Summary of findings

People had not benefitted from leadership that was consistent or effective. There were widespread, significant shortfalls in the way the service was running.

The systems in place to monitor safety and quality had not been effective at identifying issues and driving forward the required changes and improvements.

Carpenter Place

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 28 and 29 January 2015 and was unannounced.

The inspection was undertaken by two inspectors. Before our inspection we looked at the information we held about the service. This included notifications received from the provider about deaths, accidents/incidents and safeguarding alerts which they are required to send us by law.

The provider did not return a Provider Information Return. (PIR) A PIR is the registered providers own assessment of their practice against the five key questions.

During the inspection we spent time talking with the people who were living at Carpenter Place. We spent a lot of time observing and listening to the support staff offered people. With consent we visited some people in their flats. We talked with them and observed the support people had received to keep their flats clean and safe.

We spoke with seven members of staff and three representatives from the management team. We spoke with three health care professionals and two relatives or friends of people. We looked in detail at some parts of six people's care plans, so we could see how specific areas of their care had been assessed, planned and recorded. We also looked at the recruitment records of two members of staff, medicine management for seven people and a selection of records that showed how the provider was monitoring the quality and safety of the service.

Inadequate

Is the service safe?

Our findings

We last inspected this service in April 2014. At that time we found the home had breached the Health and Social Care Act 2008, Regulation 11 and Regulation 13. We found that people had not been adequately protected from the risks of abuse and that they had not been protected from the risks associated with management of medicines. Following our inspection the registered provider sent us an action plan detailing how they would improve in these areas, to ensure they were meeting both people's needs and the requirements of the law.

At this inspection in January 2015 we found that despite the action taken by the registered provider people were still not being adequately protected from the risks of abuse. We found that medicines management had improved but that it was still not meeting the requirements of the law for safe medicines handling. Arrangements in place did not ensure that people always got the medicines they had been prescribed at the correct time, in the correct dose.

People we spoke with gave us mixed feedback about how they felt about living at Carpenter Place. Some people told us they did feel happy and safe. One person told us, "I feel very safe and have never had any worries." Other people raised concerns with us which included, "Some of the staff treat me like a joke….sometimes they upset me. Sometimes I ask for a drink at 06:00 in the morning and it never comes" and, "I need a carer every two hours but they don't come. How am I supposed to get help? I am not happy." A relative we spoke with told us they had concerns about the happiness and safety of their family member living at the home.

We looked at the actions the provider took each day to keep people living at Carpenter Place safe from avoidable harm and abuse. We found that some people had habits and behaviours that may place themselves or others who lived or worked with them at risk. We looked to see how these known needs had been assessed and what plans had been put into place in response. We found that records of incidents were either missing or lacked sufficient detail to direct and guide staff responsible for providing care. Staff we spoke with were not all able to describe the action in place to support and protect people; for example when people requested to go out into the community or when they became distressed. Staff did not demonstrate a consistent approach or knowledge about people needs in this area or how to provide the support people required.

We found that some people had been assessed to be at risk of falling. The risk assessments for people had not all been completed fully or accurately and support plans had not been reviewed following a fall. We looked in detail at the support of one person who had recently fallen. There was no risk assessment for this. Following one of a number of falls there was no evidence that the person had received the medical assessment or treatment they required. We observed a person fall outside in the garden of the home. No staff were in the area to witness this. When we checked the incident report form later, staff had failed to identify all the issues that contributed to the fall. Prior to admission the assessment of this person had identified they had fallen previously but there were no assessments in place or actions identified about how to reduce the risk of falls in the new home environment.

We had previously been notified of incidents of people leaving the home without the support they needed. This had resulted in some people getting lost out in the local area and other people required treatment in hospital. Reviews undertaken at the time by the registered provider identified action and learning points to include in the pre-admission assessment of new people to the home to prevent similar incidents re-occurring. During this inspection we identified that the pre-admission assessment process had not been updated and remained inadequate and as a result incidents had occurred which could possibly have been avoided. Senior staff we spoke with were not aware of the previous issues. This did not provide evidence that the service was learning and developing in response to incidents to ensure people's future safety and well-being.

Staff we spoke with demonstrated a good knowledge about the different types of abuse and told us they had been trained. Staff were aware of how to report potential abuse and were aware of the providers own policy on this. Some staff told us they felt people living at Carpenter Place were safe and that this was a service they would be happy to recommend. The majority of staff told us of concerns

Is the service safe?

they had for people's welfare and safety. Their comments included, "I am concerned about all of the residents" and, "It is not good here- I really hope things turn out alright for the residents in the end."

We found that the care and support and management of the service was not adequate to ensure people's basic needs would consistently be met. We found evidence that this had resulted in people coming to actual harm or being placed at risk of harm. The provider made a service wide notification following our visit and the local authority responsible for safeguarding adults commenced working with the provider to keep people safe. This was a repeated breach of the Health and Social Care Act 2008(Regulated Activities) Regulation 11.

We looked in detail at the management of medicines for seven people within the home. Records showed that medicines had not all been signed for, and our audits of medicines that were boxed showed that the tablets available did not tally with records of receipt and administration. This suggested that people had not always received the medicines they had been prescribed.

Some people required medicines occasionally 'As required'(PRN) and the guidelines to support staff to know when to use these were not all available. This may result in medicines being used inconsistently or not as the prescriber had intended.

One of the people whose medicines we looked at in detail had not received one of their medicines for four days. The supply had run out. The medicine was to relieve an acute symptom that we saw the person was still experiencing. The home had undertaken a "countdown" of the medicine and it was evident from this when the medicine would run out. Despite this staff did not take timely action to determine if the medicine was still required or to re-order it. This would have increased this unpleasant symptom for this person which could have been avoided. These failings were evidence of a repeated breach of the Health and Social Care Act 2008 (Regulated Activities) Regulation 13.

We found that additional medicines training had been provided for staff and staff we spoke with felt more confident and reported that enough medicine trained staff were on duty to administer medicines each day. We found that medicines were stored safely. This meant they were not at risk of being lost or stolen.

The support people received from staff was not always adequate to meet people's needs. During our inspection we saw people waiting for help and we observed people who had not received the support they needed from staff to complete their personal hygiene. People we spoke with told us, "Sometimes they are very short staffed. It can be difficult to get support to get [move] about……Sometimes there are not enough staff to help me," and, "The staff can be very busy. You hardly get to talk to them. They seem short staffed much of the time." Other people told us there were enough staff and their comments included, "There seems to be enough staff for me" and, "There are call bells in all of my rooms [within my flat] . If you press it staff comes quickly enough." Staff we spoke with reflected this mixed feedback about the number of staff. Some staff told us they had seven people to support each morning and that they didn't have enough time to support people in the way they would like. They gave examples of people having to wait unreasonably long periods for help and not being able to help people with their personal care as often as they required. Other staff told us they felt staff ratios were adequate. We found that the registered provider had taken action to increase the number of staff on duty since our last inspection and that staff were clearer about their role and responsibilities. However overall we assessed that there were not adequate numbers of staff to keep people safe and support them when they required help in line with their known support needs. This was a breach of the Health and Social Care Act 2008(Regulated Activities) Regulation 22.

We had previously raised concerns about the facilities for people who wished to smoke at Carpenter Place. At previous inspections we had not found that the registered provider had adequately protected people from the risks associated with fire or from passively inhaling smoke. Since our last inspection we found that new smoking facilities had been provided and people had been requested not to smoke in their flats. Despite this we found people smoking in their flats with the doors wedged open. In some areas of the home you could see and smell cigarette smoke in the corridors which had escaped from people's own flats. We did not observe staff supporting or challenging people about this in the ways managers of the service had described to us. The hazard was not effectively risk assessed and the measures in place were not being effective.

Inadequate

Is the service safe?

The majority of the premises had been well maintained and repairs had been actioned promptly when identified. The provider was unable to provide evidence that the passenger lift and water temperatures had been serviced at the required intervals.

We reviewed two recruitment records and spoke to staff about the recruitment process. We found that staff had undergone robust checks before being offered a position in the home. This ensured people were being supported by staff that had been checked and assessed to be suitable for the role they had been offered.

Inadequate

Is the service effective?

Our findings

We last inspected this service in April 2014. At that time we found the home had breached the Health and Social Care Act 2008, Regulation 9. We found that people were not experiencing effective, safe or appropriate care that met their needs or supported their rights. Following our inspection the registered provider sent us an action plan detailing how they would improve in this area to ensure they were meeting people's needs and the requirements of the law. At this inspection in January 2015 we found that despite the action taken by the registered provider people were not all receiving the care they required.

We looked in detail at the care and support six people living at Carpenter Place were receiving. People we met had not all been supported to undertake their personal hygiene to an adequate standard. We were aware that some people were reluctant to undertake personal care and had risk assessments for self-neglect. While we found some isolated examples of very good practice where staff had enabled people to improve their personal hygiene, for the majority of people they were not being supported adequately in this area. We saw numerous occasions where people had not been supported with maintaining personal hygiene or been supported to select clean clothing to wear. Staff we spoke with told us, "Sometimes people are left long periods between being changed. I often find catheter bags completely full, and people sitting in wet and dirty pads." One person using the service told us they felt, "Staff could not be bothered to look after them." This evidence was further supported by a health care professional we met who reported that people they came to treat were often found wet and soiled.

We looked at the opportunity people had to maintain their health. We saw some records and people told us that they were able to see the doctor if they were unwell. We looked to see if people had been offered regular appointments with the optician, chiropodist and dentist. People were unable to confirm if they had been offered these appointments and records showed long gaps between appointments or failed to show that appointments had been offered at all. People we tracked did not all have the aids or adaptations (such as their hearing aids) on, or available to wear. We looked at the specific healthcare monitoring offered to people with diabetes. We could not see that people had received the foot care, eye care or routine diabetes monitoring appointments that is recommended to ensure the condition is well managed.

Some people had been identified as needing weight monitoring. We found this had not all been undertaken as often as required. Sometimes significant losses (in one instance seven pounds in a week) had been recorded but staff had failed to identify this as a potential issue of concern, or re-weigh the person. For other people we noticed steady decreases in weight over several months that had been recorded but not brought to the attention of the manager or doctor. Staff had failed to act on the weight loss which could be indicative that people are unwell and may require further investigation.

We saw that the emergency services had been called on occasions when there had been a health emergency. People had received the healthcare they required on these occasions. We looked for evidence about how this event had been recorded in the care plan, if there was any review or if the person's GP had been contacted. We could not see that this had occurred on any of the occasions we looked at. This did not provide evidence that changes in people's healthcare needs were being adequately followed up. We found that in respect of care and welfare issues the registered provider had repeatedly breached the requirements of the Health and Social Care Act 2008(Regulated Activities) Regulation 9.

During the inspection we observed some situations where we identified people's liberty may have been deprived. The registered provider informed us that two Deprivation of Liberty Safeguard applications (DoLS) had been submitted however they were not sure for whom these had been made or what deprivation they were regarding. Staff we spoke with suggested a number of people or situations that they thought might have been relevant but the registered provider was unable to confirm the circumstances of the applications during our inspection. This did not provide evidence that people were being supported in line with the Mental Capacity Act (MCA) 2005 code of practice. We met people and observed incidents during our inspection that identified people should have received a mental capacity assessment or that best interest meetings should have been held for people. These had not taken place. We observed a pile of post in the office. Staff we spoke with explained some of this was waiting for people's relatives.

Inadequate

Is the service effective?

There was no documentation to show that people had agreed to this or that relatives had the necessary authority to open people's private post. Staff were unaware of these issues. We saw evidence that some relatives were managing people's personal finances. Again there was no evidence that people had consented to this or that the relative had the necessary authority to do this for the person. Staff we spoke with had some knowledge about the MCA and we were informed that further training had been planned. At the time of the inspection the home was not following the MCA code of practice which ensures that people who may lack capacity to take particular decisions for themselves are protected. This was a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulation 18.

We observed the breakfast and lunchtime meals on both days of our inspection. We saw people being offered choices about what they would like to eat. People told us that cultural and religious diets could be catered for. Feedback about the food was generally positive, and comments included, "The chef is good-the food has improved. If you want something you can get it" and, "My preference is for porridge- and I can always get that." One person told us they had struggled to get food suited to their special diet. Staff told us the food was not always good and their comments included, "The food is not always as good as it should be" and, "Some days it is bad, hard potatoes, food you wouldn't want to eat yourself."

People were offered the choice of eating in the communal dining room or in their own flat. We saw people in the dining room were served a choice of meals from a hot trolley. The service of food was not smooth, and didn't ensure people always had a pleasant dining experience. People did not receive an adequate level of support during their meals. We observed dishes of vegetables served to tables up to 10 minutes before the main dish was served. One person was served a plate of toast, marmalade and butter. They then had to wait 10 minutes for a knife, by which time the toast was cold. We saw people did not always have the condiments or cutlery they asked for. At one meal time the main dish was fish. There was no sauce served with this and we saw staff added meat gravy to people's fish meals. People told us this was often the case and they now accepted this as the normal.

People were able to eat in their flats if they preferred, rather than in the main dining room. We found the meals were taken by staff to people in their flats and often re-heated in a microwave. There was no process to ensure this was to an adequate or safe temperature. People did not all have a table or lap tray in their room and we observed people eating in some very uncomfortable looking positions. People we spoke with told us it was always this way, and were not aware of any alternative arrangements. These observations did not provide evidence that people were supported to have a pleasant dining experience.

Requires Improvement

Is the service caring?

Our findings

We observed some caring and compassionate interactions between people and staff during our inspection. Some staff approached people with a very positive attitude and asked how they could help or support them. People gave us mixed feedback about the staff. Some people raised concerns about staff and other people told us that, “Staff are good-they all help me, they are friendly” and “The staff can be cheeky at times. But it is just to make us laugh. They are kind but very busy” and “The staff are very good and kind.”

We observed some staff working in ways that promoted the dignity and privacy of people. We also saw occasions when staff failed to identify times where a person’s dignity was compromised, for example where their clothing required adjusting or the person supporting to choose clothes that would be more suited to the weather conditions and their needs.

We were concerned that our findings throughout the inspection showed some staff had failed to identify people as individuals and as of having intrinsic value. We asked people if they had been involved in planning their own care. People told us they had been, and care plans we looked at reflected people’s life histories, preferences and choices. We saw evidence that relatives had been invited to provide information about each person to update relevant sections of care plans. This had not happened consistently, and relatives had not all been invited to attend reviews or been consulted when plans of care were updated or changed.

We observed times when staff provided support to people who were distressed. We saw staff varied in their ability and confidence to do this. We found this area of need was not always underpinned with written guidance and not all staff had been trained in techniques to support people when they were upset or distressed.

Requires Improvement

Is the service responsive?

Our findings

People living at the home reflected the ethnic diversity of the local area. To accommodate people's cultural, religious and gender needs staff rotas ensured that there was a mixture of male and female staff on duty, as well as staff from minority ethnic backgrounds. Staff told us people had been enabled to see representatives of their faith and to attend places of worship if they wished. A service was held in the home each week and one person told us, "We have a regular church service. I am a Christian and it helps me follow my faith as I can't go to my church anymore." We were informed that meals from different cultures were available on the menu and by request. These actions all contributed to people feeling that their faith, culture and gender needs had been recognised and respected.

Visitors told us they were always made welcome at the home and were able to visit at any time. We found that some staff had worked constructively with people important to the person living at Carpenter Place to enable people to maintain links to their home or local community where ever possible. This had not happened consistently, so people had not all been protected for the risk of isolation from people and places that had been important to them.

We looked at the opportunities people had to contribute to planning their care. People we spoke with were unable to confirm that they had been consulted or included in the process. Older records we looked at showed that people or their relatives had in the past been involved in planning care, but that this had not happened recently. During our inspection many care records were being updated or developed by staff. We did not observe any involvement of people in this process. We observed that people had developed new needs or experienced a change in their needs that had not been identified in the care records. Staff we spoke with were not all consistently able to describe people's current needs and this had placed people at risk of their needs not being consistently met. We identified from records that some people had experienced a change in needs such as a drop in their body weight. Despite staff taking this measurement and recording it on a regular basis, both staff and systems had failed to identify the weight loss. This meant there had been no referral to the relevant health professionals to get the support the person needed.

We looked at the system in place to address any complaints or feedback about the service. We found a system was in place and relatives we spoke with confirmed they had been made aware of how to raise a concern. Records we looked at showed that the evidence of how well complaints were responded to varied. Some records showed a thorough investigation and feedback had been undertaken. Other concerns and complaints had not been reviewed in such detail. This evidence indicated that people would not always benefit from a service that would respond and develop after hearing people's feedback.

We asked people what opportunities they had to undertake interesting activities each day. People told us there were activities, and feedback about these varied. One person told us, "There are activities; they are mainly for ladies, craft and films and so on." Another person told us, "They do have activities but I like my own company. I can go out as I please to the local shop." During the inspection we observed that organised activities were offered most afternoons. These included table games, craft and light exercise. For most of the day we saw people resting or chatting amongst themselves. Some people we met had been supported to maintain links and activities with people and groups that were important to them before they moved to the home. This had given people a lot of pleasure and helped them to settle quickly into the home.

Inadequate

Is the service well-led?

Our findings

We last inspected this service in April 2014. At that time we found the home had breached the Health and Social Care 2008, Regulation 10. Systems the provider had in place were not effective and at the time failed to ensure that people would be protected against the risks of unsafe or inappropriate care and treatment. During this inspection in January 2015 we found that significant efforts had been made to improve the safety and quality monitoring of the service but these had not been effective at improving the service for people. We observed and people we spoke with gave us examples of widespread, significant shortfalls in the way the service was being led.

The home was without a registered manager at the time of inspection. We were informed that a new home manager had been appointed and that they had started to apply for registration with the Care Quality Commission. The manager was not at work on the days of the inspection and they were unable to contribute to this inspection. We were subsequently informed the manager had resigned from their position. Since our last inspection the registered provider had released additional management staff from within the organisation to support the development of the service. We found that this had not been effective. We found that in some instances this had caused confusion for care staff regards who to approach for guidance. Comments from staff included, “Sometimes we are not clear who is in charge or whose word to take” and, “There are a lot of manager’s. That can be confusing.” We observed staff approach a member of staff with responsibility for facilities and premises about a care issue. The manager tried to advise the member of staff, and gave information that if followed could have placed the person at risk, as they would not have received the support they required. In this instance another manager intervened and re-directed the member of staff to the senior on duty. This did not provide evidence that leadership and lines of delegation were working effectively.

We asked people living at Carpenter Place if they felt this was a well led service. Feedback was mixed and included, “Everything here is getting better” and “I’m very lucky to live here.” Other people told us,” It was alright when I came, now it’s awful. ” Staff also gave mixed feedback. Some told us that manager’s were open and invited feedback, their comments included, “Manager’s want the best for people, they are not disconnected from us” and, “Manager’s remind us that there is no problem too small, and we should go and see them in the office.” Other staff told us, “I have tried to talk to the manager’s but they couldn’t wait to push me away. I don’t think they are approachable.”We concluded that the management arrangements at the home were inadequate and this is a breach of the Health and Social Care Act 2008 (Registration) Regulation 5.

In response to our last inspection the registered provider had introduced a wide range of audits and checks within the home. These had resulted in some improvements being made, but overall had been ineffective. We were concerned that the providers own assessment of the service did not fully or accurately reflect the findings of the inspection. The action plan generated to help drive forward improvements and developments following the last inspection had also failed to bring the improvements required.

We looked at the audits and found they had often identified shortfalls but the actions and monitoring needed to bring change had not been implemented. One audit we looked at had identified significant shortfalls in October 2014. The audit was repeated. It identified some improvements but there were still issues identified. There was no evidence that further action had been taken to monitor these findings or to address the shortfalls since that time. We found significant shortfalls in the area covered by the same audit ten weeks later in the inspection. This was an audit that had a direct impact on people’s welfare. Effective use of the audit could have improved the quality of life and people’s welfare. We looked at an infection control audit. This had been effective at reviewing the premises and showed a good score. The audit had not looked at staff practices and during our inspection we identified staff practice issues that the audit had failed to address. These findings did not provide evidence that effective systems were in place to assess and monitor the quality or safety of the service.

We were informed that regular home meetings had been held. Manager’s told us these had given people and staff opportunity to actively contribute to the development of the service. However we found records showed these had not been held regularly, and minutes had not been typed up promptly. We were informed meetings had been held in October, November and December 2014, but that minutes of these had not yet been produced. These had failed to

Inadequate

Is the service well-led?

help the management of the home share information with staff who were unable to attend the meetings, or provide a baseline from which to audit and check progress against agreed actions.

We did not find that the systems in place regarding safety and quality were working effectively enough to enable the provider to drive up standards within the home. This was a repeated breach of the Health and Social Care Act 2008 (Regulated Activities) Regulation 10.

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 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse The operation of the service was not adequate to protect people who use service from harm or the risk of harm.

The enforcement action we took:
We are considering the action we will take in response to this breach of the Health and Social Care Act 2008 and will report on this when the action is complete.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines People who use the service were not protected from the risks associated with medicines.

The enforcement action we took:
We are considering the action we will take in response to this breach of the Health and Social Care Act 2008 and will report on this when the action is complete.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing People who use the service were not supported by adequate numbers of staff to meet their known support needs.

The enforcement action we took:
We are considering the action we will take in response to this breach of the Health and Social Care Act 2008 and will report on this when the action is complete.

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

This section is primarily information for the provider

Enforcement actions

People were not being supported to meet their care and welfare needs.

The enforcement action we took:
We are considering the action we will take in response to this breach of the Health and Social Care Act 2008 and will report on this when the action is complete.

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 People who lacked capacity to make decisions for themselves were not receiving the level of care and support they required.

The enforcement action we took:
We are considering the action we will take in response to this breach of the Health and Social Care Act 2008 and will report on this when the action is complete.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 5 HSCA 2008 (Regulated Activities) Regulation 2010 Requirement where the service provider is a body other than a partnership People did not benefit from a consistent or effective leadership team.

The enforcement action we took:
We are considering the action we will take in response to this breach of the Health and Social Care Act 2008 and will report on this when the action is complete.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision The systems in place to ensure the home was working safely and providing a good quality service were ineffective.

This section is primarily information for the provider

Enforcement actions

The enforcement action we took:

We are considering the action we will take in response to this breach of the Health and Social Care Act 2008 and will report on this when the action is complete.