

Veecare Limited

The Laleham

Inspection report

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Ratings

Overall rating for this service

Inadequate



Is the service safe?

Inadequate



Is the service effective?

Inadequate



Is the service caring?

Inadequate



Is the service responsive?

Requires Improvement



Is the service well-led?

Inadequate



Overall summary

This unannounced inspection was carried out on 6 and 9 January 2015.

The Laleham provides accommodation and personal care to up to 60 people. Some people may have dementia. Bedrooms are on three floors accessed by a passenger lift. There are various shared rooms including lounges and dining rooms. The service faces the sea and has parking at the front. There were 47 people using the service when we inspected.

There was no registered manager at the service. 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. The provider Veecare Limited took over the running of the service from the previous provider in October 2014.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. Whilst no-one living at the home was currently subject to a DoLS, the manager understood when an application should be made and

Summary of findings

how to submit one. Staff had limited awareness of the Mental Capacity Act 2005 and DoLS and did not give the support people needed to give consent and to make decisions.

People were complimentary about the service they received. Most people felt happy and well looked after. However, our own observations and the records we looked at did not always match the positive descriptions people and relatives had given us.

There was not enough staff to meet people's needs. People said there were times when they had to wait for support. Staff were very busy and were not always available when people needed support. Staff did not have much time to sit and spend time talking with people. People could not be sure they would have the medicines they needed when they needed it. Some medicine was not recorded on medicine charts so people did not always receive the medicine they had been prescribed.

People said they felt safe. Staff were not aware of what abuse was and what an abusive situation might look like. Staff were not sure about who they might report any suspicions or concerns to, especially outside of the service, including social services and CQC. Staff were not aware of any policies and procedures at the service that they could use to look up what abuse was and what to do.

Staff did not all have the skills they needed to provide safe and effective care. There were gaps in training including essential training like how to move people safely. Staff had limited awareness of mental capacity and consent. Staff were not supported by having one to one meetings or staff meetings. Staff were not fully vetted before they started work at the service.

Potential risks to people were not always identified, then assessed and managed. People said that staff called

doctors when they needed them but advice given by doctors was not always followed. Medical advice had not always been sought when people became unwell. People told us the food was good, they said the food was 'homemade' and "The food is lovely. You get a choice and there's always plenty". People were not always helped to ensure they received enough food and drinks.

Nearly everyone we spoke with said that the staff were kind and caring. Comments about the staff included, "I've never met anyone like them before; they are all so friendly and cheerful". There were times when staff did not have time to sit and talk with people and times when staff did not treat people with consideration and respect. Staff did not always consider and ensure people's privacy and dignity. Not all staff knew about people's backgrounds and life histories and some staff did not know about people's needs.

Care plans were not up to date and some were incomplete. The new manager had started to review care plans but she had only been in post for one month so this was at an early stage. The complaints procedure was not meaningful to everyone and some complaints had not been investigated and resolved.

The new manager had been in post for one month, she had started to introduce new systems but this had been met with some resistance from staff. The provider had no plan about how to overcome this resistance. Staff did not understand the purpose of the service. People, their relatives and staff were not fully involved in developing the service.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

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

People were not safe. Staff did not know what abuse was and who to report concerns to. Risks to people were not managed or reduced.

There were not enough staff to meet people's needs, staff were rushed. Staff were not thoroughly vetted before they started to work with people.

People did not always receive their medicines as prescribed by their doctor. Equipment to help keep people safe was not used properly.

Inadequate



Is the service effective?

Staff did not have the skills to meet people's needs safely and consistently. Staff did not understand about mental capacity and consent.

People were offered nutritious meals but did not always have the support to eat and drink enough.

People's health needs were not always met and advice about good health was not always followed.

Inadequate



Is the service caring?

People told us that the staff were caring but that they were often rushed and so did not always have much time to spend with them.

People had limited opportunity to be involved and to have a say about their care and treatment.

People's privacy and dignity was not always promoted and protected.

Inadequate



Is the service responsive?

People had not been involved in writing their care plans and not everyone had a care plan. Care plans that had been written were not all up to date.

The complaints procedure was not accessible to everyone. Complaints were not always recorded, investigated and responded to.

Requires Improvement



Is the service well-led?

People and staff were not involved in developing the service.

Staff were not aware of their responsibilities and of the vision and values of the service.

There were no plans in place to monitor and check the quality of the service.

Inadequate



The Laleham

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 6 and 9 January 2015 and was unannounced.

Two inspectors, who had knowledge of older people's needs and dementia, visited on both days. An expert by experience visited on 6 January 2014. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we spoke with visiting case managers from the local authority and had information from visiting

district nurses and relatives. During the inspection we spoke with staff, the manager, 24 people using the service and six visitors. We also spoke with two visiting health care professionals and a visiting hairdresser.

We did not ask the provider to complete a Provider Information Return (PIR) because this was a short notice inspection to respond to concerns raised with us. The PIR 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. We gathered this information during the inspection.

Before the visit we looked at notifications we had received. A notification is information about important events which the provider is required to tell us about by law.

This was the first inspection of the Laleham under the new registered provider Veecare Limited who took over the service in October 2014.

Is the service safe?

Our findings

There were differing views about the safety of people using the service. People told us that they felt safe living at the service. One person said 'They staff are very nice and do their best, but they are very busy.' Most of the relatives we spoke with felt that their loved ones were safe. One person said "Yes, very safe", and another said, 'I'm safe here'. One person said "Most of the time I feel safe", and clarified, 'at first, anyone could come in, but now, it (the building) is locked at the front, this is much better.'

Relatives had mixed views and although they felt people were safe, they did not think there were enough staff to meet people's needs. Visiting nurses and care managers told us that they were concerned about people's safety.

Staff did not recognise the risk of harm or abuse and did not know how to report abuse. Staff were not sure about what abuse was and were not able to tell us about different types of abuse. A visiting nurse had alerted social services to a potentially abusive situation. The staff had not realised that this could be abuse and had not reported it.

Staff said they would report concerns to the manager or to the provider but did not know who else they might report to including the Care Quality Commission or social services. Staff were not aware of any policies at the service about abuse and what to do if they suspected abuse.

Staff were not all aware of what 'whistle blowing' was, or where the policy was kept about how to whistle blow and what to do. Whistle blowing is the term used when staff raise concerns. Staff said that they were not confident that the provider would act promptly on any concerns they raised. Some of the staff had not had training in how to safeguard people from harm and abuse.

People told us that they did not know how to raise a concern and who to speak to. They told us they knew there was a new provider and a new manager and said that they hadn't seen them to talk to. One person said when they raised a concern 'no one listened'.

The provider had not made suitable arrangements to ensure that people were safeguarded from the risk of abuse. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we have taken to address this at the end of this report.

Risks to people were not managed and so the risks were not reduced. Some people were at risk of falling and had fallen over. The falls had been recorded in an accident book but there was no assessment in individual people's care plans about the risk of falling. There were no risk assessments to reduce the risk and a lack of referrals for extra support to help people be steadier on their feet.

Risks to people were not always written down and so the staff were not aware of them. Information about increasing or new risks was talked about at handover meetings between shifts but not always written down in care plans. Staff said they had no time to read people's care plans so if they missed all or some of the handover they did not have the information. Some staff did not know that some people were at risk of falling or at risk of dehydration.

Equipment needed to keep people safe was not being used correctly. Some people were at risk of sore skin and so sat on pressure relieving cushions and mattresses. Staff set the pressure for these cushions and mattresses according to how much the person weighed. If the pressure was wrong the cushion became less effective and would increase the risk of sore skin. The pressure setting for two people's cushions was set too high, 20 kgs over their actual weights. One person told us, "My chair isn't comfortable. It's too hard". Another person said "I often have to ask for a footstool as I need one, but I rarely get one."

People told us, and records confirmed that the pressure cushions were not always fitted with the boxes, which kept the cushions inflated. Staff told us they checked these boxes but said they 'did not know what they were looking for'. A GP told us that there had been an increase in requests for prescriptions for dressings for pressure sores. A district nurse said that the number of visits to the service to dress and manage pressure sores had increased.

Staff were unclear about what to do in an emergency. A temporary member of staff did not know what to do in the event of a fire and how to evacuate the building. Some of the equipment to prevent the spread of fire and help people evacuate, including a fire door and three emergency lights, were not working properly. There were no individual emergency evacuation plans for people to show what support they might need if they needed to evacuate the building.

There were potential hazards around the building including stairways, a passenger lift and narrow corridors. The

Is the service safe?

provider had not assessed any potential risks that these hazards may have on people. Accidents and incidents had not been looked into in detail to see if any action could be taken to prevent further accidents.

The provider had not ensured that people were protected from the risk of receiving unsafe or inappropriate care by assessing and managing potential risks. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we have taken to address this at the end of this report.

People told us that there were not enough staff. They told us that they often had to wait for staff's help. One person said, "It doesn't seem like there's enough staff, especially at night." Another person told us, "There are simply not very many of them (staff)". Relatives told us, "I know they have had trouble with staff shortages, last week, it was hard for them, there were buzzers not being answered. I felt really sorry for them, the carers." The provider said that staffing levels had not been assessed to make sure that there were enough staff to support everyone safely.

One person was outside in a wheelchair and asked to come back in. Staff said they would help but had to help another person first so the person had to wait outside. A visiting nurse told us that they had visited a person at 10.15am one morning last month. They said that the person was still in bed with the curtains closed even though the person said they had been awake for some time. The person was uncomfortable as the bed was wet and they said that they had not been given a drink or any breakfast since waking. The person was at risk of developing pressure sores which could be made worse by lying in a wet bed.

Staff looked rushed and were moving around the service from one job to another. The service was large with lots of rooms and stairways and corridors so staff could not always be seen. Staff did not have time to sit and spend time with people. Staff said that they did not always have time to write out records. A visiting nurse told us that she had asked to see the records of a person's weight who was at risk of losing weight. Staff had not weighed the person and recorded their weight for over six months. Staff said this was because they did not have the time.

The manager told us that she was aware that there were not enough staff and had started to try to recruit more staff. The manager had rearranged the shifts as there had been times when staffing levels had dropped to only two staff for 47 people.

The provider had not taken appropriate steps to ensure there were sufficient numbers of staff to meet people's needs. This was a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we have taken to address this at the end of this report.

Recruitment checks were not thorough. Two new staff had not given a full employment history on their application forms and gaps in employment history had not been asked about. One new staff had no written references and no police check. There were no safeguards to make sure this person was safe to work at the service. Some staff had unsatisfactory references that the provider had not followed up.

The provider was not using effective recruitment procedures. This was a breach of Regulation 21 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we have taken to address this at the end of this report.

People were at risk of not getting their medicine as it had been prescribed. Some people had been prescribed supplements by their doctor to help them to put on weight. Supplements had not been added to the medicine administration record so people had not always had their supplements. Creams that had been prescribed to keep their skin healthy were not recorded on the medicines record. Medicine records were disorganised with a pile found on top of a medicine trolley. There were gaps in the records showing that medicine had not been given with no explanation why. When we asked staff how they knew that people used their cream in the right way at the right time, staff said "We just cream people throughout the day, we don't write it down anywhere".

One person said that they should have their medicine for diabetes before breakfast but 'because the staff were busy' they had to have it after breakfast. Taking this medicine before food was important as food affected the way it worked. Staff could not tell us which medicines needed to be taken before, with or after food. Some of the staff were not trained to administer medicines. There was not always

Is the service safe?

a trained member of staff on duty at night. One person said that they needed pain relief during the night but there was not always a trained staff to give then this on duty at night. Another person said 'All my tablets come on time'. They said it was very important to them that they did and they went on to say 'I do watch the clock but they are not often late.'

The provider had not made appropriate arrangements for the safe handling and administration of medicines. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we have taken to address this at the end of this report.

Is the service effective?

Our findings

Most people said that they thought the staff were competent, others had a different view. One person said, “Anything is dealt with immediately, on the spot, by whomever.” Another person told us “They will help you in any way that you need helping”. A relative said, “Staff are helpful, especially if they’ve been here a long time”. One person said “Most staff hoist me well, but I had to tell one she had got it the wrong way around, and she had to change it”.

Training for staff was not up to date and some staff lacked the skills needed to support some people’s needs. There was no up to date training record for staff or a training plan. We asked staff about some people’s individual needs including dementia and diabetes. Staff were not sure about people’s specific needs and could not tell us much detail. Some people needed to have snacks between meals to control their diabetes, not all staff were not aware of this. A visiting nurse told us that one person had not had the snacks that they needed to help their diabetes.

Training certificates in some staff files we checked were out of date for basic training including moving and handling people. We saw two staff moving a person using an underarm technique that is known to put the person and staff at risk of being hurt. Another staff member helped a person using a walking frame to sit down into an armchair. The staff member encouraged and prompted the person to turn and to hold onto the frame, for support. The staff member appeared not to know how to ensure that the person was seated safely and comfortably and left the person askew in the chair.

The provider said he was aware that staff needed training and support. He said that he had started to look at the certificates in staff files to check which staff needed what training. There was no plan to show what training had been arranged.

Some new staff had been employed. The induction training for new staff included working alongside existing staff and the completion of an induction workbook. Two new staff had been given an induction booklet to work through and we spoke with them about it. One had completed the

workbook and had been signed off as competent by the manager. The other staff member said they had not completed much of their work book and no one had checked it.

Staff had not had the opportunity to attend a staff meeting or to have a one to one meeting with a line manager. Communication between staff was not always reliable. Staff relied on verbal handover meetings between shifts as not everything was written down. There was a risk that important information about people’s changing needs or increasing or new risks would not be passed on to staff.

The provider did not have suitable arrangements in place for staff to have appropriate training and supervision. This was a breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we have taken to address this at the end of this report.

Some people had dementia and were not always able to make decisions for themselves. Staff we spoke with had limited knowledge of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DOLS). DOLS is important in case people are restricted in any way. The manager said that nobody was restricted by a DOLS authorisation. One member of staff said that they had not heard of the Mental Capacity Act and not all staff had had any training about supporting capacity and consent.

Arrangements to assess people’s capacity to make decisions were not in place, so it was not clear what support people needed to make decisions. Some people’s capacity to make decisions came and went so it was important to keep asking them about a decision at intervals. People’s capacity had not always been assessed; one assessment in a care plan was dated 2011 so it was not up to date. The lack of assessments led to a risk of decisions being made on people’s behalf that may not in their best interests.

A visitor told us that their relative had dementia but they had never been asked to take part in making any decisions about their care.

The provider did not have suitable arrangements in place to obtain, and act in accordance with, people’s consent. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we have taken to address this at the end of this report.

Is the service effective?

People told us that they saw a doctor when they needed to. One person said, “Yes, they get a doctor for me if I need it and I see a nurse”. Another person said, “Anytime. I can see a doctor anytime” and “I had a doctor once. I see the nurse every week.”

There had been times when staff did not always respond to people’s health needs. A visiting nurse reported that she overheard staff talking about one person’s health condition. The nurse suggested that she check the person and found them very unwell. The nurse advised that staff seek further medical advice and the person was admitted to hospital. The staff had not recognised how unwell the person was and had not sought any other medical advice until prompted by the visiting nurse.

Referrals to health professionals for specialist support were not always made. One person needed to be referred to a community psychiatric nurse, there was no record that this referral had been made. When referrals had been made and advice was given about how best to support a person the advice was not recorded. Therefore not all of the staff were aware of the advice and did not follow the advice consistently.

Details about what support people needed to remain healthy was either not recorded at all or not recorded in detail. For some people there was limited detail about the support they needed to remain healthy, for others there was no information about their health needs in care plans.

People who were at risk of losing weight had been referred to their doctor or to a dietician. Supplements to help people maintain weight had been prescribed in some cases. The supplements were not always recorded as being given to people. Advice from dieticians was not recorded in people’s care plans and was not followed by the staff. A visiting nurse told us that the advice they had given in relation to one person had not been followed by staff. A visitor told us that their relative had lost weight and that they needed support to eat. They said they did not know what had been done to support their relative and had not

been asked her thoughts on the matter. A relative and a visiting care manager told us they had seen people struggled to eat their meals and there were no staff around to intervene and help.

We observed the support people received at mealtimes. Staff were in the dining areas and checked that people were managing their meals. Staff gave people support when they needed it. People told us they enjoyed their meals and there was, “Plenty of choices”. People said they could have something different if they wanted to. The cook knew about people’s different dietary needs and how to prepare meals to different consistencies. People were offered snacks during the day in between meals. Most people said positive things about the food including “It’s homemade, there are good choices and you can get fresh fruit” and “It is very nice food. There’s some choice. There’s too much sometimes!”

A relative told us some people who used one of the lounges ‘can get forgotten at midmorning’ when it comes to morning drinks. They said that “Tea is at 4 30- 5.00 p.m, then there’s nothing until breakfast.”

People’s health needs were not monitored. Some people were at risk of malnutrition or dehydration so there were charts for staff to record how much people had ate and drank. These food and fluid charts were not completed. We asked staff if they completed monitoring records including food and fluid charts for those that needed them, and they said that they did not. A visiting nurse reported that a person had recently had to be admitted to hospital due to dehydration. Staff said they had stopped completing daily records for each person and were now using a ‘handover’ sheet to record different things. The information recorded on the handover sheet did not show the care that had been provided to each person.

The provider had not taken proper steps to meet people’s individual needs including health needs. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we have taken to address this at the end of this report.

Is the service caring?

Our findings

People told us the staff were kind and caring. One person said “The staff this morning suggested some honey and lemon for my cough and went down to mix it for me”. “They are caring”, said another, and “such caring staff.” A relative told us “I’ve never met anyone like them before; they are all so friendly and cheerful”. However, our own observations and the records we looked at did not always match the positive descriptions people and relatives had given us.

There were times when staff looked busy and rushed and were not always present in lounges and dining rooms. When staff were present and they had the time to talk with people, they talked kindly and respectfully to them. One staff member checked that a person was comfortable and asked them “Are you okay now?” At other times staff were rushed and did not explain things clearly or give people the time they needed to respond.

Staff did not always speak respectfully to people. One person’s trousers had slipped down. Staff moved the trousers up without asking the person’s permission saying out loud “We don’t want any streakers here.” Two visiting care managers reported that they saw people who needed help to wipe their noses and this support was not given. Staff called people ‘love’, ‘darling’ and ‘dear’ when this was not their preferred name.

A visiting nurse said that she felt the staff had compassion for people they were caring for. The nurse told us that the staff had supported one person who was very ill and said that staff had been ‘fantastic, really fantastic with them’. When staff spoke about people they seemed to care for them. One member of staff said, “I like to see people happy” and another told us, “We all try our best for people here”.

People’s privacy and dignity was not always respected. Packs of dressings for sore skin were stored in the lounge. Staff were not sure which dressings belonged to who so they asked people using the service, ‘whose is this one, whose is this?’ People told the staff what belonged to who in ear shot of everyone.

One person had support with their personal care in their ground floor room. This person’s bedroom door was left

open at all times. The bedroom was near to the main entrance so anyone walking past could see into the room. Staff did not always knock of bedroom doors before entering, they just walked in.

The provider had not checked that people’s privacy and dignity was protected. People had not been asked for their views about their privacy and dignity. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we have taken to address this at the end of this report.

Some staff did not know the people they were supporting very well. Some staff were not able to tell us about different people’s needs or about their backgrounds. Other staff had a better knowledge of people and their needs. One staff member said that they had to tell other staff about people’s needs because it was not always written down. Some of what staff told us about people’s needs did not match the persons’ care plan.

Opportunities for people to express their views and make decisions about their care were limited. A relative told us that they had not been asked about their relative’s needs and wishes. There was no evidence that meetings were held with people and their relatives to involve them in their care. People did say that they made decisions about how they spent their day.

Consideration had not been given to the way information might be shared with a person with dementia. Information was generally written and not provided in a way that was meaningful to everyone.

People were not supported with their independence. Many people needed either staff or a mobility aid to help them move around. When people were sitting in the lounge areas their mobility aids such as walking frames were moved out of reach as there was not a lot of space. People relied on staff to help them to use these aids. When staff were busy, they were not always able to pass people their aids when they needed them.

Some people were living with dementia and needed support to find their way around the building independently. A lack of signs around the service meant that people could not find their way around easily and had

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to rely on staff to help them find the toilet or their bedroom. There were some noticeboards with written information attached. Some of the information was out of date so may be confusing.

Is the service responsive?

Our findings

People told us that they had not been involved in planning their care. People told us that they did not know what was written about them in their care plans. The five care plans we looked at did not show how people had been involved. Some people had dementia so it was important for their relatives and friends to be involved and to support them to make choices and decisions. A relative told us that they had not been asked to be involved even though their loved one had dementia.

Two care managers told us they were concerned that not everyone had a care plan and that other care plans were not up to date. The care plans were not all fully filled in and had not been updated when people's needs changed. The manager had reviewed some of the care plans, following directions from the care managers from social services. Staff, including agency staff, did not have access to up to date information about the people they were caring for. There was limited information about people's life histories and backgrounds, what job they did and about their families. This was especially important for staff to know, as some people had dementia.

Staff said that they did not refer to people's care plans. Staff told us "There's no point in reading them (care plans), they aren't up to date and are a mess. We just tell each other what needs doing and what we need to know." Without up to date care plans for people, staff relied on what they knew about people and some staff did not know people's needs very well.

There was no plan or arrangements to review and update care plans on a regular basis. The provider said he had realised that care plans should be reviewed and up to date and said he had prioritised this piece of work. The manager said that she had started to review care plans but there were 47 to do and there were 'other priorities'.

The provider had not ensured that there was an accurate, up to date record for each person's care. This was a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we have taken to address this at the end of this report.

People's hobbies and interests were not always supported. On the first day of our inspection there were no organised or spontaneous activities on offer. People were sitting in

various lounges with either the television on or music playing. On the second day of our inspection an exercise class was held in one of the lounges. People who joined in smiled and laughed and appeared to enjoy it.

There were differing views about the activities on offer at the service. Some people told us they were happy with the activities. One person told us they had been given the 'service users guide'. This was a leaflet produced by the provider which informed people about the service they could expect. They told us that the 'service users guide' mentioned 'five afternoons of entertainment' but told us, "This is not true. It is more like two or three times a month". They also said they were, 'disappointed' that the mini bus had been taken out of service. Three people told us that they missed the bingo sessions as these had stopped, 'since the change of ownership'. Another person said, "There's always something going on'. There were mixed views about the entertainment at Christmas. One person told us they thought there had been 'a really good Christmas programme' while another person said, "They didn't do much here at Christmas".

There was limited opportunity for people to make complaints and to give their views about the service. The complaints procedure was not in a suitable format for everyone. The manager said that there had been no complaints but could not find the complaints records. Some people told us that they had made complaints or were unhappy with certain things but that no action had been taken to put things right. One person said that they had complained about hard cushions, another person said they had complained about having no footstool, and both said that neither had been sorted out. Another person told us, "I asked to see the manager but was told she was too busy. I eventually saw her". A relative said they had been concerned about missing items and were still not happy about the outcome and felt it had not been resolved.

Some people said they would raise any concerns they had with the staff. One person said "My (relative) asked about the complaints procedure here. It would be awkward for anyone who was a bit shy or timid, I think."

The provider had failed to record, investigate and respond to complaints. This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we have taken to address this at the end of this report.

Is the service well-led?

Our findings

People, their relatives and staff felt that they were not actively involved in developing the service. The provider had held a meeting with people before he took over the service; the minutes were displayed and dated September 2014. There had been no further meetings or opportunities for people to meet with the provider to share their views and opinions. There had been no staff meetings to give staff the opportunity to have a say about the service. One person said “I cannot understand why the new manager and owner have not been around to see us.”

A relative said, “We are missing the communication element with the families. They haven’t told me this time that (my relative) has seen a GP like they would have done before”. The provider had taken over the service in October 2014 and had not yet sent out any satisfaction questionnaires.

The manager said that the staff team needed support to adjust to the new provider’s systems but had no plans about how to do this. Staff appeared to be resistant to some changes, including changes to the rota, and needed the right support to adapt. The provider had a mission statement displayed in their website but staff were not aware of this so were not clear about the purpose of the service. Staff had not been supervised on a one to one basis or mentored to understand and carry out the purpose of the service.

The provider admitted that there had been difficulties in taking over an established staff team. He said the staff team often referred to the previous manager’s way of doing things. This had led to some resistance and difficulties when trying to introduce new systems and practices. The provider said he had no plan about how he was going to overcome these issues.

The manager had been in post for one month. The manager was experienced but had not registered as a manager with the CQC. She said she had prioritised care

plans and medicines, so was spending a lot of her time in the office on paperwork. The provider said his priorities were ‘paperwork and staffing’ and had not considered the wider issues that needed addressing. The provider had not carried out audits or checks or spoken with people their relatives or the staff to find out about any other issues.

Staff were not sure of their responsibilities and what was expected of them. When asked about who was responsible for recording people’s weight or recording what people ate, staff were not sure. The manager had introduced an ‘accountability’ sheet where staff were allocated to support named people and then signed to say that they had given the required support. Staff were not completing these records.

There was no evidence of any monitoring, audits or quality checks by the provider. The environment, care plans and medicine records had not been checked. There had been no checks to pick up that records were not being completed thoroughly or properly. There had been no checks on the quality of the service and there was no improvement plan in place. The provider had reacted to some of the recommendations from the local authority during recent safeguarding investigations.

Accidents and incidents, including falls, had not been looked into and analysed to look for any patterns or trends. People continued to fall and have accidents with no changes made to reduce falls and accidents.

Links with the local community had not been looked into and encouraged. There were outside entertainers who came into the service; otherwise links with the local community were limited. One relative said that they were concerned that the mini bus was not being used.

The provider had not regularly assessed the quality of the service and sought and acted on people’s views. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we have taken to address this at the end of this report.

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 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse The provider had not made suitable arrangements to ensure that people were safeguarded from the risk of abuse.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010 Requirements relating to workers The provider was not using effective recruitment procedures.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing The provider had not taken appropriate steps to ensure there were sufficient numbers of staff to meet people's needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines The provider had not made appropriate arrangements for the safe handling and administration of medicines.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff

This section is primarily information for the provider

Action we have told the provider to take

The provider did not have suitable arrangements in place for staff to have appropriate training and supervision.

Regulated activity

Accommodation for persons who require nursing or personal care

Regulation

Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment

The provider did not have suitable arrangements in place to obtain, and act in accordance with, people's consent.

Regulated activity

Accommodation for persons who require nursing or personal care

Regulation

Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services

The provider had not checked that people's privacy and dignity was protected. People had not been asked for their views about their privacy and dignity.

Regulated activity

Accommodation for persons who require nursing or personal care

Regulation

Regulation 19 HSCA 2008 (Regulated Activities) Regulations 2010 Complaints

The provider had failed to record, investigate and respond to complaints.

Regulated activity

Accommodation for persons who require nursing or personal care

Regulation

Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services

The provider had failed to plan and deliver care to people to meet individual needs and to ensure people's welfare and safety.

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.