Central Bedfordshire Council

Greenacre Residential Home

Inspection report

Brewers Hill Road
Dunstable
Bedfordshire
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Ratings

Overall rating for this service	Requires Improvement
Is the service safe?	Requires Improvement
Is the service effective?	Requires Improvement
Is the service caring?	Requires Improvement
Is the service responsive?	Requires Improvement
Is the service well-led?	Inadequate

Overall summary

This unannounced inspection was carried out on the 23 and 30 January 2015.

The home provides accommodation and personal care for up to 42 older people some of whom were living with dementia and learning disabilities. The home also offered a rehabilitation service for up to seven people. At the time of the inspection there were 38 people living in the home.

The service has 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.

People were not protected from avoidable risks. Risk assessments were carried out and reviewed regularly, but staff were not always aware of their contents. Medicines were managed safely, but

people were not always supported to access other health and social care professionals when required.

Summary of findings

There was not a variety of choices available on the menus and people were not supported to have sufficient food and drinks to meet their dietary needs.

People and their families were involved in the decisions about their care. The care plans were reviewed and updated regularly, but staff were not always aware of their contents.

People were supported to maintain their relationships with their family members and friends, but they were not supported to pursue their interests and hobbies.

The provider had effective recruitment processes in place, although there was not sufficient numbers of staff employed so that people received consistent care.

The staff had appropriate training. However they were not effectively supervised and supported to develop their skills and knowledge. Staff's morale was very low and they felt that they were not valued or listened to.

Staff understood their roles in relation to the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS).

Staff were not always caring, kind and compassionate and did not always care for people in a manner that promoted their privacy and dignity.

The home was not managed in an inclusive manner.

The provider had a system in place to assess, review and evaluate the quality of service provision, but this had not been effective in identifying shortfalls in the quality of care.

During this inspection we identified a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. 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?

Requires Improvement

The service was always not safe.

People were not protected from avoidable risks because staff were not always aware of the contents of the risk assessments.

Staff failed to recognise when people were at risk of neglect. Incidents of concern were not always reported appropriately.

There was insufficient permanent staff so that people received consistent care that met their needs safely.

Medicines were managed safely.

Is the service effective?

Requires Improvement

The service was not always effective.

People's consent was not always sought before any care or support was provided.

People were supported by the staff that had not been effectively trained and supported to develop their skills and knowledge to provide good care.

People were not always supported to access other health and social care services when required.

<Findings here>

Is the service caring?

Requires Improvement

The service was not always caring.

People were not always supported by staff that were kind and caring.

People's privacy and dignity were not always protected.

The staff did not always understand people's individual needs and provide appropriate care.

Is the service responsive?

Requires Improvement

The service was not always effective.

Assessments were not always robust enough to fully identify people's support needs. People's care had not always been provided in line with their individual care plans.

People were not supported to pursue their interests and hobbies.

Complaints had not been always responded to in a timely manner so that improvements could be made.

Summary of findings

Is the service well-led?

Inadequate 

The service was not well-led.

The leadership of the service was poor. Staff were not valued, listened to or supported by the management team.

Quality monitoring processes had not been effective in identifying shortfalls in the quality of the care provided.

People's records were not always stored securely to protect their privacy and confidentiality.

Greenacre Residential Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider 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 23 and 30 January 2015, and was unannounced. The inspection team was made up of two inspectors.

We reviewed all the information we held about the provider. We looked at the notifications that the provider had sent us. A notification is information about important events which the provider is required to send us by law. We also contacted health and social care professionals who regularly visited the people who live in the home. We received feedback from two health care professionals.

During our inspection we carried out observations and used the Short Observation Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experiences of people who could not talk to us due to their complex needs.

We spoke with six people who lived in the home and the relatives of two people. We spoke with the manager of the home, nine members of the care team, four team leaders, a member of the occupational therapy team, a visiting chiropodist and the head of service. We reviewed the care records of seven people including those we observed as having complex needs, and training records for all the staff. We also reviewed how the quality of service provided was monitored and managed.

Requires Improvement

Is the service safe?

Our findings

One person's relative told us that they were sure that their relative was safe at all times. Other people told us that they felt safe living at the home. One person said that this was because the staff were 'wonderful'. However we found that people were not always protected from the risks of harm and neglect. Some people were cared for in a chaotic and unsafe environment. This was because people who had very complex needs were cared for together in one sitting room and were left unattended by staff.

We saw that people who were calling out in distress were ignored by staff. This calling out continued constantly for the 25 minute period we were in the room. During this time there was a staff member completing paperwork in an adjacent room, however this was within ear shot of the people calling for help. The staff member did not respond or investigate the reasons for the calls, and continued to complete the paperwork. Subsequently they were unaware that one person who had limited mobility was trying to get up and leave the room without necessary assistance. Another person was reduced to putting their fingers in their ears to block out a person's distress expressed through constant screaming, and another person was at risk of bullying by other people because they could not leave the room and were not able to control their behaviour. This continued until we asked for staff to come and attend to situation.

Discussions with staff and a review of records showed that staff had received training in protecting and safeguarding people. Staff we spoke with demonstrated an understanding of this process, and were able to explain their responsibilities to report suspected abuse. However, staff had not recognised that their task led approach to caring for people amounted to neglect. Because staff had put the completion of paperwork before the needs of the people, they had failed to recognise the small signals that people were distressed or that they needed assistance. Consequently they failed to take any action to respond to or to report the matter to senior staff.

Staff told us that they had stopped telling the management team in the home of their concerns as they received no response. An example of this was that staff had expressed concerns about a person they felt was at risk of developing pressure areas. They said that their requests had been ignored for two weeks and it wasn't until this risk was noted by a senior staff member that the necessary equipment was ordered. This lack of effective communication put the person at risk of developing pressure areas. We noted that one person was at an immediate risk of falling out of their chair. However staff and senior staff present at the time took no action to make the person safe. We had to ask staff to do so. Following the inspection we made a safeguarding referral to the Local Authority in relation to this person. Discussions with the manager showed that they were unaware of the risk of neglect to the people.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Environmental risk assessments had been carried out and there was a maintenance plan in place. At the time of the inspection, refurbishment work was underway and appropriate risk assessments had been carried out to keep people safe throughout this process. The home had a fire plan and there was a plan in place should the home need to be evacuated in an emergency. There was a grab and go bag by the front door. This contained information on emergency contacts and other necessary information.

Risk assessments were in place for individual people and we found that they contained sufficient information on how to reduce the risk and support people's independence. One assessment identified how someone's behaviour could put themselves or others at risk and outlined measures that should be put in place to minimise the risks. However, we noted that none of these measures had been implemented. Discussions with staff, both agency and permanent, showed that they were unaware of the risk assessment and they told us that they did not have time to read them. This approach to care put people at risk of neglect and injury. One person who had recently returned from hospital did not have their risks re-assessed. We found that their condition had deteriorated and they were now unsteady on their feet and unable to express their needs. This had not been recognised and they were therefore left at risk of injury from falling.

The manager was unable to tell us how decisions were made about the numbers of staff required or how they were allocated throughout the home to meet people's needs safely. The home used agency staff and we noted that two agency staff had been rostered to work up to six consecutive days, each day for 14.5 hours shift. Staff told us that they did not want to work alongside these agency staff as they were always 'exhausted' and continually had to be

Requires Improvement

Is the service safe?

guided on what to do. This meant that there was less time to spend with people and impacted negatively on their care. We observed that one of these staff members ignored people's requests for assistance. This approach to care put people at risk of injury and neglect.

There are five units within the home and during the two days of our inspection, the ten staff on each day shift were allocated as follows: Two staff on each of the two units on the first floor where people with complex needs lived, and one staff on each of the ground floor units where people were more independent. There were three team leaders on duty whose role it was to complete paperwork, administered medicines and provide support people when required.

We were concerned that the ground floor units were regularly left unattended and people were left unsupervised. On one occasion, a member of the occupational therapy team had to step in to support a person to use the toilet because they could not find the care staff. On another occasion, the only staff member on the unit, left to look for someone to assist them to support a person to reposition in bed. We observed that they had gone for over 15 minutes and the member of the occupational therapy team made drinks for people during that period. They told us that this occurred regularly and it was common practice for them to find units left without staff.

Throughout the inspection we observed that team leaders did not get involved in care delivery with the exception of administering medication. We discussed with the manager our concerns that people were regularly being left unsupervised. They were unconcerned and unaware of this and told us that there was an intercom system staff could use to summon additional help. There was therefore, no reason why staff had to leave the units to look for help, thus putting people at risk of harm.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014:

Staff had been recruited appropriately. We saw that the provider had effective recruitment processes in place. Staff told us, and we saw that the provider had completed all the appropriate pre-employment checks including obtaining references from previous employers. Disclosure and Barring Service (DBS) reports had been obtained for all the staff. DBS helps employers make safer recruitment decisions and prevents unsuitable people from being employed. At the time of the inspection the provider had temporarily suspended recruitment into vacant positions. Therefore, the home was using a higher than usual number of agency staff.

The medicines were being managed safely. The provider had a new electronic system for managing medicines which was being trialled for all people on the first floor of the home. Paper medication administration records (MAR) were still being used on the ground floor. We observed a team leader using the electronic system to administer medicines and they told us that this significantly reduced the risk of any errors occurring. For example, it was unlikely that wrong medicine could be given to people as the barcode recognition system meant that the computer would alert the staff if wrong medicines were scanned. Also, it would alert staff if they tried to give medicines when appropriate gaps between doses had not been achieved. The paper MAR showed that these had been completed appropriately and there were no unexplained gaps. The medicines were stored securely in locked trollies within a locked room. The medicines for people who received short term rehabilitation care were kept securely in their bedrooms so that those who were able to do so, could continue to take their own medicines without support. The staff that administered medicines had been trained to do so safely and their competency was assessed regularly or when there were concerns about their practice.

Requires Improvement

Is the service effective?

Our findings

Due to people's complex needs, some were not able to tell us their views about the skills of the staff that supported them. However, those who were able to do so said that the staff supported them well. One visitor commented that staff were very good and that they took good care of their relative.

Care was not delivered in a manner that was personalised and people's consent was not always sought before any care or support was provided. For example, we saw staff move people without speaking with them to explain why they were moving them and this was common practice throughout the inspection. We saw that although this upset some people, staff carried on with the task unaware of the person's distress. People receiving rehabilitation care were more able to consent to their care and records showed that they had been involved in making decisions about their care. However, it was not always clear how the staff sought the consent of those people who were not able to tell them their wishes. We observed that some of the staff did not always understand people's communication methods, therefore were unable to communicate effectively with them to establish their needs and wishes.

Records showed that staff had received training on the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). Basic mental capacity assessments had been completed for people to assess whether they had the capacity to make informed decisions. We saw that five people had a DoLS authorisation in place and that this was held within their care records. The manager was aware of their responsibilities under the MCA. Where people lacked capacity, we saw that decisions had been sought on their behalf by their relatives and, where appropriate, other health professionals were involved in making decisions in their best interest. However we saw that the decisions made by representatives had not always been carried out as staff were unaware of them. Staff were unable to tell us who was subjected to a DoLS. We saw that the decision made in relation to one person was not carried out.

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

We looked at the training records for all staff and found that the manager had reviewed the training needs of staff and staff had completed mandatory training and there was further training planned for the future. However the manager did not have a system in place to validate the training already delivered, and was not aware that in some cases it had been ineffective in the delivery of care. For example staff had received training on person centred care. Our observations showed that staff did not deliver personalised care to people. Staff also told us that there had been occasions when people with complex needs, that they had not been trained to meet, had been admitted to the home. This left staff feeling vulnerable and the person at risk of poor and inappropriate care. We found that the training delivered to staff was not effective, resulting in people not having their needs recognised or met. The home had no effective system in place to ensure the staff that were supplied by an agency had the skills and knowledge needed to care for people effectively. This placed people at an increased risk of poor or inappropriate care.

The supervision system was not used effectively to support staff to develop their skills and knowledge. The records we saw indicated that this was being used as part of the disciplinary procedures, where staff only received supervision to highlight what they had not done well. The content of most of the supervision records was disproportionately negative. There was no evidence that this was a planned process, with supervision mainly taking place in response to concerns. Staff told us that they had begun to associate negatively with supervision as their experience was that this was always done to 'tell them off' about what they had not done well. The team meetings which at times were recorded as group supervisions, also showed very little evidence of positive support for the staff. Positively, the manager had put a process in place for the supervision of agency staff and we saw that some had been completed in December 2014. We saw that only three staff appraisals had been completed in 2014 and the manager told us that they were putting a process in place so that all staff had an annual appraisal.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

One person said, "The food is excellent. It is really welcome after eating hospital food." A person who did not like fish and chips had been given an omelette and they enjoyed it. However people were not always offered a choice of suitable and nutritious food and drink and people did not always get the appropriate support they required. No effort

Requires Improvement

Is the service effective?

had been made to make lunch an enjoyable experience. For example the tablecloths were stained and creased. No condiments had been put on the table and some people had to ask for salt and vinegar as this was not offered or readily available to them. We observed food put on the table in front of people without any staff interaction or ensuring it was what the person wanted. The main course served was limited to one choice and unless the person had the skills to ask for something else they were given the fish and chips. Some people, who needed assistance, were not offered any despite one staff member being present and available during the meal. Later during lunch another staff member arrived and tried to assist people as best as they could. However as 15 minutes had passed since the meal was served, it was cold and unappetising. We noted that a number of people left their meal, and staff failed to check if they had enough to eat or if they would like an alternative. However, in contrast we saw those people who were more independent at mealtimes enjoyed their lunch. Snacks and drinks were offered between meals. Some of the people told us that they enjoyed the food and had been given an alternative meal when they asked for it.

There were systems in place to monitor how much food people ate. However we noted that food and drinks were cleared away without staff noting how much was eaten by those people who were being monitored. People who had difficulty with eating and drinking were referred to dieticians for advice on how best to ensure they had adequate amounts to eat and drink. Families told us that this was not monitored and found that the same drinks had been in their relative's room "For days on end." A person who had returned from hospital and was unable to eat did not have their care plan updated and we saw that they did not eat and that this was not acted upon.

People were supported to have access to other healthcare services such as GPs, dieticians and speech and language therapists. A visitor told us that their relative had recently been discharged from hospital and we were told that they were well taken care of. Records showed that some people had regular support from community support teams, such as the mental health teams. This was confirmed by professionals we spoke with during our inspection. One healthcare professional confirmed that staff had referred a person appropriately so that their needs had been met. However, we found that the home was not in a position to offer a physiotherapy service. This meant that a person who required this treatment did not get it while they were at the home and therefore their recovery was delayed. The service was in the process of reviewing how they deployed the additional staff required to support people using the rehabilitation service, such as physiotherapists and occupational therapists so that people always received the care and treatment they required.

Requires Improvement

Is the service caring?

Our findings

Most of the staff were kind and caring in their interactions with people. We observed some examples of good care from individual staff that were supporting people well. One staff member tried to assist all the people who needed assistance to eat their lunch. This was too much for one staff member to achieve, but there did not seem to be any other support available. Some people told us that the staff were kind and caring and supported them with respect. One person said, "The staff are very friendly and helpful. They will go out of their way to help."

However, the service had not fostered a caring atmosphere where everyone had their dignity respected and independence promoted. We found throughout the inspection that there was a significant lack of engagement and interaction with people which left them bored, sometimes isolated and neglected. People were routinely ignored and we saw that tasks such as completing paper work took priority over ensuring people were cared for and comfortable. We conducted an observation in the part of the home where people with highest needs were cared for. We found that throughout the 25 minutes of our observation, the atmosphere was chaotic and hostile. People with very mixed needs were left sitting together. One person called out for the entire time we were there. In an attempt to block this out one person put their fingers in their ears, another person showed signs of distress by rocking themselves forward and backwards. This went unnoticed by staff as they were completing paperwork in a different room. This demonstrated that people were not treated with respect and their dignity and privacy was not supported. There was no consideration given to people's individual preferences or needs, and no effective procedures in place to involve people in making decisions about their care.

People were not always offered opportunities to be involved in or contribute to planning of their care and their needs were not always met at the times that suited them. For example, staff assisted people with personal care at a set time rather than when a person required this care. Staff referred to this as 'toilet time'. This approach to care showed that staff prioritised the task rather than the person and did not promote people's dignity or enable people to have control of how their care was provided.

This was a breach of Regulation 10 of the Health and Social Care Act 2010 (Regulated Activities) Regulations 2014.

There were no restriction on visiting times in the home and people's relatives said that they were welcomed into the home at any reasonable time. One visitor said, "Staff look after [relative] really well. Every time I see [relative] they look good and well cared for." A person told us that their family members visited regularly and they went home almost every weekend, returning either on Sunday or Monday morning. They said that they enjoyed the time they spent with family members, but accepted that they could no longer live at home permanently because they needed support with their care needs.

Requires Improvement

Is the service responsive?

Our findings

People's needs had been assessed and care records outlined people's care needs, preferences and aspirations. These contained sufficient guidance for staff on how to care for people in a way that promoted their physical wellbeing. However, staff said that they had not been given the time or opportunity to read them and therefore they were not always followed. This resulted in poor care for the some of the people they supported. The manager showed us an easy to read care plan that they had recently introduced to make care information more accessible for people who used the service and the staff. We found most were incomplete and they did not contain sufficient information that would enable the staff to support people well. One person who had returned from hospital had been left unattended and we had to intervene to get this person the support they required. Another person who had very high needs, had their care plan reviewed with their family, but the necessary changes were not made to the care delivery following this.

The initial assessment of people requiring rehabilitation care and treatment was not always robust enough to fully identify their care and support needs. The manager or the team leaders completed the assessments following a referral being received. In most cases, this involved a visit to the hospital to complete the assessment in person, but we saw that one person had been accepted following a review of the records and speaking with the professionals involved in their care. This was not always sufficient for the assessor to assure themselves that the staff at the home had the right skills and experience to meet this person's needs.

One staff member said, "The written referrals are not always detailed enough to do a proper care assessment. People should always be assessed in person." This meant that there was not always enough information on the person to respond to their needs. They also said that the care for people receiving rehabilitation care was not always good when the regular staff were not working, adding, "Some of the staff are not always responding to people's needs quick enough." They gave an example of where one person's health had deteriorated and prompt action had not been taken to seek medical advice. Subsequently the person was not supported in a timely manner to promote a swift recovery. A further example was that staff had not been given guidance on how to monitor a person's blood sugar levels. This had resulted in the person being admitted to hospital, as staff had failed to recognise unsafe blood sugar levels which resulted in deterioration in the person's health.

Staff failed to respond when people showed behaviour that could have a negative impact on others and when asked, they were unable to tell us how they worked with people to identify triggers for the behaviour and reduce incidents. These were clearly detailed in the care plan. This lack of response to the person left them isolated and distressed.

Staff kept individual daily records which detailed important information about people's health and welfare. However, we saw that, although information was recorded, it had little impact on people's experience of care. Records detailing one person's distress on the first day of the inspection were not recorded as we saw it. The information had not been used to effectively, and we noted no improvement to the care of this person when we carried out the second day of the inspection.

There was little on offer to stimulate people or create opportunities for them to pursue their interests and hobbies. The activities boards on each unit had not been updated and some of them still had information about activities that had been planned for December 2014. Most people we observed were left sitting in a small sitting room with a very loud television on. We observed that one person who had capacity chose the television channel to watch. The other six people in the room had no input into how they spent their day. There was very little interaction between the people and the staff. Staff did not spend time in the same room as the people and therefore missed the signs that people needed assistance. This left people distressed and their needs unrecognised and often unmet.

The care plans for people who were living with learning disabilities had no details on how to keep them engaged and stimulated. Although some of the more able people attended the day centre adjacent to the home and they told us that they enjoyed the opportunity to socialise with others, this was not consistent. Some people had not been offered the opportunity to access activities within the local community for many months, unless families and friends had intervened. One person told us that they were supported by a friend to visit a local social club in the evenings, but at times, they had to wait a long time for staff to open the door for them on returning to the home.

Requires Improvement

Is the service responsive?

Information from para medics showed that on one occasion they had to wait 15 minutes to gain access to the home following an emergency call. This had resulted in delayed emergency care to the person.

This was a breach of regulation 09 of the Health and Social care Act 2008 (Regulated activities) Regulations 2014.

The provider had a complaints policy. It was not clear how information about how to raise a complaint had been given to people. One person told us that their complaint had not been resolved at manager level and had to be escalate to senior managers at provider level. Other information we hold showed that another person had to escalate their concerns as they couldn't get a response from the home's management staff. A 'Residents and Relatives' notice board had nothing on it and the manager told us that the information that included the complaints procedure had been removed because the area was being painted. We looked at how the service managed and responded to complaints and found that some complaints had not been resolved despite them going on for over a year. This meant that people's concerns had not been responded to in a timely manner so that the required improvements could be made. One person told us that they had complained about how their laundry was being managed. They said, "I do not get my clothes back sometimes. They tell you that they will improve, but it happens again." The manager said that they will review the current system to see if further improvements could be made.

This was a breach of regulation 16 of the Health and Social care Act 2008 (Regulated activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

The registered manager did not have a clear and visible presence in the home nor did they demonstrate strong leadership. The morale of the staff was very low and staff we spoke with did not feel the service was well led. Prior to the inspection we were contacted by staff who had concerns about how the home was managed. Our findings supported these concerns. Some of the professional visitors said that the manager tried her best but the home was not well managed, and there was a divide between the care staff and the management team. Staff also confirmed this.

Most of the staff said that the manager never left their office and had no idea of what was happening in the home or the needs of the people. Our observations over both days of the inspection supported this view. The culture of the service was task led rather than putting people first. People were not encouraged and supported to share their views or be involved in the way in which the service was run. We found the manager's focus was on getting the paper work done and did not have a strong vision of how the service needed to be run to appropriately meet people's needs. None of the staff felt they were well supported by the manager. There was a culture of 'blame' and staff felt that they were mainly being 'told off' for what they had not done well and not praised when they did well or supported to develop their skills and knowledge. Staff felt that they were not always asked for their views on how the service could be develop, although we did see that some of the people had been involved in choosing the paint colours and wallpaper to decorate the communal areas, as well as, their bedrooms.

Systems to monitor the quality of the service were in place, but these were ineffective as they had failed to identify issues highlighted during the inspection, such as not ensuring that people's changing needs were assessed and appropriate was care given. In contrast to our inspection findings, the manager had judged that all these areas were met. She had failed to identify that people's dignity was not respected and that the service was not keeping everyone safe and not providing a caring environment. People could not be confident they were protected from the risk of unsafe or inappropriate care because the manager had not assessed or monitored the quality of the service effectively.

The care plans were not always available to staff and time given to read them so that they understood people's needs, their capacity to make decisions and know how to support them appropriately. Initial assessments completed prior to people moving to the home were not always thorough, leading to inappropriate admissions where the service could not meet people's needs.

The management team had failed to identify poor practice or the impact it had on the people who lived there. As a result, poor engagement, an environment that was not stimulating, staff working too many hours and a lack of opportunities for people to be involved in making decisions about their care had not been addressed.

Systems to assess the need for staff training, to keep training up to date, and to monitor the impact it had on practice were not effective. Most staff had received training in how to provide dignified care, but we found that many failed to do this. The manager was unable to show how they monitored the effectiveness of training or how they identified where further training was needed.

The provider had a disciplinary process in place. At the time of the inspection six staff had been suspended from work. Staff told us that 'suspensions' were used regularly and they lived with the fear of being suspended. We found it difficult to get a clear understanding on how the disciplinary process was used. For example, some staff were disciplined for what appeared to be minor matters in relation to the wearing of their uniform inappropriately. Staff told us that they felt the process was used in a punitive manner to "Keep us down and do as we are told." Another staff member told us that the disciplinary process was used to make them feel like 'a nobody.' This meant that staff were unhappy working in the home and some of them told us that if it wasn't for the people they cared for, they would leave 'tomorrow.'

The manager failed to ensure that people's records were stored securely. We saw that the records relating to some of the people who lived in the home were kept in a room that was not always locked and we sometimes found the door open during the inspection. This meant that people's confidentiality had not always been protected, particularly as there were external contractors in home doing the refurbishment work.

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

Inadequate

Is the service well-led?

The manager had notified the Care Quality Commission (CQC) of some significant events in the service.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 **The provider failed to ensure the people who used the service received personalised care and appropriate person-centred care and treatment that is based on an assessment of their needs and preferences.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect **The provider failed to ensure that the dignity of the people who used the service was promoted at all times.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent **The provider failed to ensure that the people who used the service were given the opportunity to consent to care at all times.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **The provider failed to protect the people who used the service from the risk of neglect.**

Regulated activity	Regulation

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints The provider failed to ensure that complaints were responded to in a timely and satisfactory manner.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider had failed to ensue that there were auditing systems in place to assess, monitor and drive improvements in the quality of the services provided. This included identifying and mitigate any risks relating the health, safety and welfare of people using services and others.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing The provider had failed to ensure that there was sufficient, skilled and trained staff to meet the needs of the people who used the service. Staff were not appropriately supported, supervised and managed.