Roseberry Care Centres GB Limited

Walkley Lodge

Inspection report

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Ratings

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

Overall summary

This inspection took place on 25 June 2015. This was an unannounced inspection which meant the staff and provider did not know we would be visiting. This service was last inspected on the 9 April 2013.

Walkley Lodge is a care service that provides care for up to seven people. It is a listed building which has been converted into a home. At the time of our inspection six people were living at the service. Some people living at the service had complex needs and had behaviour that may challenge others.

There was a registered manager for this 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 a legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We were not able to speak with some people using the service because we were unable to communicate verbally with them in a meaningful way. From our observations we did not identify any concerns regarding the safeguarding of people who used the service. One person told us they felt safe and would speak to staff if they had any concerns. We found that daily records showed that people were not always treated with dignity and respect.

Summary of findings

Some people had personalised their rooms and they reflected their personalities and interests. One person told us they were satisfied with the quality of care they had received and made positive comments about the staff. Another person used gestures to confirm that they were happy living at the service and that all the staff working at the service were nice.

Relatives spoken with told us they felt their family member was in a safe place. Our discussions with staff told us they were aware of how to raise any safeguarding issues.

Relatives spoken with were satisfied with the quality of care their family member had received. They told us they were fully involved in their family member's care planning.

We found the provider had not ensured there had been effective leadership and management in place at the service to create and maintain a person centred approach culture. People's care records showed that they were not actively involved, encouraged and supported to be involved in their care planning or that obtaining consent to their care planning was part of the process.

We also found the provider had not protected people who may be at risk, against the risks of inappropriate or unsafe care by having effective operational systems in place to review and evaluate care plans and risk assessments.

The provider had failed to put adequate arrangements in place to ensure the monitoring of incidents or untoward occurrences was maintained. This showed there was a risk that some people's behaviour was not managed consistently and the risks to their health, welfare and safety were not managed.

We found the arrangements in place to ensure unexpected staff absence needed to be more robust to ensure staffing levels were maintained.

Recruitment procedures were in place and appropriate checks were undertaken before staff started work. This meant people were cared for by suitably qualified staff who had been assessed as safe to work with people.

We found the provider had failed to ensure that staff acted in accordance with the requirements of the Mental Capacity Act 2005 and Deprivation of Liberties Safeguards DoLS.

The service had appropriate arrangements in place to manage medicines, so that people were protected from the risks associated with medicines. However, we found that the storage of medicines required improvement.

There was evidence of involvement from other professionals such as doctors, opticians and dentists in people's care plans. People had a health action plan in place.

People's nutritional needs were monitored so actions could be taken where required. However, we found records showed that people's consent had not been obtained to support them with weight loss.

Staff told us they enjoyed caring for people living at the service. Staff were able to describe people's individual needs, likes and dislikes.

We received mixed messages regarding the support staff received at the service. Staff told us they enjoyed working at the service. However, staff told us that staff morale was low due to the number of changes of managers at the service over the past 18 months.

We found there was not a robust system in place to ensure staff received all the training they required to meet the needs of people they supported.

We saw the service provided support for people to go on daytime activities, which included going shopping and going out for meals. One person told us they really enjoyed going on a recent trip to the seaside. People also had access to a sensory room at the service. We found the activities provided to some people could be improved by exploring different types of activities to see if people liked them.

The provider had a complaint's process in place. However, we found an accessible format to reflect the communication of people living at the service was not on display.

We found that there were not robust arrangements in place to regularly seek people's views so they could share their experience of care.

We found the records relating to people required improvement. We found examples of missed signatures or omissions within care plans. Although checks had been completed by the provider our findings showed that some of the checks were ineffective in practice.

Summary of findings

We found five 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 not always safe.

We found the provider had not protected people who may be at risk, against the risks of inappropriate or unsafe care by having effective operational systems in place to review care plans and risk assessments.

From our observations we did not identify any concerns regarding the safeguarding of people who used the service. One person told us they felt safe and would speak to staff if they had any concerns. Staff were fully aware of how to raise any safeguarding issues.

The service did have appropriate arrangements in place to manage medicines so that people were protected from the risks associated with medicines.

Is the service effective?

Inadequate

The service was not effective.

We found some staff had not received training in how to support people with behaviour that challenged, which poses a risk people may be supported inappropriately.

The service had policies and procedures in relation to the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS). However, people had not been appropriately supported to make decisions in accordance with the MCA.

People's nutritional needs were monitored so that action was taken where required. However, we found that people's consent had not been obtained to support them with weight loss.

Is the service caring?

Requires improvement

The service was not always caring.

Two people told us that all the staff working at the service were nice. People were able to name their favourite staff members. However, daily records showed that people were not always treated with dignity and respect.

Staff enjoyed working at the service. They were able describe people's likes and dislikes and their key contacts within the community. However, records showed that people's independence and autonomy was not actively promoted.

Is the service responsive?

Requires improvement

The service was not always responsive.

We found that people's care plans demonstrated a lack of understanding of what is "person centred support planning".

Summary of findings

The service promoted people's wellbeing by providing daytime activities. However, we found that the provision of daily activities within the service required improvement.

Is the service well-led?

Requires improvement 

The service was not always well-led.

We found the provider had not ensured there had been effective leadership and management in place at the service to create and maintain a person centred approach culture.

People's care records showed that they were not actively involved, encouraged and supported to be involved in their care planning or that obtaining consent to their care planning was part of the process.

Although checks had been completed by the provider, our findings showed these had been ineffective in practice.

Walkley Lodge

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 checked 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 25 June 2015. The inspection was unannounced, which meant the staff and provider did not know we would be visiting. The inspection was carried out by two adult social care inspectors who were accompanied by a specialist advisor. The specialist advisor was experienced in caring for people with learning disabilities.

Before our inspection we reviewed the information we held about the service and the provider. For example, notifications of safeguarding and incidents. We also reviewed the provider information return the provider submitted. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We gathered information from the local authority and Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

We used a number of different methods to help us understand the experiences of people who lived in the service. We spent time observing the daily life in the service including the care and support being delivered. We were not able to speak with some people using the service because we were unable to communicate verbally with them in a meaningful way. Two people spoken with were able to share some of their experience of living at the service. We also spoke with the provider's regional operations manager and four care workers. We looked round different areas of the service; the communal areas, bathroom, toilets, storage rooms and with their permission where able, some people's rooms. We reviewed a range of records including the following: four people's support plans, six people's medication administration records, four staff files and records relating to the management of the service.

Requires improvement

Is the service safe?

Our findings

From our observations we did not identify any concerns regarding the safeguarding of people who used the service. One person spoken with told us they felt safe and did not have any concerns. They told us if they were worried about anything they would talk to a member of staff.

On our arrival we found a team leader and five care staff supporting people at the service. The registered manager was attending training on the day of the inspection. A care worker told us that there had been an unexpected staff absence and staff were in the process of trying to obtain cover for the absence. Staff spoken with told us that the service was not always able to obtain cover for unexpected staff absences and were concerned that this may have an impact on people living at the service. For example, staff would not be available to support people to go out. We reviewed the service's staff rotas for week commencing 1 June 2015 and week commencing 15 June 2015. We saw staff cover had been obtained for the absences due to sickness for week commencing 1 June 2015. However, we noted the service had failed to obtain cover for some of the absences due to sickness for week commencing 15 June 2015. This showed the system in place to obtain cover for staff absence required improvement. During the inspection two additional staff members arrived due to a training session being cancelled.

We found the reporting of incidents by staff required improvement. For example, we reviewed one person's daily notes record. A staff member had described an incident that had occurred for the person. We were unable to find a corresponding incident form or an entry in the service's incident record book. The service's incident record book contained a list of incidents that had occurred at the service. The list included the name of the person, brief details of the incident and the staff involved. We noted that compared to previous months very few incidents had been recorded in the service's incident book between 1 June 2015 and 18 June 2015. We found that the process in place to monitor incidents required improvement to ensure the patterns and triggers for a person's behaviour were identified. This told us there was a risk that people's behaviour was not managed consistently and the risks to their health, welfare and safety are not managed effectively. We spoke with the regional operations manager who assured us that a robust system would be put in place.

We reviewed four people care records including their risk assessments. The purpose of a risk assessment is to put measures in place to reduce the risks to the person. It is important that individual risk assessments are completed for all areas so that identifiable risks are managed effectively and that appropriate support is put in place. We found concerns in people's individual records. For example, in one person's records we saw that one person's personal care and challenging behaviour risk assessments dated May 2015 had not been signed and their pre admission assessment was not fully completed or signed. In another person's records we reviewed a risk assessment for accessing the community. The original date of the risk assessment was 14 December 2011. It had been updated on the 19 January 2012. We saw that the risk assessment had been evaluated since this date but we could not find any information how the person was involved in the evaluation. Staff spoken with also told us that the level of staff support the person required to access the community had increased due to an incident when they had refused to return to the service. We saw this had not been reflected in their care plan.

We also found that there was a lack of understanding amongst some staff that the risks to people needed to be assessed on their current needs, responsive to changing needs and did not always remain the same. For example, a person who required two staff members to support them to go out when they lived at a previous service would not necessarily need the same level support living at this service.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, safe care and treatment.

We looked at the systems in place for managing medicines in the service. Medicines were only handled by trained support workers. We checked six people's Medication Administration Records (MAR). We did not identify any concerns in the sample of MARs checked. We observed the team leader administrating medication to different people living at the service. The team leader was patient and supportive to each person throughout the process. They remained with each person until they had taken their tablets. Some medicines, such as painkillers, were prescribed to be taken only "when required". We saw that

Requires improvement

Is the service safe?

information had been prepared for staff to follow to enable them to support people to take their medicines safely and consistently. For example, how a person communicated they were in pain if they were unable to tell staff verbally.

We reviewed the temperature records for the medication room and the fridge. We found that staff had recorded the temperature between 22-25 degrees. However, on the day of the inspection the temperature within the room was above 28 degrees. A fan was being used to reduce the temperature in the room. If medicines are not stored properly they may not work in the way they were intended, and so pose a potential risk to the health and wellbeing of the person receiving the medicine. We spoke with the regional operations manager who assured us that an air conditioning unit would be installed to ensure medicines were appropriately stored.

We found the cleanliness of the medication room required improvement. For example, the flooring was not clean and a plastic box which was being used to store syringes and plastic medicine pots was not clean. We spoke with the regional operations manager; they assured us that the room would be cleaned and that the cleanliness of the room would be maintained.

It was clear from discussions with staff that they were aware of how to raise any safeguarding issues and they were confident the senior staff in the service would listen. Staff also described the whistle blowing procedures for the service. We were able to locate information regarding the local safeguarding protocols and we saw evidence that the service followed these to safeguarding people from harm.

We reviewed the provider's procedure for the expenditure of people's monies. We noted that the procedure did not reflect where the person was able to sign a petty cash voucher and promote independence. We also noted that the procedure did not provide any guidance where a person wished to retain any monies in their room. For example, a staff member told us that one person liked to keep the change after going out for the day. We checked three people's personal allowance monies and found the balance was correct.

We reviewed four staff recruitment records. The records contained a range of information including the following: application, interview records, Disclosure and Barring Service (DBS) check, references including one from the applicant's most recent employer and employment contract. The DBS helps employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups. We also saw examples where any concerns raised during the process had been followed up to ensure the person was suitable to work with vulnerable people. This meant a safe system was in place when recruiting staff.

We found that most areas in the service were clean. We found a few areas where cleanliness could be improved. For example, the room and ensuite area used by staff and the medication room and the bannister on the main stairway. We looked at three people rooms and saw that this were clean and there were no malodours. However we noticed the linens and towels being used were "tired" and needed replacing. One person's room had a stained quilt and in another person's room there was a stained pillow. We spoke with the regional operations manager who assured us that these would be replaced.

During the inspection an external contractor carried out checks on the emergency lighting and the fire alarms at the service. A fire risk assessment had been completed at the service in February 2014 and May 2015. This showed that there were systems in place to ensure the premises were safe for their intended purpose.

Inadequate

Is the service effective?

Our findings

Two people spoken with told us they liked living at Walkley Lodge. One person told us that they went to the chiropodist and the dentist. In people's records we found evidence of involvement from other professionals such as doctors, opticians and dentists. People had a health action plan in place. A health action plan holds information about the person's health needs, the professionals who support those needs, and their various appointments.

Relatives spoken with were satisfied with the quality of care their family member had received and made positive comments about the staff. They told us they were fully involved in their family members care planning. Their comments included: "every time we come, the staff come up to us, they keep us fully informed" and "they have taken [family member] to the doctors when she needed to go".

Relatives told us they had not eaten at the service but the food looked appetising. Two people spoken with told us what their favourite foods were to eat. One person wrote down chicken and another person told us they loved braising steak. We found people's dietary needs were being met. For example, one person was being provided with vegetarian alternatives to meat.

Staff told us that if people did not like what was on the menu they were offered something else to eat. One staff member demonstrated to us how they provided meal choices at breakfast. They said "residents come to the cupboard (opened cupboard and showed us the range of cereals on shelf) and choose which cereal they want. Then we ask if they want toast and whatever drink they want".

We found that nutrition and hydration needs assessments had been completed for people living at the service. We found that one person's diet and nutrition plan had not been reviewed since the end of February 2015. The person had been assessed as being overweight and a record of their food intake was being recorded at this date. It is important that regular assessments are undertaken to ensure that appropriate support is in place.

The Mental Capacity Act (MCA) 2005 is an act which applies to people who are unable to make all or some decisions for themselves. It promotes and safeguards decision-making within a legal framework. The MCA states that every adult must be assumed to have capacity to make decisions unless proved otherwise. It also states that an assessment of capacity should be undertaken prior to any decisions being made about care or treatment. Any decisions taken or any decision made on behalf of a person who lacks capacity must be in their best interests.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care services. The Deprivation of Liberty Safeguards (DoLS) are part of the Mental Capacity Act (MCA) 2005. They aim to make sure that people in care homes, hospitals and supported living are looked after in a way that does not inappropriately restrict their freedom.

We found evidence that the MCA Code of Practice had not been followed. For example, in one person's records we were unable to find any evidence that a capacity assessment had been undertaken prior to a DoLS authorisation being sought. We found that some staff member's knowledge of the Deprivation of Liberty Safeguards was minimal.

We found the provider had not ensured DoLS authorisations had been obtained for people living at the service, where there were liberty restricting measures in place for people. For example, one person's wardrobe and ensuite area were kept locked. Another person was not able to leave the service without the support of two staff members.

In care plans we found that people had not been involved or their consent obtained in how they were supported. For example, one person was being supported to lose weight but we did not see any evidence that they had been involved in this decision or consent obtained for this support. Another person was handing in their mobile device (tablet) each night to staff before going to bed but we did not see any evidence they had been involved in this decision or consent had been obtained for this support. We saw that care planning was not person centred and that obtaining consent from people was not included in the process. It is important that people are supported to participate in making decisions to the maximum extent possible.

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

Staff spoken with gave us mixed views regarding the support they had received. They told us staff morale was low due to the number of changes in the management of the service and that there had been a succession of

Is the service effective?

managers at the service. We saw evidence on staff files that staff had received supervision sessions. Supervision is regular, planned and recorded sessions between a staff member and their manager to discuss their work objectives and wellbeing. We saw that the content of some supervisions were generic and contained the same information. We reviewed the minutes of the staff meeting completed in March 2015. We noted that the registered manager had informed staff that if staff had any concerns they could go and speak with them privately.

We reviewed the training records for four staff. We found that some of the training provided to staff was completed using local authority workbooks which were designed to be used by people who employed personal assistants. We saw staff had completed these workbooks. For example, for safeguarding and food hygiene. However, we found no evidence of the answers they had written or their competency had been checked by a senior member of staff. For example, the section in the workbooks for the manager to fill in had not been completed.

We reviewed the service's training spread sheet. This showed that bank workers had not been supported to maintain their training. We also saw that only seven staff out of 30 staff listed on the training spread sheet had completed training in behaviour that challenged. In one person's care records we saw that a clinical psychologist had removed a person living at the service from their caseload due to staff not attending a training workshop in November 2014, December 2014 or March 2015. In another person's records it stated that staff needed to be trained in Nonviolent-Crisis-Intervention. The training spread sheet showed that none of the staff had attended this type of training.

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

Requires improvement

Is the service caring?

Our findings

One person told us they liked the staff working at the service. They also gave us the names of staff they liked the best. Their comments included: "all the staff are nice here, everybody is nice". They told us that if they had any concerns they would speak to a staff member. Another person we spoke with used gestures to confirm that all the staff working at the service were nice.

Relatives spoken with made positive comments about the staff and felt their family member was supported appropriately by staff, that their family member was happy living at the service and that it was very homely. They gave us details of the names of their family member's favourite staff. They also told us that the found the manager of the service to be friendly and approachable and staff kept them fully informed about their family member's wellbeing.

Staff spoken with told us they enjoyed supporting people living at the service. Each person living at the service had key workers to support them. Staff were able to describe people's individual needs, likes and dislikes. Staff were able to described how people expressed they were in pain.

During the inspection we observed the daily life within the service. We observed one person indicating to a staff member they did not want them to go in their room and saw the staff member respected this decision. The staff member waited patiently outside their room until the person decided to let them in their room. We saw people were able to decide where they spent their time during the day. For example, to go in the lounge or spend time in their room. However, daily notes records and care plans showed that people were not always treated with dignity and respect and involved in decisions. For example, we reviewed an incident report where a staff member's actions had triggered a person's aggressive behaviour. The staff member had told the person it was time to stop watching television and tried to remove the television from their room. The person had been actively watching it. We also saw in one person's records that different areas within the service were kept locked at night so that people could not choose to access these areas.

Staff described how they promoted choice to people. For example, showing them the different food available to have for breakfast or showing them a choice of outfits to wear. However, we found examples in people's records that they were not involved in decisions about their support and that some decisions about support were staff led rather than person led. It is important that people's autonomy and independence is supported in all aspects of their care and support to the maximum extent. Feedback from staff also told us that aspects of people's support was staff led rather than person led. For example, some people liked to follow a routine and if staff disrupted this routine it was reflected in the person's behaviour.

We saw there was very little information for people visiting the service. There was no information about advocacy services available. Although we saw some information in an accessible format for people in care plans, we did not see this on display in the communal areas. For example, the complaints form.

Requires improvement

Is the service responsive?

Our findings

One person showed us their bedroom and ensuite area. They pointed out their favourite things to us. The room reflected their personality and interests. They showed us how they locked the door of their room when they went down to the kitchen or lounge area. They told us all about the activities they liked to do which included: going shopping, going to see films, going out for lunch and going to a Sports Centre. They also told us how much they had enjoyed going to the seaside recently. They said: "I went to Skegness and bought a Bob Marley T shirt". They also told us about the activities they liked to do at the service which included colouring pictures, knitting a dishcloth and completing jigsaws. They gave us a picture they had coloured in to keep. We noticed some people's weekly activities sheets showed they completed the same activities every day. For example, colouring. It is important that people are provided with meaningful activities and they have the opportunity to explore different types of activities to see if they would like them.

Staff used walkie talkies to call for assistance from other staff. People did not have access to a call bell in their rooms so where people were able they could not call for assistance from a staff member. We saw that frequent wellbeing checks were completed during the night by staff. We saw that these checks were undertaken for all the people living at the service including those with a lower level of need.

We found that people had a care plan place. However, we found the quality of the care plans required improvement and demonstrated a lack of understanding of what is "person centred planning". We found no evidence to show that people were actively involved, encouraged and supported to be involved in their care planning. One person's records stated that the following capacity assessments were required, imagination and thinking skills, social interaction, obsessions and rituals, behaviours and environmental factors. We found that none of the capacity assessments had been completed. In another person's care plan we found contradictions on the level of staff support they required. In their challenging behaviour plan it stated that they required two to one support when they went out. In their independence risk assessment it stated they receive one to one support at all times. We also found the way people's plans were evaluated required improvement. For example, an analysis of the person's behaviour had not been completed to show the risk assessment for challenging behaviour and the measures in place was meeting their needs.

We found there was not a robust system in place to ensure all aspects of people's care were reviewed regularly and that the person was involved in these reviews where able. For example, one person's vocational activities plan had not been reviewed since September 2012.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

The complaints process was on display in the staff room but not in the communal areas. We noticed that a pictorial complaints process had not been displayed to reflect the way some people living at the service communicated. The service had a complaints process in place which they followed if they received any complaints. Relatives spoken with told us they would speak with the manager if they had complaints or concerns.

Requires improvement

Is the service well-led?

Our findings

Staff told us there had been a number of changes in the management of the service and this had impacted on staff morale. A new manager had been appointed and had registered as the manager with the Care Quality Commission. During the inspection we noticed the photographs of staff displayed in the reception area needed updating and were positioned very high on the wall. Two relatives spoken with told us staff were very welcoming when they visited but they found it difficult to identify who staff were or their names. They suggested that staff wear a badge or some form of identification. We saw there was very little information available for visitors or people living at the service.

We found the provider had not ensured there had been effective leadership and management in place at the service to create and maintain a person centred approach culture. People's care records showed that they were not actively involved, encouraged and supported to be involved in their care planning or that obtaining consent to their care planning was part of the process. This was also reflected in our findings that the provider had failed to ensure that staff acted in accordance with the requirements of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS).

The service completed a range of checks at the service which included regular infection control and medication audits. The provider also completed checks at the service. We reviewed the provider visit record completed in December 2014 by the regional operations manager. The visit covered a range of areas including: care plans, cleanliness, environment, medication, staff training, supervisions and recruitment and cleanliness and environment. The regional operations manager also spoke with two people living at the service. The provider had also completed an interim visit in May 2015. This visit included discussing the level of staff support people were receiving on an individual basis and people's care plans. However, our findings during the inspection showed that some of the checks in place to assess, monitor and improve the quality of the service were ineffective in practice.

We found the provider had not protected people who may be at risk, against the risks of inappropriate or unsafe care by having effective operational systems in place to review care plans and risk assessments. We also found that the provider had failed to put adequate arrangements in place to ensure the monitoring of incidents or untoward occurrences was maintained. This showed there was a risk that some people's behaviour was not managed consistently and the risks to their health, welfare and safety not managed.

The service held regular staff meetings. We reviewed the minutes of staff meetings completed in January, February and March 2015. We saw that a range of topics were discussed at the meetings including: staff time keeping, rotas, recording books, staff recruitment, staff training, meals and care plans.

In the March 2015 staff meeting minutes we saw a decision had been made by staff not to allow people to do the food shopping because people had displayed negative behaviours in the past. People's views had not been included in the decision making process and reflected the culture we found within the service. The culture of a service directly affects the quality of life of people. This showed the provider had not ensured that people living at the service were involved in decisions about their care.

The service did not hold regular service user or house meetings with people living at the service. We reviewed service user feedback forms completed in January 2014 by two people living at the service. The questions included asking people whether they liked their room, if the food was alright and what would they do if someone wasn't very nice to them.

We found the records relating to people required improvement. We found examples of missed signatures or omissions within care plans. For example, one person's care records contained missing signatures, the client's property form had not been completed, and the pre admission assessment was not fully completed or signed. The person's description was incomplete; there were no details of their religion or ethnic origin. It is also a duty that records in all formats including photographs must be managed in line with current legislation and guidance. We saw that staff were using their own devices rather than the services to record photographs of people during activities. We saw this system did not support the confidentiality of people using the service.

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

Requires improvement

Is the service well-led?

The regional operations manager and acting manager were aware of their responsibility to inform the CQC about notifiable incidents and circumstances in line with the Health and Social Care Act 2008.

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 How the regulation was not being met: Service users were not protected against the risks of receiving care or treatment that was inappropriate or unsafe, because the planning and delivery of care did not meet people's needs and ensure the welfare and safety of service users.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent How the regulation was not being met: The provider had not made sure they had robust procedures to ensure they act in accordance of the 2005 Act.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met: The provider had not assessed the risks to the health and safety of service users receiving the care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met:

This section is primarily information for the provider

Action we have told the provider to take

Service users were not protected against the risks of inappropriate or unsafe care or treatment because the provider did not have effective systems to monitor the quality of the service provision.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing How the regulation was not being met: The provider had not ensured that staff received appropriate training and support to enable them to carry out the duties they are employed to perform.