Care Quality Commission

Sudera Care Associates Limited

Ridgeway Nursing Home

Inspection report

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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

We completed an unannounced inspection of Ridgeway Nursing Home on 5 and 9 December 2014. Ridgeway Nursing Home is registered to provide care for up to 37 people who require personal or nursing care. At the time of our inspection 34 people were being cared for, including people who have dementia.

The manager had been in post since August 2014 and had not registered with the Care Quality Commission at the time of our inspection. 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.

At our previous inspection in July 2013 we had identified breaches in regulations relating to care and welfare, management of medicines, staff recruitment and staff support, assessing and monitoring the quality of services and record keeping. Following this the provider sent an action plan telling us about the improvements they intended to make. During this inspection we looked at whether or not those improvements had been met. We found that improvements still needed to be made in

Summary of findings

these areas. In addition, we also found further areas of concern. These included, respecting and involving people, consent to care and treatment, staffing levels and the suitability of the premises.

We found that people were not assured of receiving the most appropriate care to meet their needs. This was because care plans and risk assessments had not been reviewed to reflect changes to people's care needs and did not always clearly incorporate guidance from other professionals. Other risks at the location were not always identified and information on how to evacuate people safely, should there be an emergency, was not accurate. We also found some people's bedrooms in part of the building were cold and did not have hot water.

For some people, arrangements were not in place to ensure they received their medicines in the safest, most appropriate way and at the right time. Where people did not have the capacity to make some decisions, including taking some medicines, the provider had not followed the decision making process to meet the full requirements of the Mental Capacity Act 2005 (MCA).

Improvements had been made since our last visit to ensure staff employed were suitable to work with people living at the service. Staff also had a good understanding of how to keep people safe. However, the provider had not responded quickly to concerns raised over there not being enough staff available on each shift to provide the care needed to keep people safe. Although, at the time of our inspection the provider had agreed to use agency staff and staff from the provider's other services, staffing levels were still not meeting the levels assessed by the manager as needed to meet people's needs. As a result, we found some people were left waiting for support. We also found that people's day to day needs were not always met. For example, we saw food and drink taken away from someone with dementia without staff first reminding them to have some lunch and a drink.

People we spoke with were positive about the staff who worked at the home and we observed most staff supported people with kindness and consideration of their independence and dignity. However, we found some staff practice compromised some people's independence, as did the accessibility of some communal bathrooms and toilets. People were supported to maintain their interests and hobbies however staff did not have much time to spend with people. We found the manager had taken into consideration the views of some families when planning improvements to the service.

We found that procedures for auditing and monitoring the quality of the service did not always identify actions needed to secure improvements. A range of people told us they had experienced problems when they had tried to make suggestions to improve the service. We were concerned the management approach at the service had not positively engaged a range of stakeholders.

We found seven breaches of regulations under the Health and Social Care Act 2014 (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?
The service was not safe.

Risks at the location had not been appropriately identified and rectified. Procedures to ensure the safe handling and administration of medicines had not always been followed. When people's needs changed their care was not always reviewed to make sure it was still appropriate.

The service had, at times, been operating with insufficient numbers of staff to safely and effectively meet people's needs. Staffs' knowledge in safeguarding procedures helped to protect people using the service from abuse and avoidable harm.

Requires Improvement

Is the service effective?
The service was not effective.

Not all staff had knowledge about people's needs and the restrictions placed on them to keep them safe. People's day to day needs were not always met, including providing appropriate support for people to receive adequate nutrition and hydration.

The training matrix was not effective at identifying when staff had been trained and when that training had expired.

Requires Improvement

Is the service caring?
The service was not caring.

Most, although not all staff had positive caring relationships with people using the service. However, people's dignity and independence was not always promoted.

The service was providing opportunities for people and their families to be involved in their care.

Requires Improvement

Is the service responsive?
The service was not responsive.

The service did not always take action to respond appropriately to people's changing care needs.

People were supported with their hobbies and the service took an interest in people's life and experiences, however staff did not always have time to spend with people. Feedback from some families had been acted on when changes to the service were made.

Requires Improvement

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

Inadequate

Summary of findings

Procedures to assess and monitor the quality of the service were not effective at identifying where the service was not performing well and where improvements were needed.

Some people did not feel confident to raise concerns and that the management approach had not engaged all stakeholders positively. The requirements for a manager to register with the Care Quality Commission had not been met.

Ridgeway Nursing 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 5 and 9 December 2014 and was unannounced. The inspection team was comprised of one inspector, one inspection manager and one specialist professional advisor who specialised in mental health nursing and dementia care.

Before our inspection we asked the provider to complete a Provider Information Return (PIR). 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 reviewed the PIR, information of concern that had been sent to us and routine notifications. Notifications are changes, events or incidents that providers must tell us about.

We spoke with three people who used the service and used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk to us. We spoke with six people's relatives and 16 members of staff, including the manager. We spoke with four health care professionals who were involved in the care of people living at Ridgeway Nursing Home.

We reviewed eight people's care records. We reviewed other records relating to the care people received. This included some of the provider's audits on the quality and safety of people's care, staff training, recruitment records, medicines administration records and minutes of internal meetings.

Requires Improvement

Is the service safe?

Our findings

At our previous inspection we asked the provider to take action to ensure people experienced care, treatment and support that met their needs and protected their rights. This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. At this inspection we found that adequate improvements had not been made.

We also asked the provider to take action to ensure people were protected against the risks associated with medicines because the provider did not have appropriate arrangements in place to manage medicines. This was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. At this inspection we found that some improvements had been made but that further improvements were needed.

In addition we asked the provider to take action to ensure recruitment and selection processes completed appropriate checks to ensure people employed were suitable to support people living at the service. This was a breach of Regulation 21 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. At this inspection we found that improvements had been made.

At this inspection we found that assessments of people's needs were not always reviewed to include relevant advice from other professionals and updated when their needs changed. One person was at risk of choking and their risk assessment stated they were to have a soft diet and thickened fluids. The risk assessment did not provide advice to staff on what actions to take should this person begin to choke. We observed staff provide inconsistent care to this person when they began to cough while eating their meal. The manager told us that this person's needs had changed however there was no evidence this person had been reviewed within the last 18 months by relevant professionals to ensure their care remained safe and effective.

One person had health needs that required the use of a specialised chair. We observed staff adapting this person's position in the chair by use of additional aids. Although we found an assessment involving external professionals had taken place five months ago, the practice we observed staff following was not recorded in their care plan. We could therefore not be certain the practice staff were following was safe or appropriate for this person. We made the manager aware of this and they agreed to review this person's care with appropriate professionals as a matter of urgency.

We were told some people using the service were assisted to move by staff using a hoist with different slings for individual people. We observed staff using the same sling to assist two different people, each with a different body size. When we read the care plan for one of the people assisted we found there was no risk assessment in place for the use of a sling and hoist to help assist them to move. Assisting people to move without an appropriate assessment puts them at risk of receiving unsafe care.

Some staff knew people well and we observed them engaging people in conversation and repositioning dinner tables so people could reach their food. However we also observed some staff did not have the knowledge and skills to meet people's needs effectively. We observed one member of staff removing some clothing protection from a person after lunch. This was done without the staff member checking whether that was what the person wanted and resulted in the person being shocked, upset and angry. We asked the member of staff what they knew about the person's dementia needs and they told us they did not know anything about them as they were new to the service. They told us they had not read the care plans on how to support people using the service. We spoke with another member of staff from an agency and they told us it was their first day and they felt supported. They told us they were working under the direct guidance of the nurse in charge.

Risks at the location were not identified. Heaters had been placed next to the bed of a person with dementia and we were concerned they could burn themselves. Wheelchairs and hoists were being stored in some of the bathrooms and toilets. These presented a hazard for people using these facilities independently. We found two beds designed to lift up and down were not working and no action had been taken to mend them. We also observed staff providing contradictory information on people's care and treatment to other professionals

An automatic device for keeping a door open was broken and the door was being propped open with a chair. This meant that this door would not automatically close in the event of a fire and people's safety would be compromised. We found personal emergency evacuation plans recorded

Requires Improvement

Is the service safe?

the wrong room number for one person using the service. This information is required to be accurate so that in the event of an emergency people can be found in their rooms and evacuated quickly. We asked the manager to update this information on the day of our inspection.

The above were breaches of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 9 and 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found that one part of the building was colder than the rest and extra heaters had been put in place. We ran the water for over one minute in people's en-suite bathrooms in the colder part of the building. The water was only slightly warm after being on for one minute. The showers in these bathrooms were run from the same mains water supply as the taps. The water was not warm enough for people to take a shower. We asked staff about the water and room temperatures in this part of the building. They told us it was always cold and there was not an adequate supply of hot water. When we looked at the bathing records for people in this part of the building we found that a significant proportion of them were given bed baths rather than being assisted to shower. For one of these people we found that before moving to the service their preference had been to have a shower every morning.

This was a breach of Regulation 15 of the Health and Social Care Act 2008 (regulated Activities) Regulations 2010, which corresponds to regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw the medicines administration record (MAR) chart had not been consistently completed to detail the reason people had not received their medication. We found people were prescribed medicine to take 'as required'. Guidance did not contain sufficient detail to ensure staff would be able to make consistent judgements on when these people should receive their 'as required' medication. This meant that people using the service were at risk of not receiving medicines when they needed them.

Some people refused their medicines and staff administered their medicines covertly by mixing medicine in food or drink. However, care plans did not contain clear guidance for staff to follow and did not include advice from other professionals. For example, one care plan stated 'give medicine covertly in food and drink.' This did not detail how medicine should be prepared and mixed with only small amounts of food and drink to maximise the chances of it all being taken. Another person did not have a care plan in place to cover the administration of covert medicine.

These were breaches of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The manager told us that she had determined the level of staff required was based on the needs of people living at the service and that this was reviewed as people's needs changed.

One family member told us, "Some good staff have left and there are a lot of new faces." They told us they were worried about nursing levels and concerned that using agency nurses was not as good as getting permanent staff. Two healthcare professionals we spoke with told us they had noticed recent changes in staff and one of them told us they were concerned that staff who they considered to be good had left.

On the days we visited the levels of staff required to meet people's needs as identified by the manager had not been provided. One person using the service told us, "Sometimes there is not enough staff, they do put on them." Some family members we spoke with told us they had visited and there had been no staff in the lounge with people. One family member us, "Staffing levels have been stretched, sometimes it's only been me sitting there in the lounge with all those people." Other family members told us they had not noticed any concerns with staffing when they visited.

During our visit we observed periods of time when no staff were available in the main lounge area where people using the service were seated. Some people in the lounge area at these times were vulnerable to falls. In other areas of the service we found a person who was not able to use a call bell and whose bag that they wanted had fallen out of their reach. We do not know how long they had been waiting for staff to assist them. We observed another person asking to be assisted into the lounge. This person waited 20 minutes before staff were able to assist them. We observed staff rushing between tasks during lunchtime. This resulted in

Requires Improvement

Is the service safe?

staff not noticing one person's dinner table not being positioned close enough to them and their food being spilt as it was too far away from them when they attempted to eat it.

These were breaches of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff were checked to make sure they were suitable to work with people using the service. This included checks on people's identify and Disclosure and Barring Service (DBS) records. We found one person's employment history had not been fully checked. The manager did not know why this had not been checked but confirmed it would be completed.

Staff told us they received training in safeguarding people to keep them safe. We found that staff understood how to report safeguarding concerns and their knowledge on safeguarding had been checked by their manager as part of their supervision and appraisal. This included identifying different types of abuse and how to report any concerns. Staff we spoke with told us they would be confident to report anything they were concerned about to the local safeguarding authority.

The manager told us they were part of a local safeguarding forum to help keep up to date on keeping people safe. We found information was on display about safeguarding adults, however this was out of date and contained incorrect contact information. We made the manager aware so this information could be updated.

Requires Improvement

Is the service effective?

Our findings

The manager and staff were not able to consistently identify which residents were subject to a Deprivation of Liberty Safeguards (DoLS) authorisation. DoLS is a law that requires assessment and authorisation if a person lack mental capacity and needs to have their freedom restricted to keep them safe. There was a risk staff could subject people to unlawful restrictions or not correctly implement their DoLS authorisations. Staff had not been supported to consistently know which people using the service had a DoLS authorised.

Where mental capacity assessments had been completed for people we found these did not meet with the full requirement of the Mental Capacity Act (MCA) 2005. The MCA is a law providing a system of assessment and decision making to protect people who do not have capacity to give consent themselves. For one person we found their next of kin had signed a consent form for the person to receive preventative vaccinations. There was no assessment of this person's capacity or details of any decision making that would determine if the vaccination would be in that person's best interests.

Two people using the service received their medicines covertly. Mental capacity assessments had not been completed to determine that people lacked the capacity to make decisions to refuse their medication. No best interests meetings had been recorded to show how people who knew them well, including their doctor and any other relevant professionals had decided that it was in each person's best interests to receive their medication covertly.

These were breaches of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked the manager about the induction received by agency staff and staff from the provider's other homes when they were asked to cover shifts at the service. The manager told us staff would work with an experienced member of staff to get to know people before working on their own. From our observations, some new staff were working to support people using the service without adequate skills and knowledge to meet people's needs.

We spoke with staff who worked directly supporting people with dementia and some of those staff told us they had not been trained in dementia care and some of their training was not up to date. During our inspection we observed some staff interact with people without showing an awareness of how dementia affects people's communication, memory and mood. For one person, one interaction left them angry and upset. The manager told us training for some staff needed to be updated and that the training matrix was not accurate and was going to be updated. There was no clear evidence that staff had received appropriate training to meet the needs of people using the service.

We recommend that the service finds out more about training for staff, based on current best practice, to ensure that staff have the skills to meet the needs of people using the service.

Families we spoke with told us they were happy with the food prepared for their relatives. One person told us, "The food is excellent," and another family member said, "The chef is amazing, and they will always offer an alternative." The food we saw looked attractively presented and we observed people asking for more food and this was provided.

We observed that some people had not taken their meals or drinks. We observed one member of staff staying with a person to ensure they understood their dinner was ready to eat. However, we also observed other staff taking meals and drinks away without prompting or encouraging further attempts at eating and drinking. We looked at the care plan for one of these people and it stated that this person required prompting with meals as they could forget to eat because of their dementia. People were not always supported to take appropriate food and fluids by staff to protect them from nutritional risk.

We found no action had been taken when records showed a person had lost weight. We found other people's day to day needs were not always met. One person was not able to complete their own mouth care and was dependent on staff providing this care. Records showed periods of time where this care had only been provided once a day instead of twice a day. For the month prior to our inspection mouth care for this person had not been recorded as being provided at any point throughout the day.

Requires Improvement

Is the service caring?

Our findings

We found not all staff supported people to maintain their independence. One person using the service had eaten their lunch independently. We observed one member of staff began assisting to feed this person their pudding without communicating with them. This person was not given the opportunity to use and maintain their skills and independence.

We found that communal toilets were not available for people to use without staff assistance. Some toilets were kept locked, while others could not be locked from the inside to ensure people's dignity. In one toilet the hand wash basin was inaccessible because of the amount of wheelchairs in front of it. This meant people who did not have access to their own en-suite toilet had to ask staff for assistance, even if they could have completed this task independently. This impacted on people privacy and dignity.

These were breaches of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Family members we spoke with told us they thought staff were caring. One family member told us, "It feels as if staff have got that extra special touch." Another family member told us, "The staff are the best asset."

Our observations showed most staff engaged positively with people using the service during everyday interactions. For example, some staff made conversation with people when assisting them with their lunch. At another time when staff had assisted someone with their medicines, the person told the member of staff, "You're a good one, I wish you were my friend." The staff member responded kindly with, "I am your friend." However we also observed other staff not talking to people during these opportunities for conversation. This meant the quality of contact people using the service received varied.

We found that staff had taken steps to understand the people they were caring for. One family member we spoke with told us that the manager had visited their relative before they went to live at the home. They also told us that staff had shown them the care plans for their relative. Another family member we spoke with told us, "Because of the dementia, staff have really paid attention to what [my relative] is like. They've got to know [my relative] really quickly." Another person living at the service did not have English as their first language. We found pronunciation guides for everyday phrases in this person's first language had been made available for staff to use when supporting them.

Requires Improvement

Is the service responsive?

Our findings

Information about people's health and care needs were recorded in people's care plans. However we were concerned that this information was not always an accurate record of the care people had received. Where people's needs had changed there was not always evidence that appropriate actions had been taken. We found that one person had lost weight and their doctor recommended their weight was monitored on a weekly basis. No weekly weights were recorded for this person so there was no evidence that this person's needs were being met or monitored.

We found that staff were recording the amount of fluids some people were having each day. Records for two people showed they had received low levels of fluid intake over consecutive days. As these records had not been analysed or any action taken this meant that there was a risk these people had not received appropriate care and support and that they were at risk of dehydration. Records had not been checked to ensure they reflected accurately the care and treatment people were assessed as needed.

Information on people's histories and interests was used to help support people with their hobbies. We spoke with one person who enjoyed knitting and a family member told us staff took in DVDs they thought people may enjoy watching. Another family member told us their relative had enjoyed a performance by a local brass band. One family member we spoke with told us they were made to feel welcome, they told us, "It's a bit like a little family." However, we also observed people during our inspection receiving very limited interaction with staff, other than when care tasks were being provided.

We found that people's preferences had been recorded in their care plans, however people's preferences were not always supported. We observed one person having their dinner in the lounge when their care plan recorded their wish to eat in the dining area. This person had dementia and we were concerned that their preferences were not respected. People with dementia may find eating in a dining room environment stimulates their appetite more.

Information on how to complain was displayed and the service had a system to manage any complaints received. However, we found information on how to complain was missing from the guide book produced for people using the service. We bought this to the manager's attention so this could be amended.

The manager told us they had analysed complaints received in the last year and as a result had replaced some areas of flooring. One family member we spoke with told us they were consulted about some changes and their preferences were taken into account when changes to the flooring were made.

Dates for monthly meetings with relatives were displayed on the main notice board. Records showed that the manager met with families and people using the service. Although not many people attended the meetings, we found that people who did attend were able to ask the manager questions and give feedback.

The manager had recently asked people using the service and their families about their experiences of living at the home. The results had been received and the Manager told us they would be used to identify any improvements needed.

Inadequate

Is the service well-led?

Our findings

At our previous inspection visit we asked the provider to take action to ensure an effective system was in place to identify, assess and manage risks to the health, safety and welfare of people who use the service and others. This was a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. At this inspection we found that adequate improvements had not been made.

We also asked the provider to take action to ensure accurate and appropriate records were maintained so people were protected from the risks of unsafe or inappropriate care and treatment. This was a breach of regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. At this inspection we found that adequate improvements had not been made.

At this inspection visit we found monitoring procedures had not identified risks or failings in the service. This included repairs needed to beds, door closers and the hot water and heating systems to sections of the building. Failings had not been identified where records were not accurate and where assessments were not up to date. Monitoring had not identified risks of inappropriate storage of equipment in communal toilets and bathrooms and that people using the service could not independently access the toilets. This meant that risks to people were not being managed.

We looked at the procedures for assessing and monitoring risks from infections. We found the system used to ensure mattresses were clean was effective. Audits of the daily cleaning schedules had not identified that all rooms were not being wiped down and vacuumed or that from November 2014 areas for deep cleaning had not been completed as planned. When we asked staff what had changed they told us they had less staff and they struggled to cover certain periods of time especially when people took holidays. This had not been identified by the manager for improvement.

We found staff had raised concerns over being short of staff in a team meeting over a month before our inspection. We also saw an official complaint written by staff to the provider the week before our inspection. This expressed staffs' concerns that people using the service were not getting the care they needed because there were not enough staff to meet the staffing levels identified as required by the manager. The manager told us the provider had responded and had agreed to provide additional staff from agencies and from the provider's other services. This had been agreed the week before our inspection. We could not see that the provider had responded to staffs' original concerns raised over a month before.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During this inspection some people received care in their rooms. The care plan for one person cared for in their own room stated they received close observation from staff. This was because they had complex needs and they would not be able to use the call bell to ask for assistance. Staff told us they checked on this person every hour. We found this person in distress and their records for their hourly checks had not been completed for three hours. We spoke with a member of staff about this and they then completed the three missing records to say hourly checks had been completed. This meant that records were not being completed contemporaneously and it was unclear what support had been provided to this person during this time. People using the service were not protected against the risks of unsafe or inappropriate care and treatment as records were not properly completed.

This was a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the time of our inspection the manager had not registered with the Care Quality Commission to become the registered manager. The manager had been in post since August 2014.

Recent staff changes had affected the amount of senior level support to the manager. The manager had put plans in place to ensure the position of deputy manager would be filled but this had not been finalised at the time of our inspection.

The manager told us she had support from the operational manager and also the owner. However concerns over

Inadequate

Is the service well-led?

staffing levels had been raised over five weeks before any agreement for extra staff from agencies had been agreed from the owner. This meant there had not been a prompt response to concerns raised and resources had not been made available to drive improvement.

As part of our inspection we spoke with staff, families and other health professionals who visited Ridgeway Nursing Home. Some people told us they had shared their views with the manager and felt they had been listened to. One family member told us, "We are offered a cup of tea and can have a talk with the manager." Another person said, "The manager is approachable and always here."

However, a range of other people told us the manager had not listened to them. One person told us, "I have a problem as I can't talk to the manager." Another person told us, "[The manager] doesn't listen to anything you have to say." Other people told us they had felt reprimanded for raising concerns. We also received other information of concern that stated staff had appeared fearful and intimidated by the manager.

We reviewed minutes of meetings between the manager and staff. Although the manager thanked staff for their hard work and identified areas of improvement, the main issues addressed in the meetings were about staff conduct and performance. The manager made regular references to disciplinary action being taken against staff. When one member of staff raised a question the manager told them they would discuss it in private. There was no record of how this issue was dealt with.

We were concerned that the regular references to disciplinary action aimed at all staff had contributed to create a day to day culture where people did not feel confident to raise concerns. We were concerned that when issues were raised they were not always dealt with in an open and transparent way as meetings had recorded issues raised had been concluded in private. We were concerned that the manager was not viewed as approachable by some staff, families and other visiting health professionals. We were concerned that people would not be assured of safe and effective care if staff, families and other professionals felt they could not raise concerns with the manager.

Prior to our inspection visit we received information of concern regarding staff shortages and the management culture at the service and we spoke with the manager about our concerns. The manager told us they were committed to achieving high standards of care in the service, however they were aware they had not been able to engage all staff. We were concerned the manager felt they were not being respected by staff and that there were difficulties within the staff team. The manager told us they felt on reflection they had tried to push forward too many changes without fully listening to staff and they agreed a different strategy of working with staff was needed. The manager told us they had wanted to start again with staff and had recently invited staff for a meal to try and build up trust and teamwork.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care Service users were at risk of not receiving person-centred care because not all staff knew how to appropriately meet the needs and reflect the preferences of service users when providing care. Regulation 9.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Service users were not protected against the risks of receiving care or treatment that was inappropriate or unsafe as assessments were not in place to minimise risks to service users. Systems and plans to protect service users in an emergency had not been maintained and updated. The proper and safe management of medicines was not in place. Regulation 12.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Service users were not protected against the risks of inappropriate or unsafe care and treatment because the quality of services provided was not being effectively assessed and monitored. Systems to identify, assess and mitigate risks to service users health, welfare and safety were not effective. There was not an open culture where people felt they could safely raise concerns so an informed view in relation to the standard of care and treatment provided to service users using the service could not be formed. Records of service users' care and treatment were not always completed contemporaneously. Regulation 17.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment Service users were not protected against the risks associated with unsafe or unsuitable premises as parts of the building had insufficient heating and hot water. Regulation 15.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect Service users were not always treated with dignity, consideration and respect and their independence was not always supported. Regulation 10.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent Mental Capacity Assessments did not meet with the full requirements of the Mental Capacity Act 2005 (MCA). Where service users lacked the capacity to consent suitable arrangements were not in place to ensure all staff acted in accordance with restrictions on service users. Regulation 11.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Service users' health, safety and welfare was not safeguarded as appropriate steps had not been taken to ensure that, at all times, there were sufficient numbers of suitably qualified, competent, skilled and experienced staff deployed. Suitable arrangements were not in place to ensure staff delivered care and treatment to an appropriate standard by receiving training, professional development, supervision and appraisal as is necessary to enable staff to carry out their duties. Regulation 18.