Claremont Care Limited

Beaumaris Court Care Home

Inspection report

Beaumaris Road
Newport
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Website:

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Ratings

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

Overall summary

This inspection took place 13 October 2014 and was unannounced.

At our last inspection on 08 July 2014 we found the provider was in breach of Regulation 9 and Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. During this inspection we found no improvements had been made to meet the relevant requirements since our previous inspection.

Beaumaris Court Care Home is registered to provide nursing and personal care for up to 30 people. It is a requirement that the home has a registered manager in post. The registered manager left the home in July 2014. We were made aware of this and they have submitted an application to remove their name from our register. 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's needs were not fully met because there were not sufficient and experienced staff working at all times. Although the number of staff working was in line with the provider's staffing rationale, this had not been reviewed

Summary of findings

since our last inspection when we identified this as a breach of Regulation 22. We found that the staffing levels and use of agency staff meant that people received little consistency of care and they were kept waiting for their needs to be met.

People's individual needs were not being fully met. The provider was in breach of Regulation 9 at our last inspection and we found no action had been taken to address this. People told us they were still kept waiting for their care and their preferences were not always respected.

Staff had not received the training and support they needed to ensure they had the skills and knowledge to support people. Staff did not feel they were supported in their work by managers.

People's nutritional needs had been assessed and plans were in place to identify how much people should eat and drink to stay healthy. However, where people were not drinking enough there was no information to show what was being done to address this. People and relatives raised concerns about the quality of food the home provided and some relatives bought food in for their family members.

The provider had not responded to breaches identified at our last inspection. We found they had not taken action or consulted with staff and managers about improvements that needed to be made following our last inspection. The provider was not taking into account people's opinions in helping to improve the home and there was confusion over who was managing the home. Quality assurance systems were not effective in identifying and addressing issues to drive improvements.

We found that people and staff were confused about who was in charge of the home. Staff were motivated by their desire to provide care to people but did not feel supported by managers in delivering this care.

Staff had little understanding of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS) and the implications this had on their practice. The Mental Capacity Act 2005 (MCA) sets out how to act to support people who do not have capacity to make a specific decision. DoLS are safeguards used to protect people where their liberty to undertake specific activities is restricted.

People felt safe living at the home and risks to them had been identified and assessed for their safety. Staff understood how to support people but did not demonstrate any great understanding of how to support people to make choices and keep their independence.

The home worked closely with other healthcare professionals to make sure there was a joined up approach to meeting their health needs. This included doctors and district nurses.

Most people agreed that staff had a caring approach and were respectful of their privacy and dignity. However, we saw occasions where staff did not respect people's dignity. Staff were rushed throughout our inspection. We saw they were polite but had little time for social conversation with people.

People and relatives felt comfortable raising concerns with managers but did not always feel they were responded to.

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?

Inadequate

The service was not consistently safe.

There were not sufficient staff to fully meet the needs of people living at the home. Due to the frequent use of agency staff there was a lack of continuity of care for people.

Staff understood how to keep people safe and protect them from harm and abuse. Risks to people had been assessed but we found some had not been updated or reviewed recently.

Medicines were stored and administered safely and records showed people received these when they needed them.

Is the service effective?

Inadequate

The service was not effective.

Not all staff had the knowledge or had received the training they needed to meet people's needs. Staff did not feel supported by managers in their roles.

People did not enjoy the quality of food they received. People had been assessed in relation to eating and drinking but we found information was not available to show what action had been taken when people were not drinking enough.

Staff did not understand the requirements of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Staff did not always demonstrate respect for people's dignity.

People felt staff were caring in their approach and when they helped them with their care. They felt their privacy was respected.

People felt they were involved in their own care.

Is the service responsive?

Requires Improvement

The service was not responsive.

People felt they were kept waiting for their care and that there was a lack of consistency in the delivery of their care.

People felt their preferences were not always taken into account or respected.

People were supported to follow their social interests but this was not consistently promoted.

Summary of findings

Is the service well-led?

Inadequate 

The service was not well led.

The provider had not acted on concerns we had raised at our last inspection despite being in breach of two regulations.

People and staff did not understand who was in charge of the home and did not feel their opinions mattered.

Staff did not feel supported by managers and felt unable to raise concerns with them.

Beaumaris Court Care 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 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 13 October 2014 and was unannounced.

The inspection team consisted of two inspectors and one expert by experience. An expert-by-experience has personal experience of using or caring for someone who uses this type of care service. The expert by experience who accompanied us had experience of supporting family members who used residential care services.

Before our inspection we reviewed information we held about the home including information of concern and complaints. We looked at statutory notifications we had been sent by the provider. A statutory notification is information about important events which the provider is required to send us by law. We spoke with other agencies to ask their opinions of the home. This included the local authority and Healthwatch. We used this information to help us plan our inspection of the home.

During our inspection we spoke with seven people who lived at the home, six relatives and one visitor. We spoke with nine staff which included kitchen, housekeeping, administrative, nursing and care staff. We spoke with four of the provider's managers. At the time of our inspection there was no registered manager in post at the home. The registered manager had moved to another one of the provider's homes and was clinical lead for these two homes. We looked at four records relating to people's care. We also looked at medicine records and records relating to the management of the home.

During our inspection we used the Short Observational Framework for Inspection (SOFI) observation. SOFI is a way of observing care to help us understand the experience of people who lived at the home. We used this because some people living at Beaumaris Court Care Home were not able to tell us in detail what it was like to live there. We also used it to record and analyse how people spent their time and how effective staff interactions were with people.

Inadequate

Is the service safe?

Our findings

At our last inspection on 08 July 2014 we found that the provider was in breach of Regulation 22 of the Health and Social Care Act (Regulated Activities) Regulations 2010. This was because there were not enough qualified, skilled and experienced staff to meet people's needs. We had concerns that people were kept waiting for their care and that care staff were working in the kitchen because there was not enough kitchen staff on duty.

During the three months between this and our previous inspection we had received further concerns that there were still not enough staff on duty to fully meet people's needs. We had contacted the provider on each occasion who assured us that this was not the case and sufficient staff were on duty at all times to fully meet people's needs.

Four people who lived at the home and the relatives of three others told us there were not enough staff. One person said, "Sometimes I'm left sitting on the toilet". This person went on to explain that on one occasion they had been left on the toilet waiting for assistance for so long their breakfast had been removed from the dining room and taken to their bedroom. They told us this was because they were so late for their breakfast the staff had wanted to clean the dining room.

People we spoke with told us that agency staff were used most days. They told us most agency staff did not know how to support them and there was a lack of consistency because of this. One person said, "Agency staff are in most days". Another person told us, "There aren't as many staff here at the weekend". Another person said, "Information about me is not passed onto staff, especially agency staff. There is no continuity". Some agency staff worked at the home regularly and so had got to know people's needs and preferences. However, care staff told us that agency staff were not always given enough information about the people they supported before they started working a shift. They told us that if the agency staff were not present for the shift handover meeting there was little time to give them this information.

Two people told us they could not have their shower on a particular day recently. They were told by staff that there was not enough care staff working on these days. They told us that this happened regularly. One relative said, "There are long hours when no one is around. There are so many agency staff". Another relative said, "It's noticeably short staffed today". One staff member told us, "We are short staffed today". We saw that two agency staff were being arranged to cover the morning shift on the day of our inspection and these were confirmed at 10.20am. Staff we spoke with told us management were aware the previous day of one care staff not being able to work but had not arranged cover. The other staff member had reported sick that morning. Managers we spoke with did not feel the home was short staffed.

We saw that care staff were as rushed as they were at our last inspection. We could hear people's call bells ringing almost constantly throughout the morning and some people were kept waiting for up to ten minutes before these were answered by staff. Staff told us they tried to look after people and give them what they wanted but they were usually too busy. One staff member told us, "I feel sad that I do not have the time to sit and chat with people or get to know them properly". One relative told us, "Staff have no time to spend helping people to drink or encouraging them".

The provider was recruiting for care staff and a registered manager. The general manager told us that since our last inspection the provider had employed one care staff and enough kitchen staff to fully staff this part of the service. They told us they used agency care staff because it was the "only way to cover shifts". The head of business told us that staff often phoned in sick at short notice which created problems with arranging cover for them. They told us that disciplinary action was taken against staff who did not correctly follow the sickness reporting procedure.

We found that staffing levels had not been re-assessed since our last inspection despite managers agreeing at the time that their dependency model needed reviewing. The dependency model was used to analyse how many staff were required to support people based on their current needs. We saw this was last analysed in May 2014. We asked the general manager if this had been reviewed since our inspection in July 2014. We were told it had not.

The number of staff working was in line with the provider's staffing rationale. However, by speaking with people, their relatives and staff we found that people were not supported by sufficient staff who had the right experience to fully meet their needs. The reliance on agency staff meant that people felt they were not getting consistency of care by staff who knew their needs or preferences.

Inadequate

Is the service safe?

At this inspection we again found that there were not sufficient numbers of staff to meet people's needs. This was a continued breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We looked at the procedures followed when staff were recruited. We saw evidence that appropriate employment checks were completed on new staff. This meant the provider was following legislation and ensured staff had the required checks prior to starting work at the home.

Four people told us they felt safe living at the home. One person said, "I feel safe here". Two relatives told us they felt their relatives were kept safe living at Beaumaris Court.

Staff we spoke with had received training in safeguarding and understood how to keep people safe and protect them from harm and potential abuse. Staff understood where risks had been identified with people, such as with their mobility or with their skin. Staff knew they needed to report any concerns they had about people's safety. Managers we spoke with told us agency staff had received safeguarding training from their agency. We saw records that showed risks to people had been assessed and plans put in place for staff to follow. The plans gave instruction to staff on how to reduce risks associated with people's mobility, safety and healthcare. We did note that some of these had not been reviewed or updated in the last 12 months.

Records were kept of accidents and incidents. The head of business told us they monitored these with the general manager so they were able to identify any trends or recurring issues. They told us that one person had been assessed by their doctor and district nurse due to an increase in the number of falls they had recently. Plans were in place to reduce the risks to this person.

We looked at the management of medicines in the home and found that suitable systems were in place. Medicines were stored in accordance with good practice. People's medicine administration records were complete and up to date which showed that people received their medicine when they needed them. Policies and procedures were in place for the safe management of medicines. Staff who gave medicines had received appropriate training to ensure they were competent to do so.

Some people had their medicines 'as needed' and we saw there were clear protocols in place to support staff in the administration of these. Some people managed their own medicines such as inhalers and creams. These medicines were kept in the person's bedroom for them to use and records relating to these were up to date. Staff we spoke with understood people's medicine requirements.

Inadequate

Is the service effective?

Our findings

We looked to see how staff were trained and supported to provide consistent care based on current best practice. People and relatives we spoke with told us they thought most staff had the skills to meet their needs. Care staff told us they were suitably trained although we found this was not the case. Care staff we spoke with had a poor understanding of and could not tell us how to support people's specific needs other than their basic care needs. We saw that care staff had not received any specific training to help them meet the needs of some people living at Beaumaris Court. This included supporting people with dementia, end of life care and supporting people with communication needs to help them make choices.

All staff told us that they had not felt supported since the registered manager had left in July 2014. They told us they had been relying on colleagues for advice and support and shared information amongst themselves. They told us they had raised concerns with the management team to do with delivering care to people but felt these had not always been addressed by managers. They therefore felt more comfortable speaking with colleagues for advice and support. The clinical lead told us that nurses were expected to take responsibility for their own competencies to meet the standards required by their professional body. They told us this was not monitored or evidenced by the provider. They confirmed that nurse's competencies were not assessed or recorded within the home.

We saw a training matrix which we were told was up to date. This showed that not all care staff had received training in the areas considered necessary for them to carry out their roles safely and effectively, such as safe moving and handling and safeguarding. We saw that out of 39 care staff only 19 had received training in moving and handling. The matrix stated that only four out of these 19 staff had moving and handling training that was in date. We saw that 29 care staff out of 39 had received training in safeguarding. Five of the ten care staff who had completed their safeguarding training had gone past their dates for updating this training. Care staff at the home supported people who could have limited or no capacity to make their own decisions. Training in the Mental Capacity Act 2005 would give staff the knowledge they needed to make sure people's rights are upheld. We saw that out of 39 care staff only 12 had been trained in the Mental Capacity Act 2005.

This was a breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

All the people we spoke with expressed concern over the quality of food they received, although on the day of our inspection we saw the lunchtime meal looked appetising. One person said, "A cup of soup and a roll is not enough at teatime". Another person said, "Don't bother asking for hot drinks. [Name of staff member] says we can have a drink when we want. Try asking, it's the shortage of staff". A visitor told us, "I often visit [name] and although they have a drink, it often isn't within reach". Two relatives told us they bought food in for their family members so that they were satisfied they had enough to eat as they did not like the choices on offer.

We saw that kitchen staff supported people to eat in the dining room and care staff supported other people with their meals in their own rooms. Kitchen staff told us that if there were any changes to people's diets the nursing staff would inform them. They informed care staff if people had not eaten their meals and this was recorded by care staff. Kitchen staff we spoke with understood and catered for the dietary needs of people on special diets, such as people requiring soft diets and those who were diabetic.

We found that people had received nutritional assessments to assess their risk of dehydration and malnutrition. Their weight was also recorded. We looked at four records and saw three people showed a steady fall in weight. One person was last weighed 09 August 2014 and their care plan said to 'encourage food and fluid'. We asked staff how they encouraged people to eat and drink enough. They told us they would encourage people but that it was their choice if they refused. We found that because people had capacity to make their own decisions it was their choice to refuse food and fluid. However, we saw no evidence to support this choice or how this was being addressed or reviewed when staff knew people were not eating or drinking enough.

Other records showed that although people's food and fluid needs had been assessed these were not always being monitored. One person's fluid chart showed that for the week before our inspection they had received below their recommended fluid level. There was no information to show what staff had done about this. We spoke with the clinical lead about what actions were taken when people's

records showed their fluid intake was low. They told us that people's charts were passed to head office where they were monitored. They told us that issues were taken up but could not give details about specific people.

This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We saw that people were free to move around the home and we did not see any restrictions put on people. We found that most staff had not received training in the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). Those we spoke with did not understand how to support people in line with the MCA or how to support people to make decisions if they did not have capacity. Staff we spoke with gave us conflicting information on whether people living at the home had capacity to make their own decisions. MCA sets out how to act to support people who do not have capacity to make a specific decision. DoLS are safeguards used to protect people where their liberty to undertake specific activities is restricted. Staff we spoke with were not clear about the implications of these, such as what the MCA said in terms of people's capacity to make decisions. We were told by management that no one was subject to a DoLS authorisation and they were aware of the recent Supreme Court ruling for submitting DoLS applications.

We saw that staff were giving one person their medication covertly. Records we looked at showed that this person had been assessed by appropriate healthcare professionals and this decision and protocol was fully documented and authorised. We saw records of consent in people's care records. This showed they had agreed to care being delivered by staff.

We found that suitable systems were in place to support people with their health care needs. People told us a doctor came to the home every week. A chiropodist and optician also visited if people required appointments. One person told us that they went out to see their optician and that a staff member went with them to support them. We saw that the home worked with other healthcare professionals to make sure people's health needs were met, such as doctors, district and tissue viability nurses. We saw that referrals to other healthcare professionals had been made promptly by staff when concerns were identified.

Requires Improvement

Is the service caring?

Our findings

Most people told us they thought the staff had a caring approach and their privacy and dignity were respected. One person said, “My dignity and privacy are maintained”. However, one person said, “The older staff are far more caring”. Relatives told us they were welcomed by staff when they visited their family members. They told us they were able to visit at any time and that staff respected their privacy when they were visiting.

We saw that people’s dignity was not always respected. Whilst one person was speaking with us a staff member approached them. The staff member started speaking to this person about an aspect of their personal care in front of us. On another occasion we saw a staff member walking through the dining room at lunchtime. As they were walking they shouted across the room to one person, “Have you got your food protector on?” When they saw this person had got their ‘food protector’ on they carried on walking through the dining room without any further acknowledgement to the person. We saw that this person was left visibly confused by what had been said.

We saw that staff were polite, respectful and friendly but did not have time for pleasantries or conversation with the people they cared for. Care staff we spoke with knew people’s basic care needs and how they needed to support them. When they spoke about the people they cared for they did so in a kind and compassionate way.

We saw that kitchen staff were attentive to people who had their meal in the dining room. They were present in the dining room and offered support to people when this was needed. They spoke with people, engaged them in conversation and helped to make sure the mealtime was a relaxed experience. We saw people had appropriate cutlery and aids to help promote their independence and diverse needs when they were eating.

People and their relatives felt involved in planning and making decisions about their care. One person told us their care was fully explained to them. One relative said, “I am involved about decision making about [person’s name]”. However, some people told us that because all care staff were often busy they did not feel they were listened to. Because of this they felt they were not in control of their own care. One person said, “I do not feel listened to”. All the people we spoke with told us they thought the staffing levels and use of agency staff affected the consistency of their care and the speed of staff’s response when they wanted help. They told us that they did not feel agency staff knew what their needs were.

People we spoke with told us they did not always receive their care and support when they needed or wanted it. They also spoke about agency staff not knowing them. One person said, “Agency staff don’t know anything about me. Some staff just do the job and are not really interested”. Another person said, “Care is carried out with no explanation”.

Care staff we spoke with had little understanding of how to promote people’s independence or respect their choices and why this was important. They were not able to explain how they could assist people to make choices if communication was difficult or how they could help them keep their independence. A member of staff told us that they usually knew what people wanted because they had got to know them. But they could not tell us how they supported people to make choices other than offering them a choice of drinks.

Requires Improvement

Is the service responsive?

Our findings

At our last inspection on 08 July 2014 we found that the provider was in breach of Regulation 9 of the Health and Social Care Act (Regulated Activities) Regulations 2010. This was because although care and treatment was planned it was not delivered in a way that fully met people's needs.

Since our last inspection we had received further concerns from relatives and staff that people's assessed needs were not being met. We had contacted the provider on each occasion who assured us that people's needs were being met.

We saw that staff were as rushed as they were at our last inspection. One relative told us staff were always in a rush and that this had an impact on how staff delivered care. They said, "Sometimes staff don't have the time to ensure [person's name] teeth are cleaned". There were long periods of time when there were no staff visible in the corridors or communal areas as they were helping people in their rooms. We observed that this impacted on other people who were waiting for their call bells to be answered. We also saw that people who sat in the lounge had no interaction or stimulation from staff for most of the day.

People's care needs had been assessed and we saw plans of care were in place. We found that there was little detail on people's preferences, interests or wishes on how they wanted to be looked after. One person told us that they did not feel their preferences were respected even though they had told staff what they wanted. They said, "I was woken at 3.45am by staff putting my light on to change the water in my jug. I have told them I do not want disturbing between going to bed and 7am". Staff told us they got to know people's preferences as they got to know the person and not from information gained in their care records. They told us this was because they did not have the time to sit and read them. They told us new staff or agency staff would rely on the existing staff sharing this information verbally with them. This meant there was a risk of people not being at the centre of their own care and staff not knowing their wishes on how they wanted to be cared for.

At this inspection we again found that the arrangements did not ensure that people's care was delivered in a way that met their assessed needs. This was a continued breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People's care plans that we looked at showed that some had not been reviewed recently. The clinical lead told us that these should be reviewed monthly but some had not been updated since July 2014. They told us that nursing staff had been told to prioritise these reviews. Therefore there was a risk of people not receiving the appropriate care and treatment because people's care records had not been reviewed or updated.

We looked at the arrangements for supporting people with their hobbies and interests. We found that when the 'activities worker' was on duty group activities were arranged that people were keen to take part in. The activities worker worked four days a week from 8.30am until 3pm. When this worker was not on duty care staff did not have time to support people in this way. People and relatives told us they enjoyed the activities and events they took part in when the activities worker was at the home. One relative told us the activities worker got as many people involved as possible. They told us the activities worker spoke with everyone to find out what they were interested in and to make sure their interests were catered for. Care staff told us that because they were busy supporting people with their care needs they did not have the time to sit and talk with people or help people with any hobbies or interests.

We looked at the arrangements for listening and learning from people's experiences and complaints and found these were not always effective. Relatives told us they felt comfortable to raise concerns but they were not aware of the provider's complaints procedure. One relative told us they raised complaints verbally and were happy with the responses they received. They said, "I make sure I get results". Other relatives told us they made complaints verbally but nothing happened. One relative told us, "They listen to the complaints but they do nothing, only minor things get actioned". One relative told us they had reported a fault about a piece of equipment two weeks earlier. They said, "I told them at least two weeks ago and it's been written in the book but it's still not working". This meant people could not be assured that their concerns were taken seriously and acted upon.

We spoke with the managers about what complaints they had received and the actions they had taken. They told us they had received 'fewer than 10' complaints in the last 12 months. The head of business told us that they spoke with

Requires Improvement

Is the service responsive?

people and relatives regularly and this gave people the opportunity to share concerns and complaints with them directly. They had no records to show what issues had been raised and whether these had been addressed.

We saw a resident's meeting was due the day after our inspection which indicated that families were welcome to attend. One person told us that only five people living at the home went to these meetings because most people living at the home were not able to attend. They said, "Minor changes happen but not the big things, everything else just gets forgotten".

Inadequate

Is the service well-led?

Our findings

The home does not have a registered manager in post. The previous registered manager had notified us that they would no longer be in post from 17 July 2014 and was now managing another one of the registered provider's homes. They confirmed that they had no management responsibility for the home but was the clinical lead for Beaumaris Court and another of the provider's nursing homes. They were present at the home on the day of our inspection. The head of business told us they were currently recruiting for a new manager at the home.

People and staff we spoke with were not sure who was managing the home. We asked the four managers present who had managerial responsibility and accountability for the home. The head of business said, "I think that would be shared between myself and [name of the general manager]". When pressed they confirmed that they had joint managerial responsibility for the home. The head of business told us they had accountability for the home.

We found the culture of the home was not open or responsive. People, relatives and staff told us they did not feel involved or included in what happened at the home. People and relatives told us they felt their complaints and concerns were not always addressed by the management team. People told us they sometimes did not feel listened to or their wishes respected by care staff because they were too busy. Staff told us they did not feel involved in developing the home and they felt their opinions did not matter. Staff told us they had regular staff meetings but felt there was little open or honest communication from the managers. One staff member told us that staffing levels were raised at each staff meeting. They said, "We're told there are enough (staff) and that's it".

We asked the head of business to explain the culture of the home. They spoke about the values and culture of the home and that staff were made aware of these at induction and through their staff handbooks. They said managers lead by example and that staff must feel they can whistleblow and raise concerns. Staff we spoke with were not able to tell us the values or culture of the home. One staff said, "I don't feel comfortable raising concerns as I've not been taken seriously before". Another staff member said, "Management are always right and do not like to be questioned".

We asked staff if the provider or managers had shared feedback from our last inspection or spoken about improvements that needed to be made. They told us they had received no feedback and were only aware of our report from reading it on our website. This meant the provider and managers were not involving staff in developing and helping to improve the service provided.

We asked the clinical lead and the general manager about what actions or improvements they had put in place since our last inspection. They told us they were not aware of any improvement plans and had been given no direction by the provider on any actions they needed to complete. We asked them if they were aware the provider was in breach of two regulations. They told us that they were not aware. This meant that managers did not have a shared understanding of the key concerns and risks at the home.

We asked the head of business what improvements had been put into place since our inspection on 08 July 2014. They told us that the provider was currently recruiting new care staff and that the kitchen service was now fully staffed. The managers told us about a new quality assurance auditing system they planned to put in place to monitor quality at the home but this was not yet implemented.

We looked at how the provider ensured the quality of the service the home provided. We found that there were no effective quality assurance processes in place to monitor and assess the quality of the home. Throughout our inspection we gave the four managers present opportunities to show us evidence of how they monitored and assessed the quality of the home and they could show us very little. Although the provider was in breach of two regulations we were given no evidence to show any plans for improvement or actions that had been taken since our last inspection, other than recruiting more kitchen staff. We also found that the managers had not re-assessed the dependency model they used to review staffing levels. This was despite managers telling us at our last inspection that they would.

Satisfaction surveys were used to collect the views of people who lived at the home. We were shown a report following the most recent of these from 2014. The survey found that people had raised concerns about the quality of the food provided. We asked what action they had taken in response to these findings. The managers told us that following this feedback they were working with the kitchen staff to improve the menus and choices on offer.

Inadequate

Is the service well-led?

We were told that two of the managers did a walkthrough of the home daily where they would talk with people and staff and identify any issues, such as maintenance that was required. They also told us they had spoken with every relative to ask for their feedback. There were no records of this feedback or of any actions that were planned or had been taken as a consequence. The managers agreed that these discussions should be recorded in the future so actions can be addressed and audited.

We found that some of the quality monitoring systems in place were not being consistently used. For example, the clinical lead told us that care record reviews and medicines audits should be completed monthly. They told us these had not been completed since July 2014 and therefore were three months overdue. They told us that care records had started to be updated and they had allocated this task to nursing staff.

The provider's quality assurance systems had failed to identify the shortfalls we found at our inspection. Their systems had not been effective in identifying a lack of clear action for people losing weight, people not receiving personalised care, training and support for staff and nurses competency monitoring systems. They had also failed to show actions or improvements since our last inspection.

This is a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services **The provider had not taken appropriate steps to ensure the delivery of care was always meeting people's individual needs and ensuring their safety and welfare.** **Regulation 9 (1) (b)(i)(ii)(iii)(iv).**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010 Meeting nutritional needs **People were not protected against the risks of inadequate nutrition and hydration.** **Regulation 14 (1) (a)(c), (2).**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing **People's health, safety and welfare was not safeguarded because the provider had not taken appropriate steps to ensure that all times there are sufficient numbers of suitably qualified, skilled and experienced persons employed to meet people's needs.** **Regulation 22.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff **The provider did not have suitable arrangements in place to ensure persons employed for the purpose of**

This section is primarily information for the provider

Action we have told the provider to take

carrying out the regulated activities were appropriately trained and supported to enable them to deliver care and treatment to people safely and to an appropriate standard.

Regulation 23 (1)(a), (2), (3)(a)(b).

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers People were not protected from unsafe or inappropriate care as the registered person did not regularly assess and monitor the quality of services provided. Regulation 10, 1 (a) (b), 2 (b) (i) (v)

The enforcement action we took:
We have issued a warning notice. The provider is required to be compliant by 10 March 2015