High Oak Care Limited

Rosewood Care 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?	Requires Improvement

Overall summary

The inspection took place on the 9 and 12 January 2015 and was unannounced. At our last inspection on the 17 April 2014 the provider was not fully compliant with the regulations inspected.

Rosewood Care Home is registered to provide accommodation and support for 43 older people with dementia. The manager present had recently been appointed and was currently going through the process to become a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act (2008) and associated Regulations about how the service is run.

We last inspected the service on the 17 April 2014 and at this inspection we found the service was not meeting the regulations we inspected. We found that there were not

Summary of findings

enough staff to keep meet people's care needs safely. We asked the provider to send us an action plan outlining how they would make improvements and we considered this when carrying out this inspection.

We found that the provider had not addressed the concerns from our previous inspection in April 2014. The provider had increased the staffing levels on the morning and afternoon shifts but they were using the staff to work in the kitchen rather than providing care. This meant that there was still not enough staff caring for people to keep them safe. Our observations were that people were being left in the lounge area with no staff to support or monitor them and as a result people were arguing amongst themselves or not being responded to in a timely manner when assistance was needed.

We found that staff were not being deployed appropriately to ensure people could be supported safely.

We found that the levels of agency staff being used in the home to manage the shortfall in staffing was impacting on the quality of care people were receiving. This led to an agency staff member being asked to leave the home by the manager due to their behaviour on the day of our inspection.

The Mental Capacity Act 2005 (MCA) sets out what must be done to make sure that the human rights of people who may lack mental capacity to make decisions are protected, including when balancing autonomy and protection in relation to consent or refusal of care. The MCA Deprivation of Liberty Safeguards (DoLS) requires providers to submit applications to a 'Supervisory Body' for authority to deprive someone of their liberty. We found that people's rights were not being protected in line with the legislation. Staff we spoke with had not had any training and where people who lacked capacity were unable to give consent or their liberty was being restricted the appropriate actions had not been taken. Staff did not have the appropriate skills and knowledge to ensure the MCA was being adhered to.

We found that people were relaxed amongst staff and did not show any anxiety when being cared for by staff. People we spoke with told us the staff were good, and that they were able to make choices in how they were cared for. Our observations were that staff knew how to care for people, on occasions agency staff we observed were not so caring with their approach to people. This meant that people could not always be sure as to how staff would interact with them.

We found on one occasion the service was not as responsive as it should be. One person who was poorly and in their bedroom was calling for staff support as the alarm cord was out of their reach. It was unclear as to how long they had been calling for help. This meant that when the person needed assistance they were unable to get it.

We found that people's preferences and interests were generally recorded, but staff were not consistently ensuring they were met. The staff provided activities as a way of stimulation but they were not being provided often enough and were not what people had identified as their preferences.

We found that there was no system in place so people and their relatives could share their views on the service they received so the provider was able to make improvements where required.

The provider had systems in place so people could make a complaint if they wanted too. People we spoke with told us they were not all aware of the process and relatives said they would speak to the manager if they had a complaint. We found that the provider also sent out a questionnaire to gather people's view, but the information gathered was not being analysed in order to improve the service.

We found that the service was not well led because the provider and the manager did not have a proper reliable and consistent auditing system in place to monitor the quality of the service to ensure it was being delivered safely and how people wanted it. We found that records were not accurate, consistent and in some cases there were non-existent. This meant we were not always able to verify what was being done.

There was no effective system in place to ensure that the service was meeting people's needs and be compliant with the law.

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 safe.

Since the last inspection in April 2014 staffing levels were not improved sufficiently to ensure people could be cared for safely. People were not being sufficiently supported due to there not being enough staff.

We found that agency staff that were being used to cover the shortfall in staffing were not supporting people as they wanted to be supported.

We found that staff were not being deployed appropriately to ensure people's safety.

We found that risk assessments were not being carried out consistently.

Is the service effective?

Requires Improvement

The service was not effective.

We found that staff were unable to explain what the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) meant as they had not received any training. People were at risk of being restricted by staff that were not following the appropriate legislation.

We found that people's care needs were not being reviewed consistently and where this did take place people or their relatives, as appropriate, were not involved.

Is the service caring?

Requires Improvement

The service was not always caring.

We found that when people were in their bedroom they were not always able to get assistance when they needed it.

People spoke about staff positively. We saw that people were not anxious around staff and people told us that staff were 'Caring' and 'Kind'.

Staff were observed supporting people appropriately. Staff we spoke with knew about people care needs and how they were to be supported.

People were able to make their own decisions as to how they were supported or cared for.

We found that people's privacy and dignity was respected by staff.

Is the service responsive?

Requires Improvement

The service was not responsive.

People told us they were not always involved in their assessment of need and care planning process.

Summary of findings

We found that there was no proper system in place so people could share their views regularly with the provider.

People were not always able to get their preferences met.

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

Requires Improvement

We found that care records and documentation used to manage the service was not up to date or consistently being used appropriately.

We found that the provider had recently appointed a manager who had already taken action to rectify some of the concerns identified and register with the Care Quality Commission.

We found that audits were not being carried out by the provider or the manager to ensure the quality of the service was good and that people received a service that met their needs.

Rosewood 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 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.

Our inspection took place on the 9 and 12 January 2015 and was unannounced. The inspection was conducted by two inspectors on the 9 January and one inspector returned on the 12 January to complete the inspection.

Before the inspection the provider completed 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. Before the inspection we reviewed information we held about the home, this included information received from the provider about deaths, accidents/incidents and safeguarding alerts which they are required to send us by law.

We requested information about the service from Dudley Local Authority (LA) and South Staffordshire County Council. Both have responsibility for funding people who used the service and monitoring its quality.

On the day of our inspection there were 35 people living in the home. We spoke with six people, four relatives, two health care professionals who were visiting the home, six members of staff , the deputy manager and the recently appointed manager who was currently going through the process of being registered. We looked at the care files for four people, the recruitment and training records for two members of staff and records used for the management of the service; including staff duty rosters and records used for auditing the quality of the service.

We 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 with us.

Requires Improvement

Is the service safe?

Our findings

We last inspected this service in April 2014 where we found that there was not always sufficient numbers of staff to meet people's needs or keep them safe. We asked the provider to send us an action plan outlining how they would make improvements. The provider told us they had increased the amount of staff available on the morning and afternoon shifts and were recruiting more staff.

We found on our arrival to the home that whilst there were more staff available overall, they were working in the kitchen and were not involved in providing care and support to people using the service. A number of staff we spoke with told us there was not enough kitchen staff, so care staff were providing support in the kitchen every day. We spoke with a number of people and comments received included, "Staff respond moderately quickly, but they say 'I only have one pair of hands' ". Another person said, "There is not enough staff, at night time when staff are stretched I have to wait for a long time". Two relatives we spoke with also commented on the low number of staff and one person said, "There is not enough staff, the staffing varies some days there are more staff than other days". A member of staff we spoke with said, "There is not enough staff, we have to rely on agency staff, who do not always turn up". We spoke to health care professionals who were visiting the home and they also commented on low staffing levels.

Our observations were that there was not enough staff available to provide support that was needed, people were left in the lounge with no one to support or check on them. At lunch time one person said, "Can you help me, I have been shouting for staff but there is no one". On another occasion we witnessed two people arguing and shouting in the lounge at each other. There were no staff in or around the lounge area to calm the situation down or even witness it. There were insufficient numbers of staff on duty to keep people safe or to provide the support that they needed.

We found that the provider had accepted a number of applications for people to be admitted for short term respite care. No increase in staffing numbers had been arranged to ensure that the care needs of all the people would be met. This put the safety of people using the service at risk and failed to ensure that their support needs would be met.

On the second day of our inspection we found that action had been taken by the manager to increase the staffing levels and extra staff were on the morning shift as a result of the feedback we gave the manager from the first day's inspection. However, there were still long periods of time when people were in the lounge area on their own with no staff checking or monitoring them. We found that how staff were being deployed was not sufficient to ensure people were supported safely. One person in the lounge asked us to help them sit down, which we supported them to do. We observed someone left in a wheelchair for over an hour in the lounge area while staff tried to find the appropriate equipment to transfer the person appropriately into a chair. Eventually after an hour one member of staff supported the person into a lounge chair without the use of appropriate equipment which had been identified as necessary for safely moving the person.

This lack of suitable numbers of skilled staff available to meet people's needs was a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People made a number of positive comments about their own safety, which included: "Oh yes I feel safe", and "Yes I feel safe when staff are transferring me". One relative said, "I do believe [relative's name] is safe" and another person said, "I do think [person's name] is well cared for and safe here".

The staff we spoke with told us they knew how to keep people safe and they told us that if they suspected abuse they would go straight to the manager. Some staff told us they were trained in safeguarding, however one member of staff we spoke with told us they had not received training in how to safeguard people. There were no records available to confirm which staff had received training in safeguarding. Our observations were that people were not at any immediate risk of harm. Staff interactions with people were relaxed, caring and kind and they knew how to support people safely.

The staff we spoke with told us they had completed a Disclosure and Barring Service (DBS) check as part of being appointed into their job roles. This check was carried out to ensure that staff were able to work and they would not put people at risk of harm. We found there was also a declaration process being used by the provider to ensure staff's on going suitability to work with vulnerable people. We found that the provider had a recruitment process in

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Is the service safe?

place as a way of determining whether potential staff had the right skills and experience for the job. Two references were also being sought from previous employers as a way of checking staff's character. We found that an induction process was in place that staff confirmed. This included newly recruited staff shadowing existing staff to gain the knowledge they needed. This gave assurances that staff were being recruited appropriately.

We found that risk assessments were undertaken to identify where there may be potential risks to how people were being cared for. However, they were not being used in every situation. Records showed that fall risk assessments, medication and manual handling risk assessments were being carried out. In some instances equipment to move people safely was being used to reduce risks to people. In other situations we found bed rails being used and no risk assessments in place. We observed situations where staff used this equipment for the benefit of keeping people safe.

We found that the provider had an appropriate medicine procedure in place to support staff as to how medicines should be administered. One person said, "Staff give me my medicine and I usually get it on time", another person said, "Sometimes I have to remind staff about my eye drops". Relatives we spoke with told us that they had no concerns with the way medicines were administered. The staff we spoke with that administered medicines told us that they received training before they were allowed to administer medicines and their competency was being checked. We were unable to check training records to verify this. However, we found that senior staff were checking each other's competence, which we discussed with the manager as this was not good practice and failed to reduce the risk of bad practice being passed on.

We found that a Medicine Administration Record (MAR) chart was being used to appropriately record when medicines were administered. Where people were administered medicines 'as when required' we saw that the appropriate procedures/staff guidelines were in place to ensure staff administered these medicines safely. One person said, "If I have a headache staff will give me a tablet for the pain". We saw recordings in one person's care records illustrating to staff when 'as required' pain relief medicines should be administered. Our observations of staff administering medicines identified no major concerns however the staff administering medicines were also managing staff while administering medicines. We found that when people were being administered controlled drugs, the drugs were being stored appropriately and when they were administered this was recorded following the standard guidelines for administering controlled drugs. We found that all medicines were being stored appropriately and the temperature of the environment and fridge was being monitored. This would ensure medicines were being stored safely.

Requires Improvement

Is the service effective?

Our findings

We found that the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) were not being implemented appropriately. Staff we spoke with told us they had not had any training in either the MCA or DoLS. Staff were not able to explain the impact the legislation would have on people. We spoke to the manager who was also unable to explain the impact on people and confirmed training had not taken place.

We found where bedrails were being used or people's movement around the home was being restricted where these people lacked capacity, there were no capacity assessments in place or the appropriate actions taken where DoLS legislation were required. This meant that where people lacked capacity they were at potential risk of being restricted inappropriately.

We found that staff sought people's consent before care was given, but this was not being recorded. Where people lacked capacity it was unclear how consent was being given. We found no process for determining people's capacity, for example a capacity assessment. The Mental Capacity Act 2005 (MCA) sets out what must be done to make sure that the human rights of people who may lack mental capacity to make decisions are protected, including when balancing autonomy and protection in relation to consent or refusal of care. The MCA Deprivation of Liberty Safeguards (DoLS) requires providers to submit applications to a 'Supervisory Body' for authority to deprive someone of their liberty. This meant that the provider had not followed the requirements of the law. Arrangements in place did not ensure that the provider had taken steps to ensure the legislation was appropriately applied and people's rights upheld.

This was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

All the people we spoke with felt the staff had the right skills and knowledge to support them. The relatives we spoke with all spoke highly of the staff commenting on how well their relatives looked and that they were always clean and tidy. One relative said, "Senior staff are brilliant and the care is very good". Another relative said, "I think the staff have the skills and knowledge". The staff we spoke with all told us that they had not had any supervisions for a while. One member of staff said, "It's been a while since I had supervision" another member of staff said, "The manager is doing supervision now". Staff told us that team meetings were not taking place but since the new manager had started they have arranged one. Staff told us that they were able to access a range of training for example, safeguarding, food hygiene, manual handling, health and safety and dementia awareness as part of their National Vocational Qualification (NVQ) in care. We spoke with the cook who told us they had not had nutrition training since starting in their role and were reliant on the knowledge they had from a previous job. We were unable to clarify the training information staff told us as there were no training records available to check.

We saw that staff had the skills and knowledge to support people appropriately. We observed staff using equipment to aid how people were cared for. For example, using a stand aid. However, where people were at risk of pressure sores and needed staff to manage people's skin integrity, this was not always being done appropriately. One health care professional we spoke with said, "Staff not always checking people's skin integrity so we can take the appropriate action quickly enough". But we were also told that staff once given instructions to manage people's skin integrity, this was being done. Records showed that where concerns were identified with people's skin integrity the appropriate action was recorded on people's care records appropriately. For example, on one person's records we saw instructions to staff to ensure the person sat on a pressure relieving cushion and had a pressure relieving mattress. Staff we spoke with were aware of the instruction and we saw that the person was using the cushion as required to reduce the pressure on their skin. We saw people had access to pressure relieving aids.

We saw a health care professional in the home offering people health care support that had been determined. However, records did not show which health care professional people saw and the outcomes/action taken. For example, a dentist or chiropodist. One person said, "I have not seen a chiropodist and I have asked for one".

People told us the food was good. One person said, "I do enjoy my food I can feed myself but I do have trouble doing some things like cutting up meat", "The quality of food is good. I enjoy mealtimes" another person said, "Fluids are freely available". Our observations were that drinks were freely available. During meal times people were given a choice of meals and some people changed the choice of

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Is the service effective?

meal at the dining table. We observed people being asked before lunch time to make their choice of meal for the next day. This was discussed with the manager as it could potentially confuse people as they were being expected to make another choice of meal before the first choice had even been consumed. We found that a menu was available in the dining room so people could know what was available. People who were at the end of the dining room would not be able to see the menu board on the wall at the other end of the room. We also found that the menu was not available around the home so people with poor memory could be reminded as to the choices they made the previous day. This was discussed with the manager who confirmed a pictorial menu was in the process of being introduced to support people to be able to make a more informed choice of meal.

Staff were constantly available in the dining room to support people where this was needed. Staff were observed regularly in discussion with people, smiling and where required kneeling down at tables next to people encouraging them to eat. People were also seen talking amongst themselves and enjoying their meal. Where assistance was needed staff were on hand to cut up food and make meal times an enjoyable occasion.

We found that relatives were able to support their relative during meal times where they wanted too. We spoke with the cook who had a good understanding of people's dietary requirements and showed us a sheet that was being used to show where people had specific dietary needs, for example identifying where someone required puree meal. We found that staff passed information to the cook verbally rather than recording the information down as and when people's needs changed. This was not good practice as there was a potential risk that the information could be forgotten or not passed onto staff in the kitchen. We found that nutritional charts were being used to identify where people were at risk of malnutrition. However, this information was not always being reviewed or completed consistently in every situation to ensure where there might be risks to people's nutritional needs this could be acted on quickly.

Requires Improvement

Is the service caring?

Our findings

On one afternoon of the inspection someone who was unwell and in their bedroom on the first floor we heard calling out to staff for help. It was unclear how long they had been calling for help. No staff members were present on the floor that we could see, so we asked the person if we could help. We saw that the pull cord for the call bell system was out of their reach, so we rang the call bell on the person's behalf. A member of staff arrived quite quickly and explained the person was very unwell and called out a lot. They proceeded to ask the person what they would like, offered them a drink which the person accepted and reconnected a sensor alarm which would sound to alert staff if the person stepped out of bed. Failing to ensure if the call alarm system was within easy reach of the person placed them at risk of not having their needs responded to promptly. Whilst the staff member did respond and provided the support that the person needed this would not have happened without prior intervention.

People we spoke with said the staff were 'Friendly'. One person said, "Staff treat me pretty well they do their best" another person said, "Staff are nice, get on well with them they make my life bearable". Relatives we spoke with said, "My relative had a fall and they rang me and told me" another relative said, "Staff are good they look after them well". Our observations were that staff were caring, we saw that interaction between staff and people using the service were caring and kind. We saw that when a person was being supported to transfer from a chair to a wheelchair that staff encouraged and reassured the person and provided assistance so that they could stand and transfer safely with confidence. A health care professional told us that staff were friendly and conscientious and commented that staff listened to professionals to ensure people were cared for appropriately.

One person said, "I am able to make my own decisions. We found that people were able to do things how they wanted. We observed someone sitting in the dining room on their own, it later transpired the person wanted to be there. Staff respected their view and they were able to make their own decision and sit there in private. We observed staff consistently asking people questions which allowed them to make decisions as to how their care would be given.

People told us their privacy, dignity and independence was respected by staff. One person said, "Staff are kind and caring and they respect my privacy and dignity" another person said, "I can go to my room when I want". Our observations were that people were able to spend time in their rooms when they wanted. A member of staff we spoke with was able to show an understanding of privacy, dignity and independence and give examples of how this was respected. For example, knocking people's bedroom doors before entering, covering people with towels when delivering personal care. Records showed where people had identified a preference to spend time in the bedroom rather than the lounge and people who were being supported to live their lives independently as possible by washing and dressing themselves. This meant that where people's right to privacy, dignity and independence was being met.

Requires Improvement

Is the service responsive?

Our findings

The people we spoke with were not all sure, as to whether they were involved in the assessment and care planning process, to determine their care needs and how staff would support them. One person said, "I don't remember if I was involved in my assessment", another person said, "Oh yes I was involved in my assessment and the writing of my care plan". One relative said, "Yes I was involved when [relative's name] first came to the home, but there has been nothing since". Another relative said, "I was involved in the initial assessment". Records showed that assessments and care plans were in place, but care plans were not being signed to show that people had agreed with the content. We found that reviews were not being carried out consistently and there was no evidence that people or their relatives were involved when they had taken place. One person's care records showed that reviews were being carried out monthly up to November 2014. We saw that one had not been reviewed since July 2014. One person said, "I have never had a review since coming into the home". People were not being involved in the decisions about their care needs.

We found that people's preferences and likes and dislikes were being recorded. For example, one person's records showed that they wanted to attend a day centre and we found that this was taking place, as we observed the person leaving for the centre. We found that the information recorded about people's preferences, were not always accurate. One person's records identified that they liked to have a shower in the morning, but the person told us that they like to have a bath not a shower, adding that they knew a bath was not always possible, because they needed two members of staff to assist them. Staff we spoke with had a good understanding of people's likes and dislikes. This meant that whilst people's preferences were being identified, the preferences were not always being met consistently.

An activities co-ordinator was employed to coordinate the activities people took part in, but for large portions of our visit people were sitting in the lounge sleeping or watching the television. People's preferences were not being proactively promoted. Where staff had some free time to stop and chat with someone in the lounge they did. We were informed that a hairdresser came once a week to do people's hair. We saw photos displaying some of activities that had previously taken place and the events planned over coming months. One person said, "We have religious services for people who want it, we also had singers for Christmas". Relatives told us that activities did take place, for example the activities coordinator does bingo. We found that even though there were activities taking place, they did not always meet with everyone's preferences as recorded in their records.

We found that residents meetings did not take place. This would give people and their relatives the opportunity to share their views on how the home was meeting their needs. We found that there was no process in place to enable people to share their views on a regular basis. One person said, "I don't know if there are meetings". One relative said, "No I have not been invited to a residents meeting". One member of staff said, "Residents use to have meetings". This meant that people were not able to share their views on the home or the service they received.

One person said, "If I want to make a complaint I would speak to staff. I think they would listen". One relative told us they were given information leaflets information when they first arrived to the home and they think this may have included complaints information. Relatives generally could not be sure if they were given information. However, we saw displayed on the communal notice board the complaints procedure. It was only available in one format and relatives and people were fairly clear that they had never complained but if they needed to they would speak to staff or the manager. Records showed that there was a system in place for logging all complaints and monitoring trends as part of service improvement.

Requires Improvement

Is the service well-led?

Our findings

We found that records were not being completed appropriately or consistently. Records showed that basic information on people's care needs were available for example, assessment and care plans, however they were not always signed. Other documents for example, nutritional screening, monthly weight monitoring and risk assessments were not being used consistently or completed accurately. We found there were no staff training records to show what training staff had completed and where there were still training needs. People could not be assured that the service was being led appropriately to meet their needs.

There were no records available of training that had been provided to staff. However, there was some evidence that the recently employed manager had recognised this and taken action.

The registered manager left in the summer of 2014 and the deputy manager had covered since then. In December 2014 a new manager was appointed by the provider and they are currently going through the process of registering as a manager with the Care Quality Commission (CQC). We asked people if they knew who the manager was. None of the people we spoke with knew who the manager was. One relative said, "I know the manager she is very approachable", another relative said, "The manager is very visible around the home, she dressed our mum yesterday". The staff we spoke with felt the home was much better managed now that there was a new manager in post. A number of staff made positive comments which included: "I feel there have been improvements since the new manager have come", "The manager is really nice", "Now the new manager is here you can see the changes" and "Staff are a lot happier than they were." The manager confirmed that there were a lot of changes taking place as a way of improving the service to people.

The manager told us in their Provider Information return (PIR) that they operated an open door policy, staff supervision were to take place, People were safe from abuse, Our observations were that the manager had taken action to rectify some of the concerns we had found. The manager was seen regularly walking around the home and supporting people where needed. They were seen interacting with relatives and visitors. There was a relaxed atmosphere within the home. People told us they liked living in the home. One person said, "The home is better than my last one". The PIR did reflect some of the actions being taken, but we found that there were concerns still to be actioned and not recognised in the PIR.

We found that the deputy manager would cover the home in the absence of the manager and there was an on-call system available for staff to contact senior staff during the night shift when there was no senior staff available.

We found that audits were not being completed consistently. For example, we found that window restrictors were not being monitored appropriately, where people were able they could easily press a button to open the window wide enough to fall, monthly weight loss audits were not being completed regularly and monthly pressure sore audits were not being completed. The provider was not carrying out any checks or audits on how the home was being managed or whether the management team were performing as expected or agreed. One member of staff said, "Medication audits are in place but not always done". Records we saw confirmed this. The manager had recently been employed and there was evidence that the manager was already taking action to rectify concerns we found.

We found that accident and incidents were being recorded appropriately and analysis being carried out on a monthly basis to monitor for trends as part of service improvement.

We found that some exchanges between agency staff and people who used the service were abrupt, and lacking in empathy or kindness. When these instances occurred we noted that the manager took appropriate action. This was demonstrated when the conduct and manner of agency staff members on two separate occasions was deemed inappropriate toward people in the home. On both occasions the manager responded promptly and on one of the occasions the temporary staff member was asked to leave the home. This showed the manager had the skills and knowledge required to lead the home.

People had a mixed view as to whether they had ever completed a questionnaire giving their view on the service. One person said, "Yes I have had a questionnaire", another person said, "No I have not had a questionnaire". Relatives were less certain about the circulation of questionnaires within the home. Records showed that questionnaires were

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Is the service well-led?

being used to gather people's views. The last questionnaire sent out was in April 2014 and the information had not been analysed at the time of the inspection , six months after distribution.

The provider's procedures for managing the home were not being applied consistently. For example staffing levels had not been appropriately increased since our last inspection in April 2014 despite the provider's action plan showing action had been taken. We found breaches in how the Mental Capacity Act 2005 was being implemented. Staff had not had training and this in turn limited their skills and knowledge. These issues had not been identified in the systems used to audit the quality of the home.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing **The provider had failed to ensure that there was sufficient staff deployed to support people safely.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse **The provider had failed to ensure that an effective system was in place to prevent people being unnecessarily deprived of their liberty.**