Potensial Limited

Firtree House

Inspection Report

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Overall summary

Firtree House is a care home for up to ten people and seven people were living there when we visited. The home provides care and support to people with a learning disability and complex needs. The home is located in a residential area with parking to the side of the property and gardens to the front and back. There is ramped access into the home. Bedrooms are on the ground and first floor, which is accessed by a chair lift.

Because of their complex needs some people were limited in what they could tell us verbally about their experiences. So we spent time with people to see what their daily lives were like. We saw staff were kind and caring towards people and treated them with respect. Staff showed a good understanding of people's care and support needs.

The home has gone through significant changes over the last six months following a number of incidents. All of the incidents had been fully investigated and reported to safeguarding and CQC. There had been a high turnover of staff and a new registered manager was employed at the home in August 2013. The service recognised significant improvements were needed and voluntarily agreed not to take any new admissions and this agreement was in place when we visited. We spoke with the Local Authority before the inspection who confirmed the home were working with them to make improvements to the service.

Staff were trained in safeguarding, had a good understanding of abuse and knew the reporting systems to use if abuse was suspected. However, we found recruitment processes were not robust enough to make sure staff were suitable and safe to work with people.

Although some people's bedrooms were personalised and comfortably furnished, we found other areas of the home were shabby and poorly maintained. There was a planned refurbishment programme, which was due to start this month. Access into and around the home was difficult for wheelchair users because of the design of the building. There was no call bell system in the home, which meant people were unable to summon support when they needed it.

We saw staff were kind, caring and compassionate and supported people without rushing them, They knew people's needs well. Care records were well recorded but there was no evidence to show how people had been involved in planning their care. Although some people attended regular community groups, for others there were fewer opportunities. There were no planned activities within the home to meet people's individual needs and preferences. Opportunities to go out were on an 'ad hoc' basis. People nutritional needs were met and they were offered a choice of meals and drinks.

Staff treated people with dignity and respect. We saw they were discreet when talking to people about personal care requirements and made sure this was carried out in private. Staff we spoke with described and gave examples of how they ensured people's privacy, dignity and independence was maintained.

Staff had received training in the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards (DoLS). However, the manager was not able to tell us if people's capacity had been assessed or provide us with evidence to show it had. People were not provided with information about the complaints procedure.

Although there were checks in place to monitor the quality of the service we found the home lacked strong and effective leadership.

We found standards of cleanliness in the home were poor. There were no additional staff employed to assist with cooking, cleaning and laundry tasks. This meant care staff were required to complete these tasks as well as providing care and support to people.

We found staffing levels were insufficient. Staff told us there were not always enough staff on duty to keep people safe, particularly between 3pm and 10pm when staffing levels were reduced.

There were no residents meetings, although the manager was hoping to introduce them. We saw people were consulted about day-to-day decisions such as what they would like to eat, but there were limited opportunities for people to be involved in a meaningful way in decisions about the home and their daily lives. For example,

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information was not available to people in a format they could easily access such as Easy Read or Makaton. Makaton is a language programme that uses signs and symbols to help people communicate.

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.

Are services safe?

Staff were trained in safeguarding, had a good understanding of abuse and knew the reporting systems to use if abuse was suspected. Records we saw showed safeguarding incidents had been recorded and reported to the local authority and CQC. However, we found other evidence showed the service was not safe and this meant people were not always protected from abuse and harm.

Discussions with staff showed there were not always enough staff on duty to keep people safe, particularly between 3pm and 10pm when staffing levels were reduced. There were no anciliary staff employed which meant the care staff were responsible for all the cleaning, cooking and laundry tasks. The records we saw confirmed this. The majority of people who lived in the home had complex needs and sometimes displayed behaviours which resulted in conflict with other people. This meant they required observation and support from staff, which we saw was not always available as staff were busy with other tasks.

We saw people's risk assessments were detailed and updated and found staff knew people's needs well.

The premises were not well maintained and required improvements to make sure people were safe. There was a lack of accessibility for wheelchair users into and around the home. There was no call bell system in the home. This meant people were unable to summon assistance easily or in the event of an emergency.

Recruitment checks were not robust enough to ensure that only staff who were considered suitable to work with vulnerable people were employed.

Are services effective?

People had their needs assessed and staff understood what people's care needs were. Some people were not able to communicate verbally. We saw staff involved them in decisions and knew how to communicate with them. GPs and other care professionals were consulted when needed.

People's needs were assessed and individual preferences and choices were recorded in their care plans. While care plans promoted independence by focussing on what people could do for themselves and how they wanted staff to support them, there was no evidence to show how people had been involved in their care plans.

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Information about advocacy services was not available to people.

The design, decoration and adaptations in the home did not always meet people's individual needs or enhance people's privacy and dignity.

We found people's nutritional needs were met and they were offered a choice of meals and drinks.

Are services caring?

We saw people were treated with kindness and compassion by the staff. Staff supported people without rushing, giving them time to do things at their own pace. We saw people were able to choose where they spent time and walked freely around the home. One person told us they were happy at the home.

Staff we spoke with understood people's needs well. They were able to describe people's individual preferences and knew about their personal histories. We saw staff checked people were okay. For example, a staff member knocked on the bathroom door to see if the person needed any help in the shower.

We saw staff listened to people in respect of their day to day care and responded appropriately. However, we found there were few opportunities for people to be fully involved in decisions about their ongoing care and daily lives.

Are services responsive to people's needs?

We found the home was poorly organised and although staff responded to people's needs as they arose this was reactive rather than proactive and planned.

Although a couple of people regularly attended community groups, there were no planned activities in the home and opportunities to go out were 'ad hoc'.

Staff had received training in the Mental Capacity Act and Deprivation of Liberty Safeguards. The manager was not able to tell us if people's capacity had been assessed or provide us with evidence to show it had.

People were not provided with information about the home's complaints procedure.

Are services well-led?

The home has gone through significant changes over the last six months following a number of incidents, which had all been fully investigated and reported to safeguarding and CQC. There has been a high turnover of staff and a new registered manager was employed at the home in August 2013. The service recognised significant

Summary of findings

improvements were needed and voluntarily agreed not to take any new admissions and this agreement was in place when we visited. We spoke with the Local Authority before the inspection who confirmed the home were working with them to make improvements to the service.

There were no residents meetings, although the manager said he was hoping to introduce them. We saw staff consulted with people about their preferences on a day-to-day basis, but there were limited opportunities for people to be involved in a meaningful way in decisions about the home and their daily lives. For example, information was not available to people in a format they could easily access such as Easy Read or Makaton. Makaton is a language programme that uses signs and symbols to help people communicate.

There were not effective systems in place to monitor the standards of cleanliness, which were variable with some areas that were not clean. For example, the carpet, furniture and tablecloths in the lounge were dirty as were surfaces in some people's rooms.

The manager completed monthly reports which reviewed accidents, incidents, medication errors, staffing and complaints. We saw the report for February 2014 which identified an increase in the number of accidents and incidents from the previous month and showed what action was being taken to reduce the risks of re-occurrence.

Monthly audits were completed and covered all aspects of the service including speaking with staff and people who lived in the home. The report identified progress with previous actions and set timescales for new actions and included some of the issues we have identified in this report. For example, staff recruitment and some maintenance works. A budget had been identified for redecoration and refurbishment works to be completed in the home, which started this month.

A staff meeting had been held on 4 March 2014 which was the first staff meeting since the manager started in post. There were no minutes available but the manager gave an outline of the issues discussed. A further meeting was planned for 7 April 2014.

Management arrangements did not provide strong leadership or an open and inclusive culture. The home had some quality checks in place but these did not include many of the risks we found at our inspection.

Summary of findings

What people who use the service and those that matter to them say

Many of the people who lived at the home had complex needs and were not able to communicate verbally their experiences of the home. We spoke with six people that lived in the home who were able to tell us some of this views. We spent most of our time observing daily life in the home.

One person told us they liked to go out in the garden.

Two people told us the staff were “nice”.

Another person said if they had any complaints they would tell the staff.

One person told us they were “happy”.

Another person told us they liked their room and showed us a picture they had drawn which was displayed on the wall. This person had been out to get their daily paper and said they enjoyed the walk to the newsagents.

Another person told us they liked their room and showed us around the room pointing out the things they most liked.

There were no visitors to the home during our inspection.

Firtree House

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 regulations associated with the Health and Social Care Act 2008 and to pilot a new inspection process under Wave 1.

We visited this home on 3 April 2014 from 9am until 5.40pm. The inspection was part of the first test phase of the new inspection process that we are introducing for adult social care services.

We spent time observing care in the lounge area to help us understand people's experiences as some people were not able to talk with us. We looked at all areas of the home, including people's bedrooms (with their permission), the kitchen, laundry, bathrooms and communal areas. We also spent time looking at records, which included people's care records, and records relating to the management of the home.

The inspection team consisted of a Lead Inspector and an Expert by Experience, who had experience of learning disability care services and was accompanied by a supporter.

Before the inspection we reviewed all the information we held about the home and spoke with the contracts officer at the local authority.

On the day we visited we spoke with six people who lived at Firtree House, three staff and the registered manager. The Expert by Experience had lunch with people in the home.

We had carried out a follow up inspection to this home on 25 March 2014 to check if actions had been completed regarding problems identified at an inspection in July 2013. We found the required improvements, which related to staff supervision, training and the safety of the environment, had been made.

Are services safe?

Our findings

Staff we spoke with told us they felt there were not always enough staff on duty to keep people safe, particularly between 3pm and 10pm when staffing levels were reduced. There were no anciliary staff employed which meant the care staff were responsible for all the cleaning, cooking and laundry tasks. Staff told us there were four support staff and the manager on duty from 8am until 3pm which they said was sufficient to meet people's needs. From 3pm to 5pm there were three support staff and the manager and from 5pm to 10pm there were three support staff. We saw the majority of people who lived in the home had complex needs and sometimes displayed behaviours which resulted in conflict with other people. This meant they required observation and support from staff, which we saw was not always available as staff were busy with other tasks. Staff told us with only three staff on duty they struggled to meet people's needs and keep them safe.

We looked at the staff rotas for the week prior to our visit which confirmed the details staff had told us about staffing levels. We found some staff were working excessively long shifts of fourteen hours and two staff had worked in excess of sixty hours over one week. The manager told us the home was using agency staff to cover some shifts and they were in the process of recruiting further staff. The manager told us staffing levels were determined by head office and was not able to tell us how they had been calculated or if people's dependencies had been taken into consideration. Staff told us the reduction is staffing levels meant there were limited opportunities for people to go out in the evening. We also saw instances when staff were not available to respond to situations. For example, one person in the lounge was starting to remove their clothing and we had to intervene and find staff to assist. This meant there had been a breach of the relevant legal regulation (Regulation 22) and the action we have asked the provider to take can be found at the back of this report.

We looked at risk assessment records for two people and found these were comprehensive, personalised and regularly updated. Our discussions with staff showed they were aware of people's risk assessments and they described how they managed risks appropriately. We spent time in the lounge and observed staff managed some situations well. For example, we saw one person was becoming agitated and this was upsetting another person who was in the lounge. Staff calmly approached the agitated person and suggested they went for a walk and they left the lounge. Another staff member came and reassured the person who was upset. However, we also observed one person, whose behaviour was unpredictable, frequently approaching people coming very close to them and staff were not always responsive to this behaviour. We asked two people if they felt safe. One person said: "Sometimes." The other just nodded their head.

Staff told us they had completed safeguarding training via elearning which was updated annually. The manager confirmed all staff were to attend Level 1 safeguarding training with the local authority. Staff we spoke with showed a good understanding of the different types of abuse and described clearly the correct action to take if they suspected abuse was taking place. We saw records that showed safeguarding incidents had been recorded and reported to the local authority and CQC. Information about the safeguarding reporting process was displayed in the manager's office including contact details.

The manager told us all staff had received training in the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards (DoLS). We saw a certificate for one staff member which confirmed this and staff we spoke with told us they had received training. There were no mental capacity assessments in the care records we reviewed. We saw one person had a consent to care and treatment form but this had not been signed or dated by staff or the person it related to. The same form in another person's file had been signed by the person. However, it was not clear if this person had capacity to consent to the decisions agreed. We saw the home's consent policy provided detailed information about consent and included a best interests decision form. The manager was not able to tell us if people's capacity had been assessed or provide us with evidence to show it had. This meant there had been a breach of the relevant legal regulation (Regulation 18) and the action we have asked the provider to take can be found at the back of this report.

We found the building required improvements to make sure people were safe. There was no call bell system in the home. This meant people were unable to summon assistance easily or in the event of an emergency. We asked two people how they alerted staff if they required help and they told us they had to shout or go to find staff. One person said: "I shout till they come."

Are services safe?

We identified several examples of poor maintenance. For example, in one person's room drawers had collapsed, one of the doors on the vanity cabinet was missing and the headboard was missing from the bed. There was no water from the taps at the sink and staff told us the water had been turned off because the person might flood the room. A light had been removed from above the sink leaving the wall unpainted. Staff told us the room had been like this since November 2013. There were no toilet roll holders in some bathrooms, the handle to flush the toilet was missing in another and none of the radiators were guarded in the bathrooms. One radiator was rusty with paint peeling off at the bottom. The manager was unable to tell us if the radiators were low surface temperature. This meant people may be at risk of burning themselves on the radiators.

There was a lack of accessibility for wheelchair users due to narrow corridors which made it difficult to get round the home. Staff told us two of the people in the home used wheelchairs. Access to the first floor was by a chair lift which made it inaccessible for wheelchair users. There was a loose mat on the floor by the fire exit which impeded access for wheelchair users as it caught in the wheels of the chair. The disabled access toilet in the bathroom downstairs was part of a wet room which meant the floor inside was slippery after the shower had been used. There was only one hand rail which provided little support for people trying to manoeuvre themselves to use the toilet and no emergency bell to call for assistance if required. Exits in and out of the building had high thresholds and the surfaces on the ramped access were uneven which caused problems for wheelchair users. People were not protected against the risks of an unsafe or unsuitable environment. This meant there had been a breach of the relevant legal regulation (Regulation 15(1)(a)(c)) and the action we have asked the provider to take can be found at the back of this report.

We looked at two recruitment records and one showed all the relevant checks had been completed before the staff member commenced work. In the other record we found a disclosure about a criminal record had been declared on an application form but there was no evidence to show this been discussed or risk assessed. When we spoke with the manager about this they were not aware of the disclosure and had not seen the staff member's criminal record check. They told us the criminal record checks were sent to the regional office and not seen by the manager. This meant the recruitment checks in place did not protect people from staff who may be unsuitable. It meant there had been a breach of the relevant legal regulation (Regulation 21(a)(1)) and the action we have asked the provider to take can be found at the back of this report.

Are services effective?

(for example, treatment is effective)

Our findings

During our observations, we saw that staff involved people in decisions about their daily care. For example, one person had been unwell during the night and staff had arranged for them to see their GP. We saw staff explained this clearly to the person and accompanied them to their appointment at the surgery. Some people were not able to communicate verbally yet we saw staff involved them in decisions and knew how to communicate with them. Staff we spoke with described well the different body language and signs people used to communicate their needs.

We saw people's needs had been assessed and individual preferences and choices were recorded in their care plans. While care plans promoted independence by focussing on what people could do for themselves and how they wanted staff to support them, there was no evidence to show how people had been involved in the care planning process.

The home used a computerised system for care records and daily reports. There was also a hard copy of each person's care records kept in a file. The manager advised agency staff did not have access to the computerised records and hand wrote their daily records in a separate care file. We saw this file was kept in the lounge and was freely accessible which compromised people's confidentiality. We found these systems were not effective . For example, we saw recent daily records made by agency staff identified concerns about a person's swollen, red legs. This was not reflected in the computerised records. We saw from this person's care plan that they had a history of cellulitis. When we asked the manager what action had been taken they said they were not aware of these concerns as they had not looked at the handwritten records. This meant there was a risk of people not receiving the care and treatment required to meet their needs.

We saw care records included an assessment of needs for nutrition and hydration. We saw the Speech and Language Therapy (SALT) team had been involved with one person and the care records provided clear information about how their dietary needs should be met. We saw people were offered a choice of meals and could chose where to eat their meals. Staff told us people were encouraged to assist with making their meals where possible and were also involved in shopping and planning meals. We saw one person had cooked their own breakfast and told us they enjoyed doing this. We asked to see the menus which were kept in a folder in a kitchen cupboard. These showed one option at each mealtime and said alternatives were available but not what they were. Information about meals could be improved by displaying the menus in a format accessible to people and including information about different options.

There was no information available for people about advocacy services. The manager told us there were people living in the home who had no family contact but was not able to tell us if advocacy services had been discussed or considered.

The design, decoration and adaptations in the home did not always meet people's individual needs or enhance people's privacy and dignity. Two people showed us their bedrooms and said how much they liked them. We saw the rooms were very personalised and comfortably furnished to reflect their tastes and interests. They had meaningful signs on their doors to help identify their rooms. For example, one person had a Newcastle United sign with their name on as they were a fan. We saw another two people's bedrooms were to the same standard. Staff told us people were involved in choosing the décor and furniture for their rooms. In comparison, two other people's rooms were stark and poorly maintained. For example, one person's door had a small sticker with just their first name on. The room was sparsely furnished and some furniture was broken. Pillows were lumpy and mis-shapen and one had no pillowcase on. There were no personal toiletries in the room. Staff told us this was because the person may harm themselves with the products and showed us this person's personal toiletries were stored in a plastic bucket in the cleaners' store. We spoke with the person whose room it was and asked them if they liked their room and they said "No."

On the day of our visit the dining room was out of use as the builders were finishing damp proof work. We found the lounge was functional with little to occupy or stimulate people other than the television. There were some framed pictures on the wall which staff told us had been done by people who lived in the home.

We found signage around the home was variable one toilet had a WC sign but most of the bathrooms and toilets had no signage. The home had one assisted bath on the first floor. We saw one person who came out of their room with their toiletries and heard them say to staff: "I'm ready for a bath" as they headed towards the assisted bathroom. We

Are services effective?

(for example, treatment is effective)

heard staff persuade them it would be better for them to have a shower. When we asked staff why the person could not have a bath, they told us the assisted bath was not accessible for this person and they could not manage to climb in and out of the other baths. This meant the person was not able to have a bath as the home did not provide accessible facilities to meet their needs.

The evidence we found on this inspection meant that people's privacy and dignity was not always respected and good outcomes were not achieved. This meant there had been a breach of the relevant legal regulation (Regulation 17(1)(a)(b)) and the action we have asked the provider to take can be found at the back of this report.

Are services caring?

Our findings

During our visit we observed positive interactions between the staff and people who lived in the home. People were treated with kindness and compassion by the staff. For example, we saw one staff member spent time supporting a person who was becoming distressed by another person's behaviour. Staff supported people without rushing, giving them time to do things at their own pace. We saw people were able to choose where they spent time and walked freely around the home. One person told us they were happy at the home.

Staff told us how they supported people to maintain their independence. For example, staff told us three people were involved in cleaning their rooms, helping with their own laundry and doing the shopping. One person had been out to the local shop to get a newspaper and told us how much they also enjoyed doing the food shopping with staff.

People were treated with kindness and compassion by the staff. For example, we saw one staff member spent time supporting a person who was becoming distressed by another person's behaviour.

We saw staff knocked on doors and asked people's permission before entering. We observed staff were discreet when talking to people about personal care requirements and made sure this was carried out in private. Staff we spoke with were able to explain and gave examples of how they ensured people's privacy, dignity and independence was maintained.

Staff we spoke with understood people's needs well. They were able to describe people's individual preferences and knew about their personal histories. One staff member told us one person did not like loud noises so they made sure the fire alarm tests were carried out when this person was out of the home. We saw staff checked people were okay. For example, a staff member knocked on the bathroom door to see if the person needed any help in the shower.

We saw staff listened to people in respect of their day to day care and responded appropriately. We looked at people's support plans and found these were comprehensive and personalised. However, there was no evidence to show how people had been involved in their support plans and they were not available in an accessible format for people to access. We found there were few opportunities for people to make their views known which the manager acknowledged. He told us there were no meetings for people who lived in the home, although he said this was something he was planning to introduce.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

We found the home was poorly organised and although staff responded to people's needs as they arose this was reactive rather than proactive and planned.

People were given little information to inform them and assist them in making decisions and choices. For example, there were no planned activities or opportunities for people. Only one person had a planned programme of daily activities which had been drawn up as part of a behaviour management programme with an NHS specialist team who were monitoring its effectiveness. We saw staff tried hard to encourage this person to carry out these activities. Although people's interests and hobbies were recorded in the care plans we reviewed there was little evidence to show this identified how people should spend their days. During our visit we saw staff asked people what they wanted to do and if they wanted to go out to the shops, but there was a reliance on people coming up with ideas themselves. There was nothing for people to do in the lounge apart from watch the television, which was on all the time we were there. Staff told us there were some games in a cupboard but we did not see these being used. We saw one person drawing at the table. They had a few sheets of paper and one pencil. One person told us they liked playing computer games, however staff told us people did not have access to a computer.

The manager told us two people attended regular events in the community and others went out on an 'ad hoc' basis. One person attended a day centre three times a week and another attended a community group three times a week. Our conversations with staff confirmed most outings took place during the day and there was no social life for people in the evening. The manager confirmed there were no planned activities and said staff supported people to go out when they could. We saw communication between staff meant this did not always proceed as planned. For example, while we were at the home some people asked to go out. A staff member helped one person with their coat and into their wheelchair. This person was then left for a long time while the staff member went to help the other person who was going out with them. While the first person was waiting they were brought a drink and snack by another staff member, so when the other person was ready they had to wait again until the person finished eating and drinking. This meant there had been a breach of the relevant legal regulation (Regulation 17(1))(g)) and the action we have asked the provider to take can be found at the back of this report.

People who lived in the home were not provided with information about the home's complaints procedure. The manager told us no complaints had been received. There was a detailed complaints policy which we saw in the office but this was not displayed in the home or provided to people in an accessible format. We saw an easy read version of the local authority's complaints policy which was also kept in the office. When we asked one person how they would make a complaint they said:" I'd tell staff." The manager said he thought people had been given the complaints policy in the past but confirmed people did not have access to the policy now without asking for it. This meant people who lived in the home could not freely access information about the complaints procedure or know how it would be dealt with.

Are services well-led?

Our findings

The home has gone through significant changes over the last six months following a number of incidents, which had all been reported to safeguarding and CQC and were fully investigated. There has been a high turnover of staff and a new registered manager was employed at the home in August 2013. The service recognised that significant improvements were needed and voluntarily agreed not to take any new admissions and this agreement was in place when we visited. We spoke with the Local Authority before the inspection who confirmed the home were working with them to make improvements to the service.

There were limited opportunities for people to be involved in a meaningful way in decisions about the home and their daily lives. For example, information was not available to people in a format they could access such as Easy Read or Makaton.

The manager told us satisfaction surveys were sent to relatives and care professionals. He told us surveys had recently been completed by four people who lived in the home with staff assistance. We saw one of these surveys which gave positive feedback but did not fully explore the answers. For example, a response to one question about food described it as "not bad" but there was no further comment from staff as to what the person meant. We asked the manager how the surveys were used with people who could not communicate verbally. He was not aware of any alternative formats which would be accessible for these people. The manager told us there were no residents meetings, although this was something he was hoping to introduce. We observed staff consulted with people about their preferences on a day-to-day basis but there were no formal mechanisms in place to consult with them formally about their care. This meant there was a risk the service did not consult with people sufficiently for their views on ways to improve practice.

Our observations of how the manager interacted with staff showed us the service did not have strong leadership or a positive and empowering culture. Staff lacked direction and leadership from the manager who was busy transporting people to day services and appointments as he was the only driver on duty. Communication between staff was fragmented. For example, one person's notes showed a district nurse visit had been requested. The manager told us the district nurse had been but there was no record of the visit in the person's records. The manager had to speak with several staff to clarify if the district nurse had been and what treatment had been advised.

The manager told us there had been a high staff turnover in recent months and the service was using agency staff until permanent staff were recruited. A recruitment drive was underway. We saw from the duty rotas some staff were working excessively long shifts and accruing high working hours over the week. We found there were not enough staff to meet the complex needs of the people living in the home. Staff we spoke with told us they struggled to meet people's needs when staffing levels were reduced in the afternoon and evening. The manager told us no anciliary staff were employed which meant laundry, cleaning and cooking tasks had to be completed by the care staff.

We found there were not effective systems in place to monitor the standards of cleanliness which were variable with some areas that were not clean. For example, the carpet, furniture and tablecloths in the lounge were dirty as were surfaces in some people's rooms. The laundry room was dirty and untidy with plaster dust covering the floor and surfaces as recent building work had been completed. Many of the wash hand basins did not have a supply of paper towels for staff to wash their hands.

The manager completed monthly reports which encompassed information relating to the running of the service. For example, accidents and incidents, medication errors, staffing and complaints.

We saw the report for February 2014 which identified an increase in the number of accidents and incidents from the previous month and showed what action was being taken to reduce the risks of re-occurrence.

The area manager carried out a monthly audit of the service and we saw the most recent report. This was comprehensive and covered all aspects of the service including speaking with staff and people who lived in the home. The report identified progress with previous actions and set timescales for new actions and included some of the issues we have identified in this report. For example, staff recruitment and some maintenance works. The manager told us a budget had been identified for redecoration and refurbishment works to be completed in the home, which started this month.

Are services well-led?

The manager told us a staff meeting had been held on 4 March 2014 which was the first staff meeting since he had started in post. There were no minutes available from the meeting but the manager gave an outline of the issues discussed. A further meeting was planned for 7 April 2014.

Although monthly audits were taking place, these did not identify many of the risks we have highlighted in this report which relate to the health, welfare and safety of people living in the home. This meant there had be a breach of the relevant legal regulation (Regulation 10(1)(b)) and the action we have asked the provider to take can be found at the back of this report.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	**Regulation 21 (a)(i) HSCA 2008 (regulated activities) Regulations 2010 Requirements relating to workers** The registered person did not operate effective recruitment procedures in order to ensure that no person is employed for the purposes of carrying on a regulated activity unless that person is of good character.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	**Regulation 15(1)(a)(c) HSCA 2008 (regulated activities) Regulations 2010 Safety and suitability of premises** The registered person did not ensure people were protected against the risks associated with unsafe or unsuitable premises by means of suitable design and layout and adequate maintenance.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	**Regulation 22 HSCA 2008 (regulated activities) Regulations 2010 Staffing** The registered person did not safeguard the health, safety and welfare of service users as there were not sufficient numbers of suitably qualified, skilled and experienced persons employed for the purposes of carrying on the regulated activity.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	**Regulation 17(1)(a)(b) HSCA 2008 (regulated activities) Regulations 2010 Respecting and involving people who use services**

This section is primarily information for the provider

Compliance actions

The registered person did not have suitable arrangements to ensure the dignity, privacy and independence of people or enable them to be involved in making decisions relating to their care or treatment. The registered person did not have suitable arrangements to provide appropriate opportunities, encouragement and support to service users in relation to promoting their autonomy, independence and community involvement.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	**Regulation 10(1)(b) HSCA 2008 (regulated activities) Regulations 2010** The registered person did not regularly assess and monitor the quality of the services provided in carrying on the regulated activity by, identifying, assessing and managing risks relating to the health, welfare and safety of service users and others who may be at risk from the carrying on of the regulated activity.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	**Regulation 18 HSCA 2008 (regulated activities) Regulations 2010** The registered person did not have suitable arrangements in place for obtaining the consent of service users in relation to the care and treatment provided for them.