Care Quality Commission

Bupa Care Homes (CFChomes) Limited

Shelton Lock Residential and Nursing Home

Inspection report

61a Weston Park Avenue, Derby DE2 9ER
Tel: 01332 690606
Website: www.legalcareservices@bupa.com

Date of inspection visit: 15 September 2015
Date of publication: 02/12/2015

Ratings

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

Overall summary

Shelton Lock Nursing Home provides accommodation and nursing care for up to 40 people accommodated over two floors. This includes care of people with mental health and physical health needs. On the day of the inspection 31 people were living at the home.

This inspection took place on 14,18 and 21 September 2015. The inspection was unannounced.

Two breaches of legal requirements were found on this inspection. The registered person had not ensured that people were protected from risks to their safety and that people's consent to care had not always been properly ascertained.

A registered manager was in place. 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 and

Summary of findings

associated Regulations about how the service is run. The registered manager was not managing the service at the time of the inspection. The registered manager was currently unavailable and the provider had employed an interim manager in the meantime until their return. The interim manager is referred to as the 'manager' within this report.

Since our previous inspection in June 2014, we had received information from whistleblowers which had stated that people had not been properly cared for or treated with dignity by some staff and proper action had not been taken to deal with these issues. We followed up these concerns by focusing on the issues raised.

People using the service and the relative we spoke with said they thought the home was safe. Staff were trained in safeguarding (protecting people from abuse) and understood their responsibilities in this area.

Staff told us that on occasions they thought there were not enough staff on duty to meet people's needs promptly. Some people's risk assessments were in need of improvement to help ensure staff understood how to support them safely and keep people safe.

People using the service and a relative told us they thought medicines were given safely and on time. Some improvements were needed to the way medicines were stored and recorded to evidence that medicines were properly supplied to people to protect their house.

Staff were generally safety recruited to help ensure they were appropriate to work with the people who used the service to protect people from unsuitable staff supplying care to them.

Staff needed more training to ensure they had the skills and knowledge to be able to fully meet people's needs to ensure people's needs are met at all times.

Not all staff understood their responsibilities under the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) to allow, as much as possible, people to have an effective choice about how they lived their lives and the service had not obtained legal approval for limiting people's choices.

People had plenty to eat and drink and everyone, except one person, told us they liked the food served to them.

People's health care needs had not been fully protected by timely referrals to health care professionals when necessary.

Most of the people we spoke with told us they liked the staff and got on well with them, and we saw many examples of staff working with people in a friendly and caring way which appeared to make people happy and relaxed when staff spoke with them.

People were not always actively involved in making decisions about their care, treatment and support.

Care plans were not fully individual to the people using the service and did not fully cover their health and social care needs.

People were generally satisfied with the activities provided.

People and a relative told us they would tell staff if they had any concerns. Records showed that complaints were not always been comprehensively followed up to meet people's needs.

Not all staff were satisfied with how the home was run. People only had infrequent opportunities to share their views about the service at meetings so this limited their participation in the way the home was run.

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 consistently safe.

People said that they felt safe living in the service. Staff knew how to contact safeguarding agencies if abuse occurred. Staff recruitment checks were in place to protect people from unsuitable staff.

Medication had been supplied to people as prescribed, though systems were not fully in place to prove people always received their medicines.

Fire risk assessments had not been reviewed to ensure proper fire precautions. Moving and handling practices did not always protect people's safety. People's needs in relation to protecting their skin and nutrition were not safely in place.

Staffing levels meant people's safety was not always monitored.

Is the service effective?

Requires improvement

The service was not consistently effective

Staff were not fully trained and supported to enable them to care for people to an appropriate standard.

People's consent to care and treatment was not fully sought in line with legislation and guidance.

People had plenty to eat and drink and told us they liked the food served.

People were not always referred to health care professionals when necessary.

Is the service caring?

Good

The service was caring.

People told us that staff were caring. We observed staff relating to people in a caring and friendly way.

People had been involved in setting up their care plans.]

Is the service responsive?

Requires improvement

The service was not consistently responsive.

Care had not always been provided to respond to people's needs when needed. Care plans had not always contained full information on how to respond to people's needs.

Staff had not always contacted medical services when people needed support though staff had responded properly to accidents.

A range of activities were provided to people using the service.

Complaints had not always been fully responded to.

Summary of findings

Is the service well-led?

The service was not consistently well led.

People had limited opportunities to share their views about the service at meetings but there was no evidence of changes made as a result of their input.

Management carried out some audits and checks to ensure the home was running smoothly but not all issues had been checked or actioned.

Requires improvement

Shelton Lock Residential and Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health & Social Care Act 2008 Regulated Activities Regulations 2014, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection was unannounced. The inspection team consisted of two inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We also reviewed information we received since the last inspection, including information we received from the local authority safeguarding team and information received from whistleblowers in the home.

We spoke with the interim manager, the area manager, a company quality assurance manager, a community nurse, nine people that lived in the service, four relatives, two nursing staff and four care staff. The registered manager was currently unavailable and the provider had employed an interim manager in the meantime until their return. The interim manager is referred to as the 'manager' within this report.

We observed how staff spoke with and supported people living at the service and we reviewed people's care records. We reviewed other records relating to the care people received. This included the audits on the running of the home, staff training, staff recruitment records and medicine administration records.

Requires improvement

Is the service safe?

Our findings

We looked at fire records. We found that information on file that indicated the fire risk assessment should have been reviewed in December 2014 so this was 10 months overdue. The last fire drill had taken place in August 2014, over a year ago and this did not involve all staff. This meant staff had not had a fire drill for over a year. This did not protect people's risks from fire incidents. The manager said this would be followed up. 'The registered manager stated after the inspection to state that fire drills had taken place since that date and the last drill before the inspection was in March 2015. Since the inspection of fire drill has taken place in October 2015. However, we were not supplied with that information at the time of the inspection.

A care worker told us staff received moving and handling training so they knew how to move people safely." We saw this was the case in most cases when transfers were observed. However, there was one occasion where a person was asked by staff to stand up. She said she did not want to do this but eventually agreed. She was then unsteady on her feet when she tried to sit down in a chair. This was a potential risk to her safety as she could have fallen. The manager said the person should have had a choice in this matter and she would look at the person's risk assessment and speak to staff to ensure the person was transferred safely.

People's care records included risk assessments to keep people safe. For example, risk assessments had been completed to assess people's risk in relation to their care and support, including pressure ulcers, falls and continence. These had been updated monthly to ensure safe care was provided. However, we saw people who should have had repositioning every two to three hours to protect them from the risk of deteriorating pressure sores, had not always received this care as there were some occasions when they only received repositioning every four hours. On one occasion, the records showed a gap of over seven hours to reposition them. The manager thought this was a problem of recording rather than practice but said she would follow this up with staff to ensure the person was safe from developing serious pressure sores.

We saw that a person who is a risk of losing weight and had been referred to the GP had lost over four kilos in weight over a month. In the person's file, the GP set out in his letter to the home that if someone had lost a significant amount of weight then staff should refer this to him. This had not occurred, even though a review had been carried out by staff and this had not highlighted this issue. These incidents did not protect people's safety from avoidable harm.

Staff informed us that staffing levels were largely enough to ensure that people could be protected from risks to their safety and the manager agreed with this assessment. Staff told us there were occasions where it was not possible to ensure that a staff member was present in the main lounge to ensure people were safe, for example, from falling. The manager thought this was not the case and said she would follow this issue up to ensure people in the lounge were safe.

These issues are a breach of Regulation 12 (1) (2) (b) of the Health & Social Care Act 2008 Regulated Activities Regulations 2014. You can see what we have told the provider to do at the end of this report.[CL6]

This was a breach of Regulation 12 of the Health and Social Care Act 2008 Regulated Activities Regulations 2014.

All the people and the relative we spoke with said they felt safe in the home. When asked whether she felt safe one person told us, ''yes I do".

All the staff we spoke with had been trained in protecting people from abuse safeguarding and understood their responsibilities. Staff were also aware of reporting concerns to other relevant outside agencies if management had not acted to protect the person.

The provider's safeguarding and whistleblowing policies (designed to protect people from abuse) were available to staff. These told staff what to do if they had concerns about the safety or welfare of any of the people using the service.

Policies set out that when a safeguarding incident occurred management needed to take appropriate and action by referring to the local authority, CQC, or police. This meant that other professionals were alerted if there were concerns about people's well-being, and the registered manager and provider did not deal with them on their own.

Access to the building was controlled by electronic locks. which could be operated by wheelchair high release pads. This kept the home safe from intruders.

Requires improvement

Is the service safe?

During the visit we saw no environmental hazards to put people's safety at risk from, for example, tripping and falling.

We checked three staff recruitment files. Records showed that staff worked in the home usually with required background checks being carried out to ensure they were safe to work with the people who used the service. However, one reference was from a family member. The manager and area managers agreed this was not an independent reference and another reference should have been sought from a previous employer instead. This would then fully ensure people received care from staff that were safe to provide care to them.

One person said that her medication involved taking a great many tablets a day. She was happy that she was receiving the right tablets at the right time. Another person told us she preferred to take medication after she finished her breakfast and this was accommodated by staff. We observed her taking her tablets and using her inhaler whilst she was supervised by a staff member. This ensured the person safely took her medication.

Medicines were stored in line with requirements and the temperature of the refrigerator and room where medicines were stored were checked and documented though not always on the required daily basis. The manager said this would be followed up to ensure medications were always kept in an effective and safe way.

We checked stocks of medicines and generally found the amounts correct although medicines for two people were not in the blister pack for some subsequent days. The manager checked with nurses and said medicines had been discarded as they had fallen on the floor so medicines from other days had been borrowed to ensure people had their medicines. However, this had not been documented so there was a risk that people may not have received medicines on the subsequent days. The manager said she was taking this up with nurses to ensure a safe audit trail.

The staff member responsible for giving out the medicines was friendly in her approach to people and did not rush them. She encouraged people to take their medications and supplied medicines to people in a safe way.

Nursing staff told us they were responsible for administering medicines and said they had competency checks undertaken to make sure they could do this safely. We saw evidence of these competence checks.

PRN (medication supplied when needed) protocols were in place as to when to supply the medication. We found there was an appropriate controlled drugs procedure with two signatures and daily counts in place. We counted these and found that stocks were accurate. This showed they had been provided to people safely.

Requires improvement

Is the service effective?

Our findings

We assessed whether the provider was ensuring that the principles of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) were being followed. The MCA is a law providing a system of assessment and decision making to protect people who do not have capacity to give consent themselves. The DoLS are a law that requires assessment and authorisation if a person lacks mental capacity and needs to have their freedom restricted, in their best interests, to keep them safe.

One person said; “Largely (staff ask our consent).” We observed that staff usually talked with people they supported them and put them at ease. However, we saw situations where people were told to move their arms when being involved in transfers to easy chairs without staff always telling them what was going to happen and seeking their consent.

Not all staff understood their responsibilities under the Mental Capacity Act 2005 when we asked them about this. We discussed this with the manager, and she said staff had received training but would receive more awareness to ensure they were aware of how to assess people's capacity to make day-to-day decisions about aspects of their care and treatment.

We saw that there was a form in place for assessing people’s mental capacity but these had not always been completed. Deprivation of liberty (DoLS) applications had been made though we saw that some authorisations to enable staff to take decisions in people's welfare interests had run out and not being renewed which meant restrictions were in place that were not formally approved.

These issues are a breach of Regulation 11 (1) of the Health & Social Care Act 2008 Regulated Activities Regulations 2014. You can see what we have told the provider to do at the end of this report.

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

Records showed staff had induction and on-going training. They undertook a range of courses in general care and health and safety, and those specific to the service, for example some staff had received training in dementia care. However, a number of staff had not yet received training in relevant issues such as dealing with continence and catheter care, stoma care, end of life care, visual awareness, diabetes, and stroke conditions. All nursing staff had not received training in nursing procedures such as taking blood, PEG feed, and catheter care. This meant there was a risk that effective care would not be provided to people to meet their needs. The manager said that more training would be provided on these issues to improve staff skills and she sent us information addressing these issues. This would mean that staff would be fully supported to be aware of and able to respond effectively to people's needs.

The staff we talked with said they had supervision and we saw evidence of supervision in records. This provided staff with some support.

All the people we spoke with except one told us they had a good choice of food which they enjoyed. Comments included, "the food's good", "food's very good, you get two choices”, “the food is very good on the whole," and "the chef gets most things right." People said that there was good choice of sandwiches, soup, baked potato or salad for tea.

Hot and cold drinks were served frequently. One person said "there are drinks all the time." This prevented dehydration. We also observed snacks and biscuits being served with morning and afternoon tea rounds. A relative told us that his wife liked a shandy drink and she was provided with this every day with lunch which showed effective care being provided.

We observed the lunchtime meal. People were given a choice of two options for the main meal. We saw people being given assistance to eat when this was needed. People’s care plans gave information about the person’s support needs in relation to eating and drinking.

The chef showed us an information sheet where specialist diets were needed to be provided. Staff were aware that a person had lost a considerable amount of weight and needed to have supplements such as cream to help the person regain weight.

There were no people from different cultural backgrounds living in the home. However the chef explained that when people from other cultural backgrounds had lived in the home in the past, arrangements had been put into place to ensure that they were given food of their choice and

Requires improvement

Is the service effective?

cultural background. We were told that one person had food from their cultural background brought in by their family. This showed us that effective provision for differing cultural communities had been respected.

A relative told us their family member had health appointments in the past and staff had arranged these for her. Records showed that people usually had access to a range of health care professionals including GPs, district nurses and opticians. However, we saw from records that if staff had been concerned about a person's health they did not always refer them to the appropriate health care services. For example, we saw that the person lost four in a half kilos in one month and there was direction from the GP to contact him if there had been significant weight loss, but this had not been acted upon to provide effective care to the person. The manager said this would be followed up with staff.

The manager showed us records where a person's pressure sore was recorded, which showed that the GP was contacted for antibiotics as the wound was infected. This showed that staff were responding to a person's health needs.

Good

Is the service caring?

Our findings

People told us that staff were caring in their attitude. Comments included: “the staff are very good, can't do enough ‘’you can't fault the staff'', ‘’they’re very caring" ‘’the carers are marvellous’’ ‘’can't fault the care."

A relative said of the home in general: “It’s very good, I'd recommend it to anyone."

However, one person told us:" the staff are OK on average, the majority are very patient but I could point to a couple who aren't." A person told us that staff did not talk enough to them and they talked mainly between themselves. The manager said that she was informing shift leaders to ensure they monitored staff attitude at all times.

One staff member asked a person how they were feeling and complimented them on their hair. A person told us that staff closed the door when they dressed or provided personal care.

A person told us that a church leader visited occasionally to give communion to meet people's religious needs.

We observed lots of positive interaction between staff and people who lived in the home. Staff spoke to people in a relaxed informal way which was reciprocated by people. Staff knew people's names and they seemed to have positive relationships with them. One person said that staff were always polite and respectful and knocked on her door before entering her room. We observed a member of staff speaking in a friendly fashion with a person and placing a shawl over their shoulders. One staff member asked a person how they were feeling and complimented them on their hair. These were instances of caring attitude.

People told us they knew their relatives could visit them at any time. The relative we spoke with visited every day and spent the day there. He told us that staff also provided him with a meal while he sat with his relative.

People said they liked their rooms. One said "I love my room’’ ‘’I'd be happy to spend all day in it." Another person showed us furniture from her home which she was able to bring with her when she moved in.

People who could walk unaided or with the support of a frame said they were free to move around within the home any time they liked. Two people moved around in electrically powered wheelchairs and were able to use the lift to get to the first floor where their bedrooms were. One person said she enjoyed a cigarette so could leave the building to go to the external smoking area. We saw her doing this and also enjoying a drink in the garden. No one we spoke to was mobile enough to leave the building on their own but people told us that they were taken out by relatives and they were able to get out in the garden for fresh air. These were instances of people choosing how they live their lives in the home.

We saw that people or their relatives had signed to agree their care plans. A person told us they were invited to care plan reviews. This indicated some participation in drawing up a care plan to meet people's needs. However, some of the people or relatives were not aware of their care plan was or whether they had contributed to it. This indicated that some people had not been actively involved in making decisions about their care, treatment and support. The manager said that this was being followed up with people at the moment so that everyone could contribute to their care plan.

The staff we spoke with understood the importance of ensuring people could make choices about their day to day lives. One staff member told us, “we try to make sure that people have choices in everything such as clothes and food.” We saw people were able to choose their meal when we observed staff going round asking people what main meal they would like for the following day.

In terms of respecting people’s personal privacy, a notice was hung outside the door to say personal care was being conducted. However, we noticed that some bathroom doors did not have working locks on them so there was a risk of people's privacy being compromised. The manager stated that this was being followed up at the moment and proper locks would be installed in the near future.

The staff we spoke with could describe how they would preserve people’s dignity during personal care such as covering exposed parts of the body when washing people so not all of the body was exposed. These were examples of a caring attitude.

Requires improvement

Is the service responsive?

Our findings

People told us that staff understood their individual care needs. The staff we spoke to were aware of people's preferred routines and needs.

We saw that staff were sensitive to a person's swallowing needs and gave time to allow the person to eat and drink.

A relative showed us a notice attached to the front of a food feeding chart giving clear guidance to staff regarding their relative's need for thickened fluids. They told us this had been drawn up by family and staff, and indicated what to do to meet the person's needs.

We found detailed recording of protecting the person's skin from pressure sores. This care plan contained all relevant issues and was up to date. There was a referral to the dietician and a recommended diet to effectively address the person's needs, for example having a high protein diet and vegetables.

A person told us they had a specialist mattress and chair to help them have effective treatment for their pressure sore.

Each person's care plan had some information about the person's life history and their preferences. However, this was limited in some cases by not having a full social and family history. Therefore there was no detailed information available to staff to respond to their needs relating to person's background and preferences. This meant there was a risk that staff would not know how to respond to a person's social care needs. The manager acknowledged this and said care plans were currently being reviewed and updated to include all relevant information such as hobbies and interests the person had in the past. This will help staff to respond effectively to people's individual care needs and to reduce their social isolation.

Records showed that plans of care were reviewed on a regular basis. Staff had some knowledge about some of the needs of the people who used the service as nursing staff gave them a handover of important information before they started work. They were able to tell us who needed extra support at times in order to minimise risk to the health. However, not all staff knew that a person had lost a significant amount of weight. Without this information, there was a risk of effective care not being provided to the person.

We asked staff about their understanding of people's care plans. They told us they had not read all of people's care plans or risk assessments. This meant that they were not aware of all the issues that needed to be in place to provide care that met people's needs with the risk that people may have received care that met their needs.

Care plans did not always supply detailed information to meet people's needs. For one person's care plan with continence and mobility needs, 3 to 4 hourly checks were detailed but the frequency of checks made was not always in this assessed time scale. A continence plan stated that the person needed regular checks but the regularity of these checks had not been defined. These issues meant there was a risk that people's pressure sores could deteriorate and be a risk to their health and welfare.

A person told us they had a call bell and staff usually responded to them within 10 minutes. Staff told us there were times when people had to wait up to 20 minutes to go to the toilet when the staff handover was conducted in the morning, or if there were staff absences such as staff sickness. Staff were usually replaced by staff from another company home. If they were not available then once or twice a month staffing would be short of the required staffing level. In the circumstances, people would have to wait a little longer for personal care. Staff told us that the company did not use agency staff in these circumstances. They said the registered manager had informed them of this policy. However, the manager and the area manager stated that if staff could not cover then agency staff could be used. They said they would inform staff of this so that shifts could be properly covered to meet people's needs in a timely way.

We found detailed recording of protecting the person's skin from pressure sores. This care plan contained all relevant issues and was up to date. There was a referral to the dietician and a recommended diet to address the person's needs, for example having a high protein diet and vegetables.

A person told us they had a specialist mattress and chair to help them with the treatment for the pressure sore.

A nurse told us that the specialist team had said staff should only offer a person food and drink when they were alert to prevent choking. However this recommendation

Requires improvement

Is the service responsive?

has not been recorded on the persons eating and drinking care plan. The nurse then added this to the care plan to ensure all staff responded appropriately to this person's health needs.

The home employs an activity coordinator for 25 hours a week. She explained that she consulted people about their likes and dislikes and involved them in future planning for activities. She told us she researched best practice on providing activities and that everything was focused on people's preferences. For example, she assumed that one of the group events that she thought people would enjoy was bingo. However, when she asked most people were not interested in this.

There was a large lounge devoted to activities and she ran a regular knitting club, gardening club and coffee morning. A garden had been created with raised beds so that people could reach from wheel chairs. She said one person who liked to be on their own now joined in the gardening club. On the day of the inspection she was painting people nails for people which they appeared to enjoy.

When we spoke with people, two people said they enjoyed reading and could use the library. One person loved jazz music and was able to listen to their collection of CDs in their room. Another person was a keen knitter and who we observed them doing this.

We saw a person using the garden. The activities organiser said that if people wanted to have a walk in the garden they could do so, with staff assistance if needed. There was also a bird aveiry in the garden and the activities organiser said people enjoyed watching the birds.

Staff told us that some people would like to get out more on a one-to-one basis, having outings and having more activities at weekends when the activities organiser was not working. The manager said these issues would be acted on.

When we first came into the lounge we found loud pop music on. No one appeared to be enjoying listening to this and it made it difficult for people to hear what other people were saying when they had conversations. Eventually, it was turned down. The manager said she would follow this up with staff as she said that people had not should have been asked if they wanted music on and what type of music they wanted to listen to, and staff should have done this.

People told us they would find it easy to make a complaint if they wanted to.

The provider's complaints procedure gave information on how people could complain about the service if they wanted to. This included information on how to contact the local authority should a complaint not be resolved to their satisfaction. We saw an instance where someone had used an advocacy service to obtain the care they needed. This meant that people have been able to communicate their views of the service.

We looked at the complaints file. We found details of any complaints made. These had been investigated and followed up by the registered manager to the complainant. However, the response to one complaint did not meet the communication needs of the person involved. The area manager stated that complaints would be closely monitored in the future to ensure complainants received a response that fully met their concerns. This would then show that a proper response was carried out to deal with people's issues.

We looked at accident records. We found where people had falls and been injured, nursing staff had responded to people's medical needs.

Requires improvement

Is the service well-led?

Our findings

A relative had said that he had been told by management, that if there were any problems he should speak to them. He was unsure that there were relatives meetings he could attend. The manager said that a meeting was to be arranged shortly and that she would be letting relatives know of this.

A person told us, ''I like art and the previous manager said she'd get equipment but it never happened. Also, no acrylic paints have appeared.'' This does not show an example of a well led service that people were promised equipment which did not materialise. The manager stated this would be followed up. The registered manager stated to us after the inspection that the person in question has now been supplied with acrylic paints.

Staff told us that they had received training in maintaining people's dignity but this did not form part of staff meetings or in their supervisions. This lack of emphasis of people's rights to considerate care does not indicate a well led service.

We saw that 'Residents and relatives' meetings were infrequently held as there was a gap of 11 months between meetings held in 2014 and 2015. This did not show that the amount of people had been regularly consulted about the running of the service. The manager agreed that meetings needed to be more frequently, this had been included in the improvement plan she had written and another meeting was shortly to be held. Although we were not made aware of this at the time of inspection, the registered manager informed us after the inspection that such meetings have been held quarterly and the last one was held in July 2015. This frequency has been reviewed and meetings are now held every month, with a newsletter supplied to relatives who are unable to attend.

Some quality assurance checks were in place. Health and safety audit checks showed that water temperatures had been checked, and fire records showed that fire alarms and drills had taken place to keep people safe from fire hazards. However, there was no evidence indicating that all staff had been involved in a fire drill in the past year. The infection control audit stated there was an issue with linen being stored in bathrooms but no action had been taken to rectify this as the audit stated there was insufficient storage. This did not meet the aims of the infection control audit to ensure all risks from infection were prevented.

Medicines and care plans and risk assessments for people living in the service had also been audited. However, there were no audits for essential issues such as staff practice, staffing levels, staff recruitment checks and the provision of activities for people. This did not fully demonstrate that management were ensuring the service was well led and committed to providing high quality care to the people using the service. The manager and area manager stated that issues would be audited and acted on in the future. This will then help to develop the quality of the service to indicate a fully well led service.

Staff had mixed views about the leadership of the home under the registered manager and the vision and values of the organisation. Some staff, some stated that they felt supported and were given clear guidance on maintaining personalised care for people. Other staff but others felt unsupported and said the registered manager did not come out of the office and check to see if the home was running smoothly and that people's needs were being met. One staff member said she was reticent about approaching the registered manager as she thought she would receive a negative response if she raised any issues. She thought the registered manager had favourites amongst the staff and only listened to this group and not all staff.

Another staff member said that essential information had not been communicated to her by the registered manager such as issues that whistle-blowers had made about poor care.

This indicated that not all staff felt able to raise concerns or ideas with the registered manager. They did not always feel the registered manager was always available to speak with if there was a problem or concern or that she would try to follow this up and resolve it. We saw from staff survey results in 2014 that nearly 40% of staff did think that action would be taken if issues were raised. This indicated a service that was not always responsive to staff concerns. Although there were also positive results from over 80% of staff regarding the manager's leadership qualities.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **People had not been protected from risks to their safety**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent **Staff had not sought and received people's consent when they had supplied care to them**