Epping Care Homes Limited

Treetops Care Home

Inspection report

23-25 Station Road
Epping
Essex CM16 4HH
Tel: 01992 573322
Website: www.treetopsepping.webs.com

Date of inspection visit: 18 November 2014 and 19 November 2014
Date of publication: 20/04/2015

Ratings

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

Overall summary

This inspection took place on 18 and 19 November 2014.

Treetops Care Home provides care and accommodation for up to 52 people, some of whom who have dementia care needs. There were 40 people using the service on the day of our inspection, two of whom were in hospital.

There was no registered manager in post at the service as required. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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. A new manager had been appointed at the service however they were not available at the time of this inspection.

At our last inspection of 19 August 2014, we issued a warning notice requiring the provider to make improvement to their assessment and monitoring of the quality of the service they provided. The warning notice also required the provider to improve their identification, assessment and management of risks to people living in the service and others. We also asked the provider to make improvements to supporting staff in their role and

Summary of findings

to keeping accurate records that protected people from the risk of receiving unsuitable care. Following that inspection, the provider sent us action plans to tell us the improvements they were going to make.

We found at this inspection that effective improvements had not been made. A quality assurance system had been introduced but the provider was unaware of how to implement it. As a result, monitoring of the quality of the service people received had not improved and the service was not being run to take account of their best interests.

The provider was unable to show us how they identified where improvements to the service were needed to ensure that risks to people's safety and well-being were being safely managed. They had failed to implement changes and follow advice of organisations such as those who commission care and the environmental health authority.

Formal arrangements were not in place to ensure that newly employed staff received a full and comprehensive induction. Effective systems were not in place to support staff appropriately, identify their developmental needs or check that they had learnt from their training. Not all staff had received appropriate training to enable them to deliver care and support to people who use the service safely and to an appropriate standard.

We found that people's care plans did not always reflect current information to guide staff on the most appropriate care people required to meet their individual and assessed needs. Information on people's interests was not used to design suitable activities and people received little mental stimulation.

People's safety was being compromised in a number of areas. People's medication was not safely managed putting them at risk of unnecessary pain or deterioration in their health.

Checks on staff had not always been completed before they started working in the service to make sure they were suitable to work with vulnerable people. There were not always enough skilled and competent staff available to meet people's needs safely.

Mental capacity assessments were not carried out and people who knew the person well were not involved in making decisions or helping to plan the person's care. The approach to caring for people living with dementia was weak and people's dignity was not respected. Staff did not engage and communicate with people effectively and the environment did not support people to feel orientated and safe.

People's personal privacy was respected although written information about them was not.

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

An effective system was not in place to gain the views of people using the service and use these to improve it. People using the service did not feel confident to raise concerns and complaints. The provider had not learned from complaints and other incidents and used them to improve the quality of the service people received.

You can see the action we told the provider to take at the back of the full version of this report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was not safe.

People were at risk because areas of the home were not safe.

There were not enough staff to provide people with the support they needed.

People did not always get their medicines when they needed them.

Inadequate

Is the service effective?
The service was not effective.

Staff had not always been trained and supported to carry out their roles and responsibilities.

Care staff did not have an understanding of the Mental Capacity Act or the Deprivation of Liberty Safeguards and how this affected people living in the service.

Inadequate

Is the service caring?
The service was not consistently caring.

Some staff demonstrated a lack of respect, compassion and interest in the people they cared for.

People's confidential information was not securely held.

Inadequate

Is the service responsive?
The service was not responsive.

Some people's needs had not been thoroughly assessed and planned for.

People had limited opportunities for social interactions and hobbies that met their individual needs or provided them with mental stimulation.

Complaints were not responded to in a positive way and learnt from so as to improve the quality of the service that people experienced.

Inadequate

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

Action had not been taken to address previous breaches of regulations we had identified.

The provider's systems to check the quality and safety of the service were poor and had not identified shortfalls in the quality of the service.

Inadequate

Treetops 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.

This inspection took place on 18 and 19 November 2104 and was unannounced.

The inspection team included two inspectors on both days. On 18 November 2014 an expert by experience and a specialist professional advisor were also present. An expert by experience is a person who has personal experience of using or caring for someone who uses care services, in this case, for older people. The specialist professional advisor is a person who has specialist knowledge and experience, in this case, of dementia care and associated needs.

Before the inspection, we looked at information that we had received about the service. This included any notifications from the provider. Statutory notifications include information about important events which the provider is required to send us by law.

As part of the inspection process, we also gathered information from three external professional bodies.

We spoke with 11 people and two of their visiting relatives. As well as generally observing everyday life in the service during our visit, we used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We spoke with the deputy manager, the registered provider's representative (the Nominated Individual), six care staff and two members of the housekeeping staff. We also spoke with two healthcare professionals.

We looked at eight people's care records including medication records. We also looked at the arrangements for staff recruitment, training, supervision, complaints and quality assurance and risk management in the service.

Inadequate

Is the service safe?

Our findings

People told us they felt safe at the service; however we found several areas of concern.

Arrangements were not in place in the service to ensure that medicines were obtained, administered and recorded safely for the protection of people who used the service. Due to our level of concern during our inspection, we immediately reported this to the local safeguarding authority who are responsible for investigating circumstances where people may be at risk.

People's medicines were not obtained in a way that made sure there was always a supply of their medicines available to them. One person told us that they did not always receive their inhaler, prescribed to help them with their breathing. The person's medication had been ordered but not available for them for a seven day period. Another person did not have the medication they needed for 13 days as it too was on order. These people were at risk of their health deteriorating because they did not receive the medicines prescribed for their medical conditions.

Where people were prescribed their medicines on a 'when required' basis, for example, for pain relief, we found, in some cases, there was insufficient guidance for staff on the circumstances these medicines were to be used. This meant that that staff did not have the instructions they needed to ensure that people might receive their prescribed medicines for pain when they needed it. One person told us that they had not received their pain relief medication and that they were in pain. They said, "I was awake all night with the pain."

People told us that they did not always receive their prescribed cream. The creams were prescribed for skin conditions which meant that people's conditions could be left untreated and they could have suffered discomfort.

Staff told us that they could not explain why some people's medicine was not recorded as having been given to them. They also could not tell us if people had received those medicines or not.

We found that the registered provider had not protected people against the risk of poor medicines management. This was in breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People told us that there was not enough staff to help them when they needed it. One person told us that they had waited half an hour having asked for help and said, "I have waited so long I have done it in my pants. The first time since I was a child." One person told us that they did not get their medications when they should because they were not always enough staff available to administer medication at the expected times.

We found one person walking up and down an upstairs corridor saying "Where is someone to tell." There were no care staff on that corridor at that time, however a care staff member came upstairs soon after and attended to the person. There were periods of 15 minutes when there were no staff present in the lounge.

People in the lounge required constant staff supervision because of steps in the lounge that placed people at a high risk of falls. All staff were not aware of the risks associated with the steps in the lounge and of what actions were in place to reduce the risk until the barrier was put in to reduce the risk of falls. At several points during the day we saw this did not happen when staff were busy assisting people, or when they were called away to another area.

The deputy manager told us that changes and increases to people's needs had not been taken into consideration when determining how many staff were on duty or how they were deployed.

We found that the registered provider had not protected people against the risk of insufficient numbers of appropriate staff to meet people's needs. This was in breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Safe recruitment processes were not always completed to ensure staff were suitable before working at the service An assessment were not in place which reflected the risk posed to people when staff worked in the service without having current references and background checks in place. Additionally, the provider was unable to show us that they had confirmed the identity of some agency staff on duty in the service or verified that proper checks had been completed on all of these staff. This meant the provider could not be sure that all staff were of suitable character and competence to work with people who use the service.

Inadequate

Is the service safe?

Some staff knew how to safeguard people from harm but not everyone had completed the training. Staff we spoke with were able to demonstrate a good understanding and awareness of the different types of abuse and how to respond appropriately where abuse was suspected. The manager had notified us as required of some safeguarding incidents in the service since our last inspection. However, they had not recognised that risks associated with people's medicines were also matters which needed reporting to us and to the safeguarding authority, in accordance with the local arrangements. Failing to do this meant that the service was not sharing incidents effecting people so that they could be discussed, monitored or investigated as appropriate.

Inadequate

Is the service effective?

Our findings

At our inspections on 4 February 2014 and 19 August 2014, we found that staff were not consistently provided with induction, training, supervision, appraisal and support to enable them to provide people with the care they needed in a safe way. We asked the provider to send us an action plan outlining the actions taken to make improvements. We found at this inspection that improvements had not been made.

A new member of staff was to commence working at the service on the day after our inspection. However, while a brief overview was in place, there was still no induction programme in place to ensure that new employees understood their role. There was no clear information available to show which staff working in the service had been provided with training. Although some staff had completed training on dementia on the day before our inspection it was not effective because they were unable to explain how they would use the training in practice to better understand and support the people they cared for.

People told us that staff did not manage their medicines competently. One person told us that staff did not always apply their prescribed cream when, and in the way, that they should. They said, “It’s a job to get them [staff] to do it. They rub me too hard.” Given the concerns identified in relation to people’s medicines, we looked to see if staff who administered medication had received appropriate training and if they had had their competency assessed at regular intervals. We found that three out of four members of staff had last received medication training in 2012 and only one member of staff had received a medication competency assessment in October 2013. This was confirmed as accurate by the deputy manager.

Some care staff had not completed training in moving and handling, safeguarding people, fire safety, first aid or dementia care. This meant that people continued to be cared for by staff who were not consistently trained and competent to provide people with the care that they needed. One person told us, "I don't think some staff are trained. A staff member last week pulled my bed rail out instead of up. It took ages to sort it out." We saw that staff were not skilled and competent in engaging people with dementia associated needs so as to provide them with the necessary care and support. For example, staff did not have an understanding of how to engage people in meaningful conversation to enrich people’s social and emotional experiences or to communicate with people in a way that helped them to understand and show preferences, such as what to eat and drink.

We found that the registered provider had not protected people against the risk of staff receiving inappropriate supervision, training and appraisal. This was in breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 18(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessments had not been made to consider whether individual people had capacity to make their own decisions. Where decisions were made on people's behalf, there was no information to show that others who were legally allowed to had been involved in making the decisions to represent the person’s views and preferences. Sometimes this is a family member or an independent advocate. This meant we could not see if decisions had been made in the person's best interest and in the least restrictive way.

One person told us the front door was locked. They said, “I say I want to go out they don't answer me. I'm only one person. If there were more than one of us, things would be different. I do not want to live here.” No referral had been made or further assessment undertaken in response to this person's views and so it was not clear if their freedoms and human rights were being respected.

We saw that the front door was locked and there were key pads preventing people from opening some doors within the service. The provider could not explain what actions had been taken to ensure that people's freedom was not being restricted unnecessarily. There was no system in place to show what effect this might have on people who were able to make their own decisions about going outside or to move about freely and how their rights were to be supported.

Staff told us that they did not really understand the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS) or how this might impact on people living in the service. These safeguards protect people’s rights by ensuring that any restrictions on their freedom and liberty, needed for their safety, are assessed by appropriately trained professionals. Information provided by the provider confirmed that the majority of staff had not

Inadequate

Is the service effective?

received training on the MCA or DoLS. Because staff did not have a full understanding of taking people's capacity into account when making choices on their behalf, they were at risk of restricting people's freedom unnecessarily and not having regard for their best interests.

We found that the registered provider had not protected people against the risk receiving care and treatment without the consent of the relevant person. This was in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Suitable adjustments had not been made to support people living with dementia associated needs. Signage throughout the building was poor or confusing and did not follow best practice and up to date guidance to support people with dementia to orientate themselves. There were few clear signs, symbols or colours to help people to recognise their own bedroom, or the use of other rooms such as toilets. Most of the stairs had little contrasting colour on the steps and several of the floors included slopes which presented a significant fall hazard. The large combined lounge and dining room meant it was difficult for the service to offer different activities and experiences or accommodate people with different tolerance to noise and other distractions. This meant that people did not have access to premises suitably designed to meet their needs.

We found that the registered provider had not protected people against the risk of receiving care in premises not suitable for their purpose. This was in breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 15(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us that they enjoyed the food they were served and that they had enough to eat and drink. People were provided with equipment such as a plate guard to help them maintain their independence skills. The nutritional needs of people were identified and regular checks of their weight completed. Where people who used the service were considered to be at nutritional risk, regular monitoring was in place and we found that an appropriate referral to a healthcare professional such as GP had been made.

However, the service did not support people to make informed choices about they liked to eat and drink. Some people were eating steak and kidney but believed they were eating turkey. People with memory loss and confusion were asked for their meal preference the day before and were unable to tell us which choice of meal they had picked. The staff not had taken into consideration the use of specialist equipment or communication aids such as picture cards or menus to help people living with dementia to choose their preferred meal, although these were available.

A health professional told us that staff picked up on concerns quickly, informed them, listened and carried out their advice.

One person had a health condition that needed aspects of their health to be reviewed and monitored by their GP. Staff were unclear as to whether this monitoring had taken place. Another person was noted to have three recent nights where they were, for example, 'shaky, very confused and unsettled'. Staff and the deputy manager were unable to confirm that this had been reported the person's GP. The deputy manager confirmed that there was no entry in the person's records to show that a health professional had been accessed to check the person's health and well-being.

Inadequate

Is the service caring?

Our findings

People did not consistently receive a service that was caring and compassionate. People we spoke with told us that the staff were kind and offered comments such as, "The girls are wonderful. I have no concerns. They are cheerful, good, kind girls." Another person told us that staff treated them “most kindly.” We saw some instances where staff, particularly domestic staff, spoke kindly to people.

Staff gave more time and attention to those people who were able to chat and communicate easily with them. Staff spoke regularly to some people, addressing them by their preferred name and showing an interest and knowledge of things and people that were part of people’s lives. However, other people who were withdrawn and communicated less easily, such as people living with dementia, were consistently isolated even within the communal setting of the lounge. Staff did not regularly take opportunities to make eye contact with all people living in the service, respond to them in a caring way or engage with them in conversation.

We saw, for example, that one person was sitting in the lounge one morning. When the staff member came into the room and asked the person about their breakfast, they did not look at the person. They did not wait for the person’s answer or notice that the person was attempting to speak and hold their hand out to the staff member. Instead the staff member gave the person some tea and toast without any personal involvement and moved on to another person. This showed a lack of consideration for the person and their needs as an individual. It also showed that the completion of tasks was given priority over the delivery of care that was sensitive to, and met, the person’s individual needs.

People did not always feel well cared for or cared about. One person said, “All day yesterday I looked a wreck. They hadn’t seen to me.” We saw that staff gave some people drinks during a mid-morning drinks round without asking them what they would like. One person told us that the only one who asked them for their preference was the chef.

People living in the service were not made to feel that they mattered. Three people told us that they felt very much that their views and interests were irrelevant to staff as they were at the end of their lives. One person said, "They forget you exist." Another person said, “I’m having a rotten time here. I don’t think you’re treated properly. Do as you’re told. That’s it.”

People were not always treated in a respectful way by staff. A relative told us that some staff were more concerned than others about this and said, “Because [person] is a pleasant person they pay [person] a lot of attention. I never come away thinking there are problems. There are minor issues. Sometimes [person] has no teeth or glasses and is wearing other people’s clothing. There are several sets of teeth in [person’s] bedroom and glasses that the staff have bought for [person] with their name on.”

People's dignity was not always considered. At lunchtime, a member of staff administered one person's eye drops to them while they were seated at the table without asking their agreement or consulting others also seated at the dining table. This did not respect that person’s feelings, or the feelings of others at the meal table.

Additionally, we found that people’s records were not securely stored. People’s records were stored in an unlocked cabinet in a side area of the communal lounge and available to all. There were several times when no staff were in this area and anyone could have accessed this confidential information. We also found the door to the manager’s office to be open and the room unattended on several occasions. Records were stored on open shelves. This compromised the privacy and confidentiality of people’s personal information.

We found that the registered provider had not protected people against the risk of not being treated with dignity and respect. This was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service responsive?

Our findings

Previous inspections, identified concerns that people were not protected from the risk of unsafe care as records were not sufficiently personalised, accurate or detailed. This was a breach of Regulation 20 of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2010. The provider sent us an action plan that confirmed that a new record system was up and running to ensure that accurate and appropriate records were maintained. At this inspection we found that the required improvements had not been made.

People's care records included a personal life history section to identify life events, people and experiences that were important to the person. They also noted people's interests and hobbies so that staff could provide opportunities for activities that interested people or were suitable to their needs. The life histories contained varying levels of information and for one person, who had lived in the service since 2012, had not been completed at all. This limited the information on which to build opportunities for meaningful conversations and develop relationships with people.

One person's medical history identified them as living with dementia and their activities of daily living noted that they had memory loss and confusion. There was no further information on how this affected the person in a day-to-day way and what actions staff should take to ensure that the person's individual needs were identified and met. The deputy manager told us they were aware that one person's behaviour, which was affected by their dementia, should have been monitored on a chart. This was to help identify what may have triggered the behaviours so that strategies could be developed to better support the person. The deputy manager, however, was unable to tell us why these were not in place. The daily notes of the care that staff provided to people were seen to be almost identical on several occasions and about different people. This did not demonstrate that the care and support provided was individual, personal and sensitive to each person's needs and mood at the particular time. It did not confirm that the service was proactive in supporting people with dementia or that the person's assessed needs were being met.

One person had had six falls during October 2014, some of which had resulted in them sustaining an injury. There was no evidence to show that staff had contacted healthcare professionals, such as the local falls prevention team, in response to the changes in the person's needs. The person's moving and handling assessment had not been updated to show this and the changes to the number of staff required to meet the person's needs to ensure their safety following the first four falls. The most recent review of the care plan did not reflect the two most recent falls. The meant that the person's care records did not provide an accurate record of their care needs so that staff could provide the care the person needed in a safe way.

We found that the registered provider had not protected people against the risk of insecure and accurate records about people. This was in continual breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 17(1) and (2)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not protected against the risk of inappropriate or unsafe care as their needs were not fully assessed. This meant that staff did not always have personalised information available to them on how best to give each person the care they needed and in the way they preferred. Consequently, people may not have received care in the way that they would wish to. None of the people we spoke with were involved in planning their care. One person's record noted in a recent review that the person was happy with their care. When we spoke with the person, they told us they were unaware that they had been asked about this.

People were at risk of receiving inappropriate or unsafe care as their care was not clearly planned and records were not always clear, accurate or fully completed. People's individual risks, such as for falls, were identified within their care records but there were no clear instructions for staff on what to do to reduce the risk for each person so as to promote people's safety.

People's care plans did not fully reflect people's care needs and had not been updated to reflect new information where a person's needs had changed. For example, we saw that a health professional had identified the need for a person who had a pressure ulcer to be repositioned two hourly at night, to be recorded on a chart. This was to limit pressure to specific areas of their body and prevent further damage. The information had not been carried forward into the person's care management records. Two of three staff were unaware that the person had a pressure ulcer. The deputy manager confirmed that a specific turning chart was not in use to show that the person had received

Inadequate

Is the service responsive?

the care that they needed. One person's daily care notes showed that "fluids were improving with prompting". There were no records or charts within the person's care plan to explain whether there was a particular concern around fluid intake or whether there was any systematic way of monitoring this.

People's individual social care needs were not assessed and provided for to ensure their welfare and well-being. People had limited social activities to meet their needs. One person told us that the new manager had recently taken them to a Remembrance Day event which really mattered to them. Other people did not experience social activities and pastimes that interested them or were suitable to their needs. A visitor said that the person living in the service, "Is very much with it, but has no opportunity to go out. There is not enough stimulus." Staff told us that they recorded all social activities provided to people. The records we looked at showed that some people had not been provided with any social activity for several weeks. Another visitor said, "When [person] first came two years ago there was entertainment but now [they] just sit around. The new manager held an open evening. It was very good and mentioned doing more entertainment."

People were isolated because staff did not spend time talking with and listening to them to find out about their particular feelings and wishes at that time. This included people who chose to stay in their bedroom. One person said, "You are not treated as someone who knows more. You are just one of them. I sit here doing nothing."

We found that the registered provider had not protected people against the risk of care and support that was unsafe and did not meet their needs. This was in breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 9(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A person using the service did not feel confident to complain. They told us they felt staff had treated them in a less favourable way after they had made a complaint. Another person told us that the management team were aware of a matter of dissatisfaction but had done nothing about it. Another complainant felt that the provider had not listened to their concerns or addressed them appropriately and that it was only when the complainants involved external agencies that the provider took any action.

We attempted to follow up people's concerns but we were unable to ascertain if the complaints had been dealt with and if they were actioned and monitored by the provider as planned. We were unable to confirm that complainants had received any further feedback or reassurance that all of their concerns had been acted upon. It was not evident that actions had been implemented and sustained because the complaints system had not clearly recorded the process and outcomes of all complaints.

Inadequate

Is the service well-led?

Our findings

At our previous inspections we found that the provider did not have an effective system in place to regularly assess and monitor the quality and safety of the service that people received. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

As a result of a continual breach of this regulation, a warning notice was issued on 22 September 2014 and the provider was required to achieve compliance by 20 October 2014. We also asked the provider to make improvements to two other areas of concern; supporting staff and record keeping. Improvement plans were sent to us by the provider between 1 October 2014 and 11 November 2014 to tell us of the steps taken to achieve compliance with regulatory requirements.

At this inspection we found continued breaches of the regulations. The provider had not met the requirements of the warning notice or taken suitable actions to address the other areas of concern.

Systems for improving the service through auditing and monitoring were not effective. For example the provider had implemented a system for staff to check the water temperatures. However this had not been properly completed by staff and remedial actions were not taken where issues were identified such as water being too cold or too hot. The provider had not monitored this to reassure themselves that effective action had been taken. As a result people told us that there was insufficient hot water available in some bedrooms to allow them to wash.

The services' own medication audits identified serious failings with the medicines system. These were not addressed so that when the Clinical Commissioning Group completed an audit of the medicines in the service a month later many of the failings identified by the manager's audit remained.

The provider had not responded positively to complaints received or used them as a way of improving the service for the people living there. For example, people were not offered the opportunity of having an apron to protect their clothing, although this had been an agreed action for the provider to take following a complaint.

The provider did not learn from past events and use them to promote people's safety and well- being. Procedures were not in place to ensure safe and effective operation of the service in the event of emergency, for example, in the event of an electrical failure or should the lift break down. The lift had previously broken down for several days but there were no detailed plans in place to guide staff on what to do and how to keep people safe and well cared for in such an instance. Staff were unclear how they would, for example, manage to get food or people's medicines to them in this instance.

The provider did not have a system in place to check that records supported effective management of the service so that people were protected. The deputy manager confirmed that no audits of the care records were completed so as to ensure that accurate information was available on the care people needed. The provider had no system in place to work out how many staff were required to meet the needs of people living in the service, or to judge if staff were effectively supported and competent. There was no strategy in place to provide additional staff in response to an emergency in the service.

Staff had not been provided with all the training they needed to enable them to meet the needs of people using the service in a safe way. The manager had introduced a programme of staff supervision. However, nine staff involved in direct care of people using the service had not received any supervision session since the last inspection. Appraisals had not yet taken place. This shows that the provider had not completed the improvements they told us of in their action plans following our previous inspections.

Views of the management in the service varied. Some people expressed confidence in the new manager, while other people told us they did not know who the manager was. One person living in the service said of the manager and deputy manager, "You could not get a finer pair but they relax too much", while another person said, "They could be a little harder on the staff, especially about the alarm bells (responding to the call bells)."

There was not an open and respectful culture in the service that supported good staff morale and teamwork. Leadership was inconsistent with staff being positive about the new manager, but raising concerns about the provider's attitude and relationship with staff. We looked at six staff surveys. These reflected that staff felt dissatisfied in their

Inadequate

Is the service well-led?

current job, received only limited information, and did not feel there were enough opportunities for the employee to let the organisation know how they feel about things that affect them at work.

The provider did not create a culture where staff could provide a service with clear objectives aimed to ensure that people's needs were met and risks were identified and actioned. There was a lack of policy and procedure to ensure that staff and management were consistent in their approach. The quality assurance system was not effective in identifying areas for improvement. Even when areas for improvement were identified by other professionals, action had not been taken in a timely manner to ensure that the service worked to improve and keep people safe. For example, action required by the environmental health officer for risk assessments in relation to safe moving and handling and the safe management of the water system to limit the risk of infection were repeatedly not completed. This meant that risks to people's safety were not effectively managed.

These issues demonstrated that the service was not well led and were a continual breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

A new manager had been appointed but was not registered and was not available at the time of our inspection. The manager had arranged a recent meeting so that people using the service and their relatives and friends could share their views about the service. Records of these were not available so we could not be sure that people's views were actively sought, listened to and acted upon. One visitor told us they had attended a meeting and felt that it had been useful. One person said, "They try to help you. I went to a meeting and said the food was good. They asked what we should do with the old people. I suggested bingo."

We met with the provider during our inspection. The provider was unable to tell us what the aims and objectives of the service were or how they ensured that these were met. The provider had failed to recognise their responsibility to address concerns identified by us, and others, such as the local authority, the clinical commissioning group and the environmental health officer. The provider had relied on external consultants and senior staff to ensure the safety and quality of the service people received. They had not however, provided sufficient support or oversight to ensure that improvements were achieved and sustained and did not demonstrate competence in running the service. The provider had failed to comply with, and was unable to demonstrate how they intended to comply with, the regulations as set out in the Health and Social Care Act 2008.

We found that the registered provider had not protected people against the risk of poor quality and safety of service provision. This was a breach of Regulation 8 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 8 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 18 HSCA (RA) Regulations 2014 Staffing We found that the registered provider had not protected people against the risk of insufficient numbers of appropriate staff to meet people's needs. This was in breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing We found that the registered provider had not protected people against the risk of staff receiving inappropriate supervision, training and appraisal. This was in breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 18(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent We found that the registered provider had not protected people against the risk receiving care and treatment without the consent of the relevant person. This was in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment We found that the registered provider had not protected people against the risk of receiving care in premises not suitable for their purpose. This was in breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 15(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect We found that the registered provider had not protected people against the risk of not being treated with dignity and respect. This was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance We found that the registered provider had not protected people against the risk of insecure and accurate records about people. This was in continual breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 17(1) and (2)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care We found that the registered provider had not protected people against the risk of care and support that was

This section is primarily information for the provider

Action we have told the provider to take

unsafe and did not meet their needs. This was in breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 9(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 8 HSCA (RA) Regulations 2014 General We found that the registered provider had not protected people against the risk of poor quality and safety of service provision. This was a breach of Regulation 8 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 8 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment People who used the service did not benefit from a service provider that had robust systems in place to manage their medicines safely.

The enforcement action we took:
We have served a warning notice to be met by 24 February 2015.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance People who used the service did not benefit from a service provider that had robust systems in place to monitor and improve the quality of the service that people received.

The enforcement action we took:
We have served a warning notice to be met by 27 February 2015.