Guysfield House Limited

Guysfield Residential Home

Inspection report

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Ratings

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

Overall summary

The inspection took place on 7 January 2015 and was unannounced. At previous inspections we found that people were not getting their care needs met, the environment was not cleaned to an appropriate standard, medicines were not managed safely and there was insufficient numbers of staff to meet people's needs. We also found that systems in place to monitor and manage the quality of the service were ineffective. We had taken enforcement action to ensure the provider took the required action, however, at this inspection we found that improvements in these areas had not been made.

Guysfield Residential Home is a care home which provides accommodation and personal care for up to 47 older people. At the time of our inspection there were 42 people living at the home. Although there was a manager in post they had not yet completed their registration. A registered manager is a person who has registered with

Summary of findings

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 associated Regulations about how the service is run.

Care Quality Commission (CQC) is required to monitor the operation of the Mental Capacity Act (2005) (MCA) and Deprivation of Liberty Safeguards (DoLS) and to report on what we find. DoLS are put in place to protect people where they do not have capacity to make decisions and where it is considered necessary to restrict their freedom in some way, usually to protect themselves or others. At the time of the inspection applications had been made to the local authority in relation to people who lived at the service. The manager and staff were familiar with their role in relation to MCA and DoLs.

Staff were clear on their role on reporting concerns to external agencies and had done so previously. Some staff were dedicated to their role and the people they supported. Most staff were caring and showed kindness.

However, we identified concerns in relation to the care and support people received. People's care plans had been updated but they did not always identify specific risks or issues. People were not having their needs met. In addition we identified that people were at risk of not getting sufficient amounts of food and drink.

Staffing numbers had greatly reduced due to staff leaving and the service had not been able to recruit sufficient numbers of staff to replace them. Recruitment files seen demonstrated that robust recruitment procedures were not always followed. Staff had received training and this was ongoing.

People did not always receive their medicines safely. The environment was dirty and standards of cleanliness were poor.

Management and leadership was not effective and systems in place to monitor and manage the service were inadequate.

We raised our concerns with the local authority who are working with the service to ensure people are safe.

At this inspection we found the service to be in breach of Regulations 9, 10, 11,12, 13, 14, 17, 22 and 23 of the Health and Social care Act 2008 (Regulated activities) Regulations 2010. You can see what action we told the provider to take and what action we are taking at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

There were insufficient staff to meet people's needs and recruitment procedures were not robust.

Medicines were not always managed safely.

Accidents and incidents were not reviewed to reduce further occurrences.

The environment was dirty and had malodour.

Is the service effective?

Inadequate

The service was not effective.

People's health needs were not always identified and responded to.

People did not always receive sufficient amounts of food and drink.

Staff received training. However, they did not feel supported.

Is the service caring?

Requires Improvement

The service was not caring.

Most staff interacted with kindness and were caring.

Dignity and privacy was not promoted.

People, or their relatives, were involved, where possible, in the planning of their care.

Is the service responsive?

Inadequate

The service was not responsive.

People did not receive care that was responsive to their needs.

Activities were limited which meant some people were isolated.

Complaints were not always resolved effectively.

Is the service well-led?

Inadequate

The service was not well led.

The service lacked strong and consistent leadership.

Monitoring systems were inaccurate.

Action plans were ineffective and incomplete.

Guysfield Residential 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 was meeting the legal requirements and regulations associated with the Health and Social Care Act 2012 and to look at the overall quality of the service.

This visit took place on 7 January 2015 and was carried out by an inspection team which was formed of three inspectors.

Before our inspection we reviewed information we held about the service including statutory notifications and enquiries relating to the service. Statutory notifications include information about important events which the provider is required to send us. The service completed a 'Provider Information Report' (PIR) for a previous pilot inspection. The PIR is a form that asks the provider to give some information about the service, what the service does well, improvements they plan to make and how they meet the five key questions.We requested that this was updated but this had not been carried out at the time of our inspection.

During the inspection we spoke with six people who lived at the service, five relatives and visitors, 11 members of staff and the manager and regional manager. We received feedback from health and social care professionals. We viewed seven people's support plans and five staff files. 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 due to complex health needs.

Inadequate

Is the service safe?

Our findings

When we inspected the service on 9 July 2014, we identified a breach in relation to the management of medicines. At this inspection we found that there were still issues in relation to the way people's medicines were managed.

People's medicines were not always managed so that they received them safely. Medication administration record charts (MAR) contained a profile sheet that recorded people's allergies and personal details including a current photograph for easy identification. People who needed medicines on an as needed basis had an assessment carried out for each person's individual condition. The dosage, type of medicine and reason it had been prescribed was recorded along with the expected outcome. Staff had also documented possible signs and symptoms that people may display where they are unable to communicate verbally.

Medicines being received into the home had two staff counted these and signed the record. This included controlled medicines, which were stored securely. The deputy manager told us that a daily audit was carried out to check stock, in addition to a monthly audit. When we selected random medicines, including controlled medicines we found each had the correct number of tablets remaining.

However, we saw a copy of a prescription for one person's antibiotic medicine. The recorded amount on the prescription was for 28 tablets, but by checking the MAR chart we saw only 14 were received and administered. We spoke with the deputy manager and asked why only half the required prescription had been given to the person. They were unable to explain why. At the request of the inspector, the deputy manager ordered a further 14 tablets to complete this person's courcs of antibiotics. However the MAR chart recorded course complete and there had been a gap of one day since the last tablet was given.This meant that this person's course of antibiotics had been interrupted due to the gap in their course occurring and therefore may have impacted on their health.

On the day of our inspection the times for administering people's medicines had been changed. Previously the home gave people their medicines four times daily; however this had been changed to three times. The new times were now 10am, 4pm and 9pm. We observed people being given their breakfast at 9am and shortly after, however some people did not receive their morning medicine until 10.45am and 11.05am. We saw people's prescribing instructions and saw that some medicines were required to be given 30 – 60 minutes before food. Where they had received their medicine one hour and forty five minutes after food, this meant it would not be as effectively absorbed. This meant that people were not given their medicines in accordance with the prescriber's instructions and therefore this may have impacted on their health.

We saw medicine left on a side table for person in two small beakers whilst a small child was visiting their relative. The medicine was left for a substantial period of time with no supervision by staff. It was eventually removed by the regional manager without the person taking it. This meant that there was a risk that the child may have inadvertently consumed medicines not prescribed for them and also that the person did not received their medicines in an appropriate timescale.

This was a continued breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

When we inspected the service on 9 July 2014 we identified concerns in regards to cleanliness and infection control. At this inspection we found that there had been some improvements in realtion to them management of laundry however some areas of concern remained.

People were not protected by the prevention and control of infection. Staff were observed to wear appropriate personal protective equipment (PPE) when providing both personal care and when preparing people's meals. For example, gloves, aprons and hair nets. However, we observed occasions where the regional manager provided personal care to people where it would be appropriate to wear PPE to mimimise the risk of infection and they did not wear PPE as required.

Throughout our inspection there was an unpleasant odour in many areas around the home .. The toilets on the ground floor had not been cleaned effectively and were stained with bodily fluid, as were the commodes and other equipment located in the bathroom to support people to shower.. We found an armchair in a small lounge which was used by people and this was visibly soiled and stained.Staff told us that it was likely that most chairs would be soiled

Is the service safe?

and we should check prior to sitting on any of them. In all communal areas we identified chairs and sofas which were in use that had been soiled We were told that cleaning of chairs was the responsibility of the housekeeping manager. These chairs had not been cleaned.

Cleaning staff were not available in the home until the afternoon when an agency domestic worker was on shift. Cleaning checks had not been carried out by the cleaning staff on shift the previous day. We asked to see a cleaning schedule for the staff to follow, however this was not shown to us on or following our visit.

The kitchenette serving area was dirty. This included food stains to the area around the hatch were food was served to people. The microwave was stained with food and food was splattered on the walls. The work surfaces were also dirty and the fridge had not been cleaned, the fridge also contained opened foods which were not dated or sealed and posed a contamination risk. People were drinking from plastic beakers which were heavily stained with brown marks, and which also had become frayed around the rim due to wear. This meant the beakers were difficult to clean and could pose a risk of infection.

People's bedrooms were also dirty and poorly maintained. For example, one person's room had a blind which was broken and dirty, covering a window which had not been cleaned for some time. On the floor next to their bed we saw heavy staining and remnants of food stuff. We showed this to the carer and they told us, "All I know is that the cleaner is not working today." The person was unable to tell us how they felt about their room being so dirty however we observed that this room would not maintained with an appropriate standard of cleanliness.

Previously we found that the laundry was poorly managed and soiled clothes were piled up awaiting cleaning. There was no separation of items as required and this impacted on people's bedding not being changed regularly or when required. However at this inspection we found that improvements had been made and laundry was managed appropriately. Soiled laundry was placed in the appropriate red bag, which would dissolve in the washing machine to minimise the risk of additional staff coming into contact with the soiled items and these were laundered appropriately.

This was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

When we inspected the service on 9 July 2014 we identified issues in relation to the numbers of suitably qualified staff at the service. At this inspection we found that the issue had not improved and staffing levels had further deteriorated.

People who lived at the home where unable to express their views about the staffing levels. Relatives told us that staffing levels were of great concern. One relative told us, "There are not enough staff and I can see the stress and pressure this puts the remaining carers under. Most agency staff try their hardest but you cannot expect them to be familiar with all of the residents."

The manager told us that 17 staff had left in recent weeks and two more when leaving at the end of the coming week. They had started recruitment but had not achieved the numbers they required. Staff told us that the staffing situation was "at breaking point" and at times they were working at very low numbers. One staff member told us, "We are not supported enough by managers [manager and senior staff] and particularly when we are working so hard with staff shortages." Staff told us when they were short staffed, the manager did not cover a shift themselves. Staff also told us that they had been told over Christmas they were told that the rota 'put out' was "in case the CQC turned up and was not factual". The rota we viewed, which the management team struggled to find, confirmed this and was supported by some of our observations. We asked for time sheets of staff to corroborate staffing levels, however, the management team where unable to access it and we have not received it. We spoke to the manager about the staffing levels for the home. They told us that what the minimum staffing levels for the home were at the current level of occupancy. Rotas we looked at covering December 2014 showed numerous occasions when the set staffing level was not met even with the use of agency. The manager agreed that shifts were not always able to be covered. They told us, "In December we had 16 people leave, of this 12 were carers. We use agency now, but we are unable to get the consistency of staff we need. Although they had identified the issues and were planning to address them through recruitment, prompt action had not been taken to ensure that people who supported by

Is the service safe?

adequate staffing numbers consistently. This had impacted on people who lived at the service as they did not get their care needs met and were left without the appropriate assistance.

We discussed the ongoing staffing issues with the management team. The manager told us that they completed a dependency assessment of people living at Guysfield on a monthly basis. The last available assessment of people's dependency had been completed on 07 October 2014. This had identified that within the present budgeted hours, the home was unable to provide 31 hours of care. The accompanying action plan did not address how these hours were to be filled to cater for the identified needs of people living at Guysfield at the time . Call bell audits were not routinely reviewed to assist with reviewing staffing levels. We looked at the call bell response times for when people call for help. The manager told us that anything over three minutes is a concern, however we showed the regional manager numerous calls that went unanswered for more than three minutes. Some of these were for periods of five to fifteen minutes where people were not receiving assistance. Where people may require assistance due to a fall or emergency they may not receive this in a timely manner.

Staffing shortages meant that there was an impact on others areas of the service. This included the, cleanliness of the environement, the way in which people received their medicines, and people were not having their basic care needs met.

This was a continued breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People were unable to tell us if they felt safe at the service. We observed that at times people were calling out or looking for assistance and they did not receive it. Staff we spoke with demonstrated their awareness of their role and responsibilities in relation to safeguarding and were confident to raise concerns both internally and to external agencies. We noted that there was information available on how to report or raise concerns about people's safety. However, several of the staff said they were not confident that their concerns were acted on when raised internally. One staff member told us, "It's as if we are ignored and are not worthy or important enough to raise good ideas about the welfare of our residents."

Staff told us that when they had brought concerns relating to people's safety and welfare to the management team there had been no action taken. This included where people's needs being met and staffing restrictions or skills which impacted on people's safety. Staff told us that the lack of action being taken resulted in people being at risk. We reviewed the information the management team sent us in regards to monitoring accidents, incidents and risks. Where issues had been identified, such as an increase in falls there was no clear action plan and no record of additional control measures being put into place.

Throughout our inspection we saw examples of where people had not had their basic care needs met for example, people were observed to be in soiled clothing for long periods of time and two people had not had their pressure care needs met which had resulted in the development of pressure sores. This placed people at risk of neglect which could cause them harm and impact on their safety.

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

The service did not ensure safe recruitment practices were followed. We looked at four recently recruited members of care staff. In each file staff had completed an application form and where appropriate attached a covering CV. Interview records were kept and staff completed health screening questionnaires and supplied copies of relevant training certificates. However, in two people's employment records the information was incomplete. This included unexplained gaps in their employment history and missing references. Interview records had not discussed these with the person, and no further attempt had been made to determine where a person had worked, or the reason for their departure.

Inadequate

Is the service effective?

Our findings

When we inspected the service on 9 July 2014 and 19 September 2014 we identified concerns in relation to people's care and welfare. At this inspection we found that there had been no improvement in this area and people were not receiving the appropriate care and support.

People's care notes showed that they had access to visiting health and social care professionals. We saw that referrals had been made to specialist teams such as Speech and Language Team (SALT), mental health professionals and the GP regularly visited. On the day of inspection we saw that when a change to the condition of a person's health was identified, the senior staff member contacted a health care professional. However, following the inspection we raised concerns about the standard of care people were receiving with the funding authority and they arranged for people to have review of their care by healthcare professionals. The reviews found people to have healthcare issues which impacted on their health which should have been identified and raised by the service. For example, people had untreated and unidentified pressure ulcers, people were dehydrated and people were also found to have faecal matter under their nails. This meant that people did not have their health or care needs met.

This was a continued breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Staff had received some training to support them in their role. However, they told us that due to time restraints they were not always able to deliver care in accordance with their training. Staff had access to an online training tool which they were encouraged to complete by the manager. However, we saw that not all staff had completed all the areas required of them. Staff told us that they had been receiving regular one to one supervision. We saw that these supervisions were recorded. However, they told us that they did not feel supported as concerns and requests for support were left unanswered.

During our observations we saw some appropriate practice by staff who were following the guidance they had been given. However, we also observed poor moving and handling practice for example, we saw staff members drag lifting a person. At the time of this poor practice a senior member of staff was present who did not intervene or discuss with the staff members for their own development. Staff told us that senior managers within the service also used these poor techniques and that these were used as they did not have the time to do things in accordance with their training and available guidance.

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

People were not always supported to eat and drink sufficient quantities to maintain their health. People told us they were hungry and others were calling out for a drink. These people had dry encrusted mouths indicating that it had been some time since they received a drink. Staff told us that they had a particularly busy morning and this impacted on providing people with food and drink. Some people did not receive breakfast until 11am. Health care professionals told us that people that they had assessed were dehydrated and had not received sufficient food intake.

Staff we spoke with knew of only one person who was on a supplement drink and were unable to tell us of anyone else who may require a fortified diet. A fortified diet is when food is supplemented with milk, cream, cheese or similar to increase its calorific and protein value. There were a number people who lived at the home who were assessed as being at high nutritional risk. We heard staff discussing that some people had refused their meals or drink and this was accepted. There was not always a plan to go back and try to encourage people to eat. We saw in records that people regularly refused their meals and this was recorded as "Declined".

We saw that at mid-morning and afternoon snacks and drinks were available. Night staff told us that providing drinks and snacks was part of their role at the start of their shift. However, we observed that only people who were able to request and support themselves with snacks had these.

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

People had their ability to make decisions monitored and where they were unable to make a decision, a relative had been consulted. There was a record of best interest decisions on people's care plans where a meeting had been held to ensure a person's needs were being met and these were being reviewed. For example, we saw one person who's health had deteriorated, we saw that their

Inadequate

Is the service effective?

family, health professionals and the staff had been involved in the decisions related to their changing care needs. The manager and staff had knowledge of DoLS and MCA and had implemented the process where needed in accordance with legislation.

Requires Improvement

Is the service caring?

Our findings

Some of the staff we spoke with knew people well and were able to tell us about their needs and life histories. We saw that staff did not always respond to people's needs promptly, for example we watched one person walking around in an anxious state as they needed support to go to the toilet. Staff did not respond to the person's needs and they remained in an state of anxiety and their dignity was not respected in this instance. We saw another person who had no footwear for two hours who told us "My feet are freezing cold." On several occasions we needed to bring people's requests for assistance to staff member's attention to ensure they had their needs met appropriately. This meant that people's dignity was not always promoted and staff did not support to people to promote their independence.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People who lived at the service were unable to comment on the relationships they had with staff. A relative told us, "The carers really work hard and they know my relative very well." Another said, "I have been really pleased at the progress my relative has made since they have been here. Give the staff credit as it is down to them."

We observed some positive interactions during our inspection and staff were kind in their approach. One staff member told us, "I love working here and I am so fond of our residents, we try to treat our residents as we would do our own family." However, staff told us that as they were busy they were only able to provide basic care and not in a way that met people's individual preferences and needs. We saw throughout the inspection that care was delivered in a task orientated manner. For example, staff were assisting more than one person at a time, standing over a person to help them eat and leaving people alone on the toilet when they were calling for assistance One staff member we spoke with told us, "We just don't get the time any more to provide care to people with care, it is just rush, rush, rush to get through the work. It is not a people job here anymore."

People were encouraged to be involved in the planning of their care. However, they were unable to tell us about this. We noted that their preferences had been sought and this was recorded in their care plan. When able, people had signed to indicate their involvement and in other instances, a relative had signed. A relative told us, "Yes I am involved in reviewing the care provided to my relative."

Inadequate

Is the service responsive?

Our findings

When we inspected the service on 19 September 2014 people were not receiving the appropriate pressure care to meet their needs. We issued the home with a warning notice which stated they must make improvements to become compliant with this regulation. However, at this inspection we saw that there had been no improvements in this area.

People who were at risk of developing pressure ulcers had care plans in place which stated they required regular repositioning. Staff were aware of what their needs were even though they told us that they had not read people's care plans. However, records showed that people had often been in the same position for up to 12 hours. Staff told us that this was due to staffing levels and ability to meet people's needs. Care plans also stated that pressure relieving equipment must be set to the appropriate setting in accordance with the person's weight to provide effective pressure relief. However, two of the three mattresses we viewed were set incorrectly. This meant that people were at increased risk of developing a pressure ulcer as people's care plans were not being followed. Following our visit to the home people received a review by the district nurses. People were found to have developed pressure ulcers and moisture leisions. The manage then notified us of people who had developed pressure ulcers. This meant that staff had not identified, and therefore not provided the required pressure care to people.

Many of the people we saw had dirty nails, crumpled clothes, un-brushed hair and men were unshaven. Staff told us that they were too busy to anything other than basic care. The district nurses found that people were in the same unkempt state when they carried out reviews after our inspection. This meant that people were not receiving care that was responsive to their needs and continued to not have their needs met after we had brought it to the manager and staffs attention.

We saw that staff did not identify people who needed assistance. For example, we saw people who needed to use the toilet facilities and they were ignored by staff who did not recognise when people needed to use the toilet. We also saw people who were dressed inappropriately, for example, without any footwear and staff did not recognise or do anything to ensure people were dressed appropriately.

People's care plans had recently been completed. They included information about individually assessed needs, preferences and specific care plans which demonstrated that the people had been involved. These had been regularly reviewed. However, these reviews did not always take into consideration changes to a person's health and were in places generic with a "No change" comment even when a change had occurred. For example where a person had developed a pressure ulcer.

We noted that most of the people in their bedrooms, who had been there all day, did not receive any stimulation. Staff did one to two hourly checks but this was a visual check and did not always include interaction. Bedroom doors were closed and people were isolated. We heard one person who was in a quiet part of the house was calling out most of the day. Staff told us that they had encouraged this person to get involved in an activity the previous day. However, we noted that this person was alone in this area and did not know how to summon assistance and was reliant on the room checks as their only interaction. We also noted this was an issue for another person who was in a lounge alone all day. This may have increased people's anxiety and therefore impacted on their health and welfare.

People were unable to give their views on the activities provided. Relatives told us that they needed to have more variety and frequency. One relative told us, "There are not enough activities provided which stimulate my relative sufficiently or which are interesting or fun."

We saw some musical activities being offered in one of the communal areas. Staff were trying to encourage people to join in. However, the activity for the afternoon, which was hand and nail care, did not happen. The manager told us this was due to being an activity organiser short due to sickness.

We observed the handover in the morning which covered the emergencies from the previous night shift. However this did not discuss people's changing support needs for the day ahead. For example, people who had visitors, appointments, or who were unwell, were not prioritised. Out of 42 people living in Guysfield the senior discussed the needs of only five people.

This was a continued breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Inadequate

Is the service responsive?

We saw that complaints received related to the heating, laundry, cleanliness, lift breaking down and staffing issues. In some instances these were logged as substantiated.

There was a log of actions following the complaint. However, similar concerns from different complainants over a long period of time indicated that issues had not been resolved.

Inadequate

Is the service well-led?

Our findings

When we inspected the home on 9 July 2014 and 19 September 2014 we brought our concerns to the management team. Since those inspections a new manager has started in post. We met with the manager and regional manager in December 2014 who told us about the plans they had to make improvemetns within the service. However, at this inspection we found that previous issues remained a concern and there had been little or no improvement. We saw that the action plans developed by the management team were inaccurate and incomplete. This meant that they had not followed their own service improvement plan.

The manager and regional manager carried out audits. However, action plans were unclear in regards to who would complete the action and when it was done by. In some instances we saw where it had been signed as being completed, the action was still outstanding. For example, on cleaning audits stating cleanliness was at an acceptable standard and a medicines audit had identified that a copy of staff signature list of those authorised to administer medicines was not available in the MAR's. This had been signed as completed but we identified this was still missing from the MAR folder.

We also saw from audits and analysis documents that information was inaccurate. For example, in relation to the number of falls, incidents and notifications. Therefore the information the regional manager was reporting on was not able to identify issues in the home and an effective action plan had not been developed or implemented. This meant that the management team did not have a robust quality assurance system to ensure people received an appropriate and safe service.

Call bell audits were not routinely reviewed to assist with reviewing staffing levels. We found that even though significant staffing issues had been indentified and people's needs were clearly not being met, the manager had not used this information to review the service and make the required improvements. This meant that the management team were not using information available to them to improve the quality of the service.

Since our previous inspection the regional manager had conducted a home audit. In this audit they had satisfied themselves thatfloors and furnishings appeared clean and chairs were not soiled and dirty In On our inspection we found that floors and furnishings were soiled and dirty, the audit had It noted that these tasks were part of the night cleaning staffs responsibility, and that the manager and regional manager conducted regular checks. In addition the plan was updated on 02 January 2015 and noted, "Home using senior housekeeper from another of the provider's homes and improvements noted in the home. Reducing to one agency housekeeper from Monday 4th January. However, at our inspection we noted issues relating to infection control remained an ongoing concern.

A survey had been issued in October 2014. Responses were received and collated, however, an action plan was yet to be developed or shared with people and their relatives. Staff told us they were not kept informed of learning outcomes following a complaint or feedback. One staff member told us, "Yes we have team meetings and supervision and we are all generally assertive and raise issues and concerns but nothing ever changes." Another told us, ""The communication here is very poor. The staff group is completely disheartened."

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

People who lived at the home were unable to express their views about the management of the service. Relatives told us that there had been ongoing concerns. They told us that a relatives meeting had been held. The notes to this meeting stated that the concerns, along with our inspection reports, had been brought to both the management teams and provider's attention

Staff told us that there were "Serious issues" which they felt were not being addressed. Staff told us that they felt there was a lack of leadership and support. Comments included, "Our new manager is always in the office. I accept there must be a lot to sort out in there but we need some visible leadership." And, "Our manager is relatively new but there are more senior managers who have been around longer and still nothing is taken on board." We observed during the inspection that the manager had very little contact with people or the staff team and remained in their office for most of the day.

Staff went on to say that it was unusual for senior staff to be assisting with care and it was for our benefit. They told us they were unsupported on the floor by the senior team.

Inadequate

Is the service well-led?

Comments included, “Most seniors do not work directly with residents and certainly do not assist with personal care delivery.” And, “What you see today with seniors and managers assisting with personal care is not the usual way things happen here.” This meant that staff had no clear leadership and this was impacting on the quality of the service.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services **People were not having their needs met and the registered person did not promote their health, safety and welfare.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision **The registered person did not have effective systems in place to ensure the quality of the service.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse **The registered person did not ensure that people were safeguarded against the risk of abuse.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control **The registered person did not ensure that the environment was cleaned to an appropriate standard.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines

This section is primarily information for the provider

Action we have told the provider to take

The registered person did not ensure that people received their medicines safely.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010 Meeting nutritional needs The registered person did not ensure that people received sufficient amounts of food and drink.

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 ensure that staffing numbers were sufficient to meet people's needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff The registered person did not have suitable arrangements in place to ensure that persons employed were appropriately supported to enable them to deliver care to people safely and to an appropriate standard.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services People were not having their needs met and the registered person did not promote their health, safety and welfare.

The enforcement action we took:
We have issued a notice to impose conditions on their registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision The registered person did not have effective systems in place to ensure the quality of the service.

The enforcement action we took:
We have issued a notice to impose conditions on their registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse The registered person did not ensure that people were safeguarded against the risk of abuse.

The enforcement action we took:
We have issued a notice to impose conditions on their registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control The registered person did not ensure that the environment was cleaned to an appropriate standard.

This section is primarily information for the provider

Enforcement actions

The enforcement action we took:
We have issued a notice to impose conditions on their registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines The registered person did not ensure that people received their medicines safely.

The enforcement action we took:
We have issued a notice to impose conditions on their registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010 Meeting nutritional needs The registered person did not ensure that people received sufficient amounts of food and drink.

The enforcement action we took:
We have issued a notice to impose conditions on their registration.

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 ensure that staffing numbers were sufficient to meet people's needs.

The enforcement action we took:
We have issued a notice to impose conditions on their registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff The registered person did not have suitable arrangements in place to ensure that persons employed were appropriately supported to enable them to deliver care to people safely and to an appropriate standard.

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Enforcement actions

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