Metropolitan Housing Trust Limited

Fen Road

Inspection report

71-73 Fen Road
Chesterton
Cambridge
CB4 1UN
Tel: 01223425634
Website: www.metropolitan.org.uk

Date of inspection visit: 30 October and 2 November 2015
Date of publication: 10/12/2015

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

Fen Road is registered to provide accommodation and nursing care for up to 10 people. There were 9 people with a learning disability living in the home at the time of the inspection. People were accommodated in two bungalows and all bedrooms were single rooms.

This unannounced inspection took place on 30 October and 2 November 2015.

At the time of the inspection there was a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission to manage the home. 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 home is run. The registered manager was not in the home during the inspection.

The system to monitor the quality of the care being provided and to drive improvement was not effective and this impacted on all areas of the service.

Summary of findings

Risks had not always been managed to keep people as safe as possible. Risk assessments had not always been completed. This meant that staff did not have the information they required to ensure that people received safe care.

Accidents and incidents had not been managed effectively or reviewed to identify and address patterns or common themes. We could not be confident that people were receiving their medication as the prescriber had intended. Not all staff who administered medication had completed annual assessments of their competence. Current legislation was not being followed regarding the storage and recording of administration of medication. Medication audits were not being completed to identify any areas for improvement.

Action had not been taken in a timely manner to maintain, repair and replace equipment when necessary. Contingency plans had not been reviewed or updated so that staff knew what action to take in the event of an emergency.

Not all recruitment records were available. This meant that we could not be assured that staff had completed the necessary recruitment checks before being employed. We could not judge if the training provided to staff was sufficient to meet people's needs. This was because staff training information was not available for all staff. Staff could not tell us when they had last received their training. Staff were not receiving regular supervisions.

The Care Quality Commission (CQC) is required by law to monitor the Mental Capacity Act (MCA) 2005, Deprivation of Liberty Safeguards (DoLS) and to report on what we find. The provider was not acting in accordance with the requirements of the MCA including the DoLS. The provider could not demonstrate how they supported people to make decisions about their care and where they were unable to do so, there were no records showing that decisions were being taken in their best interests. This also meant that people were potentially being deprived of their liberty without the protection of the law.

People's dignity, respect and privacy was not always maintained. People's records were not held securely and confidential information was accessible to other people and visitors to the service.

Adequate food and drink was provided. However people were not always offered choices about what they would like to eat and drink.

Care plans did not contain all of the relevant information that staff required so that they knew how to meet people's current needs. We could not be confident that people always received the care and support that they needed.

Staff were aware of the procedure to follow if they thought someone had been harmed in any way.

Some staff knew how to communicate with people in a way that made people happy.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

Summary of findings

We found ten breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was not safe.

There was not a safe system in place to ensure that the necessary recruitment checks were completed before staff commenced employment at the home.

Risks to people had not been consistently assessed and action had not been taken to reduce risks to people.

Medicines were not managed safely.

Inadequate

Is the service effective?
The service was not effective.

Staff were not acting in accordance with the Mental Capacity Act 2005 including the Deprivation of Liberty Safeguards. This meant that people's rights were not being promoted or protected.

Staff were not receiving the support or training that they required to meet people's needs.

Inadequate

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

People were not always treated with dignity and respect.

Peoples confidentiality was not always maintained and personal records were not held securely.

People were offered some choices and staff knew how to communicate with people in the way that made them happy.

Inadequate

Is the service responsive?
The service was not responsive.

People were not always provided with care that was person centred and met their needs.

The complaints system was not effective and complaints had not been dealt with appropriately.

Inadequate

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

Staff were demotivated. Staff were not held accountable for the care they provided.

There was no effective quality assurance system in place to identify improvements needed and ensure that they were carried out.

Inadequate

Fen Road

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 30 October and 2 November 2015 and was unannounced. The inspection was carried out by one inspector on the first day and two inspectors on the second day.

Before our inspection we reviewed the information we held about the home. We reviewed notifications the provider had sent us since our previous inspection. A notification is important information about particular events that occur at the service that the provider is required by law to tell us about. We contacted local commissioners to obtain their views about the service.

Because we could not verbally communicate with the people living at Fen Road we observed how staff interacted and supported people to help assist us in understanding the quality of care they received.

We spoke with the area manager, acting deputy manager, four nurses and two care and support workers. We looked at the care records for two people. We also looked at records that related to health and safety including audits, and fire records. We looked at medication administration records (MARs).

Inadequate

Is the service safe?

Our findings

Steps had not always been taken to reduce the risks to people living in the home. Some risk assessments had not been reviewed when appropriate to ensure that they were still valid.

We found that risk assessments for people living in the home had not been fully completed. For example, we were by a nurse told that one person was being assisted to reposition regularly because there was a risk that they may develop pressure areas. The risk assessment front page was completed in November 2014 and showed that the person was at a very high risk of developing pressure areas. However there was no information to inform staff about the actions that they should take to reduce a pressure area developing. A nurse told us told us that risk assessments weren't regularly updated. We asked three different members of staff how often the person should be repositioned and we received three different answers. Although there were repositioning charts in place for staff to record when they repositioned the person we found that these hadn't been regularly completed. The charts showed that the person had been reposition at intervals of between two and eleven hours. We asked the area manager if this meant that the person hadn't been repositioned regularly or if the records had not been completed. The area manager stated, "I have told the staff that if they don't record things then they haven't been done."

We saw in another person's care notes dated 18 October 2015 that they had redness to the sacral area. A nurse could not provide us with a risk assessment for this person. The nurse showed us a "Waterlow" form that was blank. We asked if there was a completed form and they said they didn't know.

Accident and incident forms had not been completed as necessary. We found body map's for two people which recorded unexplained bruising. We asked two nurses what action they should take when bruising was identified with no explanation of how it may have been caused. Both nurses told us that they would record it on the body map and the person's clinical notes. There was no record in the clinical notes relating to the body maps. Both nurses stated that they would not take any further action. One of the body maps showed that the bruising on one person had been seen the day before our inspection. The nurse in charge of the shift stated that the bruising had not been mentioned when the previous nurse handed the shift over to them. The area manager stated that the policy for unexplained bruising was that an incident report should be completed and a referral sent to the local safeguarding team. There were no incident forms completed in relation to the bruising and it had not been referred to the local safeguarding team. There was no process in place for reviewing accidents or incidents to make sure that themes were identified and any necessary action had been taken. This meant that care was not always being provided in safe way and risks had not always been managed appropriately.

The hoists had been regularly serviced. The fire alarm system and fire extinguishers had been serviced annually The fire records stated that the fire alarms and emergency lighting must be tested weekly. The records showed that the most recent test was in July 2015. There was no record of a fire drill taking place. Fire drills should be carried out at a minimum of annually (or when new staff commence working in the home) to ensure that staff training has been understood. The deputy manager stated that she had not been present for a fire drill since she commenced working in the home in January 2015.Failure to test the fire alarms and emergency lighting and carry out a fire drill could place people at risk of harm in the event of a fire. The legionella risk assessment stated that the water should be tested weekly. However this had not been done since July 2015. The fire risk assessment in the home had not been reviewed and updated since March 2014. The area manager stated that the risk assessments, fire and legionella had been updated and they provided us with a new version of the risk assessments after the inspection.

The business contingency plan on display in the home had not been reviewed since October 2013. The details of staff to be contacted in the event of an emergency were no longer employed in the home. Failure to review and update the plan could put people at risk of harm.

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

The nurses were responsible for administering medication. The provider's medication protocol stated that all staff should complete an annual medication competency assessment. The acting deputy manager and area manager could not tell us if this protocol was applicable to nurses. The acting deputy manager (a nurse) confirmed that they had completed a competency assessment for the administration of medication when they had commenced

working at Fen Road in January 2015. However when we asked another nurse if they had completed a competency assessment they replied "We don't do that here." One nurse told us "I don't need to do medication training as I'm a nurse." Another nurse thought that it would be a good idea for the nurses to complete refresher medication training as some of the nurses had completed their initial training many years ago and best practice had changed. Training records and competency assessments were not accessible to us whilst we were in the home. The training records we were provided with after the inspection showed that the nurses had not completed training in the administration of medication whilst working at the home. There was no record of competency assessments.

We looked at the medication administration records and storage of medication and found significant concerns. Not all medication could be accounted for. Although there was a record of some medication being in stock this could not be found in the home .We were told that the medication had been returned to the pharmacy but that the return had not been recorded.

There was no signature list available so that we could identify which initials belonged to which member of staff.

The medication was supplied to the home in its original containers and was then stored on the shelves in the medication cupboard. The shelves had stickers on them with people's names. Because there was so much overstocking of medication people's medication was not always in the correct area. The provider's medication protocol stated that there should be no overstocking of medication. Because the stock levels of medication hadn't always been recorded it wasn't always possible to check if the stock levels reflected the records of medication held in the home. We checked that medication records reflected the amount in stock for four different medications. The records and amount of medication were incorrect for two of them. For one there was four tablets too few and for another one there was five tablets too many.

One box of tablets had the instructions crossed out and someone had written on it that the dose should be increased from once a day to twice a day. There was no signature to show who had made the change. The medication administration record had not been changed and the person was still receiving their medication once a day. The clinical notes for the person showed that during an admission to hospital the doctor had contacted the home and advised that the medication should be increased.

The medication administration chart for another person showed that they should be receiving their medication twice a day. However for the previous 30 days records showed that it had only been administered once. We asked the area manager and the nurse working at the time of the inspection if they were aware of why this had happened but no explanation could be given.

The medication on some medication administration records had been crossed through. We asked the nurse what this meant and they stated that this medication was no longer prescribed. When a code had been used on the medication administration records that required further explanation on the back of the chart this had not always been given. There had been no audits of the medication storage, administration or recording. This meant that we could not be confident that medication was being managed safely or that people were receiving their medication as prescribed.

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

Some areas of the home were in need of repair or redecoration. The furniture in the kitchen was three office chairs and two kitchen chairs that didn't match and a kitchen table. Two of the chair seats were covered in stains. There were shelves in the kitchen with various files about the people living in the home and policies and procedures. The kitchen wall was decorated with a black and white picture. Staff told us that the decoration on the kitchen wall had been put up to reflect a staff members interests when they had held a leaving party for them left in July and had not been taken down since. The registered manager had been advised by the area manager to replace the baths in the home several months before the inspection as they were in need of repair. During the inspection people living at 71 Fen Road were having to use the bath at 73 Fen Road. One bath at 71 Fen Road was not safe to be used and had been condemned by the manufacturer and the other was too small for people. The area manager stated that new baths were due to be fitted but a date had not been given for the work to be carried out. The second bath was also in need of repair or replacement. One person's bed had been broken for several weeks. This meant that that they could

not choose to go to bed when they wanted as they needed to be in a certain position during the day which they could not currently achieve in bed due to the repairs needed. The staff stated that they had reported the issue but were not aware what was being done about it. They also stated as the height of the bed could not be adjusted this was also putting a strain on their backs.

This was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us about their recruitment and that they were only employed after the necessary checks to ensure they were suitable to work in the home had been completed. However not all recruitment records were available in the home. We checked the records for two members of staff. For the member of staff who had been most recently recruited there was no staff file so we were unable to see all of their records. Their application form was found in a drawer in the office but no other information was available. We looked for the recruitment records for a second member of staff but no recruitment information could be found. The area manager stated that the registered manager had been instructed to request all recruitment information for all staff and to keep it on file in the home.

This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The staffing levels were not based on the needs of the individuals living at Fen Road. The area manager told us that the minimum staffing levels had been determined several years ago, but it was not known what those levels were based on. The area manager was currently reviewing with the commissioners the hours of support that were needed for each person living in the home. Due to staff vacancies bank staff and agency staff were being regularly used. The acting deputy manager told us that they tried to use the same bank and agency staff so that they were aware of the needs of the people living in the home. However there had been an issue recently when someone had been cancelling the agency shifts without management authorisation and this had left them under staffed at times. Other than when the agency staff had been cancelled staff told us that there was sufficient number of staff working on shift. On the day of the inspection staff were busy but had enough time to assist people with the support they required and had time to sit and talk with people.

Staff told us and records confirmed that staff had received training in safeguarding and protecting people from harm. A safeguarding policy was available and staff told us that they had read it. Staff were knowledgeable in recognising signs of potential abuse and were able to tell us what they would do if they suspected anyone had suffered any kind of harm.

The hoists had been regularly serviced. The fire alarm system and fire extinguishers had been serviced annually.

Inadequate

Is the service effective?

Our findings

The Care Quality Commission (CQC) is required by law to monitor the Mental Capacity Act (MCA) 2005, Deprivation of Liberty Safeguards (DoLS) and to report on what we find. The MCA aims to protect the human rights of people who may lack the mental capacity to make decisions for themselves. The DoLS are part of the MCA and aim to protect people who may need to be deprived of their liberty, in their best interests, to deliver essential care and treatment, when there is no less restrictive way of doing so. Any deprivation of liberty must be authorised by the local authority for it to be lawful. The service was not acting in accordance with the principles of the MCA. The area manager confirmed that all nine people may lack capacity to make some decisions for themselves. However, we saw no evidence of any mental capacity assessments or best interests decisions in people's care records. For example staff told us that some people would not understand that they were being given medication. This meant that decisions were being made on behalf of people without ensuring that they were being taken in the person's best interests.

The area manager told us that DoLS applications needed to be made for some people but this had not been done. Because the provider was not acting in accordance with the MCA, they were unable to properly identify whether people were being deprived of their liberty. This meant that potentially people were being deprived of their liberty unlawfully and without the protection and oversight of the authorising body.

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

Staff told us that when they commenced working in the home they worked "shadow shifts" where they observed and got to understand what support people needed. They also told us that they were expected to complete an induction which was recorded in the "Passport to excellence" workbook. We looked at the records for three members of staff and noted that the workbook had not been fully completed and in one case had not been completed at all.

It was not clear what training staff were expected to complete. We requested training records and although received some, we did not receive them for all staff. It was not clear from the records provided which members of staff were fully up to date with their training and which were not. The training records we received showed that although some of the people living at Fen Road had epilepsy not all staff had received epilepsy training. An internal audit of the home carried out in October 2015 by a representative of the provider had found that the lack of this training had impacted on people as it meant that not all staff were competent to accompany people outside of the home. This had reduced people's opportunities to take part in activities away from the home.

One nurses probation review in April 2015 stated that they should have tissue viability training. The nurse confirmed that this training had not been booked for them to attend. It was not clear from the records when staff had last received a supervision or appraisal. The nurses and care and support workers told us that they had not received any supervision sessions since the previous deputy manager had left in July 2015. This meant that we could not be confident that staff had the training and supervision they required to fulfil the requirements of their role.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us and records confirmed that people had been referred to the GP and other health professionals as needed. The acting deputy manager told us that the GP visited every Thursday to review people's health if necessary. We saw evidence that people had been referred to the dietician as necessary. However the guidance from the dietician hadn't always been shared with the staff team in a timely manner. The dietician had advised different nutritional supplements for one person on 1 October 2015 and had informed the registered manager but the information had not been shared with the staff. Health check documentation was seen in people's care plan's however this information wasn't always complete. People's files contained weight charts. The charts stated it was a legal requirement to weigh the person monthly. However people had not been weighed every month. No explanation was given as to why people had not been weighed every month. Staff did not know why people had not been weighed each month. Staff stated that fluid intake and output charts had been, "Rolled out about a month ago with no guidance". There was no guidance recorded about what the expected intake of fluids was for each person. The fluid charts that we looked at had not been

Inadequate

Is the service effective?

totalled at the end of the day to show what the total intake had been. An internal audit in October 2015 found, "One customer not attending regular health checks identified in their care plan. This will have a detrimental impact on the customer's health and well-being". This meant that we could not be confident that people were always receiving the appropriate care to meet their needs.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us that people were unable to choose their meals so they choose them based on what they had seemed to enjoy in the past. However when we asked if anyone living in the home would be able to choose meals from pictures of food we were told that one person may be able to. Where necessary people had been referred to a speech and language therapist for eating and drinking assessments. The information about how people's food and drink should be prepared was available for staff and was being followed. We saw that people were given the support they needed to eat and drink. We observed that one person had not been well and did not want to eat their meal. Staff respected this and offered them food again later in the day.

Inadequate

Is the service caring?

Our findings

Staff told us how they treated people with dignity and respect. They told us that they made sure that people's needs were met and that, they were treated as individuals. We saw that people were sometimes offered choices. For example, we observed a member of staff talking to someone about choosing the clothes that they were going to wear. One person's care plan included clear information about how they made choices. Staff told us that they knocked on people's doors before entering their bedroom and kept them covered up when offering personal care. We observed how staff interacted with people and saw that staff knew how to communicate with people. They spent time talking to people and they knew how to make people happy. For example, one person was not paying any attention to a care and support worker who was talking to them. The care and support worker started singing a song that the person liked and they laughed and smiled back at them.

We did not always see people being treated with dignity or respect or having their privacy upheld. We saw that staff didn't always knock before entering people's rooms. We also observed one person being assisted with personal care without their bedroom door being closed. We also observed that one person was left on their bed with their trousers around their knees and no sheet covering them. Their door had been left open. Staff explained that they would be going back to assist them with personal care.

One person had a monitor in their room so that staff would be able to hear if they were having a seizure whilst they were alone in their room. Staff told us that the monitor was switched off when the person was being assisted with personal care to promote their dignity and privacy. However during the inspection the monitor was left on whilst the person was being assisted with personal care.

Care plans were not always written in a way that promoted people's dignity. For example, one person's care plan stated that they can become quite agitated even though the problem "is usually minor and quite often nothing at all." Although the problem may seem minor to the member of staff the person may see it as more serious. The care plan then went on to state "[Name] has now received some attention though." This implies that the person is only doing something for attention, when actually they may be upset about something.

People's confidential records were stored on a shelf in the kitchen. This meant that anyone in the home could access this information.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service responsive?

Our findings

We looked at two care plans. One of the care plans was inaccurate and out of date and referred to the person walking with a frame even though staff told us that the person had not been able to walk for several months. It also referred to the person having a bath every morning however staff told us that the person did not like having a bath and regularly refused. Staff also stated that the person could no longer independently complete the personal care tasks as stated in the care plan. The care plan was dated November 2013 and had been written by the staff where the person had previously lived. There was no evidence that the care plan had been reviewed. Parts of the care plan were blank, for example, "All about me" and "Ring of support".

The second care plan we looked at had also been written by the staff where the person had previously lived. The care plan referred to various protocols that staff should follow. One of the protocols referred to how one person's physiotherapy exercises should be completed. The protocols were not in the care plan. We asked the nurse in charge and the care and support worker who had carried out the exercises for the person that day if they had ever seen the protocols. They stated they hadn't and didn't know where they were. The area manager found the protocols in another folder in the office. We checked with staff how they were carrying out the person's physiotherapy compared to what the protocol said. The staff were not following the protocol and thought that they were just applying cream for "dry skin" rather than to help with the person's mobility. The person's care plan also stated that the exercises should be completed in the evening however the staff were not aware that they should also be carried out in the evening. There was a chart for recording that the exercises had been completed. It had been completed on the 25, 28 and 29 October but no the 26 or 27 October. One person's care plan stated that they required regular mouth care throughout the day using a, "Green mouth swab". We asked the person's named nurse if a risk assessment had been completed for this. We were told that it was not good practice to use the swabs as it was a choking risk so it was not being done. However this information had not been removed from their care plan. Considering the high levels of agency staff being used it is very important to ensure that care plans are accurate. This meant that people were at risk of receiving inappropriate care and support.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was a complaints procedure in place and this was displayed in the entrance hall. There was no record available of any complaints that had been made to the staff at the home. The area manager confirmed that when opening post found in the office they had found complaints that had not been dealt with. The relatives of one person had also stated to the area manager that they had raised complaints in writing and had not received a response.

This was a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

One person attended a day centre from Monday to Friday. Other people living at Fen Road relied upon staff to support them with their activities. The daily activities coordinator stated that she was not aware of what the available budget was to be spent on daily activities or what people should pay for themselves. Each person had a weekly planner of activities. However this was not always being followed. Staff told us that activities outside of the home were often limited as there were only a few members of staff that could drive the vehicles and the taxi account had been closed as the bill had not been paid. During the inspection the area manager stated that the taxi account had been paid, however as the staff had not been made aware of this they had not tried to use a taxi to access activities. We also found that people had paid for their own taxi on occasions so that they could access activities outside of the home. People were not given the opportunity to get involved in everyday tasks such as shopping for the weekly food. We were told it was because the food had to be purchased using a card which only the registered manager and one senior nurse had access to. Each person had a weekly plan of activities written by the activity coordinator taking into consideration what they enjoyed. Activities included reflexology, foot spa and manicure, Thai- chi group, church, ball games and going for a walk.

Inadequate

Is the service well-led?

Our findings

There was a registered manager in place at the time of the inspection. The registered manager was not working during the inspection. One of the nurses was the acting deputy manager although they had only been working in that position for one week at the time of the inspection.

There was a lack of effective quality assurance systems being used to drive improvement. For example, care plans had not been audited which meant that the inaccurate information we found during this inspection had not been identified.

Although the provider had introduced a system of health and safety audits in August 2015 no audits had been carried out. An audit had been completed by another manager in May 2015 which highlighted various areas of concern. However the registered manager had not made the necessary improvements and the provider had not checked to see if the improvements had been made until October 2015.

Despite other health and social care professionals providing support and information on how to improve the home, issues had not been addressed to make the changes in a timely manner. For example, in May 2015 the Cambridgeshire County Council report had identified improvements were required in relation to mandatory training, staff meetings, risk assessments, quality audits and care plans. We found that the necessary improvements had not been made. There was no regular audit of the medication system to ensure that there was a safe system for storage, administration and recording of medication. The area manager stated that people should have three monthly reviews of their care and support. We asked when the last reviews had been completed for one person and the area manager couldn't find any completed after August 2014. Quality assurance surveys had been completed by people's relatives in April 2014.There was no record of the outcome of the surveys available. People, their relatives and staff had not been asked their views on the running of the service since April 2014.

There was a lack of staff taking responsibility for their work. For example each person had a named nurse. Nurses are bound by their registration to ensure that records are up to date and accurate. However care plans and recording of the care and treatment received were not up to date and were not compliant with the standards expected by the nursing and midwifery council. However, the nurses were not being held responsible for their lack of action. There wasn't a culture of staff working together to improve the outcomes for people. For example, important paperwork had gone missing, agency staff had been cancelled and medication had run out even though the correct amounts had been ordered. It was not known where the medication had gone.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us that staff morale in the home was very low. Staff stated that they had not received the support they needed. They also told us that due to their only being 19p in the petty cash tin since July 2015 they had have to purchase bread and milk out of their own money and bring in toilet paper. They told us that people had paid for their own activities and taxis and been told that they would be reimbursed at a later date. The records showed that there had been only 19p in the petty cash tin since July and that people had paid for their own activities and taxis.

Staff told us that there hadn't been regular team meetings. They also stated that they couldn't add to the agenda and hadn't seen a copy of the minutes after meetings were held. The only minutes for team meetings that were available were in April 2015 and June 2014. Staff thought that there may have been another meeting since April 2015. However the minutes could not be found. There was no process in place to ensure that staff received regular support and supervision. There was no process in place to ensure that staff had completed the necessary training.

There was no process in the home for checking that people's bank statements reflected the in-house records of what money had been withdrawn from the bank. We asked to see the bank statements for those people that the provider was an appointee for to ensure that the statements and records tallied. However no statements could be found dated later than September 2014. We were told that a member of staff checked that the money held for people accurately reflected the records on a monthly basis. We checked two people's financial records and found that they had not been checked since September 2015 and before that it was last checked in June 2015.

There was a whistle blowing policy in place that staff told us they were aware of and would use if necessary.

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 9 HSCA (RA) Regulations 2014 Person-centred care People were not protected from the risks of receiving care that was inappropriate and did not meet their needs. Regulation 9 (1)(a)(b).

The enforcement action we took:
This will be reported upon at a later stage when our action has been completed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care People's assessment and planning of their care and treatment did not ensure all their needs were met. Regulation 9(3)(a)&(b)

The enforcement action we took:
This will be reported upon at a later stage when our action has been completed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect People had not been protected from the risks associated with their dignity, privacy and respect not being upheld. Regulation 10 (1) &(2)(a)

The enforcement action we took:
This will be reported upon at a later stage when our action has been completed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent

This section is primarily information for the provider

Enforcement actions

People were not protected against the risks associated with a lack of consent, application of the Mental Capacity Act 2005 and associated code of practice. Regulation 11.

The enforcement action we took:
This will be reported upon at a later stage when our action has been completed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment People were not protected against the risks associated with unsafe and inadequate assessment of and action to reduce identified risks. Regulation 12 (1)&(2)(a)&(b).

The enforcement action we took:
This will be reported upon at a later stage when our action has been completed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment People were not protected from the risk associated with not having proper and safe management of medicines. Regulation 12 (2)(g).

The enforcement action we took:
This will be reported upon at a later stage when our action has been completed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment People have not been protected from the risks associated with having premises and equipment that are not properly maintained. Regulation 15 (1)(e).

The enforcement action we took:
This will be reported upon at a later stage when our action has been completed.

This section is primarily information for the provider

Enforcement actions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance People who use services were not protected against the risks associated with unsafe and inadequate monitoring and assessment of the quality of the service provided. Regulation 17(1)(2)(a)&(2)(f).

The enforcement action we took:
This will be reported upon at a later stage when our action has been completed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing People were not protected against the risks associated with the inadequate provision of training and supervision for staff members to ensure people's health and care needs were properly met. Regulation 18 (2)(a).

The enforcement action we took:
This will be reported upon at a later stage when our action has been completed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed People were not protected against the risk of not operating an effective recruitment procedure. Regulation 19(3)(a)

The enforcement action we took:
This will be reported upon at a later stage when our action has been completed.