Lee Mount Healthcare Limited

Lee Mount Residential Home

Inspection report

32-34 Lee Mount Road
Lee Mount
Halifax
HX3 5BQ
Tel: 01422 369081
Website: No website

Date of inspection visit: 8 & 9 June 2015
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Ratings

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

Overall summary

We inspected Lee Mount Residential Home on 8 and 9 June 2015 and the first visit was unannounced. Our last inspection took place on 26 September 2013. At that time, we found the provider was meeting the regulations.

Lee Mount is a 25-bed service and is registered to provide accommodation and personal care for older people, including people living with dementia. There are 25 single bedrooms, seven of these have en-suite toilets. There are two lounges and a dining room on the ground floor and an enclosed patio area at the rear of the building. On the first day of our visit there were 19 people living at the home and on the second day there were 18 as one person had sadly died overnight.

There has been no registered manager at the service since February 2014. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations

Summary of findings

about how the service is run. The current manager told us they would not be applying to register until systems were in place to support the improvements they wanted to make.

We found there were delays in getting essential equipment repaired and staff not following infection prevention procedures. The lighting levels in some rooms were poor and we found mattresses which smelt of stale urine.

We found there were not always enough staff on duty to care for people safely or to keep the home clean. Some staff told us they felt supported by the manager but had no confidence in the providers and did not feel valued by them.

The medication system was not well managed and there was no assurance people were receiving all of their medication as prescribed by their doctor.

Staff had attended safeguarding training but were not identifying situations which needed to be referred to the local authority safeguarding team.

We found the service was not meeting the legal requirements relating to Deprivation of Liberty Safeguards (DoLS). There were a number of restrictions preventing people from moving freely around or leaving the home.

The cook had a good knowledge of people's dietary preferences and spoke with them directly about the meals on offer. We saw a lot of the food stocks were of the supermarket 'budget' variety which may not have been to everyone's taste.

We found staff were vigilant and involved a variety of healthcare professionals to make sure people's healthcare needs were met in a timely way.

We saw staff were kind, caring and compassionate. People using the service responded well to staff and we saw good humoured exchanges between people.

There were no care plans in place. Staff were delivering care and support based on their knowledge of people's individual needs and information from a variety of assessments.

There was a complaints procedure in place but this was out of date and complaints were not being recorded. This meant there was no evidence to show what had been done to resolve any concerns people had raised.

We found there was a lack of provider oversight and very few checks were being made on the overall operation and quality of the service. This meant there was no ongoing improvement plan to develop the service. We also found people using the service and their relatives were being asked for their views about the service but no action had been taken in response. This meant people views were not valued or acted upon.

Overall, we found significant shortfalls in the care and service provided to people. We identified four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The Care Quality Commission is considering the appropriate regulatory response to resolve the problems we found.

The overall rating for this provider is 'Inadequate'. This means it has been placed into 'Special measures' by CQC. The purpose of special measures is to:

• Ensure that providers found to be providing inadequate care significantly improve

• Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.

• Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.

Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains 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 the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will 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

Summary of findings

is not enough improvement we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration.

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 were not always enough staff on duty to provide care and support or to keep the home clean.

Although staff had received safeguarding training they did not recognise some situations as safeguarding concerns.

People's medicines were not always handled and managed safely.

Inadequate

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

Staff felt supported by the manager but not the provider. There were some staff whose training was not up to date.

We found the service was not meeting the legal requirements relating to Deprivation of Liberty Safeguards (DoLS).

We saw people were offered a choice of meals and staff monitored people's weights and took action if people were losing weight.

Records showed people had regular access to healthcare professionals, such as GPs, opticians, district nurses and podiatrists.

Requires Improvement

Is the service caring?
The service was caring.

People told us they liked the staff and we saw staff were kind and caring to the people they were supporting.

Good

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

There were no care plans in place which gave staff detailed information about people's care and support needs.

Some activities were on offer to keep people occupied and stimulated, but staff were not always available to provide these.

The complaints procedure was out of date and complaints were not being recorded.

Requires Improvement

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

Inadequate

Summary of findings

People were not protected because the provider did not have effective systems in place to monitor, assess and improve the quality of the services provided. This was evidenced by issues identified at this inspection.

People's feedback was not consistently sought, valued or acted upon.

Lee Mount 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 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 8 and 9 June 2015 and the first day was unannounced.

The inspection team consisted of one inspector.

Before the inspection we reviewed the information we held about the service. This included speaking with the local authority contracts and safeguarding teams. We asked the provider to complete a Provider Information Return (PIR).

This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. This document was returned to us but only contained limited information.

On the day of our inspection we spoke with six people who lived at Lee Mount Residential Home, one visitor, the owner, manager, three night care workers, six care workers, cook, housekeeper and district nurse.

We spent time observing care in the lounge and dining room and used the Short Observational Framework for Inspections (SOFI), which is a way of observing care to help us understand the experience of people using the service who could not express their views to us. We looked around the building including bedrooms, bathrooms and communal areas. We also spent time looking at records, which included; four people's care records, three staff recruitment files and records relating to the management of the service.

Inadequate

Is the service safe?

Our findings

The accommodation at Lee Mount Residential Home was arranged over three floors. There were two lounges, a dining room, kitchen and bedrooms on the ground floor and bedrooms on the first floor. The laundry and food stores were in the basement.

We looked around the building and identified issues which presented a potential risk to people living at the service. There was a fire exit in one of the ground floor bedrooms. We saw there was a chair in front of this exit. We also saw the 'break glass' on the lock was broken. This meant this door could be opened and someone could leave the building unnoticed.

In one en-suite toilet we saw there was no call bell and in another the call bell could not be reached from the toilet. This meant people occupying these rooms would not be able to summon assistance from staff.

When we arrived on 8 June 2015 only one of the three lights in one of the lounges was on and only two of the four light bulbs were working. The room was dark. We turned on the other two lights and in both of these only two of the four light bulbs were working. We found the lighting levels in some of the ground floor bedrooms to be dull with little light being emitted from the light bulbs. We also saw on one survey from a relative they had commented that rooms could be brighter. People with deteriorating eye sight need good lighting levels, poorly illuminated areas could increase the risk of people falling.

We brought all of these issues to the provider's attention before we left on the first day and they told us they were unaware of the things we found.

When we went downstairs to the laundry we found one of the steps was not secured properly and felt 'springy' underfoot. This was presenting a potential hazard for anyone that used these stairs.

We looked in the shower room on the first floor and could not get the shower to work. We asked a member of staff if the shower worked and they told us they did not use that shower. This meant people occupying bedrooms on the first floor would have to use the shower facility on the ground floor.

We looked in the repairs book and saw none of these issues had been reported, except the light bulbs in the lounge that we had brought to the attention of staff.

Staff told us the assisted bath had been out of use for 'months' and had only been repaired recently. We asked the provider about this and they told us the bath had been out of use for eight weeks because they had had difficulty in finding a battery charger. The manager told us they had asked the provider to get a spare charger so the same problem would not re-occur but this had not been provided.

Staff also reported delays in getting the washing machine repaired, the shower chair replaced and said the tumble drier kept breaking. The delay in getting the bath repaired meant people using the service could only have a shower.

The provider told us they did the portable electrical equipment testing. We asked to see the results of the testing and evidence of the testing equipment being calibrated. The only evidence of equipment testing was the 'stickers' on individual pieces of equipment and there was no evidence of the testing equipment being calibrated.

We saw there was a legionella risk assessment in place which required weekly, monthly and three monthly actions. We saw none of the required actions were up to date. For example, a three monthly descale and disinfection of showers was required. The last documented time the showers had been descaled and disinfected was 25 December 2014. We asked the provider about this and they were unable to tell us why these actions were not up to date. This meant the provider could not assure themselves people were being protected from the risks associated with legionella.

We looked at the servicing records and saw the fire alarms and fire extinguishers were due to be serviced in June 2015. We asked the manager if visits from the contractors had been booked. They told us there was nothing in the diary regarding this. We asked the provider and they told us the services had been booked that week (week ending 12 June 2015). Following the inspection the manager confirmed the services had taken place.

We looked at the infection prevention policy which stated there must be an infection prevention and control lead. We asked the provider who this person was and they told us they did not have one.

Inadequate

Is the service safe?

We looked around the building on Monday 8 June 2015 at 8:45am. There had been no domestic staff on duty at the weekend and we found areas of the home which were not clean. In the ground floor lobby, which led to the outside patio area, we saw cigarette ends behind the radiator cover and hoist slings on the floor. We also found some areas smelt of stale urine.

In some bedrooms there was no liquid soap or paper towels and in others paper towels were in the holders but had not been fed into the dispenser so could not be pulled down to be used. This meant staff could not wash and dry their hands properly after delivering personal care. There was an absence of bins in the bedrooms for people and staff to dispose of their rubbish. We found some mattresses were stained and smelt of stale urine and beds had dirty sheets and duvet covers.

In the kitchen the cook was lifting the lid off the bin with her hand as the electronic lid required a new battery. We also saw staff wearing rings with stones in them, staff with long false nails and staff wearing nail varnish. The lack of adherence to infection prevention procedures increased the risks to people using the service. We went back to the areas we had identified with the provider at 3:00pm to make them aware of the infection prevention issues. Before we left on the first day the provider told us they had ordered six new mattresses.

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

We asked the manager about staffing levels and they told us there were three care workers on duty during the day from 8am – 8pm. At night there were two care workers on duty from 8pm to 8am with a third night care worker from midnight to 8am. We asked why at night the third member of staff did not start work until midnight and they told us they had asked the provider for an additional person to work from 8pm – 8am but had been told they could only have an extra person from midnight. We asked the provider how the decision to have a care worker on duty from midnight to 8am, instead of 8pm – 8am had been made and they were unable to tell us.

We spoke with three members of night staff who told us they needed three members of staff at night to make sure people's care needs were met and to keep people safe. They told us when they were in the laundry they could not hear the emergency call bell and if they were on the first floor they could not always hear the call bell. This meant there needed to be a member of staff on the ground floor at all times in order to be able to respond to calls for assistance. We saw there was no call bell indicator board on the first floor. This meant if staff were on the first floor and heard a call bell they had to go downstairs to see who required assistance. We saw five people had fall sensor mats in place by the side of their beds. These mats were connected to the emergency call bell system to alert staff if they were getting out of bed, so staff could offer assistance quickly to reduce the risk of them falling. This meant if two staff were offering someone assistance in a bedroom upstairs, there would be no one available to respond to the emergency buzzers.

Staff also told us when the manager was away in May 2015, the administrator had contacted staff who should have been working the midnight to 8am shifts over three consecutive nights and told them not to come in. We asked the manger about this and they told us the staff had been told not to tell them. When we looked at the duty rota these shifts were showing as having been worked. We asked the provider if the duty rota was an accurate record of what people had worked they were unable to answer us.

On 8 June 2015 we saw after tea at 16:40 hours one care worker was in the kitchen, one care worker was giving out medication and the third was supporting someone who was unwell. The manager was upstairs assisting someone with their tea time meal. We saw one person take their trousers down in the hallway and we assisted them to the bathroom in the absence of the staff. Another person, who was at high risk of falls, got up from the dining table and started to walk without assistance, because they said they wanted to go to bed. The senior care worker, who was giving out medication, had to break off to assist.

Staff told us they had asked the administrator, who is one of the providers, if they could have additional staff as they were finding it difficult to meet people's changing needs. They were told perhaps they could get a member of staff to come in at mealtimes to assist but this had not happened at the time of our visit.

We asked the provider what tool they used to calculate the staffing levels. They told us there was a dependency assessment in people's care plans. We asked them how they used this information and they were unable to tell us and said the staffing levels were up to the manager and they could have as many staff as they needed.

Inadequate

Is the service safe?

We spoke with the housekeeper who told us they worked six hours a day from Monday to Friday. They told us there were no domestic staff at weekends and care workers did the 'basics'. We saw the housekeeper was very busy on both days of our inspection. They had responsibility for cleaning the whole house, the laundry and putting people's clothing away. The provider told us they had recruited a domestic to work weekends, but they had not started work. This meant no arrangements had been made to make sure there was domestic cover at weekends.

This breached Regulation 18 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

We saw there was a safeguarding policy and procedure in place and saw from the training matrix staff had completed safeguarding training. On the first day of our visit we witnessed one person shouting at another at the dining table. We asked one member of staff about this and they told us sometimes the person who was shouting swore at the other individual. We asked them what they did about this and they told us they would remove the person who was being sworn at from the situation. We asked them if they thought these incidents should be reported to safeguarding and they told us they did not think it was a safeguarding issue. We discussed our observations of the incident with a senior carer who, after some consideration agreed it was a safeguarding issue and said perhaps one of the people could sit at another table. However, on the second day of our visit we saw the two people were still sitting at the same table. We asked the provider how they checked staff's understanding of safeguarding issues after they had completed the training on the computer and they told us there was nothing in place.

We asked staff what they would do if they did not think there were enough staff on duty to meet people's needs. No one saw this as a safeguarding issue.

This meant staff were not recognising potential abuse, reporting it or taking action to reduce the risk of it happening again.

This breached Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

During our visit we looked at the systems that were in place for the receipt, storage and administration of medicines. We saw a monitored dosage system was used for the majority of medicines with others supplied in boxes or bottles. We found medicines were stored in a safe way. We observed people being given their medicines during our visit and saw staff supporting them with patience and kindness. We saw staff who administered medicines had received medication awareness training but had not completed any medication administration training.

We looked at the medicine administration records (MAR) for six people. Some medicine administration records had a front sheet which included a photograph of the person but these were not in place for everyone. The absence of photographs meant there were no visual identity checks for staff to refer to. We noted there were a number of 'gaps' on the MAR where staff had not recorded if people had been given their medicine or any reasons as to why it had not been given.

We saw that controlled drugs were stored securely. We checked the controlled drugs for one person and found stock levels were correct.

We looked at some MAR's with the manager. We saw one person had been supplied with 21 antibiotics but only 19 had been signed for as being given. The same person had been prescribed Paracetamol. Staff had been signing the record when these had been given but were not always recording if they had given one or two tablets. This meant it was not possible to calculate an accurate balance of the medication that should have been in stock.

Another person had been dispensed 60mls of antibiotic suspension and had been prescribed 10mls twice a day. When we looked at the MAR we saw staff had signed on eight occasions to acknowledge the medicine had been given. This meant staff had signed as giving 20mls more medication than had been supplied.

We saw body maps were in place to show care workers where people's creams and lotions needed to be applied. However, staff were not completing the corresponding MAR to show these had been applied.

We saw some people had been prescribed 'as required' medication but there were no protocols in place to inform staff in what circumstances these medicines should be administered. For example, one person had been prescribed medication for anxiety but there was no guidance to guide staff about when this may need to be given.

This meant there was no assurance people were receiving all of their medication as prescribed by their doctor.

Inadequate

Is the service safe?

This breached Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Safe recruitment procedures were in place to ensure only staff suitable to work with vulnerable adults were employed. These included ensuring a Disclosure and Barring Service (DBS) check and two written references were obtained before staff started work. We looked at three staff recruitment files and saw all of the necessary checks had been completed. We spoke with a newer member of staff who confirmed these checks had taken place before they started working at the service. This meant prospective staff were being properly checked to make sure they were suitable and safe to work with older people.

Requires Improvement

Is the service effective?

Our findings

We spoke with staff who told us they felt supported by the new manager and found them approachable and responsive. However, some staff told us they did not feel supported, respected or appreciated by the providers. They said they were frequently asked to cover shifts at short notice and were never thanked by the providers. We asked them if they had received any feedback following the staff survey in 2014 and they told us they had not.

We looked at the staff appraisal policy and saw staff should receive annual appraisals that were reviewed after six months. We asked the provider for evidence that these had taken place. They said they thought the last manager had completed them, but could not produce any documentation to support this.

We looked at the staff supervision policy which stated, "Staff to have a nominated supervisor and planned supervision to meet individual needs." The new manager had provided some staff with supervision and some staff told us they had a supervision session booked. These sessions gave staff the opportunity to discuss their working practice and future training and development needs.

We talked to staff about training and they told us much of this was completed on the computer. One person told us they came in on their days off to complete the on line courses.

We looked at the training matrix which showed not all of the staff were up to date with their basic training such as moving and handling, fire safety, food hygiene, emergency first aid, infection prevention and fire safety. None of the care workers had received Mental Capacity Act 2005 (MCA) or Deprivation of Liberty Safeguards training.

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

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. We saw there was one person using the service who was subject to authorised deprivation of liberty. At the time of our visit this person was in hospital so we were unable to confirm the requirements of the Mental Capacity Act 2005 deprivation of liberty safeguards and imposed conditions in the authorisation were being met.

We asked the manager if they had completed training in relation to the Mental Capacity Act 2005 and the DoLS. They told us they had completed MCA in their last job but had not had any training in relation to the DoLS.

We saw an incident report had been completed by staff regarding someone who had used the service for a short stay. The report stated the person was, "Determined to go outside." Staff explained that they couldn't go out on their own and phoned their relative to come in. We asked staff about this and they told us the family came in every evening during this person's stay to take them out. Staff had not considered this as a DoLS issue.

When we looked around the building we saw there were a number of restrictions in place. Staff told us they locked people's bedrooms on the ground floor during the day to stop other people going in and taking any of their possessions. The manager's office was located in the reception area. The door leading to this area from the main part of the house had a release button above head height. Only some people that used the service knew how to operate it. This meant people's freedom to move around the home was being restricted.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw that care plans recorded whether someone had made an advanced decision on receiving care and treatment. The care files held 'Do not attempt cardio-pulmonary resuscitation' (DNACPR) decisions. The correct form had been used and fully completed recording the person's name, an assessment of capacity, communication with relatives and the names and positions held of the healthcare professional completing the form.

We saw staff were monitoring people's weights and were involving the GP when weight loss was noted. Staff explained some people had food supplements to help them maintain or put on weight. We spoke with the cook who had a detailed knowledge of people's likes and dislikes. At lunch times we saw there was a choice of meals on offer and saw people enjoyed their meals. The cook also told us they asked people what they wanted and put their

Requires Improvement

Is the service effective?

requests onto the menu. Mid-morning we saw people were offered a choice of drinks, crisps, biscuits or fruit. When we looked at the food stocks we saw the majority were from supermarket's budget range, which may not be to everyone's taste. We saw there was no butter available and people were given toast with margarine on it. We spoke with two people who told us they would prefer butter on their toast. We asked the provider about this who said they could order butter.

In the four care files we looked at we saw people had been seen by a range of health care professionals, including, GPs, opticians, district nurses, specialist nurses and podiatrists. On the first day of our visit staff had noticed a decline in one person's mobility and felt this could have been due to an infection and contacted the GP to get treatment. Another person was also unwell so staff contacted the district nurse and the GP to provide treatment. We spoke with the district nurse who told us staff were very good and sought advice in a timely way and followed any instructions they were given. This meant staff were vigilant and people's health care needs had been met.

Good

Is the service caring?

Our findings

We looked at the care files for four people who used the service. They all contained some information about people's life history, personal preferences, likes and dislikes. When we spoke with staff it was clear they knew people well and were aware of people's personalities and interests.

Some of the people living at Lee Mount Residential Home smoked cigarettes and we saw staff supporting them to the smoking area at regular intervals. Staff also told us one person liked a drink of whiskey in the evenings and another sometimes liked a pint of beer and these drinks were made available to them.

When we looked in people's bedrooms we saw some had been personalised with pictures and ornaments. Wardrobes and drawers were tidy showing staff respected people's belongings.

When we spoke with people that used the service one person said, "They (staff) are good, I like them." Another person said, "They are kind to me." Some people who had complex needs were unable to tell us about their experiences of the service. We spent time observing the interactions between the staff and the people they cared for. We saw staff approached people with respect and support was offered in a sensitive way. We saw staff were kind, caring and compassionate when interacting with people. People that used the service responded well to staff and we saw good humoured exchanges between people.

When staff were offering personal care we saw them do this discreetly, encouraging people to use the bathroom.

We did see people's dignity was compromised at times. For example, we saw people on the toilet because no staff had been available to close the door for them and people wearing clothing with food stains on them. Again this was because staff had not had time to support them to change.

When we looked around the bedrooms we saw a number of clocks had stopped. This meant people would not be aware of the correct time of day. This is particularly important where people's cognition is impaired due to living with dementia or other conditions.

We spoke with one visitor who told us staff made them feel welcome when they visited. On one of the surveys we saw, one of the questions was about being able to see their relatives in private. One person had commented that this had never been offered but also said they had not asked. The provider had not picked this issue up and put measures in place to address this.

Is the service responsive?

Our findings

We looked at four people's care files. We saw there was an assessment of people's needs but no actual care plan. There were also some risk assessments in place which showed what had been done to reduce certain risks to individuals. For example, one person had been identified as being at risk of falling. Staff had referred them to the falls prevention team and put a falls sensor mat in place in their bedroom. (This is a device which is connected to the emergency call bell system and alerts care workers when the person is getting out of bed). We asked staff what we would look at if we wanted to find out about people's needs and they told us it would be these documents. We spoke with the manager who told us there were no care plans in place and this was one of the areas they would be looking at getting input from people themselves, relatives and staff.

This meant there were no up to date care plans for people giving staff clear instructions about what actions they needed to take in order to meet people's needs.

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

We did see people who used the service had been asked for their views in a survey. We saw one person had indicated they wished to vote in elections. We asked staff if anyone that used the service had voted in the elections and they told us they had not. This meant people's views were being sought but no action had been taken in response.

The manager told us they were trying to recruit an activities co-ordinator, but in the interim, care workers had undertaken this role. We saw staff organising ball games, singing and dancing which we saw people clearly enjoyed. We also saw them spending time with individuals just having a chat. Staff told us they did their best to provide some occupation and stimulation for people but said sometimes they were too busy and activities did not take place.

We saw the complaints procedure was on display in the lobby, but was out of date. We saw in the staff meeting minutes a complaint had been received about the laundry, toilet rolls, toilet and light bulbs not working. When we looked at the complaints log the complaint had not been logged or any details recorded about what had been done to resolve the complaint. We discussed with the provider and manager the need to record concerns and complaints together with the action taken to resolve them and the outcome. Without clear records it is not possible to spot any common themes or trends.

Inadequate

Is the service well-led?

Our findings

The registered manager left the service in February 2014 and there has been no registered manager since. The provider told us they thought the manager who left in April 2015 had been registered with the Care Quality Commission. However, we saw in the minutes of a meeting the provider had in January 2015, with the consultant they employed, that recruiting a registered manager had been discussed. This meant the provider was aware there was no registered manager in post at that time.

We saw the service's statement of purpose and service user guide were displayed in reception but the information about the management of the service was out of date. On one page it referred to the registered manager who left in February 2014 and on the other the acting manager who left in April 2015.

The current manager started working at the service in April 2015 and told us and the provider they were not prepared to register with the Care Quality Commission until systems were in place to support the improvements they wanted to make.

The provider employed the services of a consultant up until April 2015 to undertake quality assurance visits upon their behalf. However, the last report that could be found was from September 2014. We saw in this report it had been identified no business plan had been available.

We looked at the financial procedures policy which stated: 'The business has a financial plan for the organisation as part of its business plan which is open to inspection and reviewed annually and includes a current cash flow forecast for the business set over a 12 month period. Annual accounts are prepared and submitted by a professional independent accountant and include; a profit and loss account, a balance sheet, an auditor's report and a directors report.' We asked the provider for the business and financial plan and they told us they did not have one. This meant the provider was not responding to the actions identified by the consultant and was not following their own policy and procedure.

The manager told us they did not have any petty cash in the home and had no budgetary control. Any repairs, replacement equipment or shopping had to requested from the provider. Staff told us they were generally unhappy about the length of time essential repairs were taking and there was no redecoration or refurbishment plan in place.

We saw the provider had a quality assurance policy in place which stated they were committed to meeting the Care Quality Commission's standards and would conduct a monthly regulation quality visit.

We asked the provider what quality audits they had completed. They gave us an undated document and told us this was the first one since April 2015. One area they had completed was headed bed rail compliance. We asked them what they checked to assure themselves the bedrails in use were safe and they were unable to tell us. The audit record showed the provider had also looked at one care plan and found it satisfactory. They had also stated policies and procedures were up to date. When we looked at the policies and procedures we found they were all undated and unsigned.

We asked the provider to show us their audits of medication, the environment, mattress audits and audits of people's weights. The only audit available was a medication audit dated 30 January 2015. We spoke with the provider and established none of the other audits were taking place.

We asked the provider for the analysis of accidents and incidents and established no analysis had been completed.

This meant there were no systems in place to assess, monitor and mitigate the risks relating to the health safety and welfare of people that used the service and others.

We asked the provider for the analysis of any concerns or complaints. Again no analysis was taking place to see if there were any common issues that had been raised.

We saw five relatives had completed surveys this year. We saw relatives had suggested trips out and better lighting. We asked the provider what they had done with the information relatives had provided and they told us they had done nothing with the information. This meant people were being asked for their views about the service but the provider was not acting on this information.

We saw a staff survey had been sent out and returned in 2014. Staff raised concerns about team working, staff induction, not being valued and pay. We asked the provider

Inadequate

Is the service well-led?

what they had done with the information staff had supplied and they told us they had done nothing with it. This meant staff had been asked for their views and responded but no action had been taken as a result.

In the service user guide it stated 'We encourage clients to take an interest in running the home by inviting their comments on a monthly review and at client meetings.' We found no evidence of either of these activities taking place.

This was a breach of Regulation 17 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 Service users were not provided with care and treatment in a safe way as the management of medicines was not safe and proper; and the risks in relation to the spread of infection were not assessed, prevented, detected or controlled. Regulation 12 (2) (g).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment Service users were not protected from being deprived of their liberty. Regulation 13(5)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance Systems and processes were not established or operated effectively to assess, monitor and improve the quality of the services provided or to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk. Accurate, complete and contemporaneous records were not maintained in respect of each service user, including a record of the care and treatment provided to the service user and decisions taken in relation to the care and treatment provided. The provider did not act on the feedback they received from relevant persons. Regulation 17 (1) (2) (a) (b) (c) (e).

This section is primarily information for the provider

Enforcement actions

Regulated activity	Regulation
	Regulation 18 HSCA (RA) Regulations 2014 Staffing Sufficient numbers of suitably qualified, competent, skilled and experienced persons were not deployed and had not received appropriate support, training, professional development to enable them to carry out the duties they were employed to perform. Regulation 18 (1) (2) (a).