Strathmore Care

Whittingham House

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**

Summary of findings

Overall summary

Whittingham House provides accommodation and personal care for up to 70 older people including people living with dementia. However, the provider had placed a restriction on the service provision and there were 43 people living at the service on the day of inspection.

We carried out an unannounced comprehensive inspection of the service on the 10, 11, 12, 13 and 14 July 2017. Previously, the service had been inspected in November 2016 and received an overall rating of requires improvement.

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 time frame. If not enough improvement is made within this time frame 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 this registration.

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. The Care Quality Commission is now considering the appropriate regulatory response to resolve the problems we found during our inspection.

The service did not have a Registered manager. It is a requirement of the service's registration with the Care Quality Commission that there is a registered manager in place. A registered manager is a person who has

registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

There were no systems in place to ensure that staff were deployed in a way which met people's changing needs and circumstances. This meant that staffing levels were not adequate to ensure that people's needs were met and people were put at potential risk of harm.

Care records, plans, and assessments were very generic and did not take account of people's individual needs effectively. Information had not always been recorded or assessed to demonstrate how the service was going to mitigate any risks to people's safety. People were at risk as the processes in place to safeguard people from potential incidents remained inadequate.

Staff training had not been embedded in everyday practice. Staff training was out of date in some cases and their competency to perform their duties had not been reviewed. Staff did not receive regular supervision and support, which meant that staff lacked the skills and support to perform their roles effectively.

Improvements were required to the way in which the service assessed people's capacity to make decisions and how they supported people to make choices. People's dining experience was not always positive. The service needed to improve the way mealtimes were organised and how choices were offered to people, including offering clear support and explanations to people which choices were being served.

Some staff were not knowledgeable of people's individual care needs nor did they have knowledge of their histories and backgrounds so as to enable them to deliver personalised care in all instances. People's care was not always planned and assessed to ensure their safety and welfare. Individual's preferences relating to their diet had not been considered. Where there had been efforts made to provide people with specific care this was not being adhered to. People did not always receive care in a person centered way because the deployment of staff meant the approach was mainly task and routine focused.

Roles and responsibilities were unclear and staff were unsure what they were accountable for. The culture of the service was not a positive one and staff lacked time, knowledge and understanding. Quality assurance systems and processes, which assessed, monitored or improved the quality of the service were not effective or established. Support and resources needed to run the service were not available and the provider was not operating the service in line with their own philosophy of care. The lack of good quality governance had impacted on the delivery of safe and effective care.

There was a complaints procedure in place. Relatives told us that they would speak with the manager if they had any concerns or complaints, however some relatives were unsure if they would be listened to. There was not a comprehensive system in place to demonstrate that lessons were learnt from past concerns and complaints or that formal analysis of concerns and complaints had been undertaken.

There was thorough recruitment procedures in place to ensure staff were suitable to work with vulnerable adults. This was carried out by the head office. Medications were managed safely and as needed.

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.

Staffing levels were not adequate to ensure that people's needs were met and people were put at potential risk of harm.

Care records, plans and assessments were very generic and did not take account of people's individual needs effectively..

Medicines were stored and disposed safely and medication management was safe.

Is the service effective?

Inadequate

The service was not effective.

Staff did not have a structured opportunity to discuss their practice and development to ensure that they continued to deliver care effectively to people.

Improvements were required to ensure that staff's training was effective and good practice was embedded through their everyday practices with people who used the service.

The dining experience for people was variable and not always appropriate to meet people's individual nutritional needs.

Is the service caring?

Requires Improvement

The service was not always caring.

Not all care provided was person centred, caring and kind.

People and those acting on their behalf were not always involved in the planning of their care.

People were not always treated with dignity and respect.

Is the service responsive?

Inadequate

The service was not responsive to people's needs.

People were not always engaged in meaningful activities and supported to pursue pastimes that interested them, particularly for people living with dementia.

Not all people's care records were sufficiently detailed or accurate.

Staff were not consistently responsive to people's needs.

Arrangements were in place for the management of complaints however they had not proved effective.

Is the service well-led?

Inadequate

The service was not well-led.□

There was no registered manager.

There was a lack of oversight and scrutiny by the provider.

The quality assurance system was not effective because it had not identified the areas of concern and there were no plans in place to address them.

Whittingham House

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 registered manager was 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 the 10, 11, 12, 13 and 14 July 2017 and was unannounced. The inspection was undertaken by two inspectors and a pharmacist inspector.

We reviewed other information that we held about the service such as notifications. These are the events happening in the service that the registered manager is required to tell us about. We used this information to plan what areas we were going to focus on during our inspection.

As part of the inspection we spoke with seven people who used the service, five relatives and 10 members of care staff, deputy manager, care team manager and care supervisor. We also spoke with the local authority's contracts and social work team.

Some people were unable to communicate with us verbally to tell us about the quality of the service provided and how they were cared for by staff. We therefore used observations, speaking with staff, and relatives, reviewing care records and other information to help us assess how people's care needs were being met. We spent time observing care in the communal areas and used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

As part of this inspection we reviewed 10 people's care records. We looked at the recruitment and support records for five members of staff. We reviewed other records such as medicines management, complaints and compliments information, quality monitoring, audit information and maintenance records.

Inadequate

Our findings

During and prior to our inspection, we had concerns about the amount of staff available to meet people's care and support needs. People's views on staffing levels and how they were deployed were mixed. One person informed us, "I am no longer able to walk so I need support to get to the lounge; however I opt to stay in my room as I have to wait about an hour for staff to come and help me." Relatives expressed concerns that when they have visited, they had not been able to find a member of staff to support or assist their relative.

Staff we spoke with told us they felt there were not enough of them to meet the needs of people in a timely and safe manner. One staff member informed us, "In the morning and night time we can be rushed as we trying to either get everyone up for breakfast or ready for bed." Although some staff told us that staffing levels were acceptable and they could meet people's day to day needs, others informed us staffing levels were inadequate to meet people's needs and that this could be stressful especially at busy period of the day.

On the ground floor, we found staff to be alert to any concerns or dangers resulting from people's choices, being distressed or anxious, however on the first floor despite staff being alert to people's needs, staff were rushed and task focused and often there was a lack of presence.

Our observations on the first day of the inspection showed that although there were staff on duty, there were five people sitting in the back dining room/lounge with one person who was regularly calling out for help. During this time, no staff came into the lounge to ascertain why the person was distressed. This was due to the members of staff supporting people with their care needs elsewhere. This appeared to upset other people sitting in the lounge. Due to the amount of distress that was being shown by this person.

The care supervisor informed us that they used the resident forum tool to determine people's dependencies and the required staffing levels. The care supervisor informed us during the inspection that they felt the current dependency tool used did not give a true reflection of people's current care needs. The care supervisor had recently completed 20 Barthel dependency assessments and found that 17/20 of the completed assessments reflected that the people's needs were higher than being currently assessed. There was no systems in place to ensure that staff were deployed in a way which met people's changing needs and circumstances. This meant that staffing levels were not adequate to ensure that people's needs were met and people were put at potential risk of harm.

After the inspection, we wrote to the provider raising our concerns around staffing levels in the home. The provider responded advising that staffing levels would be increased to ensure that people's needs were being met adequately. Although this was encouraging, we judged the service to be in breach of regulation due to the poor care outcomes people had experienced and because this had already been highlighted as a concern during a previous inspection and not addressed sufficiently.

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

During the inspection we found one person's room was covered in faeces. We immediately alerted the management team to our findings. The care supervisor was unable to demonstrate that they were cleaning schedules for the room and home to demonstrate that the room was regularly being cleaned and checked despite informing us that this was a recurring event. In addition on reviewing the person's care plans and risk assessment it was apparent that this information had not been recorded or assessed in regards to how the service was going to mitigate any risks of infection control to either the person or other people who may access the bedroom.

Care records, plans and assessments were very generic and did not take account of people's individual needs effectively. During the inspection, the temperature exceeded 25 Degrees Celsius. Every person had a heat risk assessment in place; but it did not reflect their personal circumstances. For example, one person who was diabetic did not have this considered as part of the risk assessment and records we reviewed showed the person was assessed as medium risk. The person's nutritional risk assessment stated they were at high nutritional risk in addition they were on warfarin however this did not appear to have been incorporated in the heat risk assessment. This meant the person would be at high risk of dehydration and the service had failed to highlight this. Another person had been assessed as being at low risk however they were bed-bound and needed assistance and encouragement from staff to ensure they ate and drank well. We reviewed 42 heat risk assessments which showed most people had been deemed at risk of dehydration and sunburn, however this was not always relevant in all cases for example one person who was bed-bound and did not access the outdoors it was identified that were they would be exposed to direct sunlight. The heat risk assessment form being used by the service lacked clarity on what HIGH, MED, LOW level risks stood for which meant staff completing the form were unable to inform us what and why actions needed to be taken. The care supervisor and deputy manager informed us that all staff were aware of the need to push fluids however records of people's fluid intake also did not demonstrate that this area of people's care was being provided effectively.

Care plans and risk assessments we reviewed for one person showed us that despite being assessed by healthcare professionals to be at risk of developing pressure ulcers, on reviewing their turning chart in their room we found that the person spent most of the time their back. The inspector discussed this with the care supervisor and they informed us that the person did not like to lay on their side so staff left the person them on their back. This information was not recorded in their care plan/risk assessment neither was there information on how staff would monitor and manage the risk of pressure sores.

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

In general, staff were able to indicate how people may be at risk of harm or abuse and how they would go about protecting them and ensuring their safety. Staff knew about the provider's whistleblowing policy and procedures. Staff told us that they would escalate their concerns to the registered manager. If the concerns were about the registered manager staff stated they would contact the provider and/or other external

agencies, such as Social Services.

We found the risk to some people was not always well managed, for example, we observed staff attempting to mobilise one person in a four-wheeled rollator, this put the person at risk as this rollator was being used for the wrong purpose and a four wheeled-rollator is to aid people to walk rather than being used as a wheelchair. However the person did not injure themselves on this occasion.

During the inspection we were informed by the care supervisor that currently there was only one on going safeguarding investigation, however after the inspection we received information from the local authority which showed that during the period 06 April 2016 to 14 August 2017 they had received 21 safeguarding concerns/alerts. One alert was in respect of neglect however the investigation was not taken further and a further 20 concerns were for neglect/physical abuse and institutional abuse. Two safeguarding concerns had been substantiated by the Local Authority, three partially substantiated and five have been 'unsubstantiated' and closed. The remaining safeguarding concerns are subject to on-going investigation. The care supervisor/home manager was unable to demonstrate to us that all safeguarding incidents were thoroughly analysed and measures put in place to mitigate re-occurrence. This meant that people remained at risk as the processes in place to safeguard people from potential incidents remained inadequate.

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

The service ensured that it employed suitable staff because a clear recruitment process was followed. This made sure that staff were suitable to work with people in a care setting. Relevant checks had been carried out including obtaining at least two references, ensuring that the applicant provided proof of their identity and undertaking a criminal record check with the Disclosure and Barring Service (DBS).

We observed a staff member during their medication administration duties and they ensured that people received their prescribed medicines safely, as required and in a timely manner. Staff administered medicines to people in a way that showed respect for their individual needs, for example, they explained what was happening, sought people's consent to administer their medicines and stayed with them while they took their medicines to ensure that it had been administered safely. Staff had received training in administering medicines and had their practice checked periodically. We reviewed medicine administration records and found these to be in good order. Medicines were stored and disposed safely.

Inadequate

Our findings

Although staff training records showed and staff told us that they had received suitable training to meet the needs of the people they supported, this was not embedded in their everyday practice. Staff told us that the majority of the training provided was through e-learning or watching a video and staff did feel that this was an appropriate method to aid their knowledge, understanding in their role or test their competency.

Of the five staff files we reviewed, we found that these staff had not received up to date training nor had their competencies been assessed since commencing employment. One staff member commenced employment in April 2017 and had no training record on file; the only documentation we could find was certificates for NVQ2 and attendance at a moving and lifting workshop from 2004. We found in another staff member's file training dating back to the 29 September 2016 however; we noted that they had only recently returned to work after a period of time away but had not had any refresher training. None of the management team present were able to demonstrate any other documentation or observations to show that staff were using their training appropriately and adhering to best practice.

Several people were living with dementia, some in the early stages of the condition whilst others were living with more advanced dementia. Although staff told us they had received training relating to dementia, we found examples of poor staff practice which indicated a lack of understanding and application of the learning from training provided. Some staff did not demonstrate an understanding of how to support people living with dementia and how this affected people in their daily lives; for example, some staff did not communicate effectively with individual people or provide positive interactions. One person tried to initiate a conversation with a member of staff and held out their hand. The member of staff was observed to be dismissive. Although the member of staff was seen to look at the person, they walked out of the room without responding to them. The training did not equip staff to communicate effectively with people living with dementia nor had communication difficulties. We observed another staff member mobilising a person in a four wheeled rollator, this put the person at risk as this rollator was being used for the wrong purpose. Purpose of this rollator is to be used as a walking aid with a perching stool when the person using it wishes to rest. The staff member was using this as a wheelchair which was not the purpose and it had not been risk assessed. The member of staff's training record showed that they had received training in manual handling which included safe moving and mobilising of staff.

Staff informed us that when they commenced employment they went through an induction programme, had on-going training, one to one support, team meetings and daily handovers. We found that the majority of the staff had not received regular supervision in the last 12 months. Staff confirmed that there was not

enough time in the day for formal supervision to be undertaken.

Staff records did not demonstrate that all staff had received regular supervision. For example, one staff member had been working for the service since 28/09/2016 but had only had one supervision on the 08 December 2016; this was in relation to the staff member not completing documentation correctly. On further review of the staff member's file, we found it had been recorded that they had been struggling to communicate, as English was not their first language. The staff member informed us that at times they felt isolated and left out of conversations due to not being able to understand what was being said. Senior management could not find any records or information to demonstrate that the service was offering them any support to further develop their language or understanding. No risk assessment had been completed for the member of staff in relation to this and their competency in their job role or the potential impact this could have on how they communicated with those they were supporting effectively.

Where staff supervisions showed discussion of poor practice had been held, there was no follow up documentation to show what improvements were made and how this was being monitored and checked. For example we noted that one staff member had attended supervision for failing to record people's daily care progress, however there was no record of actions the service was taking to support the member of staff. Records did not demonstrate that supervision was being used as a platform to enable staff to express any challenges they may be experiencing, rather our findings suggested supervision was being used as a tool to reprimand staff for any wrong doing.

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

The Mental Capacity Act 2005(MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called DoLS.

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. The care supervisor/manager had an understanding of the principles and practice of the MCA and DoLS. Multi-disciplinary meetings had taken place for people in order to review their circumstances and ensure that everyone acted in their best interests in line with legislation. One relative told us that they had been involved in meetings to discuss their relative's mental capacity and expressed to us that they were confident that they could work with the manager and care workers to support their relative's decision making.

We found mental capacity assessments on day to day decision making to be based on people's cognitive impairment diagnosis. For example, people had been deemed not to have capacity to make any day to day decisions due to them having dementia. Each individual's needs should have been assessed as capacity can vary depending on the decision being made, for example what clothes they liked to wear, where they would like to eat their meal, choice of food, the time they got up in the morning and the time they retired to bed and how they liked to spend the rest of their day.

People's dining experience was not always positive. The service needed to improve the way mealtimes were organised and how choices were offered to people, including offering clear support and explanations to

people which choices were being served. Although staff were heard asking if the food was satisfactory and people were offered some encouragement to eat, there was no explanation nor description of what people were eating. However we did see some positive experiences for some people, as staff were observed supporting people to eat in the lounge and one person in their bedroom. Staff were seated next to or in front of the person they were assisting and were heard to encourage an upright sitting position.

We spoke to the care supervisor who could not demonstrate if the service had consulted people or their relatives as to what food and drink they would like to have or how it was prepared. The care supervisor informed they were in the process of making visual aids menus as the previous manager had removed the old ones.

Improvements were required in the way the premises were maintained to meet people's individual needs by the adaptation, design and decoration of the service. We found the premises tired, worn and in need of redecoration and refurbishment throughout.

Requires Improvement

Our findings

Although some people told us that staff were kind and caring and relatives said, "Staff here are very nice, my relative has been to several other homes before this one and the care they receive here is very good." and, "When my relative first moved here twelve months ago we were told that they only had days to live however since coming here their health has improved immensely.", we found that some staff were not knowledgeable of people's individual care needs nor did they have knowledge of their histories and backgrounds.

Staff did not always support people in a person centred way, their responses and interactions with people were often task led and routine based. For example, people, at times, had to wait long periods before being supported and people were not being engaged. Where staff did speak to people, although they did so in a calm, respectful manner, they did not also allow them the time they needed to carry out any tasks.

For those people able to communicate verbally, we were told that staff treated them with dignity and respect. People's privacy was respected and they were able to spend time in their bedrooms or in communal areas as they preferred. Although most staff's practice demonstrated an understanding of the need to treat everyone with dignity and respect this was not always the case for those living with dementia who experienced poor care outcomes at times because staff did not attempt to engage with them to help them maintain their dignity.

Some people were asked for their views and were involved in their day to day care through being offered choice as far as possible in their daily lives. Some relatives we spoke with confirmed that they had been involved in care planning and felt their views were listened to. One relative
told us, "The manager and care staff are always around if I have any questions." We spoke to relatives who informed us that the service always sought advocacy support when needed to ensure that people had an independent voice, in addition, we found information on advocacy support posted around the home. This meant that people and their relatives had access to the information should they require it. Advocacy services support and enable people to express
their views and concerns and may provide independent advice and assistance.

We noted that people were smartly dressed. Staff informed us that people's well-being and dignity was very important to them and ensuring that people were well-presented was an important part of their caring role. People were able to maintain contact and continue to be supported by their friends and relatives. People's relatives told us that they were able to visit the service at any time without restrictions.

Inadequate

Our findings

At our last inspection in November 2016, we had concerns about person centred care and people's involvement in their care delivery and activities. At this inspection, we found that the improvements had not taken place and people were not being supported as individuals and their individual social interests and well-being was not very well catered for.

We found that people's care was not always planned and assessed to ensure their safety and welfare. We checked seven care plans which were not fully reflective or accurate of people's care needs. People's care plans did not contain sufficient relevant information on how their dementia affected their day-to-day living and how they were to be supported. They did not include details about people's strengths, abilities and aspirations. For example, people admitted from hospital did not always have care plans in place for staff to understand and meet their needs. At the time of our inspection, we found one person who had recently been admitted from hospital, had no care plans in place. There was an 'Assessment of Needs' document provided by the local NHS Hospital but no guidance for staff on how to support the person, any associated risks or the steps to take to mitigate these. We found some staff to have no knowledge about the person's preference.

Individual's preferences relating to their diet had not been considered. We saw that the chef and kitchen staff did not have an up to date list of people's dietary requirements. For example, one person's care plan stated that they were to have a kosher diet and this would be brought in by their relative, however we observed staff providing them with food from the kitchen which the person declined as they knew this was not kosher food. Information on this was not recorded in the person's care plan and staff, including the chef were unaware of their dietary needs. We discussed this with the care supervisor who told us interim arrangements had been made with the relative to bring in food; however we noted that this information had also not been recorded or reflected in the care plan. This had not been identified by any of the service's quality assurance processes and, although action was then taken to communicate and share dietary needs, the inspector had initiated this. In addition, we found the dietary needs list provided to the kitchen staff had not been updated and contained names of people who were no longer in the service and some people in the service who had dietary needs had not been added to the list. This however was resolved immediately after we discussed it with the kitchen staff.

Where there had been efforts made to provide people with specific care this was not being adhered to. For example, we observed staff not using 'flash cards' when communicating with one person who had very limited understanding of English. There was no reference of flash cards contained in the communication

care plan although this was recorded in other areas of the care record. Staff were not routinely using the cards and on one occasion we had to remind a staff member that the person had them to aid their communication. As a result, the person was isolated as no other methods had been explored to communicate effectively either in their own language or through other tools such as google translate.

People did not always receive care in a person centered way because the deployment of staff meant the approach was mainly task and routine focused. For example, an activities coordinator had been supplied with a monthly activities plan by head office. The activities coordinator told us that people had not been consulted or involved in the choice of the activities on the plan. This meant that interactions between staff and people were primarily focused around the provision of drinks and meals and not about what they wanted to do or when they wanted to do it. Our observations throughout the inspection showed that there were few opportunities provided for people to join in with social activities to ensure that their time was spent in a meaningful way.

Throughout our inspection we found the all lounges to be uninviting and held little to occupy a people. The lounge had an institutional feel, with the chairs set out along the three walls with the television at one end of the room. We spent five hours observing people in the downstairs lounges. During this time, we observed that the television aerial had not been working, this was further supported by a person we spoke to who told us, "The aerial has not been working since the weekend, I am lucky I have my tablet so I can watch my programmes." We carried out room checks and found that several of the TV's in people's rooms did not have an aerial signal. This was brought to the attention of the care supervisor who informed us that they were waiting for the maintenance person to access the roof and check if all the connections were in place and connected.

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

People and their relatives told us that if they had any concerns then they would discuss these with the management team or staff on duty. People told us that they felt able to talk freely to staff about any concerns or complaints and they would be addressed when brought to the attention of the management team. Staff told us that they were aware of the complaints procedure and knew how to respond to people's concerns. There was a policy and procedure in place and people's concerns had been listened to and acted upon. Records showed us that concerns and complaints had been raised and responded to in timely manner. However, we found there were no comprehensive systems in place to demonstrate that management learnt from concerns and complaints and that formal analysis of concerns and complaints had been undertaken.

Inadequate

Our findings

At our inspection in November 2016 we found that the quality assurance arrangements and processes which assessed, monitored or improved the quality of the service required improvement. At this inspection, we found that no improvement had been made.

At the time of the inspection the service did not have a registered manager in place as the previous registered manager had left. After the inspection the provider informed us that recruitment had started for an experienced manager to manage the service. Despite the presence of the care supervisor, there was lack of clear leadership in regards to who was managing and running the service. Staff told us that they found the change of managerial roles confusing as they were not always sure who to go to for advice and support. However, some staff did inform us that one of the providers did spend a lot of time in the home and were always helpful and offered staff support.

Roles and responsibilities were unclear and staff were unsure what they were accountable for. The culture of the service was not a positive one and staff lacked time, knowledge and understanding. Observations during our inspection showed there was no effective leadership. The care supervisor/home manager informed us that they had limited communication with the provider and were yet to meet them to discuss the progress of the service.

We found the service to be continually failing to ensure that there were robust systems in place for effective oversight and governance, to ensure people were living in a safe environment, supported by adequate numbers of staff, competent in their roles and deployed in a way which met people's needs effectively. The provider and care supervisor had not been proactive in checking that improvements were being made and were largely left unaccountable whilst placing the blame with the failure of previous manager; this included those responsible for oversight of quality and training.

Quality assurance systems and processes which assessed, monitored or improved the quality of the service were not effective or established. The provider and manager could not evidence any effective systems or processes which assessed, monitored or mitigated the risks relating to the health, safety and welfare of people using the service. The provider and care supervisor/home manager was unable to demonstrate how they continually analysed, evaluated and sought to improve their governance and auditing practices in line with their own quality assurance policy.

Records relating to staff employed and people who used the service were not properly maintained. This

related to staff training, induction and supervision. Where an internal audit and areas for improvement had been highlighted, the provider and care supervisor failed to demonstrate that actions needed had been completed or whether they required to be followed-up further. For example, the audit in December 2016 highlighted that care plans for people newly admitted to the service required completion and risk assessments required review. Our evidence at this inspection on 10 July 2017 showed that these remained outstanding and had not been completed. The provider did not have an effective system in place to review staffing levels to ensure that the deployment of staff was suitable to meet people's needs. It was apparent from our inspection that the absence of robust quality monitoring was a contributory factor to the failure of the provider to recognise breaches or any risk of breaches with regulatory requirements sooner.

Support and resources needed to run the service were not available and the provider was not operating the service in line with their own philosophy of care which stated that, 'Our belief in caring for the elderly is to maintain the highest standards of quality care. Our abiding personal and professional concern is safeguarding the interest and well-being of all residents as well as offering person-centred care.'

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

Since our inspection we have written to the provider highlighting several concerns we found and have requested an action plan to be drafted, on how the service will improve care and treatment for people using the service.

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 RA Regulations 2014 Person-centred care We found that service users' care was not planned and assessed to ensuring that they have care or treatment that is personalised specifically for their needs.

The enforcement action we took:

Impose conditions on your registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Care records, plans and assessments were very generic and did not take account of service users' individual needs effectively.

The enforcement action we took:

Imposed conditions on registration

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 The service failed to protect the people in your care from abuse and improper treatment.

The enforcement action we took:

Imposed conditions on registration

Regulated activity	Regulation
Accommodation for persons who require nursing or	Regulation 17 HSCA RA Regulations 2014 Good

personal care	governance There was no evidence to show that the provider's quality assurance systems effectively analysed and evaluated information so as to identify where quality or safety were compromised, to drive improvement or to respond appropriately.

The enforcement action we took:

Imposed conditions on registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There was not sufficient staff to ensure people's needs were met at all times and in such a way that ensured their safety and wellbeing

The enforcement action we took:

Imposed conditions on registration