Whisselwell Care Limited

The Priory Residential Care Home

Inspection report

10 Paternoster Row
Ottery
St. Mary
EX11 1DP
Tel: 01404 812939
Website: www.prioryresidentialcarehome.co.uk

Date of inspection visit: 3 and 4 December 2014
Date of publication: 18/02/2015

Ratings

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

Overall summary

We visited the home on 3 and 4 December 2014. The visit was unannounced and was carried out by one inspector. The service provides accommodation without nursing care and is registered for 21 people to live at the home.

There was a registered manager. 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.'

No-one living at the home was subject to a Deprivation of Liberty Safeguards (DoLS). However, during the inspection, the registered manager and senior staff

Summary of findings

identified several people who required an application. The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes.

People were not protected from abuse. Following incidents, there was a lack of evidence of action taken to keep people safe. Risk assessments were poorly completed for people whose actions or care needs put them and/or others at risk. Care Planning did not people's individual needs and did not ensure the welfare and safety of people. People living at the home were not protected against the risks of an unsafe building.

People living at the home were not protected against the risks of unsafe management of medicines. People living at the home were cared for by staff who had not been appropriately supported through induction, training and supervision.

Suitable arrangements were not in place to obtain, and act in accordance with, the consent of people living at the home. Suitable arrangements were not in place to protect people living at the home against the risk of inappropriate restraint.

There was not an effective complaints system to address people's concerns. There was not an effective system to regularly monitor and assess the quality of the service and the risks to the people living there. The provider is required by law to notify the Commission of any allegation or instance of abuse. Two notifiable incidents should have been reported and were not.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of this report.

People said they felt safe and comfortable, and the staff team was generally stable. People said their medication was provided when they needed it. They said there were generally enough staff and their call bell was accessible to request help. People said staff cared for them and knew what to do.

People were positive about the quality and range of food at the home. They said the food was well cooked and they enjoyed their meals. People living at the home shared the following comments about staff "they do everything for us", "all very nice" and "very good". Several people said they would recommend the home and other people said "I'm happy here" and that the home was "reasonable". There was generally a good rapport between the people living at the home with people chatting in both the main lounge and the TV lounge.

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 because people living at the home had not been safeguarded against the risk of abuse. Assessments linked to people's care needs were poorly completed so risks to their safety were not well managed. Several windows in the home were unsafe. The service's recruitment procedure was not effective or robust. People were not protected from risks of unsafe management of medication.

Inadequate

Is the service effective?
The service was not effective because staff had not been appropriately supported through training and supervision. Suitable arrangements were not in place to obtain people's consent and were not in place to protect people against the risk of inappropriate restraint.

Inadequate

Is the service caring?
The service was not always caring. People said staff were kind and caring. And there were some good interactions between staff and people. However, there were other examples where practice did not respect people's dignity, for example how people were supported with their meal.

Requires Improvement

Is the service responsive?
The service was not responsive because care planning did not meet people's individual needs and did not ensure the welfare and safety of people. There was not an effective system to address people's concerns.Work was taking place to provide a range of activities.

Inadequate

Is the service well-led?
The service was not well-led.There were a number of concerns during our inspection which had not been identified by the registered manager including staff training, staff recruitment, the management of complaints and audits of the building. This showed a lack of a robust quality assurance system. Two notifiable incidents had not been reported to CQC as required by the regulations.

Inadequate

The Priory Residential Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

We visited the home on 3 and 4 December 2014. The visit was unannounced and was carried out by one inspector. We 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 comment directly on their experiences of living at The Priory Care Home.

Prior to the inspection we reviewed a range of information to ensure we were addressing potential areas of concern and to identify good practice. This included the Provider Information Record (PIR), which asks the provider to give some key information about the service, including what the service does well and improvements they plan to make. We also reviewed previous inspection reports and other information held by CQC, such as notifications. A notification is information about important events which the service is required to tell us about by law.

During the visit we met with 14 people and eight of these people shared their views on living at The Priory Care Home. We spoke with three visitors to the home, six staff, the registered manager and we contacted the district nursing team and the local commissioning and contracting team. We observed care and support in communal areas and also looked at 12 people's bedrooms and two bathrooms. We reviewed a range of records about people's care and how the home was managed. These included the care plans for three people, the training and induction records for five staff employed at the home, the recruitment files for three staff working at the home and medication records. We also discussed the quality assurance audits systems in place.

Inadequate

Is the service safe?

Our findings

People said they felt safe and comfortable. Staff could recognise the signs of abuse, and knew they should report concerns to a senior member of staff. However, two staff members could not remember being shown the safeguarding or whistle-blowing policy as part of their induction and were unsure where they would find it. A third staff member thought they had seen the safeguarding policy and knew it was kept in the office. All were unclear where to find the contact number for an external agency if they wished to make an alert as a whistle-blower. When asked about the timescale for reporting abuse, two staff members were not confident that their action would be to report their concerns immediately.

Staff said the actions of a person who had recently lived at the home had put other people living at the home and staff at risk of harm, and had endangered the person. The person's daily records stated they had damaged property, distressed and frightened other residents through their actions towards them, and physically abused staff. Records showed staff had been in contact with local GPs and the local authority to request help but the registered manager had not made a safeguarding alert to help ensure a co-ordinated multi-disciplinary approach. This did not follow the home's own safeguarding policy.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 because people living at the home had not been safeguarded against the risk of abuse.

There were no risk assessments to reduce risk to the person and to other people around them. No changes had been made to the person's care plan following these incidents. There was no written guidance to staff as to how they should to respond to the regular incidents. Accident forms logged 12 occasions in a month when the person was on the floor; the moving and handling assessment was a tick box form which indicated the person was mobile and used a stick. The falls assessment gave no guidance to staff in how they should respond when the person was found on the floor despite information from a hospital, which said 'high risk of falls'. Staff did not recognise the importance of incidents and accidents and therefore failed to report them appropriately. This meant they could not show they had considered the significance of the accidents and incidents and therefore had not taken precautions to help prevent recurrence.

There were other examples where there were poor quality risk assessments for other people living at the home relating to skin care, moving and handling and risk of abuse. However, health professionals who visited the home said staff contacted them appropriately and generally followed their advice. They said they had no concerns regarding staff moving and handling practice.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 because risks assessments were poorly completed or not completed for people whose actions or care needs put them and/or others at risk.

In a person's daily records there were two entries that stated the person had been 'hanging out of the window' and had been found in another room with the window 'wide open'. During the inspection, the registered manager's husband checked one room and confirmed restraints needed to be fitted to the window but said the window was hard to open. The sash window in the second room opened wide enough for a person to fall out of it. There were no restraints fitted and it was not difficult to open. The provider locked the second room, which was not in use. They also informed staff of their actions.

The registered manager said they ensured the home was a safe place for people to live by staff carrying out monthly checks of the building. There was an undated record of an assessment of the building, which staff said had taken place in October 2014. They said this was the most recent audit. This was after the above recorded incidents and did not record the windows not being restricted. Staff said it was not always possible to ensure building audits happened regularly. During the inspection, a person said in front of staff that they kept their bedroom door ajar with a basket; some other bedroom doors in the same corridor had restrictors on their fire doors. There was no assessment in the person's care file to show if this practice had been risk assessed and whether advice had been sought from the fire service. There was a book for staff to log maintenance concerns; these entries were dated but unsigned and there was not a date logged showing when they had been completed.

Inadequate

Is the service safe?

This was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 because people living at the home were not protected from the risks associated with an unsafe building.

People said the staff team was generally stable, which was reflected in the Provider Information Record (PIR). Staff recruitment procedures at the home were not effective or safe as three staff files lacked information to ensure staff were suitable to work with vulnerable people. The missing information varied for each file but included no references and an incomplete application form with inaccurate information for one person, no formal identification for one person and no current information for three people from the Disclosure and Barring Scheme. These checks identify if prospective staff had a criminal record or were barred from working with vulnerable people. The registered manager said the company's recruitment policy had not been followed. There was information on one staff member's file, which required further investigation by the registered manager as they were unsure where the decisions had been recorded regarding the person's suitability. The decisions were not recorded. The registered manager said they would complete a risk assessment for this person's employment.

This was a breach of Regulation 21 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 because the provider did not operate an effective recruitment procedure.

People said their medication was provided when they needed it. Medication was stored in a locked cabinet and medication trolleys were stored securely. Medication records showed the administration was up to date, and where medication had not been given there was an appropriate code to explain why. However, there was a list of staff signatures so there could be a record of who administered medication but five staff signatures were missing. This meant there was not a clear audit trail of who had administered medication. Practice was variable regarding dating when liquids and ointment medication had been opened. Handwritten entries in medication administration records were not always double signed to ensure written errors were not made. The temperature of a fridge used to store medication was not effectively monitored.

The registered manager confirmed there had been four recent incidents of poor medication practice by staff. This was despite recent training, which staff and records confirmed. Senior staff said as a result there had been four disciplinary procedures against different staff to try and stress the importance of safe medication practice.

Prior to the decision by senior staff to instigate disciplinary measures an incident occurred, which involved one person living at the home. The staff member administering medication did not follow the home's medication policy and delayed reporting an error. The resident's care record also had no log of the GP being called for advice, which the registered manager said they had requested to happen. They were not aware this advice had not been followed. There was no log of a supervision session with the staff member and staff confirmed there had been no observation of the staff member's practice after the incident. The registered manager explained why disciplinary action had not been taken but there were no written records to evidence this decision.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 because people living at the home were not protected against the risks of unsafe management of medicines.

People said there were generally enough staff and their call bell was accessible to request help. During the inspection, call bells were not ringing regularly and a spot check of the record of response rates by staff showed call bells were responded to promptly. Two visitors said there seemed to be enough staff, although one person said there had been a recent Sunday shift which had been "short", which was reflected in the rota. Sometimes people in the TV lounge did not benefit from staff observation; one person invaded another person's personal space. The other person looked agitated, slapped the first person's hand on two occasions and at one point pushed their arm away. The first person's care plan stated they could be vulnerable because of the actions of other people. These two incidents were reported to care staff at the time and to the registered manager as people's well-being using this room was not being monitored appropriately. The registered manager said they would advise staff to be more vigilant.

Four staff said it had been a difficult year at the home because of long term staff sickness and the complexity of some people's care needs. Five staff told us they were asked if they could pick up extra shifts and some staff changed their role and worked 'on the floor' to help out. Three staff indicated this was not a problem if it was not on

Inadequate

Is the service safe?

a regular basis, but two other staff said it impacted on their other roles and responsibilities. Visiting health professionals said there were generally enough staff but that staff were very busy. Their view was that staff knew the people they were caring for. Visitors told us the staff team was fairly stable and this was the view of the people living at the home. The registered manager confirmed agency staff had been used at times during 2014 to ensure there were appropriate staffing levels. They told us they had been pleased with the quality of the agency staff but their aim was to cover vacant shifts within the existing staff team.

Inadequate

Is the service effective?

Our findings

The home's PIR stated people at the home were kept safe 'by monitoring staff performance through supervision and providing all staff with up to date training'. The monitoring and assessment of staff skills and knowledge was variable. One staff member said they had not been told how to assist a person to stand despite the person's complex communication needs and variable mobility. Another staff member demonstrated poor practice when they assisted the same person, and a third person described poor practice when they explained how they moved the person. Records showed the third person had received recent moving and handling training in this area of care, which the staff member confirmed.

One staff member said there was no written advice in the person's care plan as to how to support them with moving. The care plan did not provide guidance. The staff member also said they had been expected to use a piece of moving and handling equipment for another person living at the home, which they had not used before. They felt it was just assumed they would use it but they had to ask for help. They said they did not feel supported in this aspect of their role. They said their moving and handling practice had not been observed or assessed. They said they had not received the information and training they felt they needed to carry out their role.

In contrast, another staff member said their moving and handling practice had been observed and they had watched other staff members use equipment to learn from them. New staff members' induction sheets were not signed or dated by newly recruited staff. The induction sheet format did not include moving and handling or observations of practice. New staff members' files did not include information recording that their moving and handling practice had been assessed. The registered manager acknowledged that the service's current induction process could be improved. The current induction was not comprehensive.

Staff training at the home was not well managed. The training matrix for staff was not accurate; it contained the names of former staff no longer working at the home. The training files for two established staff who had worked at the home for over six months showed neither had received training in caring for people living with dementia. This was despite senior staff identifying six people living at the home as showing symptoms for this progressive disease. According to the training matrix, one of these people had not received safeguarding training but a member of the management team said the staff member was in the process of completing this training. Both staff members had received medication training but neither had completed infection control. Staff records did not demonstrate how training was allocated to staff and why key training relating to key areas for care were not provided. However, people said staff cared for them and knew what to do.

The registered manager said that all staff members should have received at least two supervisions in the last year; they recognised this quantity should be improved. The dates for supervision for three staff members who had worked at the home for over ten months did not demonstrate this commitment. In one staff member's file, there was no log of supervision sessions. The registered manager told us they understood that they had taken place because there had been issues which needed addressing with the staff member. There was also a lack of supervision records in the two other staff files.

This was a breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 because people living at the home were cared for by staff who had not been appropriately supported through training and supervision.

The Mental Capacity Act (2005) provides the legal framework to assess people's capacity to make certain decisions, at a certain time. When people are assessed as not having the capacity to make a decision, a best interest decision is made involving people who know the person well and other professionals, where relevant.

Senior staff said they had completed mental capacity act training through distance learning. Discussions with staff demonstrated that this training had not been translated into practice. Senior staff identified some people living at the home as not having the mental capacity to make some decisions relating to their care. Mental capacity assessments had not been completed for them. This meant there were no records of best interest meetings taking place to help protect the identified people's rights and how decisions were made.

A person said an item of furniture had been removed from their room because it impacted on their health; they were

Is the service effective?

not happy about the loss. Staff explained the reasoning behind this action based on advice from healthcare professionals; they said the person had been involved in the decision but there was not a record of the decision-making process. Staff confirmed the person had capacity to make a decision regarding this aspect of their care.

Deprivation of Liberty Safeguards (DoLS) provides legal protection for those vulnerable people who are, or may become, deprived of their liberty. The registered manager said they had sought advice from an external organisation regarding making Deprivation of Liberties applications but during the inspection they concluded they may have been wrongly advised. No applications had been made despite some people living at the home needing to be protected by this legislation. One person's file contained information from a hospital discharge that indicated an application would have been necessary but this had not been recognised as part of the home's assessment process.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 because suitable arrangements were not in place to obtain, and act in accordance wit, the consent of people living at the home.

An entry in one person's care file recorded 'staff had to restrain' the person because their behaviour impacted on the safety of others living and working in the home. There had been a number of recorded incidents which demonstrated the person's behaviour was erratic and impacted on the safety and well-being of others. The person's records showed some staff were able to de-escalate incidents, which was good practice. But there was no guidance in the person's care plan for staff as to how they should react.

A policy called 'Policy on Physical Intervention by Staff' had not been reviewed since October 2013. It had not been updated to include the Mental Capacity Act (2005). It stated that 'physical interventions should only be used as a last resort by trained staff'; the training offered by the provider did not include the type of training detailed in the policy.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 because suitable arrangements were not in place to protect people living at the home against the risk of inappropriate restraint.

People said staff listened to them. For example, one person said they sometimes liked to stay in bed as this was more comfortable and staff respected this wish. A staff member confirmed this was the person's chosen routine. However, another staff member started a personal care task without asking the permission of the person to carry out this type of support; the person clearly stated several times that they were not happy but the staff member continued. Other examples during the day showed other staff did not always check with the person that they were in agreement to support or the choices made by staff on their behalf.

The home's PIR stated that 'we ensure good nutrition and hydration by providing home cooked meals, using good quality ingredients and having water at all time as well as tea, coffee and squash.' People were positive about the quality and range of food at the home. Staff ensured people knew there was a choice of main meal and recorded their choices. People said the food was well cooked and they enjoyed their meals. People said they could choose where they ate their meal as some people preferred to eat alone. During the inspection, staff discussed the arrangements for Christmas Day as a number of visitors were coming for a meal. A visitor said they regularly ate a meal at the home, this was important to them as it enabled them to spend more time with the person living at the home.

During the inspection, staff made sure most people had regular access to drinks. This included a short period when the lift was out of action so staff brought drinks to people in their rooms. People had jugs of water in their rooms. Staff knew people's preferences when they were serving drinks. The registered manager agreed to check why one person was having cold drinks served in a beaker as this was not detailed in their care plan. The person did not respond well to the beaker and therefore the beaker was left in front of them. Later another person picked it up and drank from it; they had not been provided with a drink when they came into the lounge with a staff member. The registered manager was unhappy the person had not been provided with a drink as she said staff were told to ensure people drank regularly.

Requires Improvement

Is the service caring?

Our findings

In the minutes from four staff meetings, there were reminders to staff to maintain people's dignity and respect through their practice and in the way they communicated with people and each other. This indicated this was an area for improvement for some staff but also showed that by reminding staff the service was committed to prioritising people's dignity. There was some kind and respectful practice on the day of the inspection as staff talked with people about their previous roles in life and listened to their views.

But there were also some actions by staff that compromised people's dignity relating to their personal appearance and care, including how they were supported with their meal. For example, a staff member did not interact with the person whilst supporting them with a meal. They did not gain their agreement before offering another spoonful and they did not tell the person what type of food they were being served. They did not check if the food was the right temperature. The person's care plan gave no personalised information to help support their dignity and their involvement.

Two bedrooms out of 12 needed improvements to support people's dignity. The provider advised us that a new carpet was already on order for one room. A regime was in place to deep clean the carpet in the second room The provider told us the plan was to replace the carpet and flooring if the odour could not be eradicated.

Health professionals who visited the home said staff could meet the needs of people living there. They said they had no concerns regarding staff practice in relation to dignity and respect. Two people said they had not been asked if it was acceptable for a male care worker to provide personal care but they said they did not mind this arrangement. The registered manager said people were always asked but their decision may not always be recorded. Three people said staff supported them with personal care in a way which did not embarrass them and respected their dignity. During the inspection, staff confirmed there was a log of compliments and complaints. There was a log of compliments, which covered a range of issues including the kindness of staff and their professionalism.

People living at the home shared the following comments about staff "they do everything for us", "all very nice" and "very good". Several people said they would recommend the home and other people said "I'm happy here" and that the home was "reasonable". There was generally a good rapport between the people living at the home with people chatting in both the main lounge and the TV lounge. People spoke about the activities they had participated in and commented on events around them. People were relaxed with staff; several staff were particularly skilled at putting people at ease.

Inadequate

Is the service responsive?

Our findings

The provider identified in their PIR that the service needed to 'continue to develop and improve our care plans.' A review of three care files during the inspection showed further improvement was needed. Staff said their practice was to visit people before they moved to the home. The registered manager was not able to find the service's assessment on a person's care file who had recently moved to the home, although an assessment provided by the local authority had been filed. A visitor to another person living at the home said they had wanted to be with their relative when they had been assessed in hospital but staff had not told them when they were visiting. The registered manager said they tried to visit when relatives were present as long as the individual considering moving to the home agreed.

Care files did not show how each person had been involved in their assessment or their care plan. There was no place on the care plan for people to sign to show they or an appropriate representative had agreed to the content. Three care plans held basic information which was not personalised or detailed. For example, for a person who needed support and encouragement with their meal, the guidance was 'feeding'. The person's care plan did not encourage staff members to deliver personalised care.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 because care planning did not meet people's individual needs and did not ensure the welfare and safety of people.

Since the service was inspected in 2013, CQC have not received any complaints about the service. Staff told us the complaints policy had been displayed in a more prominent position following feedback from a survey. A copy of the policy had out of date information on it. This had been highlighted to the provider at the last CQC inspection in October 2013.

In the PIR it stated there had been 11 compliments and no written complaints. During the inspection, staff confirmed there was a log of compliments and complaints. Three written complaints had been logged, which showed the information in the PIR was inaccurate. The home's complaints policy had not been followed for any of them. The registered manager agreed the home's policy had not been followed and could not show through records how they had been involved in resolving the complaints.

Poor recording meant that the quality of the response to complaints was hard to judge as there was little written detail. For example, a record for one complaint said 'spoken to staff' and staff showed us a reference to the concern in a staff meeting three months later. A visitor said they had made a verbal complaint in 2014. Senior staff had listened to their concern and they were pleased with the senior staff member's response. However, this complaint had not been recorded despite it concerning a staff member's poor attitude. This did not follow the home's complaint's policy.

This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 because there was not an effective complaints system to address people's concerns.

Care plans and systems within the home did not support person centred care. In the PIR it stated that 'each service user has a keyworker. We try to give opportunities for the key workers to spend time with the individual as often as possible.' However, during the inspection staff told the registered manager it had been hard to sustain the keyworker system because of staff changes and it was not currently in place. This showed the information in the PIR was inaccurate. Two care files logged people's life histories and their interests; the third did not. The registered manager looked at the individual record of people's activities to see if people's interests were met. The record was unclear and the registered manager agreed the recorded codes did not follow the systems activities codes. A member of staff with the role to develop activities told us more work was needed to ensure people's personal interests were met.

Two visitors whose relatives were living with dementia said they worried sometimes that staff forgot to include them when arranged entertainment took place, such as visits from external entertainers. On the first day of the inspection, staff had ensured one of these relatives had been supported to leave their room to join in with a session called 'Tranquil Moments'.

The registered manager told us a volunteer had been providing one to one activities for people living with dementia but said the volunteer was currently unable to visit the home. Throughout the second day of the inspection, the TV was playing loudly in one of the lounges.

Inadequate

Is the service responsive?

One person commented they could not hear another person because of the volume and few people actively watched the TV. A staff member chose a TV channel without consulting people in the room.

A staff member said they were committed to changing the perception of residential care by providing stimulation to people and activities that was meaningful to them. They said they ensured there were a range of external entertainers visiting the home to provide art, poetry and music. However, they said people's care needs were becoming more complex and recognised as a result that a review of the type of activities provided was needed.

Inadequate

Is the service well-led?

Our findings

The registered manager said they spent two days a week at the home but they were available by telephone the rest of the time. Staff agreed they could usually contact the registered manager by phone. People living at the home and visitors to the home named the three assistant managers when they were asked who managed the home. One of the assistant managers told us their role was being developed so they could experience the responsibilities of the registered manager. The registered manager and one of the assistant managers did not record their hours on the rota, although they both said they generally kept to the same working days each week. New staff were unclear about the role of the registered manager. One staff said it was a lovely home to work in and they felt well supported by other staff.

Staff were told of the change of roles in a staff meeting in July 2014 ; this included one of the assistant managers be acting as manager. There were no records to show that this change had been shared with people living and visiting the home.

Senior staff said they had been developing their new management roles, particularly when the registered manager had been away. In the PIR it stated communication books were used to pass on information, which staff confirmed. The assistant managers did not have regular supervision from the registered manager. There were no records of the registered manager meeting with senior staff. And there was evidence that the registered manager was not always aware of some issues linked to the running of the home. For example, the complaints that had been received and how they had been responded to by other staff members. The complaint's policy stated it was the role of the registered manager to respond to complaints but the record of complaints showed this did not happen.

One staff member's file only contained one supervision record, which was not clearly dated but the registered manager said it had taken place in 2014. She said other supervisions had taken place for another staff member and she did not know why they had not been recorded. Staff said they did not receive regular supervision, which was confirmed by the lack of records in their files. Minutes showed there had been three staff meetings in 2014 and a seniors meeting; none had been attended by the registered manager.

The registered manager or a delegated person did not have systems in place to demonstrate how they monitored the support people received at night or how they monitored the performance of staff at night. A visitor said there had been a complaint that had been made regarding a staff member's attitude but there was no log of what action had been taken to address this with the staff member.

The registered manager was not involved in the recruitment of three new staff; they had not checked that other staff had followed the home's recruitment policy and that the correct information had been obtained before the staff began working at the home.

The registered manager expressed concern that the audit of staff training was inaccurate; this showed they had not reviewed the document to ensure staff received appropriate training to meet people's needs. They had not ensured training overview tool was fit for purpose.

The accident and incident records were not accurate as one person's care records showed there had been a significant number of events that had not been recorded. This meant the monthly collation of incident and accidents, which was completed by staff, was not accurate and did not provide an accurate audit of how people's safety was managed.

The registered manager did not carry out a regular audit of the safety of the building as this had been delegated to other staff members. There was a lack of records for these audits, which staff said they struggled to carry out regularly. The registered manager had not reviewed the most recent audit which according to staff had been carried out in October 2014, although it was not dated.

The content of the audit was mainly concerned with decoration improvements rather than safety. The audit did not record if window restraints were in place, despite the entries in one person's daily records that indicated two windows were not restricted appropriately. After the inspection when further feedback was given, the registered manager said they were not aware that one person's bedroom door was being inappropriately propped open with a basket.

Inadequate

Is the service well-led?

Policies relating to the home and how it was run had not been reviewed since October 2013 and some contained inaccurate information. The statement of purpose in the respite room was out of date. A visitor commented they were not told there were two cats living in the home, which they said was information their relative, should have been told before moving in.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 because there was not an effective system to regularly monitor and assess the quality of the service and the risks to people living at the home.

Notifications had not been sent to the CQC regarding a safeguarding issue and for an incident where money for one person had gone missing.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 because CQC had not been notified of incidents within the service.

The registered manager held relevant qualifications. They told us they had completed a qualification called level 5 diploma in health and social care. One of the assistant managers confirmed they had also completed this qualification to help them develop their management skills.

There was feedback from a survey to gather people's views on the service, which staff had begun to collate. They had changed the position of the complaints policy based on feedback from the survey but had not yet sent out a report summarising the outcomes and planned actions to address any concerns or ideas for improvement.

People said they were generally happy with the standard of their bedrooms; one visitor said they were disappointed with the standard of the decoration in a bedroom. Other people said the communal areas were homely, which they appreciated. After the inspection, staff sent evidence of the maintenance records for the home, which showed there was a programme of general maintenance and redecorating, as well as updating a wet room. Records showed that equipment in the home was serviced at suitable intervals.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse **People living at the home had not been safeguarded against the risk of abuse.** **Regulation 11(1)(a)(b)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services **Risk assessments were poorly completed or not completed for people whose actions or care needs put them and/or others at risk. Care planning did not meet people's individual needs and did not ensure the welfare and safety of people. Regulation 9(1)(a)(b)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises **People living at the home were not protected from the risks associated with an unsafe building. Regulation 15 (1)(c)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010 Requirements relating to workers **The provider did not operate an effective recruitment procedure. Regulation 21(a)(b)**

Regulated activity	Regulation

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines People living at the home were not protected against the risks of unsafe management of medicines. Regulation 13.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff People living at the home were cared for by staff who had not been appropriately supported through training and supervision. Regulation 23(1)(a).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment Suitable arrangements were not in place to obtain, and act in accordance with, the consent of people living at the home. Regulation 18.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse Suitable arrangements were not in place to protect people living at the home against the risk of inappropriate restraint. Regulation 11(2)(b).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA 2008 (Regulated Activities) Regulations 2010 Complaints There was not an effective complaints system to address people's concerns. Regulation 19 (1)(2)(c).

Regulated activity	Regulation

This section is primarily information for the provider

Action we have told the provider to take

Accommodation for persons who require nursing or personal care	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment CQC had not been notified of incidents within the service. Regulation 18 (1) (2)(e)(f).

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers There was not an effective system to regularly monitor and assess quality of the service and the risks to people living at the home. Regulation 10(1)(a)(b)(2)(b)

The enforcement action we took:
A warning notice was served on 21 January 2015 to be met by 30 April 2015.