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Willows Care Home

Inspection report

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Ratings

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

Overall summary

The inspection took place on 16 and 20 October 2014 and was unannounced.

The last inspection took place in July 2013 under the Commissions old way of inspecting. The provider was not in breach of the regulations that were inspected during that inspection.

Willows care home is split into two units that support people with conditions associated with old age as well as people living with dementia. The service was registered to accommodate a maximum of 73 people. There were 62 people living at the home at the time of our inspection. The provider employed a compliance manager who worked alongside the home manager who was registered with the Commission. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are

Summary of findings

'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.

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. Most of the people we spoke with gave us positive feedback about the services they received. However, three people gave negative feedback when we asked them about their experiences. They told us that staff did not always respond to their care needs in a timely manner.

We saw that equipment was poorly maintained and poor medication practices had been used which put people at risk of not receiving their medicines safely. Staff had not received training in key areas such as first aid, the Mental Capacity Act 2005, medication and challenging behaviour. Therefore people's health, safety and welfare was compromised as they were being supported by staff who had not been appropriately trained to perform their duties within the requirements of the law and associated best practice guidance.

The provider had failed to inform us of significant incidents that had occurred in the home to ensure that people were fully protected from the risk of harm.

We found that staff recruitment processes were robust and people were supported by sufficient numbers of staff.

We found that people's health care needs were assessed and they had access to external health and social care services. However, people's care was not planned consistently in relation to pressure area care. Where people were at risk of pressure ulcers, four people did not have appropriate care plans in place. The records that nurses kept to guide them in relation to pressure areas were not up to date and this put people at risk.

We found that the dementia unit was not always a dementia friendly environment as appropriate signage was not in place to assist people if they became confused.

We saw that care took into account people's preferences and choices were available to them. During our visit we saw that staff were caring and spoke with people in a caring and compassionate way. Our observations showed that staff were attentive to people's needs in a timely manner.

Activities took place during our visit and the activities co-ordinator was knowledgeable about the people she supported and knew what activities they liked to do.

The provider had a complaints procedure in place. People told us that when they had raised concerns they had been dealt with to their satisfaction. Records showed that the registered manager investigated and responded to people's complaints. However, the complaints procedure that was on display was out of date and potentially misleading.

Although the registered manager had systems in place to check the quality of the service, they had failed to pick up on many of the discrepancies we found during our visit to the home. In addition to this, the provider did not have an effective system to monitor the quality of the service on their behalf and therefore had also failed to identify the risks that were posed to people who used the service and others.

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.

People were put at risk because systems were not in place to ensure equipment was well maintained. Medicines were not always managed safely.

The registered manager did not always adhere to legal obligations and inform the Commission when people's safety had been compromised.

People were supported by sufficient numbers of staff who had been robustly recruited.

Inadequate

Is the service effective?
The service was not effective.

Staff were not following the Mental Capacity Act 2005 for people who lacked capacity to make informed decisions about the care that was provided.

Appropriate and up to date records were not always introduced or detailed enough in order to provide care that was safe and appropriate to people's needs.

People enjoyed the home's food and had a choice about what to eat.

Inadequate

Is the service caring?
The service was caring.

People told us that staff were caring and this was supported by our observations during our visit.

We saw people's privacy, dignity and independence was respected and promoted throughout the day of our visit. Discussions with people and examination of records showed that people were involved in the planning and delivery of their care.

Good

Is the service responsive?
The service was not always responsive to people's care needs.

Most people provided positive answers around how the service was responsive. However, two relatives and one person who used the service told us that there had been occasions when care needs had not been met in a timely manner and this had caused them distress.

We saw that meaningful activities took place at the home and people were supported to take part during our visit.

The registered manager had a system in place to deal with complaints and people told us that when they raised a concern or complaint that it was appropriately dealt with.

Requires Improvement

Summary of findings

Is the service well-led?

The service was not well-led.

Although people, their relatives and staff spoke highly of the manager, we found that people had been put at risk because systems for monitoring quality were not effective. Sometimes such systems were not in place which further compromised people's health and safety.

Inadequate

Willows 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 checked 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.

The inspection team consisted of an inspector, a specialist advisor with a nursing background and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert-by-experience on this inspection had experience of using services for older people with dementia.

Before the inspection, the provider completed 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. Before our inspection, we reviewed the information in the PIR along with information we held about the home, which included notifications they had sent us. We spoke with seven health and social care professionals before this inspection to obtain to their views on the service.

During the visit we spoke with six people who lived at the home, six relatives, two nurses, four care staff, the registered manager and the compliance manager. We observed care and support in communal areas and the dining room during lunchtime. 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 talk with us. We also looked in people's bedrooms.

We reviewed a range of records about people's care and how the home was managed. These included the care plans for six people as well as an additional six care plans in relation to pressure area care only. We looked at the training and induction records for five staff employed at the home. We also looked at maintenance records, the medication records for six people and quality assurance audits that the registered manager and delegated staff had completed.

Inadequate

Is the service safe?

Our findings

Before this inspection we contacted the local authority to see if they had received any recent safeguarding referrals. They told us they were investigating how a pressure ulcer had been managed for one person who used the service after a complaint was made. This investigation was on-going at the time of our inspection. A health care professional told us that at least three people were receiving treatment at the home for pressure ulcers at grades 3 or 4. This is regarded as a serious injury and providers are legally bound to notify the Commission when such injuries occurred. We examined the records that we held for the provider and saw we had not been notified of these pressure ulcers as legally required. At the beginning of our inspection, we asked the registered manager about this and she confirmed that she did not inform the Commission. In addition to this, we looked at the safeguarding file that the registered manager completed and saw that an incident that constituted an allegation of abuse had been referred to the local authority. However, this had not been reported to us.

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

We saw people's welfare and safety had been put at risk. For example, we looked in 46 bedrooms within the home and saw that 26 people did not have a call bell. We spoke with the registered manager about this, who confirmed that people were assessed for this when they had moved into the home. However, since the initial admission assessment we saw this risk had not been regularly reviewed in any of the care plans we looked at. In addition to this, five people had a call bell that was either not working or out of their reach due to the person's poor mobility. We informed the local safeguarding authority of our concerns.

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

We saw that fire alarms and equipment were tested on a regular basis and a fire drill had recently taken place. We looked at certificates that showed fire equipment had been recently passed as fit for purpose by an external company. In addition to this the provider had certificates to show compliance where gas and electrical safety was concerned.

We looked at a fire risk assessment that was carried out in November 2013 and saw that several concerns had been identified by an external assessor. It was clear that actions had been set and people were delegated to manage them. However, it was not clear if any of the actions had been addressed and by whom. Therefore the safety of service users and others had been put at risk. We have referred our concerns to Cheshire Fire and Rescue Service.

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

We looked at how equipment was managed in the home. We saw certificates that showed lifting equipment such as hoists had been examined by a competent person in the last six months. The maintenance person also conducted their own monthly checks of lifting equipment. One person had a pressure relieving mattress, but we found that it was on the wrong setting for the person's weight and therefore might not have been effective in helping a pressure ulcer to heal or in preventing more pressure ulcers. We saw that several mattresses were too big for people's beds. This meant people were at risk of not having their feet and lower legs supported whilst they were in bed. We saw also that one bed rail bumper was ripped. We spoke with the registered manager about this who confirmed that no formal checks on bed rails or mattresses had been carried out. In addition to this, no checks had ever been carried out to see if the profiling beds (hospital type beds) were in good working order. We informed the registered manager of our concerns during our visit. We have also referred our concerns to the local safeguarding authority.

This was a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We looked at the medicines records for six people who used the service. We saw that accurate and consistent records were kept on medicines that were administered, received and disposed of. We saw that people were given their medication at safe time intervals with times accurately recorded on the Medication Administration Record sheets (MARs). People told us they received their medicines on time. A visiting relative told us; "He has regular medication and they always stay with dad, give him a drink and make sure he swallows his tablets".

Many people who lived in the home were prescribed medicines to be taken only 'when required'. For example, painkillers and medicines for anxiety. We found that no

Inadequate

Is the service safe?

information was in place to guide nurses on how to give these medicines to ensure that the medicines were given correctly and consistently with regard to the individual needs and preferences of each person.

We found that suitable arrangements had been made for the safe storage of most medicines. However we saw that creams were not stored securely in people's bedrooms. We also found that there were no risk assessments in place to show it was safe to store creams in this way. We saw that one person's medication was stored in the fridge when the label on the medication clearly stated 'Do not refrigerate'. If medicines are not stored correctly people's health may be at risk and medicines also may not work properly.

We saw that care plans were in place for covert medication (medication hidden in food or drink). We spoke with a nurse on duty that was able to describe how certain medicines were to be given. However, there was no guidance in place for staff on how to disguise the medicines and this placed people at risk of not receiving their medicines safely if they were supported by staff who did not know them well.

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

People who lived at the home said they felt safe living at Willows Care Home. Comments from people who used the service included; "I'm safe and happy" and "They look after me well and I'm safe". Relatives of people we spoke with told us they believed that their relative was safe living at the home. One relative told us; "It's a very safe and secure environment".

Staff had undertaken training on safeguarding adults from abuse. We looked at training certificates and spoke with staff who confirmed that they had completed this training. Records confirmed that training in safeguarding was current for all members of staff. Discussions with staff demonstrated they were knowledgeable about the different types of abuse that could occur and they knew how to report it. Staff said they could approach the manager with any concerns and felt they would be appropriately dealt with.

We found that staffing numbers were adequate and were based on meeting people's individual needs. Our observations throughout the inspection showed that people received support when required. People who used the service and their relatives told us that staff were always busy but this had not impacted on their care needs. However, one person who lived at the home and one relative told us that there were times in the recent past when personal care needs were not met during the day time due to staff shortages. We spoke with staff about this who told us that they reported these concerns to the registered manager who responded quickly by increasing staffing numbers.

We checked the recruitment records for five members of staff. We saw that before any member of staff began employment with the company two references were obtained. We saw that Criminal Record Bureau (CRB) disclosure checks, and more recently Disclosure and Barring Service (DBS) checks were completed. This showed the provider had a system in place to check that people who lived at the home were supported by people of a suitable character.

Inadequate

Is the service effective?

Our findings

We saw that people's freedom in the home had been unlawfully controlled. For example, during a tour of the home we saw that bedroom doors had been locked with a key when people were not inside their rooms. We asked the compliance manager about this who informed us that the doors were locked to stop people going into each other's rooms. We were told that when people wanted to go back to their rooms they would ask staff to let them in. We looked at some of the DoLS applications that had been made by the registered manager to the local authority and saw this had not been considered.

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

During this inspection staff told us they felt supported by the management team at the home and received regular supervision and an annual appraisal. Discussions with them and examination of training certificates showed that training was current in areas such as moving and handling, safeguarding, food hygiene, dementia awareness and fire safety. However, all staff members spoken with confirmed that they had never received training from the provider regarding first aid, Mental Capacity Act 2005, DoLS, and challenging behaviour. Training had also not been provided around the safe use of bed rails and pressure mattresses. We looked at the training records held by the service and saw that training was not recorded in relation to these subjects. We asked the management team if staff had ever received this training during their employment. We were told they had not received this training. We looked at the induction pack that new employees had to complete when they started work at the service. This training was also not part of the induction plan. Because people were not supported by competent staff, their health and welfare was at risk of being compromised.

A nurse told us they required more training around tissue viability in order to provide more effective care to people with pressure ulcers. We looked at the staff meeting minutes for August 2014 and saw that nursing staff had requested this training. We looked at the training matrix and saw there were still shortfalls for nurses where this training was required. The compliance manager explained that some of the nurses still required this training and it had not yet been arranged. This put people at risk of receiving ineffective care.

Care staff told us that they administered creams to people who lived at the home and this task had been delegated by the nurses. However, we found that care staff had never received any training around the how to apply creams. The registered manager and nurses spoken with were not aware of the current National Institute for Health &Care Excellence (NICE) guidance that states care home providers must ensure that designated staff administer medicines only when they have had the necessary training and are assessed as competent.

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

The Care Quality Commission monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. DoLS are part of the Mental Capacity Act 2005 legislation which is designed to protect people who can't make decisions for themselves or lack the mental capacity to do so. The registered manager was aware of the recent Supreme Court judgement and its implications on compliance with the law. We saw that two people who lived at the home had a DoLS that had been authorised by the supervisory body (Cheshire West and Chester Safeguarding Authority) and applications had also been submitted to the supervisory body for several people who lived at the home.

However, we found that suitable arrangements were not in place for obtaining and acting in accordance with, the consent of service users in relation to the care and treatment provided for them. We asked staff if they knew the differences between lawful and unlawful restraint practices. Two members of staff told us that during a recent shift, a person had to be held down in order for the nurse on duty to provide personal care. We asked staff members about their understanding of the Mental Capacity Act 2005 and DoLS. All of them were unable to answer questions in relation to this. The registered manager told us she was not aware of this incident and the service user concerned did not have the capacity to give informed consent. A DoLS had not been authorised for this person by the local authority. There was also no system in place for monitoring the use of restraint in the home. We raised a safeguarding alert to the local authority following our inspection. They later informed us that following an investigation by them, there was no evidence of any mental capacity assessment or best interest meetings to

determine if the person understood the implications of refusing personal care. Therefore an unlawful form of restraint had been used and this showed the provider did not have regard for the Mental Capacity Act 2005.

We were told that four people received their medication covertly (hidden in food or drink). We looked at the care records for each of them and saw that mental capacity assessments had not been carried out for all of them to determine if they understood the implications of refusing their medication. Best interest meetings had also not been held. The Mental Capacity Act 2005 and current best practice recommendations issued by the National Institute for Health &Care Excellence (NICE) requires that best interests meetings are held with the person's representative and relevant professionals. These meetings are to determine whether it is in the person's best interests to receive medication covertly and which medicines this should apply to. Mixing medicines in food and drink may alter the way in which medicines work and may lead to them being ineffective or conversely, dangerous to use. This should be discussed with the pharmacist as part of the decision making process but there was no evidence this had been done. We spoke with the registered manager and a nurse on duty about this. They were not aware of the current best practice guidelines in relation to covert medication issued by the NICE.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People's care plans included risk assessments for pressure care, falls, personal safety and mobility and nutrition. We saw they had been evaluated and updated on a regular basis to ensure that the information available to staff was current. Records also showed that people had regular access to healthcare professionals, such as GPs, physiotherapists, chiropodists, opticians and dentists and had attended regular appointments about their health needs.

Before this inspection we spoke with a health professional who told us they had concerns with how a pressure ulcer was managed for one person who lived at the home. They also said that where care planning was concerned, some of the nurses at the home were not as good as others.

Although we found some good examples of pressure area management, staff were not always effectively managing people's healthcare needs. For example, formal assessment tools had been used and identified four people at high risk of pressure ulcers. Prevention care plans were not in place for these people. In addition, we saw that one person who recently had a pressure ulcer did not have prevention care plan in place after healing. This meant there was risk that care may not be effective in helping the pressure ulcers to heal or in preventing more pressure ulcers. There was also no information recorded for staff to follow in relation to the body areas that were to be checked.

We looked at the resource file of pressure ulcer information that was held by the nurses. A nurse said that they use this to identify grades of pressure ulcers. We found that some of this information was out of date and some of the images we saw were graded incorrectly and were not in line with current NICE guidance.

When care staff applied creams to people who used the service, we saw that this was recorded on the MAR's. However, there was no guidance in place for staff to follow as to where the creams were to be applied. This put people at risk of receiving inappropriate care.

Records were not always kept securely. We saw that a communication book that was used by staff at the home contained sensitive information and was left out in communal area.

This was a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Relatives of people who used the service told us that the care was effective in the home. Comments from them included; "When I come to see [My relative], their chair is always at the right height and had she has a cushion to support her". Another said; "Nursing staff are very vigilant, especially in relation to a [medical condition] [My relative] has".

People who used the service said they had plenty of choices with regards to what they wanted to eat and drink at the home. Comments from them included; "I get as much as I like" and "The food is excellent. The lunch is great and there are good choices. There's enough of what we want". One visiting relative told us; "There is a nice menu and the food is good".

We saw that food and fluid charts that were completed by staff throughout their shift. They were a tick list that demonstrated when people had had something to eat or

drink. However, they weren't specific as to what people had actually consumed. Although we could not see any evidence that people had received inadequate food and fluid intake, poor records showed that people weren't fully protected against the risks of malnutrition.

A nutritional assessment had been completed for people who lived at the home using a formal assessment tool. These were supported by a detailed nutritional care plan. People's food and drink preferences were recorded in their care plans and any special dietary needs were also recorded. Where people were identified at risk of malnutrition or were deemed over weight, we saw the service had sought the advice and support of a dietician where there was a concern around malnutrition. People's weight was also monitored and recorded on a regular basis.

We spent the lunchtime period with people who used the service. The atmosphere was calm and relaxed. There was a constant staff presence throughout the lunchtime period and people were assisted to eat when required. There was a daily menu displayed on the wall. However we saw this was not displayed in a pictorial format so some people may not be able to understand the choice of meals available for each day. Although staff were seen to offer choices to people, there was a risk that people who could not communicate effectively would not be able understand the choices available to them. Staff told us they knew what people's likes and dislikes were. Where people required a soft or pureed diet, we saw all foods were pureed separately so that they retained their individual colours and flavours. The meals that were served were hot, looked appetising and contained various vegetables in order to promote a healthy diet. Drinks were served to ensure people remained hydrated throughout the day and lunchtime.

We saw that people's bedroom doors were clearly numbered and were personalised with photos of the individual and their hobbies and interests. The grounds and gardens that surrounded the home were pleasant and well maintained. People were seen to be supported to go outside during our inspection. We saw that there were several lounges throughout the home and most people were seen to spend time with each other within them. There was also an activities room that was equipped to support people to do activities they enjoyed. Several of the bathrooms within the home had also undergone extensive refurbishment and were equipped to support people with physical disabilities and poor mobility.

We saw there was no dementia friendly signage in the dementia unit to identify rooms such as toilets and the dining room. There was also no directional signage to guide people if they became confused or disorientated. We spoke with the compliance manager about this who said there used to be signage but it had been taken down by people who used the service and had not been replaced. We saw there was a sensory room at the home that was designed to support people's sensory needs.

Good

Is the service caring?

Our findings

People who used the service told us that the staff were caring. Comments from them included; “They really do care for me”, “The quality of staff is good and they are all very kind” and “They treat me very well”.

Relatives also told us that the staff were caring towards their relative and they were able to visit the home whenever they liked. Comments from them included; “All the staff are friendly and very respectful”, “The staff are very kind and pleasant. They are easy to talk to” and “I am made to feel welcome when I visit and feel I am an important part of their support”.

Health and social care professionals believed caring attitudes were adopted by staff. A healthcare professional told us; “The staff are exceptionally caring. I can’t fault them”.

People spoken with told us they were involved in putting the care plans together before they moved into the home and during their time there. This was evident in the care plans we looked at.

Throughout the day of our visit we observed that people looked content, happy and comfortable with the staff that supported them. We saw staff being kind and supportive to the people they supported. Staff spoke to people in a caring and compassionate manner. When people became confused and upset, staff dealt with the situation calmly and were attentive to people's needs.

We saw that advocacy services such as Age UK and the Independent Mental Capacity Advocate (IMCA) were available to people should they be required. One advocate who had past involvement with the service told us that registered manager had made a referral to them on behalf of a person who live at the home. They also said; “The manager and staff are kind and polite and were always willing to listen to my views and suggestions”.

Staff had been trained in how to respect people’s privacy and dignity, and understood how to put this into practice through a training course titled ‘Customer care’. We saw this had been put into practice during our inspection. We saw staff promoting independence and choice. For example, we saw people making decisions on what they wanted to eat and drink, whether they spent time in their bedrooms, taking part in activities, in the communal lounge or going outside. We saw staff knocked on the doors of the people who used the service before entering. This showed that people's privacy was respected. Staff told us that various religious denominations visited the home throughout the week to ensure that people's religious beliefs were respected.

We saw that ‘resident and relative’ meetings took place at the home on a regular basis. We looked at the minutes of these meetings and it was clear that they were well attended and people were supported to attend.

Requires Improvement

Is the service responsive?

Our findings

We asked people if staff at the home were responsive so that their needs were met. One person who used the service told us; "My catheter bag is not changed enough. Sometimes it has been full and leaked. This has caused me pain". A relative also said; "On occasions [My relative] pads have leaked because staff haven't changed them enough. Staff need a kick up the backside". Another relative told us; "[My relative] hearing aid was lost at one stage. On another occasion they had it on but the battery was dead. I think that staff should check each day that they are wearing it and it's working properly." We informed the registered manager and the compliance manager of some of the negative feedback we received during feedback following of our inspection.

Positive responses from people included; "The staff are good at handling difficult situations" and "Any concerns are always acted upon". A relative told us; "They are well tuned in and respond to their needs".

Visiting professionals spoken with believed the service was responsive to people's needs. One professional told us; "The management team are very good and respond quickly to any issues". Another said; "I did make some recommendations and there was an incident during my visit, this was addressed by the service".

We spoke with the activities co-ordinator who told us they provided sessions throughout the week with people on an individual basis or as a group. We saw they made detailed notes about the progress of each person and this was kept in an activities file. Throughout our inspection we saw people engaging in activities with the co-coordinator and a full afternoon had been planned on the day of our visit. We also saw one person who used the service playing the piano with other people gathered in the room singing along to the music.

The staff who we spoke had a good understanding of people's preferences, likes and dislikes and wishes. We saw that this information was recorded in care plans along with their life histories

The care plans we looked at were person centred which meant they were written around the needs of the person and what was important to them. We saw they were evaluated on a monthly basis or sooner if required.

Relatives told us they knew how to make a complaint or raise concerns to the service. One relative told us; "Every concern I have raised has been addressed". Another said; "I can always speak to the management team if I have a concern. They will always sort things".

On entrance to the home we saw there was a suggestions box that people could post comments or concerns in. We saw the complaints procedure was displayed for people to see. However, this stated that in the event of people not being satisfied with their complaint they should contact the Commission who would resolve it. Although the Commission encourages people to raise any concerns with us, the provider's complaints procedure was misleading as we do not investigate complaints. There was also no mention of the local authority in the complaints procedure. We raised this concern with the compliance manager and the registered manager who believed that the Commission handled complaints about services.

We looked at the system in place to deal with complaints. It was evident there was a detailed audit trail of how concerns and complaints were managed and dealt with to the complainants' satisfaction where possible. Staff felt that complaints would be investigated thoroughly by the management team and would be quickly resolved. They also told us that they learnt from any concerns or complaints that were made during handover between shifts and staff meetings that occurred frequently.

Inadequate

Is the service well-led?

Our findings

We looked at the systems in place for monitoring the quality of the services that were provided at the home. Audits (checks) had been carried out by the management team and delegated staff on a regular basis. However, we found them to be ineffective because they had failed to identify and/or address any of the concerns we had found in relation to care planning, record keeping, medication, staff training, equipment, consent, restraint, failure to inform the Commission of safeguarding concerns and health and safety. Therefore the health, welfare and safety of people who used the service and others had been put at risk.

The registered manager said she felt supported by the provider who visited the service on a regular basis. She said that there were no financial constraints on their budgets and the provider was always willing to invest when required. The provider employed a regional manager who also visited the home on their behalf. We saw that their visits were recorded in the form of 'management meeting' minutes. However, we saw that no formal processes were in place to assess the quality of the service provided and therefore had also failed to pick up all of the concerns found by the Commission. This showed that the registered provider had no effective monitoring systems in place and this had placed the health, welfare and safety of service users and others at
risk.

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

The service has a registered manager. They have been in post at the service for approximately 18 months.

People who used the service and their relatives spoke positively of the management team. One relative told us; "They are very approachable. It's like being part of an extended family". Another said; "There is a good open culture. The manager raised the issue of whistle blowing saying if we have any concerns we should always let her know". A person who used the service told us; "I received poor care once. The manager came and apologised".

We saw that surveys had been completed by people who used the service and their relatives throughout 2014. Surveys had focussed on areas such as medication, care and welfare, the homes environment and nutrition. Where people were unable to fill in the surveys, records suggested that they had been assisted to do so by a member of staff. When people had made any negative comments, it was clear that they had been investigated and the necessary changes had been made. Positive comments from people included; "Staff always go the extra mile" and "Staff have created a very positive and supportive environment for residents". The compliance manager told us that visiting professionals had been given surveys to complete although they had not been returned to them.

Visiting professionals said they had no concerns with the management team. One person said; "I know they put a lot of effort into what they do". Another told us; "I know the manager has had some difficult situations to deal with but she had dealt with them well".

Staff spoke positively of the management team and said they were approachable. They told us the manager often sends round 'memos' to advise staff of any important information that they needed to know about. One staff member told us; "When people move in with a particular medical condition we are not aware of, the manager always provides us with information so we know how to support the people we care for". Another said; "The manager shows compassion and listens to what we say. As soon as we raised the issue about staff shortages it was addressed immediately".

However, we found staff were not always aware of the requirements of their roles and responsibilities in order to keep people safe because they had not received appropriate training from the provider.

We saw the service had a mission statement that deployed a set of values. These were choice, dignity, fulfilment, independence, privacy and rights. However, we saw this had not always been put into practice where people's independence and rights were concerned. This was because the provider did not have regard for the Mental Capacity Act 2005 and people's movements in the home were sometimes restricted.

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 Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services How the regulation was not being met: The registered person did not take proper steps to ensure each service user received care that was appropriate and safe. Regulation 9 (1)(a)(b)(i)(ii)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse How the regulation was not being met: The registered person did not respond appropriately to allegations of abuse and suitable arrangements were not in place to protect service users against the risks of unlawful control. Regulation 11 (1)(b) (2)(a)(b) (3)(b).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines How the regulation was not being met: People were not protected against the risks associated with medicines because the provider did not have appropriate arrangements in place for the safe administration and storage of medicines. Regulation 13.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 16 HSCA 2008 (Regulated Activities) Regulations 2010 Safety, availability and suitability of equipment How the regulation was not being met: People who use services were not protected against the risks associated

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Action we have told the provider to take

with unsafe equipment because systems were not in place to ensure equipment was because of adequately maintained and used correctly. Regulation 16 (1) (a)(b) (3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records How the regulation was not being met: People who use services and others were not protected against the risks associated unsafe or inappropriate care because records did not contain up to date and appropriate information. Records were not kept securely. Regulation 20 (1)(a) (2)(a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff How the regulation was not being met: People who use services and others were not protected against the risks associated with unsafe or inappropriate care because staff had not been adequately trained to support them. Regulation 23 (1) (a) (2) (3) (a) (b)

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 Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers How the regulation was not being met: People who use services and others were not protected against the risks associated with unsafe or inappropriate care because the registered person did not have effective systems in place to monitor the quality of the service delivery. Regulation 10 (1)(a)(b)(c)(i) (2) (c) (i)

The enforcement action we took:
We have served a warning notice.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment The registered person did not have suitable arrangements in place for obtaining, and acting in accordance with, the consent of service users in relation to the care and treatment provided for them in accordance with the Mental Capacity Act 2005 and the Deprivation of Liberty safeguards. Regulation 18.

The enforcement action we took:
We have served a warning notice