Leyton Healthcare (10) Limited

Beech Tree Care Home

Inspection report

Sprents Lane, Overton, Basingstoke, Hampshire, RG25 3HX
Tel: 01256 771353
Website: www.leytonhealthcare.com

Date of inspection visit: 8 and 9 December 2014
Date of publication: 13/03/2015

Ratings

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

Overall summary

This unannounced inspection took place on 8 and 9 December 2014. Beech Tree Care Home provides accommodation and nursing care for up to 60 people who have nursing needs. There were 31 people living at the service when we visited. The home consisted of three floors, with bedrooms and bathrooms on each floor, and a communal lounge on the ground floor. Stairs and a lift provided access between floors. At the time of our inspection the third floor was closed for refurbishment.

There was a registered manager in post. 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.

People's safety was being compromised in a number of areas. People were at risk of harm from infections caused by unclean surroundings, particularly in the kitchen and bathroom areas. They were also exposed to the potential risks arising from the unsafe storage and disposal of pharmaceutical waste, including medicines. When we informed the deputy manager of these concerns they immediately took action to ensure the safe storage and disposal of this waste.

Summary of findings

The provider did not have a robust system to ensure staffing levels were always appropriate to meet people's needs when they changed. The provider could not be assured that there were always enough qualified staff to meet people's needs. People, their relatives and staff had raised concerns about the low staffing levels, and the high percentage of agency staff being used at this service.

Staff had not received training in relation to the Mental Capacity Act 2005 (MCA) or the Deprivation of Liberty Safeguards (DoLS). The Mental Capacity Act 2005 sets out how to act to support people who do not have capacity to make a specific decision. DoLS safeguards protect the rights of people by ensuring if there are any restrictions to their freedom and liberty these have been authorised by the local authority as being required to protect the person from harm. Staff did not understand their responsibilities in relation to the MCA or DoLS. The provider had not always ensured that people understood and had given valid consent to their care and treatment.

People's health care needs had been assessed. However, care was not always planned or delivered to meet their identified needs consistently. This meant some people were at risk of receiving unsafe or inappropriate care that did not meet their needs. People were not always supported to eat and drink enough to meet their needs which meant they were at risk of malnutrition and hydration.

Records did not always document people's current needs and wishes or how they had been involved in or consented to their plan of care. The provider could not be assured that the care plans accurately reflected the person's wishes. Care was mainly based around completing tasks and did not take account of people's preferences. People's end of life wishes were not consistently recorded or acted upon. There were not enough meaningful activities for people, either as a group or to meet their individual needs.

Staff had not received appropriate training, supervision and appraisals to ensure people were safe and their health and welfare needs were met by competent staff. Staff told us they were unable to raise concerns with the registered manager or the provider without fear of recriminations.

Some people did not know how to make a complaint. Staff knew how to respond to complaints and understood the provider's complaints procedure. However, relatives told us they had stopped complaining to the registered manager because their previous concerns had not been addressed.

Leadership within the service was weak and the management did not understand the principles of good quality assurance. The provider did not regularly assess and monitor the quality of service provided for people. Although the provider had systems in place to identify, assess and manage risks to people's safety, health and well- being the registered manager had failed to operate these effectively.

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

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was not safe.

Due to poor standards of cleanliness and hygiene people, staff and other people visiting the service were at risk of acquiring or transferring infections.

There were insufficient numbers of suitably qualified, skilled and experienced staff to ensure that at all times people received appropriate and safe care.

Staff had not always read the guidance in support plans to enable them to understand how to manage risks to keep people safe.

Inadequate

Is the service effective?
The service was not effective.

People were supported by staff who had not received adequate training, supervision and appraisals to carry out their roles effectively.

Staff did not understand their responsibilities and what they were required to do to comply with the Mental Capacity Act 2005.

People had not been provided with suitable food and drink to meet their dietary needs. People's fluid and food intake were not effectively monitored, which placed them at risk of malnutrition and dehydration.

Inadequate

Is the service caring?
The service was not caring.

Staff did not always know the people they were caring for, including their preferences and personal histories.

Care was mainly focused on getting the job done so people were not always treated with respect and dignity.

Information about people was not always treated confidentially and respectfully by staff.

People's end of life wishes were not consistently recorded or acted upon.

Inadequate

Is the service responsive?
The service was not responsive.

People had not received personalised care that was responsive to their needs.

People had not had their individual needs regularly assessed, recorded and reviewed. Staff did not respond appropriately when people's health deteriorated.

The provider did not listen and learn from people's experience.

Inadequate

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

Inadequate

Summary of findings

The provider did not promote a positive open culture. Staff were not listened to and did not feel able to raise concerns with, or seek advice from, the registered manager and provider.

The registered manager and deputy manager were frequently performing the roles of absent nurses. This restricted their availability to respond to any concerns raised or to lead and guide staff.

Assessments and monitoring of the quality of the service to ensure the delivery of high quality care were not completed. The provider had not reacted promptly or robustly when issues were identified.

Beech Tree 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 of Beech Tree Care Home took place on 8 and 9 December 2014 and was unannounced. The inspection team consisted of two inspectors and a specialist advisor. The specialist advisor had clinical experience and knowledge of working in the care field of nursing.

Before the inspection we looked at previous inspection reports and notifications we had received. A notification is information about important events which the provider is required to tell us about by law. At our last inspection on 3 May 2013 we did not identify any areas of concern.

We asked the provider to complete a Provider Information Return (PIR) before the inspection. 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. They did not return a PIR and we took this into account when we made the judgements in this report.

Information from health and social care professionals regarding staffing levels, nutrition and hydration, infection control and end of life care were used to inform our inspection. Before the inspection we contacted three local authority commissioners of the service, members of the South Central Ambulance Service, the provider of agency care workers and a clinical commissioning group nursing advisor. We spoke with a district matron following our inspection to obtain their feedback about Beech Tree Care Home.

We spoke with 12 people who use the service, nine people's relatives, and four people's friend's. The provider, the registered manager, the deputy manager and the service administrator spoke with us. We received feedback about the service from four nurses, ten support workers, an agency cook and kitchen assistant, the housekeeper and two domestic cleaners and the service maintenance engineer.

Some people were unable to tell us about the care and support they received. To find out about the care they experienced we spent time observing activities, mealtime support and the administration of medicines. We also spoke with the service's GP on completion of their scheduled weekly visit.

We pathway tracked four people. Pathway tracking is a process which enables us to look in detail at the care provided to people to ensure they received planned care to meet their needs. We looked at records, including 16 care plans, and eight staff recruitment, supervision and training files. We reviewed staff training files and the working rosters, a selection of policies and procedures, and information relating to the management of the service.

Inadequate

Is the service safe?

Our findings

People and relatives told us they were concerned about the lack of cleaning staff and constant unpleasant odours within the service. One person told us, "I don't like it here. It smells." A relative told us, "There aren't enough cleaners and all I see them doing is mopping the floors." There was hand washing guidance displayed in communal bathrooms and on other noticeboards. However, there were no alcohol hand gels available for staff and visitors to the home. An agency nurse told us, "I have real concerns about hygiene. There is no hand gel and I worry about the general standards of cleanliness."

Staff told us there were not enough cleaning staff to change bedding and turn mattresses frequently. We looked in two rooms of people who were no longer at the service and found the bed linen had not been stripped and removed for several days. We saw that some people's bedrooms, as well as the communal bathrooms, were not properly cleaned. The bath within the communal bathroom on the first floor had not been cleaned and the toilet seat was marked with a dried liquid. Poor cleaning practices increased the risk to people and their visitors of acquiring infections.

On the middle floor breakfast was prepared in a small kitchenette. The sink was stained and unclean, with dirty dishcloths left on the side. The work surface used for preparing breakfasts was frequently left unclean. The oven in the main kitchen had not been cleaned. The hot cabinet had a pool of mechanical grease overflowing from runners in close proximity to plates used for people's meals. The milk machine and all of the metal kitchen sides and sinks were unclean. The large rubbish bin in the kitchen was open and full of rubbish. Food in the fridge had not been properly covered or dated. An agency chef told us that they did not have time to complete full cleaning schedules. On their arrival two weeks earlier they described the cleanliness of the kitchen as "disgusting". We reported our findings to a local authority environmental health department. The poor standards of cleanliness in the kitchen placed people at risk of acquiring infections.

One person identified to be at risk of urinary infection did not have an appropriate care plan to manage their catheter care safely to reduce the risk of infections.

The service had an infection control policy. However there was no reference in the policy to laundry management. Soiled clothing was being washed at 60 degrees and not in line with the national guidance of 65 degrees or upwards required to ensure effective decontamination. The laundry process did not effectively reduce the risk to people of acquiring infections from contaminated laundry.

Staff had not completed appropriate infection control training. The provider did not have an infection control champion in accordance with national guidance on infection control. The purpose of an infection control champion is to ensure compliance with good practice and to identify and challenge poor practice. This meant the provider did not have an oversight over issues relating to infection prevention and control.

Issues, such as poor standards of cleanliness and hygiene, a lack of clear infection control guidance and training for staff were putting people, staff and visitors to the home at significant risk of acquiring or transferring infections. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

There were not enough staff with the appropriate experience and knowledge to meet people's needs safely. People and staff commented on there being far too many agency staff who did not know the people they were supporting. A relative of one person told us the permanent staff were "wonderful" but had been "run ragged". They said their relative frequently had to wait far too long for support to use the toilet. This often caused them great distress as they took great pride in remaining continent. They told us that on one occasion this person had to wait for 45 minutes for care staff to support them.

People and relatives told us there were not enough staff, which adversely impacted on the quality of care. One person said, "I miss talking to people but the staff are so busy". Another person said, "All I want is for staff to stay and chat but they don't have time." We observed a number of occasions when people had waited in excess of five minutes for staff assistance after they had rung their call bell. A person had become very distressed and anxious whilst they had waited for staff. We found this person could not reach their alarm so we intervened and called a member of staff to support the person.

Staff we spoke with said they were always under pressure and rushing from one task to another. One staff member

Is the service safe?

described their working day as being, "stretched to breaking point". All of the staff we spoke with said that there was not enough staff to safely support everyone and provide high quality of care. They said that people had to wait for long periods of time when they called for help, even when urgent assistance was needed. One care assistant said, "It really upsets me because I never get chance to speak with people anymore. I would have left ages ago if I didn't care for people so much."

The registered manager told us that 19 people were highly dependent and required nursing care. These people had more complex needs and often required two staff to support them. People requiring nursing care were not segregated from those who were more independent. The nurses were therefore constantly rushing from one side of the home to another. This caused delays in staff response times to answer people's call bells.

The registered manager and deputy manager disagreed about the current staffing requirements for the service. Nurses told us that more staff were required due to the number of people who required the support of two staff to meet their needs. The registered manager told us that they completed a staffing needs analysis weekly but was unable to provide evidence of this. There were a large number of vacancies for nurses, care assistants and permanent kitchen staff. The deputy manager was the only daytime permanent nurse. Rotas highlighted the high dependence on the provision of agency nursing staff to provide support for people. Permanent staff voiced concerns that whilst agency nurses and care assistants had been provided they often did not know the people's needs and people did not recognise the staff supporting them.

On the day of our inspection the registered manager arrived at the service to discover that two agency nurses and three agency support workers were not available. The provider's arrangements of using managers to provide nursing cover meant they had less time to provide guidance and supervision for staff.

On 9 December 2014 a permanent care assistant called in sick for night duty. This left an agency nurse, who had only worked at the service once before, supported by two care assistants. The registered manager told us they stayed to provide support until people had gone to bed. However, low staffing levels had increased the risks to people's safety and welfare.

The provider had not ensured that at all times there were always sufficient numbers of suitably qualified, skilled and experienced staff to safeguard the health, safety and welfare of people. This was a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People had their medicines at the times they needed them and in a safe way, administered by staff who had the required competency and skills. However, the service had not disposed of medicines safely. In the nurses office there were boxes labelled pharmaceutical waste stored under the desk. These boxes were not secure. There was a risk that medicines stored in these boxes could be accessed by people and visitors. There was a destroyed or returned medicine record in place but this had not been signed by the pharmacy or waste collector to confirm that disposed of medicines had been collected from the premises. When we informed the deputy manager of these concerns they immediately implemented a new system and arranged for the pharmaceutical waste to be stored securely in a locked cabinet.

Identified risks to people's health were not always managed by staff to reduce the risk of harm. Five care plans identified people to be at risk of pressure ulcers, falls and malnutrition. There were no management plans in place to address these risks. Permanent staff were aware of these risk assessments and the relevant support required, whilst agency staff were not. This increased the risk of people experiencing unsafe or inappropriate care when agency staff were supporting them. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Staff told us they had recently received training in safeguarding adults. Staff training records confirmed this. Staff were able to recognise the different types of abuse. They told us how they would respond to allegations or incidents of abuse, and also knew the lines of reporting in the organisation. People we spoke with said that they felt safe and did not have any concerns about abuse or bullying from staff.

Inadequate

Is the service effective?

Our findings

The registered manager had not completed annual appraisals or two monthly supervisions in accordance with the provider's policy. The registered manager told us that they were responsible for completing all supervisions but had been unable to complete any for four months because they had to deliver nursing care. Staff had not been supported to deliver care and treatment to people safely through the provision of supervision and appraisals. This was a breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The Mental Capacity Act 2005 (MCA) assessment forms in people's care plans were incomplete or had not been signed by the people involved. MCA assessments did not effectively detail which decisions people could make and those where they needed support. Where people needed support with decisions these assessments did not identify who should be consulted to ensure decisions were made in their best interest. In people's end of life plans when and by whom decisions had been made had not been recorded. Decisions in relation to resuscitation were being made on behalf of people with the capacity to make these decisions without their involvement and consent. There was potential for health care professionals to take action which contravened the wishes of the person.

The provider had not always ensured that valid consent had been obtained from people. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. Whilst no-one living at the home was currently subject to a DoLS, we found that the registered manager was aware of a Supreme Court Judgement which widened and clarified the definition of a deprivation of liberty. However, the registered manager was not sure about their responsibilities. This could mean people were at risk of being deprived of their liberty without lawful authority to do so. The registered manager told us they were going to complete a review of all people's MCA and DoLS assessments on completion of their training in January 2015.

People had regular access to healthcare professionals, such as GPs, physiotherapists, chiropodists, opticians and dentists. People requiring specialist dietary advice or specific care to meet their changing needs had not always been referred to an appropriately qualified health care professional. One person had a referral to a dietician delayed for five months. Where advice had been sought from a health professional this had not always been followed. For example, advice from a GP to provide hourly fluids for one person had not been followed by staff. This meant people were at risk from inadequate nutrition and dehydration.

There were no kitchen staff employed at the service for two months and care staff had assumed these roles. None of these care staff had previous experience of providing meals in volume or had received additional training in relation to nutrition and hydration. People and staff told us that since the permanent chef had left the quality of food was poor and often cold. One relative said, "Sometimes the food is disgraceful. They recently served up a sausage roll mashed up with vegetables. It was cold and totally unappetising".

The agency chef did not know people's dietary needs. The chef did not have access to any dietary profiles or specific diet plans. The chef was unaware which people had diabetes and who may be at risk of choking. The chef did not know people's likes and dislikes or their allergies. The chef understood how to provide a "soft", "pureed" or "fortified" diet but did not know which people required these. The chef told us they relied solely on the care staff to provide this information. However agency staff might not know their specific dietary requirements and people were at risk of having inappropriate food and drinks.

People may not have been provided with suitable food and drink to meet their dietary needs. Food was not prepared in a hygienic environment, by staff who had been appropriately trained. Where people had been identified to be at risk of malnutrition or hydration they had not been referred to dietetic specialists. These were a breach of Regulation 14 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Inadequate

Is the service caring?

Our findings

People and their relatives told us that some permanent staff were very caring. However, people, relatives and staff told us that the caring atmosphere of the service had deteriorated in the past year. Permanent staff told us that due to the high percentage of agency staff they were always being called to explain people's care needs or support people who did not wish to be cared for by unknown staff. There was a lack of continuity of staff, so people were not familiar with the care staff which caused them to worry.

People's needs had not always been responded to by staff in a caring manner. A relative of one person told us they had been disappointed with the compassion and caring shown by staff for their loved one. Their health had deteriorated to such an extent that they were removed from the service by their family. Whilst the staff had responded to the deterioration in the person's health needs the provider had not contacted the person's main carer or family to keep them informed of the person's declining health. Another relative told us their loved one had recently been left sat in a sling for 25 minutes whilst staff were called away. This left their loved one feeling anxious and uncared for. The friend of another person told us, "I came in last week about 10.30 am and found them sat all alone in their night dress, shivering with cold. There were no staff to be seen." The friend of one person told us about one agency staff member walking into their friend's room and waking them up by shouting their name and telling them to wake up. This behaviour had shocked and upset this person's friend.

The registered manager told us that no one had an advocate. They said they did not have any information to give to people about how they could find one. The provider had not respected the right of people to have an advocate to support them in understanding their options and enable them to make an informed decision.

Staff did not always know the people they were caring for, including their preferences and personal histories. Staff told us about the importance of promoting people's privacy and maintaining their dignity. However, this was not always demonstrated in practice. During the lunchtime service we saw the registered manager asking people if they "wanted a bib". We also observed care assistants engaging in conversations with other staff whilst providing support to people. These people were excluded from these conversations. We saw some people asked where they wished to sit for lunch, whilst others were pushed in wheelchairs to a position without being asked.

There was a lack of respect for people's beliefs and their wishes. The provider had an end of life policy which sets out clear guidance regarding people's culture and religious preferences. However, care plans did not demonstrate that these matters had been discussed with people and assumed people's faith, which showed a lack of respect and understanding. People's end of life wishes were not consistently recorded or acted upon. Care plans contained information about advance end of life decisions regarding resuscitation but frequently did not have an end of life plan. Where people did have an end of life plan these were not person centred and did not consider things people did not wish to happen. An end of life plan referred to the person by their preferred name followed by the expression 'is for cremation'.

Staff had not always treated people with dignity and respect whilst providing personal care or support during mealtimes and activities. Staff had shown a lack of respect for people's diversity and had not considered their faith and culture when planning end of life care. These issues were a breach of Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Staff told us the provider respected people's right to have their records treated confidentially. However, we saw one person's care record left unattended on the nurse's desk on the first floor. The deputy manager told us the record had been removed from their room because this person did not wish to be disturbed during the night. This record had remained on the desk throughout the day, accessible by any visitors on the first floor. The provider had not held people's personal records securely and could not be assured they had remained confidential. In the unlocked nurse's room we saw a clear box under a desk which contained various confidential records relating to people's advanced decisions, medicine requests and notifications of people's deaths. These records could be accessed by unauthorised people.

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

Inadequate

Is the service responsive?

Our findings

People were not adequately stimulated and their social care needs were not met. People were unaware of any activities or said that there was "nothing to do". One person told us, "It's a shame because we never go out and the activities here are boring." Relatives told us there was not enough for people to do and not enough staff to stimulate them. People were frequently left in the communal lounge unsupported. People and relatives told us they felt that staff were task driven and could not sit and talk with them for a meaningful period to consider their well-being. We spoke with one person who told us that they often felt lonely and wished staff had more time to sit and talk. The activities coordinator told us they had not arranged any activities outside of the home. This was because there were insufficient staff to support such activities and the provider had relinquished the service minibus. The activities coordinator who was also trained as a care assistant told us that they were frequently taken away from providing activities to support care staff. We noted from rotas that they had also frequently been used to provide cover for the chef.

Insufficient numbers of staff to provide meaningful activities or to spend time talking with people to prevent them feeling socially isolated was a breach of Regulation 22 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Care plans were not person centred and there was no evidence that people and their representatives were involved in the development of their care plan. Care plans included information about what name people preferred to be known by. Permanent staff knew all of the people's names, whilst agency staff did not.

People's initial care needs had been assessed prior to using the service but had not been reviewed in response to any changes in their health. Staff failed to respond appropriately when a person required support for a suspected chest infection. This person felt nauseous and experienced breathing difficulties. Medicines to be taken when required had not been administered to effectively manage this person's pain. Staff had not responded effectively to provide coordinated person centred care. This meant that people did not always receive personalised care that was responsive to their needs.

Another person who was being supported with end of life care was only being administered nutritionally fortified drinks. However staff had recorded on their food and hydration chart that they had "refused sausage and mash." This meant the provider had not responded appropriately to this person's changing nutritional needs.

One person's family raised concerns about the weight loss sustained by their relative. There was no evidence to indicate the service sought advice from a GP or dietician and they had provided no reassurance to the family. This demonstrated that the provider had not listened to the concerns of people or their relatives.

Care plans had not been reviewed to identify people's changing needs. Changes in people's health had not received an appropriate response from staff. The provider had not listened to people's concerns. These were a breach of Regulation 9 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider did not always listen and learn from people's experiences. Staff knew how to respond to complaints and understood the complaints procedure. However, some people told us they did not know how to make a complaint. Some relatives told us that they were fed up of complaining to the manager who took no notice. We spoke with a person's relative who confirmed they had raised a verbal complaint following a recent incident and they were not fully satisfied with the response they received. Another person's relative told us they had not made a complaint. However, they did not have much confidence in any complaint being responded to by the provider if they did. There was a complaints process but people's relatives lacked confidence in the process and were worried that their concerns were not listened to.

This was a breach of Regulation 19 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Inadequate

Is the service well-led?

Our findings

People and staff were not actively involved in developing the service. People and their relatives told us the registered manager and provider were not visible within the service and were not readily approachable. They said when they had raised issues regarding poor quality of care the provider had either been defensive or dismissive.

People did not benefit from an open culture where staff felt listened to and supported. Staff said they were unable to raise concerns with the registered manager or the provider without fear of recriminations. Staff provided examples of when they had received destructive criticism from the registered manager. Care assistants told us that whenever they approached the registered manager with a problem they were told to, "see the nurse". Staff told us this left them feeling demotivated and under-valued. Staff told us this had resulted in large numbers of staff leaving the service in recent months. This was reflected in the staff rotas. Exit interviews had not been completed by the provider to secure any learning from staff or drive improvements within the service.

Health and social care professionals raised concerns about the ability of the management team to provide clear and direct leadership. During the inspection the registered manager and deputy manager were very busy performing the roles of the two absent nurses. This restricted their availability to respond quickly to any concerns raised by the care assistants, or to observe how they were interacting with people. They were unable to lead and guide staff.

Staff rotas demonstrated that the deputy manager was the only permanent day nurse and therefore did not have time to fulfil their responsibilities as the deputy manager. People and staff praised the deputy manager for their caring attitude but were concerned that they were always under pressure and trying to do too much.

The registered manager had not been supported by the provider to ensure there were adequate levels of staffing to meet people's needs safely. For example on the first day of our inspection the registered manager was unaware that five agency staff were not available, which adversely impacted on the quality of service delivery and safety of people.

Staff and relatives had raised concerns regarding staffing levels and the loss of experienced staff during the summer. There had not been a chef and chef's assistant employed at the service for over two months. The provider had appointed unqualified permanent care staff to provide cover for the kitchen duties which had meant that the quality of food, care provision, activities and cleaning had deteriorated. The provider and registered manager had not taken prompt or robust action in relation to the recruitment and retention of staff. This meant they had not led effectively to ensure there were sufficient staff to meet people's needs. This resulted in poor standards of cleanliness and food hygiene within the service.

The provider had a call bell response monitoring system but did not use it to assess response times. The registered manager was unable to provide us with an analysis of the response times relating to incidents observed during the inspection. They told us that they did not audit this facility. The provider had not assessed and monitored response times to inform their staffing needs analysis and to identify actions required to improve the quality of service delivery.

Although the provider had systems to assess and monitor the quality of service provided through a series of monthly audits, these had not been operated effectively. The manager told us they had been unable to assess and monitor the service because they were constantly covering nursing shifts. This meant the provider had not assessed and monitored the quality of care and treatment being provided.

When the regional manager completed an audit of the care files in July 2014 the following issues were identified: incomplete information, overdue risk assessments, catheter change dates and people's weights were not recorded. The registered manager had not completed an action plan to address these issues. The registered manager was unaware of action plans resulting from the completion of care plan reviews in July 2014. They were unsure whether the actions had been completed. This meant that the service had not used information from audits to monitor and review the quality of the service or to drive improvements.

This failure to effectively operate systems to regularly assess and monitor the quality of the service and to identify, assess and manage risks to people's health, welfare and safety was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

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 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services Regulation 9 (1) (a) (b) (i) (ii) Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. **Care and welfare of people who use services** The registered person did not take proper steps to ensure each service user received care that was appropriate and safe.

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 Regulation 18 (1) (a) (b) Health and Social Care Act 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.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
	Regulation 23 (1) (a) HSCA 2008 (Regulated Activities) Regulations 2010 **Supporting workers** People were at risk of unsafe care and treatment because staff did not receive appropriate training and supervision to deliver care and treatment to people safely.
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services Regulation 17 (1) (a) 9 (b) 2 (a) Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. **Respecting and involving people who use services** The registered person did not make suitable arrangements to ensure the dignity, privacy and independence of service users. The registered person had not enabled service users to make or participate in making decisions relating to their care or treatment. th registered person had not treated service users with consideration and respect.
Accommodation for persons who require nursing or personal care	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records Regulation 20 (2) (a) Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. **Records**

This section is primarily information for the provider

Action we have told the provider to take

The registered person had not ensured that records were kept securely.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA 2008 (Regulated Activities) Regulations 2010 Complaints Regulation 19 (2) (a) (c) (Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. **Complaints** The registered person had not brought the complaints system to the attention of service users and people acting on their behalf in a suitable manner and format. The registered person had not ensured that any complaint made is fully investigated and so far as reasonably practicable, resolved to the satisfaction of the service user or person acting on their behalf.

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 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 **Staffing** Appropriate steps had not been taken to ensure at all times there were sufficient numbers of suitably skilled and experienced staff to safeguard the health safety and welfare of service users.

The enforcement action we took:
We have asked the provider to take action to ensure there are sufficient staff available, with the required skills and experience, to meet people's identified health and welfare needs. They must complete this action by 31/03/2015.

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 provision Regulation 10 (1) (a) (b) Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. **Assessing and monitoring the quality of service provision.** The registered person did not have effective systems in place to monitor the quality of the service delivery

The enforcement action we took:
We have asked the provider to take action to ensure there are systems in place which are operated effectively to monitor and asses the quality of service and identify, assess and manage risks relating to people's health, welfare and safety. They must complete this action by 31/03/2015.

Regulated activity	Regulation

This section is primarily information for the provider

Enforcement actions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control Regulation 12 (1)(a) (b) (c) (2)(a) (c) (i) Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. **Cleanliness and infection control** The registered person did not have effective systems in place to protect people from the risks of acquiring a health care associated infection as appropriate standards of cleanliness and hygiene were not maintained. The registered person did not effectively operate systems designed to assess the risk of and prevent, detect and control the spread of a health care associated infection.

The enforcement action we took:
We have asked the provider to take action to ensure there are systems in place which are operated effectively to protect people from the risks of acquiring a health care associated infection by maintaining appropriate standards of cleanliness and hygiene. They must complete this action by 31/03/2015.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010 Meeting nutritional needs Regulation 14 (1)(a) (c) Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. **Meeting nutritional needs.** The registered person did not have suitable arrangements in place for ensuring service users were protected against the risks of inadequate nutrition and hydration.

The enforcement action we took:
We have asked the provider to take action to ensure there are suitable arrangements in place for ensuring people were protected against the risks of inadequate nutrition and hydration. They must complete this action by 31/03/2015