Mrs Susan Irene Ann Hill

Highland Mist Care Home

Inspection report

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Ratings

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

Overall summary

Highland Mist Care Home is a small care home providing support for up to eight people with mental health needs. At the time of the inspection seven people were living at the home.

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The inspection took place over two days, the 4 November 2014 and 11 November 2014.

In April and May 2014 we inspected the home and found people people's needs were not fully met. Aspects of people's care was not safe and they did not have their medicines as prescribed. We set compliance actions and two warning notices were issued relating to medicines management and quality assurance. These warned the provider we would take enforcement action if improvements were not made.

We inspected again in July 2014. We found that whilst there were some improvements, there remained concerns regarding staffing, safeguarding, medicine management and quality monitoring. Repeated compliance actions were made.

Following that inspection the provider wrote to us and told us of the improvements they were going to make. They told us they would make all the changes by November 2014.

Summary of findings

During this unannounced inspection we found that not all of the providers action plan had been progressed. We found improvements started in July 2014 had not been sustained, particularly in medicine management and quality assurance. We found areas of improvement suggested at previous inspections such as ensuring people consented to their care and treatment and improved infection control practices, had not been actioned. We also identified concerns with keeping people and their belongings safe, and continued problems with staffing levels and training to meet the needs of people at the home.

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 the report.

The registered provider of this service was the manager and the owner of Highland Mist Care Home.

Due to unforeseen circumstances the registered provider was only available on the first day of the inspection. The person in charge during the second day of the inspection did not have the keys to the staff files so we were unable to review information related to staff training and support.

People's safety was compromised in a number of areas. This included the management of medicines and a lack of ongoing staff training. We found staffing levels were inadequate to support staff and people at the home with behaviour which at times could be challenging to the service.

Care plans were not always reflective of people's current needs. We found the home did not have essential information about people under supervised community treatment orders and were unsure whether some people were under current deprivation of liberty safeguards (DoLS). This is an authorised, legal restriction on a persons freedom to enable staff to care for a person in a safe way.

We were concerned the home had not reported incidents and accidents within the home to the commissioners, local safeguarding team and to CQC. We also had concerns about how people's money was managed within the home. Staff did not know the correct processes to report safeguarding concerns outside of the home.

Audits were in place to monitor medicine management, the environment and cleanliness but these had not been effective in identifying medicine management errors and had not identified the multiple concerns we found during the inspection.

Staff were kind, caring and knew people well. An example of this was the compassionate care they provided to one person receiving end of life care. Staff frequently went the extra mile to ensure people had support when they were unwell. However, low staffing levels at the home affected their ability to support people to integrate into the community, follow through on people's goals, and develop people's external social contacts.

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?

Inadequate

The service was not safe. There were no clear safeguarding policies in place for staff to follow. clear records were not kept to ensure people or their money was safe.

Areas of the home were not clean which put people at risk of acquiring infections.

People's medicines were not always administered safely or as prescribed.

People's records were not accurately maintained to reflect the care they received and they were not kept securely.

Is the service effective?

Requires Improvement

The home was not effective.

There was a poor understanding of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards to ensure people consented to their care and treatment and were not deprived of their liberty unlawfully.

Staff training was evident in areas but staff did not understand aspects of their training or consistently put this into practice. Staff were not aware of areas of poor practice and this affected aspects of their approach to people's care.

People received a balanced diet to meet their nutritional needs.

The service monitored people's health and well-being and supported people to attend to their physical and mental health.

Is the service caring?

Good

The service was caring. People were positive about the caring attitude of staff.

Care and support was provided by staff who knew their preferences and respected their individuality.

Staff were kind, respectful and compassionate.

Is the service responsive?

Requires Improvement

The service was not responsive. People did not always receive the care and support detailed in their care plans.

Staff were not always available to support people to engage in meaningful activities or occupation.

People felt able to discuss their concerns with staff.

Is the service well-led?

Inadequate

The home was not well-led.

Summary of findings

People were placed at risk of inappropriate care because of the lack of leadership and governance arrangements.

The management had a system to monitor and improve the service people received but this was not effective at driving up standards at the home.

Highland Mist Care Home

Detailed findings

Background to this inspection

We carried out this inspection under the Health and Social Care Act 2008 as part of our regulatory functions, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection took place on 4 November 2014 and 11 November 2014 and was unannounced. The last inspection was on 3 July 2014 and 17 July 2014. We identified breaches of the legal requirements at this inspection.

The inspection was undertaken by two inspectors for adult social care.

Prior to the inspection we reviewed the information we held about the service, previous inspection reports and the notifications we had received. A notification is information about important events which the service is required to send us by law. We spoke with commissioners and requested their feedback on the joint work they had been undertaking with the registered provider following our previous inspections this year.

Following the inspection we liaised with the commissioners of the service, the local safeguarding team and CQC registration colleagues. We also spoke with mental health professionals supporting people under the Care Programme Approach (CPA). This is a particular way of assessing, planning and reviewing someone's mental health care needs.

During the inspection we spoke with six of the seven people living at the home. The registered provider requested we did not speak with one person due to their mental health condition at the time of the inspection. We also contacted the local pharmacist and one person's doctor during the inspection to clarify aspects of their prescription.

We reviewed seven people's care files and records and spoke with the owner and registered provider about people's care. We spoke briefly with four care staff as they were required to support people due to staff sickness within the home. We examined seven people's medicine charts and talked to two staff about people's medicines. We observed staff interactions with people during the inspection.

We looked around the premises and in some people's bedrooms. We were unable to look at staff recruitment, staff rosters and training files as the keys were not available during our inspection, however, we spoke to staff about their training. We were unable to look at the accident / incident book as this was not available during the inspection on either day. We requested this on the first day of our inspection but on the second day of the inspection, a week later, this was still not available. We looked at the records which were available to us related to the management of the service including quality audits and policies. We requested the financial records and contracts of people but these were not available during the inspection.

Following the inspection we raised a safeguarding alert regarding medicine management and the management of people's money within the home.

Inadequate

Is the service safe?

Our findings

We previously inspected Highland Mist Care Home on 3 July 2014 and 17 July 2014. At the time of this inspection we had ongoing concerns staff had not completed safeguarding training. Staff were not recognising incidents in the home as safeguarding or reporting them to the local authority. There were not local policies and procedures for reporting safeguarding concerns in place for staff to follow. This was a continued breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

During the inspection we were informed all staff had completed a safeguarding training workbook staff. Staff had not accessed the local authority safeguarding training and staff were unable to find a safeguarding policy to refer to in the absence of the registered provider. Two staff were unclear of the correct local procedure for raising a safeguarding alert. This meant staff may not respond appropriately, in a timely fashion, or notify the correct agencies of allegations of abuse which might place people at risk.

We were concerned that we were given different accounts by the registered provider and people at the home regarding how their money was managed. The registered provider informed us the staff did not handle anyone's money but some people at the home told us they were giving the registered provider money. We asked for receipts and invoices where people had given the registered provider money but these were not forthcoming during the inspection. We also saw records in one person's notes that money had been handed over to the registered provider for repairs but these repairs had not taken place.

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

We spoke to people about whether they felt safe at the home. One person informed us that they did feel safe and would approach the registered provider and deputy and that they trusted them. However, other people told us that the behaviour of one person made them feel unsafe at times and they would withdraw to their rooms and keep out of that person's way. People told us "We don't all get on - some people shout a lot, I ignore them"; "I feel safe in my room". People told us they had spoken to staff about how they felt but nothing had changed.

The staff we spoke with told us that when people were agitated and distressed they would sit with them and reassure them to help them feel safe and secure. This helped to reduce the person's anxiety and reduce the likelihood of verbal and physical incidents towards other people in the home.

At our previous inspection on 3 July 2014 and 17 July 2014 we found concerns related to the management of medicines. We found that there were not detailed policies in place regarding the safe administration, recording, handling and dispensing of medicines. Staff were not following procedures to ensure people at the home received the medicines they required when they needed them. Additionally, there was not a clear audit trail of medicines administered. We set moderate compliance actions at this inspection. This was a continued breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) 2010.

The provider told us policies would be updated, staff administering medicines would receive training and written confirmation of people's prescriptions would be taken.

During this inspection we were unable to see a sustained improvement in the management of medicines. This meant people were at continued risk of not receiving the medicines they required in a safe way or as prescribed.

We examined all seven people's medicines and medicine administration charts. One person was on a controlled drug. These are medicines which require additional safeguards to ensure they are administered and given safely.

Staff had taken a verbal order from a doctor for this medicine and incorrectly altered their medicine chart. Changes to the medicine chart had not been signed or dated. There were problems with the recording of this person's medicine which meant on two occasions within two weeks the person had run out of their controlled medicine for pain relief.

The controlled drug book was not accurately recording the amount of medicine received, administered or in stock. Additionally staff were not following guidelines to ensure

two staff checked this medicine and signed for it in a timely way. For example, although the controlled drug book indicated one person had received their medicine on the second day of our inspection, the medicine administration record (MAR) was blank. We asked the staff member who had signed the controlled drug book that morning whether the person had received their medicine. Despite staff having signed the book, they were not sure whether the person had taken their morning medicine. This indicated staff were not following the correct, safe procedures for administering a controlled drug.

We saw staff had completed medicine management training although we were concerned that people were not competent to be administering medicines and not following procedures detailed within the home and on the noticeboard.

Staff had been observed for their competency in medicine management by the registered provider but the registered provider was also making errors and not following published guidance related to the management of medicines, particularly the Medicines Act 1968, Misuse of Drugs Act 1971 and Misuse of Drugs (Safe Custody) Regulations.

In addition, the keys to the medicine cupboard and controlled drugs container were not held securely or separately. The keys were left in an open office in a paper filing tray. These keys were accessible to people who lived at the home and who entered the unstaffed office for their tobacco frequently throughout the inspection. We raised this with one of the staff and no action was taken to secure the keys or the office during the inspection.

People's records did not give staff guidance related to their medicine and when PRN (medicine as and when required) should be given and / or what other options might be pursued other than medicine to control people's behaviour. This meant some people were receiving large amounts of additional medicine on a regular basis.

These issues were a continued breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) 2010.

At our inspection on 3 July 2014 and 17 July 2014 we were concerned there were not sufficient staff on duty with the right competencies, qualifications and skills needed to support people with mental health needs. Furthermore, we were concerned about the low staffing levels at the home to support people's complex needs.

The registered provider informed us recruitment was ongoing and mental health training would be accessed to ensure staff were up to date with current mental health and recovery approaches and de-escalation techniques to reduce the potential for incidents occurring within the home.

During this inspection we were unable to see evidence that progress had been made with these areas. Staff files were not available for us to review during the inspection as the keys were not available. Due to staff sickness on both of the inspection days we remained concerned that there were not sufficient staff to support people within the home.

On the first day on the inspection, 4 November 2014 the registered provider and deputy manager were on duty. On the second day of the inspection due to unplanned sickness the deputy manager was on duty and one night staff had stayed on duty until a further care worker was on the premises late morning.

Staff at the home were responsible for all aspects of maintaining the home and caring for people. Duties of the care staff included cooking, cleaning and supporting people to attend their community activities and physical and mental health appointments. Three people at the home relied on staff to enable them to leave the home safely and engage in community activities. One person required intensive support to reduce their anxiety and agitation. Staff reported to us that three further people were showing signs of relapse.

We spoke with the registered provider about recruitment at the home and they told us this was ongoing. Staff informed us that they worked flexibly to cover the shifts and that the deputy manager or registered provider were always on-call and would be able to come in to the home at short notice. The staff rosters were not on the premises during the inspection for us to clarify the numbers of staff on duty across the week or the skills of the staff supporting people at the home. There was not a needs analysis or risk assessment used to decide sufficient staffing levels.

This was a continued breach of Regulation 22 of the Health and Social Care Act 2008.

Inadequate

Is the service safe?

People who lived in the home were not safe because they were not protected against the risk of infection. We found the home was not hygienic. The downstairs bathroom had a cleaning checklist on the wall and staff had checked the bathroom on both days of our inspection as being clean. However, we found that paper towels were not available for people to use, people used a communal towel to dry their hands and there were no dustbin liners in the bins. The downstairs shower was not clean and we were unable to clarify when it had last been cleaned.

We visited one person in their bedroom. The room was unhygienic. There were dark, sticky stains across the floor and the bed sheets were not clean. We spoke to the registered provider about how often people's rooms were cleaned. They told us that the cleaning of bedrooms took place daily and that people were encouraged to maintain their own environments with support from staff. However, records indicated this person's room had not been cleaned for five days. This person had personal care needs which meant they required support to maintain the cleanliness of their room on a daily basis.

Staff told us they had not received infection control training. They were unable to find any disposable gloves on the second day of the inspection. Staff informed us that they must have run out of gloves.

We saw that the staff in the home did not take action to ensure people were provided with a clean environment to live in. Chairs were stained and unclean, carpets were torn and tiles were missing in the downstairs bathroom. Staff were not familiar with the guidance available from the Department of Health regarding infection control and prevention.

These matters were a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

During our inspection we were told there had been a serious injury at the home. The accident book was not on the premises for us to review the incidents which had occurred at the home. We requested this on the first day of our inspection, a week later on the second day of the inspection, the accident book was still not within the home.

People's records were not kept in a safe, secure environment to protect people's confidentiality. During our inspection people frequently entered the office where people's private information was held on shelves and on the desktops. There were no staff were present to supervise their office access.

These issues were a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) 2010.

At our inspection on 3 July and 17 July we found that appropriate recruitment checks had not always been undertaken before staff came to work at Highland Mist Care Home. Staff records were not accessible at the time of the inspection as the keys were not available. This meant we were unable to assure ourselves these essential recruitment checks had been conducted.

We shared our concerns about people's safety with the local safeguarding authority.

Requires Improvement

Is the service effective?

Our findings

Staff at the home understood and respected people's choices wherever possible but did not have a good understanding of the laws which protect people's human rights. Two members of staff had recently undertaken mental capacity act and deprivation of liberty safeguards training. However, these laws were not clearly understood by the staff to enable them to put this into their clinical practice.

Some people at the home did not have capacity to consent to all aspects of their care and treatment due to their mental health needs. Staff at the home made decisions in people's best interests. For example, whether people should go out of the home or have their medicine. However, there was no recording of people's capacity or these discussions. We were unable to see documentation relating to who had been involved in decision making.

Some people at the home were unable to leave without staff support due to their vulnerability in the community. We were informed if these people left the home, staff would bring them back. The staff at the home had not considered or sought advice as to whether they may be depriving people of their liberty. At previous inspections in May 2014 and July 2014 we had raised this with the registered provider. No action had been taken to seek advise from the relevant authority, or to apply for legal authority to deprive people of their liberty.

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

Staff knew people well. Staff understood people's personal stories and histories. Staff supported people to access healthcare appointments such as cervical screening, physiotherapy, smoking cessation clinics, diabetes checks and their mental health team appointments. Maintaining people's physical health was seen by staff to be as important as their mental health. However, professionals told us they were not always informed in a timely manner of incidents which might indicate that people's physical and/or mental health needs had changed.

People at the home told us that staff supported them to meet their health needs. One person told us "They support me with my medicines and inhalers." Another person told us they supported them to see their GP, mental health nurse, optician and dentist."

Information and explanations to people about more complex medical problems were given sensitively by staff and these conversations were dependent on the mental state and capacity of the person. Staff knew people very well and this meant they were able to tailor the information people were given so they understood it. For example one person at the home had recently received confirmation of serious health problems. The staff, particularly the registered provider, supported them through the hospital tests and results.

Staff told us and we saw that where people's behaviour had put them at risk due to their vulnerability, the home had sought advice from people's GP promptly and arranged the necessary health checks. We were concerned that some of these incidents were not seen as possible safeguarding issues. For example, people's sexual vulnerability in the community.

We saw one person had concerns about their mental health medicine and the registered provider had supported them to have this reviewed. They were now receiving less medicine which they liked and wanted.

Staff told us a person at the home had been behaving out of character. The staff arranged a health check and diabetes was confirmed. The registered provider knew people well and responded to their changing physical presentation.

We saw that two people were unwell during the inspection. We read in care records that people had been displaying signs which might indicate a mental health relapse. People had not had mental health reviews requested.

We found that people's records including their care plans and risk assessments were not maintained in a timely manner as people's needs changed. For example one person was very unwell but the changes to their health and medicine had not been incorporated into their care plan or risk assessment.

Due to unforeseen events, we were unable to access staff files and look at staff induction, supervision and training records. However, we spoke to the registered provider and three care staff about these areas.

Staff said they felt supported in the home and we observed a close knit staff team. Staff told us there were staff meetings where developments in the home and changes in

Requires Improvement

Is the service effective?

people's needs were discussed. We saw that daily records were kept of people's progress and significant events so staff were able to keep abreast of changes in people's needs.

The local authority quality team told us they had found it difficult working alongside the registered provider and requests for information was not forthcoming. Quality audits and information requested had not been provided.

We observed how staff interacted with people, the language they used to talk with them and how they described people to us. The language used by a few staff to describe people's behaviour was not always person-centred. For example when one care staff was describing someone's agitated state and the subsequent behaviour which may follow, they were described as "kicking off". We had spoken previously with the registered provider about the way some staff spoke about people's behaviour at our previous inspection in July 2014.

In July 2014 the registered provider talked to us about the training modules which had been purchased for staff to develop their skills and knowledge. During this inspection we were unable to obtain records from the registered provider in relation to progress made with this. We were told by the registered provider that staff had completed recent training in safeguarding and medicines training. Our discussions with staff indicated this training was not fully understood or put into practice. Staff we spoke with told us they had not had any refresher mental health training. This would support staff to be familiar with best practice in this field.

People were supported to eat and drink. Most people told us the food was good and there was plenty of food.

We observed the care staff cooking homemade food with meat, potatoes and vegetables during our inspection which looked healthy and nutritious. People told us there was a variety of food available and "Meals are nice, I peel the potatoes." Some people enjoyed shopping for their own food and cooking independently. One person at the home had eating difficulties and staff were mindful of their weight and dietary intake.

Lunchtime meals were a social occasion and people ate together and helped to prepare the table. No one at the home had specific cultural or religious food requirements. Staff told us about one person who had recently been unwell and in hospital and how they visited daily to ensure their dietary intake was maintained.

Good

Is the service caring?

Our findings

People we spoke with, who were able to communicate and share their views, told us they were well cared for. Positive comments included, "Staff are understanding, especially X - they take me shopping"; "They respect who you are as an individual"; "They take me on trips"; "I'm more well cared for now than before I came here"; "They've done all they can for me, I couldn't expect more, they work hard"; " Staff are kind, they help me."

Staff spoke about people with compassion and kindness regardless of the age, sexual orientation or beliefs.

We were told about how one person had been unwell in the summer who had been admitted to hospital. Staff told us they had visited regularly, encouraging the person to eat and to support their emotional needs. When the person passed away the home arranged their funeral and celebrated their life with people at the home.

Another person had developed an illness requiring hospital tests. Staff supported them to attend these appointments. Staff explained to them what was happening in a way they could understand. Staff worked flexibly to accommodate people's needs on these occasions. During our discussions with staff it was clear they cared deeply about people at the home, were personally affected when someone was unwell and went the extra mile to ensure people were cared for well.

During our inspection we heard conversations which indicated people at the home trusted staff, and were particularly close to the registered provider. We were told by the registered provider people were like her family. A family atmosphere was evident throughout the inspection.

People at the home had experienced challenging lives and they were accepted by staff regardless of their difficulties, behaviours or past. One person required a great deal of one to one time and reassurance. We observed staff to be tolerant and patient. Staff prioritised caring for people above the tasks that were needed to be carried out.

Throughout our inspection we saw that people were respected, given choices and their privacy and individuality was upheld by staff. People's bedrooms were their private areas, staff knocked on doors and respected people's lifestyle choices. People told us residents' meetings were held when they needed to be. We were informed not all people at the home liked to attend these.

People were encouraged to be as independent as possible. People who liked to cook their own meals were able to. Some people liked to spend time in the local town and this was encouraged if they were independent. Where possible people were encouraged to take personal responsibility for their healthcare appointments with prompting from staff as necessary. This enabled staff to focus on those people with the greatest support needs.

Requires Improvement

Is the service responsive?

Our findings

We reviewed people's care plans and assessments during the inspection. Although some required updating to reflect people's current needs there was a range of information about people's personal backgrounds and histories which enabled staff to know people's preferences, histories and interests.

We saw people's interests detailed in their care plans for example where people liked football and play station games. However, we were unable to see from the care records how people who needed help were supported to maintain these interests.

For example we saw in one person's care file that counselling and swimming were part of their care plan. This had been agreed at a review with their mental health professional but we could not see in the records or monthly reviews that these things had been tried with the person.

The activity sheets we reviewed indicated people who required support to attend community activities rarely left the home. People who needed support to leave the home told us they wanted to do more. Activities recorded for people included eating and drinking, watching television and chatting to staff. We felt these activities did not meet people's social and emotional needs. For example it appeared from the records one person had only left the home twice in eleven days.

We were unable to see from the records that the activities people liked or had indicated they might enjoy were a regular part of their care plans. One person told us "Nothing to do, I can't get to go anywhere, I feel like I'm a prisoner even though I shouldn't be a prisoner." We were not able to see and people told us that their care plans were not developed alongside them where this was possible. One person told us they had not seen their care plan. We were unable to talk to staff about these areas to discuss people's comments as they were required to support people's needs during the inspection.

Two care staff were on duty for seven people on the days of the inspection and one waking night staff. One person required intensive support. The service improvement plan shared with commissioners advised there should be four staff on duty and two waking staff at night. Care staff had additional cooking and cleaning duties. This limited their ability to be responsive to all people's needs, carry out people's care plans and provide personalised care in a planned way.

For those who were able to engage in activities of their own accord and independently we saw this occurred. For example people who enjoyed shopping and cooking were able to do this. One person liked playing the guitar and they happily did this in the home.

Staff were unable to find the complaints policy or show us any verbal or written complaints raised. This meant we were unable to review how complaints had been documented and responded to. However, most people told us they felt confident to discuss their concerns with the registered provider and they had no complaints. They told us their was a suggestions box by the porch where they could put their concerns in confidentially. One person told us they had complained about someone who lived at the home. They said the staff had spoken with the person but nothing had changed. We were unable to discuss this with the registered provider as they were unavailable on the second day of the inspection.

Inadequate

Is the service well-led?

Our findings

During our previous inspection in July 2014 we found the systems in place to monitor the quality of service provision had not been sufficiently thorough. There was no progress noted at this inspection.

The provider informed us in writing that a full quality assurance process would be started following our previous inspection and a full audit of the service would be produced by 10 November 2014. We did not see this document during the inspection.

Mrs Susan Hill is registered with CQC to carry on and provide the regulated activity of accommodation and personal care at Highland Mist Care Home. Notifications relating to events and incidents within the home and related to the registered provider had not been shared with CQC in a timely way.

At the end of the first day of the inspection we informed the registered provider we would return for a second day to complete the inspection. We gave notice that this would be a week later. The provider could not attend the second day of the inspection. The person in charge and who had been designated responsibility for the second day of the inspection, was unable to provide support for the inspection. The owner had not given the keys to staff training records and files to this person . Documents requested on the first day of the inspection such as the accident book were not on the premises on the second day and the person in charge could not access them. Policies and procedures relating to safeguarding and medicines management could not be found and the responsible person was unable to provide information we requested in relation to the management of the home. The lack of organisation meant we were unable to fully inspect the areas we had planned to. These included recruitment, training and staff support.

Inadequate systems were in place to ensure the delivery of high quality care provision in the home. During the inspection we identified failings in a number of areas. These included record keeping, staffing levels, medicine management and infection control. These issues had not been identified by the provider prior to our visit.

Following the warning notice for medicine management in May 2014, the registered provider wrote to us and told us weekly medicine audits would be undertaken by the management. These audits had failed to identify that staff were continuing to take verbal orders for medicine and altering the MARs and not signing changes. Audits had not identified when medicine stock was running low nor ensured the keys to the medicine cabinet and controlled drugs were held separately from the general house keys and held securely at all times.

The infection control, environmental audits and staff daily checks which occurred within the home were not robust. During our inspection we found some rooms were unhygienic, furnishings stained and a lack of personal protective clothing for staff to reduce the likelihood of infection and cross contamination.

The provider did not have an effective system in place to formally assess and monitor the quality of care provided to people. There was no evidence of recent quality monitoring of the care records to ensure they reflected people's current needs and treatment. Some care plans lacked detail and some did not have sufficient guidance for staff to follow. We found instances of care not being delivered in line with people's care plan reviews. These issues could have been identified through a formal auditing system to assess and monitor the quality of care records.

There were no formal system to assess and monitor the levels of staffing required. There was no dependency tool to monitor the level of support people required to ensure there were sufficient staff on duty at all times to meet people's care needs and manage the home. We found staffing levels were inadequate on both days of the inspection. This impacted on the service's ability to be proactive in identifying risks and areas for improvement.

Where previous issues had been identified during inspections we found these had not been acted upon. For example, previous inspections had identified a need for the registered provider to ensure all staff received training in the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards. We found these laws and the registered providers responsibility under this legislation remained poorly understood. The registered provider had not made contact with the supervisory body to discuss individuals who required constant supervision and control.

Previous inspections had identified the need for ongoing staff training to improve the quality of care, staff skills and develop competence. Training which had been identified to support development of staff from previous

Inadequate

Is the service well-led?

inspections had not been booked, for example conflict resolution training. Staff competence following training was not regularly assessed through one to one's and the management had failed to ensure staff were following policies and instructions such as the medicines guidance.

We did not see a system in place where complaints were documented and considered as part of the quality audit and service improvement plan. People told us they had made verbal complaints and having a system in place to record these and the actions taken to resolve issues would enable the service to consider possible improvements required.

Previous inspections had identified the need for improved management systems to aid organisation. During this inspection we did not see improvements. Information about people and their care or support that was requested was not available in the home. We were told this would be made available from the owner's own home, but this did not happen. Staff were unable to find policies and procedures, incident reporting forms, or the financial and quality assurance documentation requested.

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

We saw that a quality assurance system that actively asked for people's opinions of the service had recently been reinstated. Questionnaires had been given to people at the service and health professionals to obtain feedback. At the time of this inspection feedback had not been collated.

The registered provider promoted an inclusive culture by role modelling acceptance of all people at the home. We saw this in our observations of interactions and conversations between people and staff. The caring attitude of the staff was part of the culture of this service, and meant positive relationships were developed with people.

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 **The registered person had not protected service users, and others who may be at risk, against inappropriate or unsafe care and treatment by having an effective system in place to identify, assess and manage the quality and risks within the home.**

The enforcement action we took:
Regulation 10 (1) (a)(b) (2)(b)(iii)(iv)(v)
The registered person did not have effective systems in place to monitor the quality of service provision.

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 **The registered person had not protected service users, and others who may be at risk, against inappropriate or unsafe care and treatment by having an effective system in place to identify, assess and manage the quality and risks within the home.**

The enforcement action we took:
Regulation (11) (1)(a)(2)(a)(b)(3)(a)(b)(c)(d)
The registered person did not have suitable arrangements in place to ensure that people were safeguarded against the risk of abuse.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control **The registered person had not protected staff or people against the risk of infection. The home was not clean and hygienic.**

The enforcement action we took:
Regulation (12) (1)(a)(b)(c)(2)(a)(c)(1)

This section is primarily information for the provider

Enforcement actions

The registered person did not have an effective system in place to protect people from the risks of acquiring an infection. There was not appropriate standards of cleanliness and hygiene in relation to the premises, equipment and materials available to reduce the likelihood of acquiring an infection.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines People did not have their medicines when they needed them in a safe way. Medicines were not handled safely and securely. Published guidance about how to use medicines safely was not followed.

The enforcement action we took:
Regulation (13)
The registered person did not protect people against the risks of unsafe use and management of medicines.

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 There were not clear arrangements in place to ensure people consented to their care and treatment. Staff did not understand the laws which protect people's human rights such as the Mental Capacity Act (2005).

The enforcement action we took:
Regulation (18)
The registered person did not have clear procedures and arrangements in place to ensure consent of people in relation to their care and treatment was sought.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records People's records did not accurately reflect their current care and treatment plans. Records in relation to the regulated activity were not properly maintained or accessible. People's records were not kept securely.

The enforcement action we took:
Regulation (20)(1)(a)(b)(i)(ii)(2)(a)

This section is primarily information for the provider

Enforcement actions

The registered person did not ensure accurate records in relation to people who lived at the home were maintained. There were not appropriate records in relation to the management of the home and records were not kept securely.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing **There were not sufficient numbers of suitably skilled and qualified staff to safeguard the health, safety and welfare of people.**

The enforcement action we took:

Regulation (22)

The registered person had not taken appropriate steps to ensure that there were sufficient numbers of suitably qualified, skilled and experienced staff for the purposes of carrying out the regulated activity.