First For Care Limited

Mill Lodge Care Home

Inspection report

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Date of inspection visit: 16, 17 and 18 June 2015
Date of publication: 11/09/2015

Ratings

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

Overall summary

This inspection took place on 16, 17 and 18 June 2015 and was unannounced. At our last inspection on 1 August 2014 the provider was meeting all of the regulations required by law.

Mill Lodge Care Home is a residential home that provides accommodation for up to 20 older people who require personal care. At the time of our inspection there were 17 people living at the service with three people waiting to move in.

There is currently no registered manager at the service. 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 did not always receive their medicines safely and as prescribed. We found that medicines were not stored safely and medical intervention had not been sought when people had missed doses of their medicines.

People and their relatives told us that they felt safe. We found people were not always protected from potential

Summary of findings

abuse and harm. Staff did not always understand the severity of concerns about people's safety and well-being and which concerns required escalating to the local authority. They were not able to tell us how they would refer these concerns. Recruitment practices were not rigorous enough to ensure that all staff members were suitable to work in the roles they were recruited for.

People were receiving care and support without having provided their consent. We saw an incident where one person was very distressed by staff providing care without their consent. We found that there were no systems in place to assess people's capacity, obtain consent or to make decisions where people were lacking capacity within the boundaries of the required legislation.

We saw that most people enjoyed the food they ate. Food was prepared freshly on site and hygiene standards were good. People were not supported to eat at times of their choosing due the provider offering meals at set times during the day. Nutritional risks were not always identified and managed in order to protect people's health.

Staff were not always given access to effective training and they were not given the skills needed to support people effectively. Not all staff had completed training in important areas such as dementia and nutrition.

People were supported by a staff team that were caring in their interactions. We saw staff using warm, supportive tones of voice and taking their time when supporting people.

People's care was not always personalised to their individual choices. We saw that choices were not offered in certain areas such as personal care. People's privacy was mostly respected although their dignity was sometimes compromised. People were not supported to access a range of leisure opportunities and we found that people's needs and preferences were not always reflected in the care they received.

People told us that they felt comfortable raising issues with staff and managers and we saw certain changes had arisen in the environment as a result of people's feedback.

People living at the service and staff were not supported by a robust leadership and management structure. Quality assurance systems were not in place and the provider had failed to identify the areas of improvement required within the service. Staff were not working in an open and supportive environment. They did not always feel that they were able to escalate concerns to the provider and felt their position may be at risk if they did so.

We found areas in which the provider was not meeting the requirements of the law. You can see what action we told the provider to take at the back of the full version of the report.

The overall rating for this provider is 'inadequate'. This means that is has been placed into 'special measures' by CQC. The purpose of special measures is to:

· Ensure that providers found to be providing inadequate care significantly improve

· Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made

· Provide a clear timeframe within which the providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration

Services placed in special measure will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will be kept under review and if needed could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration.

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 always safe.

People did not always receive their medicines safely or as prescribed. People were not always protected from harm due to inadequate risk management.

People were not protected from potential harm due to the provider not following safe recruitment practices and the provider and staff had an inadequate knowledge of safeguarding practices. There were not always enough staff members available to support people in a timely manner.

Is the service effective?

Inadequate

The service was not always effective.

People's human rights were not protected by practices that supported them to make choices and consent to their care. People were not always supported by staff with the skills and knowledge to meet their needs.

People's health and welfare was sometimes compromised due to staff not always obtaining intervention by external healthcare professionals when it was needed. Staff did not ensure specific nutritional needs were identified and risks to people were minimised.

Is the service caring?

Requires improvement

The service was not consistently caring.

People were not always involved in making decisions about the care they received. People's dignity was sometimes compromised.

People were supported by a staff team who were caring and who supported people to maintain relationships with those most important to them.

Is the service responsive?

Requires improvement

The service was not always responsive.

People were not supported to access a range of leisure opportunities. Their preferences and needs were not always reflected in the care they received.

There was no formal complaints system in place however people had provided feedback and this had been acted upon.

Is the service well-led?

Inadequate

The service was not well-led.

There was no registered manager in place at the service. The provider had failed to ensure that the management structure was effective. They had not met their responsibilities to ensure that the service was well-led.

Summary of findings

The provider had not identified issues within the service and taken the required corrective actions. There was no quality assurance system in place to assist with driving improvements and to ensure that people received effective care.

Mill Lodge Care Home

Detailed findings

Background to this inspection

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

This inspection took place on 16 and 17 June 2015 and was unannounced. The inspection team consisted of two inspectors 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.

As part of the inspection we reviewed the information we held about the service. We looked at statutory notifications sent by the provider. A statutory notification is information about important events which the provider is required to send to us by law. We sought information and views from the local authority. We also reviewed information that had been sent to us by the public. We used this information to help us plan our inspection.

During the inspection we spoke with ten people who lived at the service. Some people who lived at the service were unable to share their experiences so 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 spoke with six members of staff and eight visiting relatives. The manager was not available at the time of our inspection but we spoke with the provider who was responsible in the managers absence. We reviewed records relating to medicines, three peoples care and records relating to the management of the service. We also carried out observations across the service.

Inadequate

Is the service safe?

Our findings

People living at the service were not supported to maintain good health as they did not always receive their medicines as prescribed. We found that one person had missed a blood thinning medicine for one week and medical intervention had not been sought to ensure that this person was protected from harm. We found that the blood tests this person was due to have in April to determine how much medicine they needed were overdue. We saw that one person was unwell during our inspection and had been prescribed antibiotics. On the second day of our inspection two doses of these antibiotics had been missed. The staff that we spoke to told us medicines had been missed as the person was late to get up that morning and then left the service for a medical appointment. Alternative provisions had not been made to ensure that the person received their medicine and medical advice had not been sought following the missed doses until we requested that this was done.

People were not protected by the safe management or administration of 'as required' medicines. These are medicines that are not prescribed to be routinely taken but are used when they are needed. We found that staff were offering these medicines to people routinely rather than identifying when they were needed. There were no clear protocols in place to describe to staff when these medicines should be given and staff did not understand how to administer 'as required' medicines safely. As a result of this practice one person had been receiving strong painkillers regularly four times a day. Staff were not able to clearly confirm if this was due to the person experiencing increased pain or it if was due to them being offered the painkillers routinely. Staff had not considered whether this person might require a re-evaluation of their health needs by a health professional in light of their regular use of 'as required' pain relief. The risk to this persons health from taking this medicine for a prolonged period of time had not been considered. We were told by the provider that a medicines specialist from the local authority had visited in December 2014 and had highlighted that improvements were required with 'as required' medicines. We found these improvements had not been made.

We found that the recording of medicines administered was not always done safely. Handwritten records were made without being signed and checked by another member of staff. One person who had recently arrived at the service did not have a medicines record in place which meant there was no evidence to show whether they were receiving their medicine as prescribed. We found that staff had not given this person some prescribed thickeners and staff were not able to tell us about this person's specific needs.

People were at an increased risk of harm due to medicines not being stored securely. We found prescribed medicines left unattended in a communal bathroom area. One of the medicines that we found was prescribed for a person who was no longer living at the service. This person's name had been crossed out and another name was written on the medicine. The name that had been written was also that of someone who no longer lived at the service. We spoke to the provider and staff about this and they were unable to explain why this had been done. The provider told us that a staff member had subsequently thrown the medicine away and had not followed safe practices for disposing of this medicine.

On the first day of our inspection we found that the medicines trolley was locked but it was not secured to the wall using the locking cable that had been fitted. We also found that the medicines fridge was situated in a communal area, unlocked and had medicines stored in it. We were told that the lock was broken and that this had been reported to the maintenance person although it had not yet been fixed. We found that the temperature of the medicines fridge was not monitored which increased the risk of medicines being stored at the wrong temperature and therefore becoming ineffective. We found that the temperature of the room in which the medicines trolley was stored was monitored, however, this temperature was consistently at the recommended maximum of 25 degrees. We saw the temperature in this room increase to 27 degrees during our inspection. Staff had not recognised the level of the temperature and had taken no action in relation to reducing the room temperature or considering alternative storage for the medicines to ensure they remained effective.

We looked at disposal processes for medicines that were no longer needed. Staff were unsure as to what the procedures for this were and advised us that the manager would normally deal with this. Staff could not tell us what the processes were for disposing of medicines in the managers absence. We asked staff what the process was for

Inadequate

Is the service safe?

disposing of refused medicines that had been taken out of medicine packs. A staff member advised us that the medicines refused the previous day had been put into a pot in the medicines trolley. We were told that this pot had become lost and therefore staff were unable to confirm where these medicines had gone.

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

The provider did not follow appropriate safe recruitment processes to make sure that people were supported by staff who were safe to work in a care service. We saw that references were not always obtained prior to the first date of employment. The provider did not have evidence that all required pre-employment checks had been completed for some staff members. These checks include ID and the person's criminal history. The provider was unable to evidence that staff members were suitable to work in the positions they were recruited for and that they had been effectively assessed. There were no risk assessments in place for those who began work without recruitment checks having been completed or if the returned checks contained information of concern.

This is a breach of Regulation 19 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us that they felt safe living at the service. One person said "I also feel very safe at night time". Relatives told us that they felt people were safe. One relative said "[Person's name] is well looked after, I think [they are] safe." Staff were able to describe to us various different types of abuse and they said they would report concerns to the manager. However, when we asked the provider to report a specific concern that was found during our inspection, we identified that the provider and the staff did not know how to report concerns relating to people's safety and well-being to the local authority. The local authority lead in investigating concerns of this nature. We reported a second incident that we observed, directly to the local authority following the inspection.

People were not always protected from harm by effective risk management within the service. One person who was not able to eat effectively without their dentures did not have them in during our inspection. We found this person had not been eating as much as normal although no action had been taken to manage this risk and there was no nutritional risk assessment in place. We found that other risk assessments were in place but these were not always updated or specific to people's needs. We saw that bed rails were being used in two people's rooms without the risks being managed and recorded. People were sometimes at an increased risk from injury while staff supported them to move within the service. We saw multiple examples of people being supported in a way that increased the risk of injury to those people. Staff we spoke with were unaware that the practices being used could increase the risk of harm.

One relative told us "I think that they could do with one extra staff on at night time." Staff told us that they felt more staff were required in order to meet people's needs. One staff member said "I don't think there is enough staff. [Name] needs two staff and if another [person] needs the toilet". We observed that two staff members were supporting one person while another staff member was observing people in the lounge area to ensure they were safe. There were three staff members on shift which meant there was nobody available to respond to other people's needs. The provider confirmed that there were no formal tools in place to assess how many staff members were needed to support people in a timely manner based on their level of needs. The provider told us that staffing would be improved through reassessing the deployment of staff and restructuring tasks and routines during the day.

Inadequate

Is the service effective?

Our findings

People at the service were receiving care and support without giving appropriate consent. We found that decisions were being made for people regarding all aspects of their care and well-being without their consent. For those people who were unable to consent due to their capacity, we found that decisions were not being made in their 'best interests' in consultation with representatives and in line with current legislation. We found one person particularly distressed by staff members making them shower against their wishes. Staff told us that the person did not like to shower and always shouted out when they tried to shower them although their care plan stated that they liked to shower twice a week. We found that there had been no consideration of this person's lack of consent to the shower. The person appeared to have reduced capacity and there had not been an assessment of this person's ability to make decisions about their personal care. There had been no consideration of less distressing alternatives in this person's 'best interests'.

We observed a member of staff beginning to dry a person's hair with a hairdryer. The person became distressed and started shouting out although the staff member did not recognise this lack of consent. A senior member of care staff recognised the person's distress and told the staff member to stop. This meant that not all staff members were recognising when people were not consenting to the care and support they were giving.

We were told by staff that only two people had the capacity to make decisions about their care although no assessments for capacity had been completed for anyone living at the service. We found that decisions were being made for people regarding all aspects of their care and well-being without their consent. For those people who were unable to consent due to their capacity, we found that decisions were not being made in their 'best interests' in consultation with representatives and in line with current legislation.

We found that one person had refused to take blood thinning medicine. This persons care plan stated that they were 'unable to sign' to consent to their care. Staff told us that this person lacked capacity to make decisions and this was supported by our observations during the inspection. There was no evidence of any capacity assessments having been completed for this person and staff confirmed that they had not been done. Staff had not taken action in line with the Mental Capacity Act 2005 in order to safeguard their health and well-being in the absence of them having the capacity to understand the impact of their decision to refuse medicines. We asked three members of staff what their understanding of the actions they needed to take were and they were unable to answer.

All of the staff we spoke with told us that they had not received sufficient training in capacity and consent. We confirmed that recent training completed consisted of a written exercise booklet. Staff we spoke with who had completed this booklet were unable to describe how they should consider people's capacity, support their decision making and obtain consent appropriately.

This is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's liberty was sometimes restricted without the correct legal consent. Where people's liberty is restricted in order to protect their safety and well-being, the provider is required to submit an application to the local authority. The provider advised that there were no current applications in progress. We were told by staff that two people regularly asked to leave the service and they were not enabled to do so as front doors were locked and support would be required. There was no information in the plans of care for these people about this restriction and how staff should support them in order to ensure that their rights were protected.

We observed most people enjoying the food they were given although some people were seen to leave part of their meals. We were told by one staff member that breakfast time was flexible for people when they got up although our observation was that everyone was taken through to breakfast at the same time. We observed some people having been up from 6.30am waiting for breakfast until 9am. The person responsible for the kitchen during our inspection told us that the main cook planned menus for people that considered the preferences of people living at the service. We were told that if people did not like an option provided they would be given an alternative. We saw that fresh food was prepared in the kitchen and was presented well. Regular snacks were provided during the day at fixed times. People were not able to help themselves to a drink during the day but were given cups of tea at fixed

Is the service effective?

times. We saw people asking for drinks outside of these fixed times but staff were not able to respond to these requests in a timely manner. We saw there were no choices of drink offered at mealtimes.

We observed one person not eating lunch and staff taking their meal away believing them not to be hungry. We spoke to staff about this person appearing to be struggling to chew their food and were told that they were not currently able to wear their false teeth due to the adhesive for their dentures having run out. Staff had contacted family members to request that additional denture adhesive was supplied although it had not been provided and alternatives had not been considered. We were told that the person had not been eating properly due to their teeth for up to a couple of weeks, however, their food intake chart stated that they had eaten well. We were told by one member of staff that it appeared this person had visibly lost weight. We checked this persons records and their weight had not been recorded and monitored. Support from external healthcare professionals had not been sought and action had not been taken to support this person. On the second day of our inspection staff had obtained the denture adhesive and we were told they were booking a dentist appointment to ensure that the dentures were fitting correctly.

We saw that one person who had recently moved into the service had been prescribed thickeners. We saw reference to the thickener on their plan of care and asked staff how this was given. We found that only one member of staff was aware of the thickeners and we found that they had not been given. None of the staff were able to tell us why they were given and it was unclear as to how they should be given.

We saw that external healthcare professionals were involved in people's care. We saw evidence that people were given access to the doctor and other services such as the podiatrist. People and relatives that we spoke to told us that they were able to see the doctor when they needed them. We saw that staff called the GP for advice but often this was not as responsive as it needed to be. For example, a call had been made to the GP following missed medicines but this was after the medicine had been missed for a week. We confirmed that a second person had not got false teeth due to them being lost during a recent hospital stay. The dentist had not yet been involved to arrange a replacement. Staff were unaware of certain healthcare professionals that were available to support people when needed. Staff were unaware that speech and language teams were available to support with certain nutritional needs such as issues with swallowing. After we highlighted that this support was available for people one referral was made to a GP to request this intervention.

The provider had not ensured that people were always supported by staff who had been given the skills they needed to support them. Staff did have access to training although this had not always been completed. The training records showed that not all staff had received training in key areas. For example the training records showed that moving and handling training had not been completed for all staff and we observed poor techniques used that increased the risk of injury to people. We saw that one to one meetings had been completed between the manager and staff and we saw a record of annual performance and development reviews having been completed.

Requires improvement

Is the service caring?

Our findings

People were not always involved in making decisions about the care they received and they were not supported to express their views. One person when asked about their preferences told us "You are speaking to me like I have a choice; which I don't, they tell me what to do". We found that people were not being offered the choice of a bath. One relative told us "[Name] prefers a bath but I know has showers. I think it's the policy. They think showers are best." We spoke to staff about the bath and were told it has not been used for several years and some people told us that the bath chair did not work. The provider checked the bath chair during our inspection and it was found to be working although they were unable to locate the most recent servicing records. We were told that the relevant safety checks would be completed following our inspection to ensure the bath was safe to use and this option would be provided to people living at the service.

We did not see evidence that the provider promoted choice and independence. We found that people were supported to get up by night staff between 6.30-8am with the exception of one person who always stayed in bed until a later time. We found that this did not always meet people's needs and we observed people asleep in the lounge area as early as 8.30am. One staff member told us "They are exhausted by the time we taken them to bed as they are up so early." Mealtimes, snacks and drinks were served at set times during the day. We spoke to the provider about this practice and were told that they would like to see more choice and flexibility developed for people living at the service and they would review this following our inspection.

We saw that people's privacy was protected with tasks such as personal care being done discreetly and in private. We saw that people's dignity was not always upheld. For example, pads used for personal care were not stored discreetly in peoples' rooms meaning their visitors were viewing these personal items. We saw that people's laundry was not separated and saw one large load of hosiery being washed together. One relative told us that washing was often mixed up with other peoples.

People were supported to maintain relationships with relatives. We saw eight relatives visit during the two days that we completed our inspection. The relatives we saw were made to feel welcome by staff and most spoke well of staff working at the service. We were told by staff that relatives were welcome to visit at any time.

We saw that people were supported by staff who interacted with them in a caring way. Relatives told us that staff were caring. We were told, "Staff are excellent" and "Staff are friendly and make you welcome. They're good at their job. Nothing is too much trouble for them." Another relative told us "[Name] wouldn't be here after four space years if I had any concerns.". We asked one member of staff how they made people feel valued and cared for and they told us "The way I talk to them makes them feel important". We saw staff using warm, supportive tones, talking to people at eye level and taking their time with people. Staff told us that they were committed to making sure that people were happy in their home and were well looked after. This reflected what we saw, although staff were not always given the skills need to do this effectively.

Requires improvement

Is the service responsive?

Our findings

People were not supported to access a range of leisure opportunities. We observed televisions being put on for people in the lounge areas although we did not see people consulted about whether this was something they wanted or the choice of viewing. Relatives told us "I would like to see more entertainment, more interaction, more things to do", "There's a lot of times when nothing is going on." Another relative told us there were "No stimulating activities, most of the time it's the television that is on, with not many people watching it in both rooms playing loudly." Another relative said "I don't think that the activities are relevant to the residents here."

We saw that there was an activities timetable on the notice board in the reception area although the activities listed did not take place on the days that we were present at the service. We saw that a hairdresser had visited during our inspection and people enjoyed getting their hair done. We saw that an activity for flower arranging had been planned and flowers were delivered in preparation. The activity did not take place as a double booking had been made with the hairdresser and staff had turned the activities person away. We were told that an activities coordinator was now working at the service on a part time basis and more activities were being planned.

We found that people's preferences and needs were not always reflected in the care they received and the records that were kept. We saw that people's changing needs were not always identified and responded to. For example, we saw people without their false teeth and the care provided was not adapted to meet their needs.

People and their relatives told us that they were able to raise issues and complaints with staff and managers. The most recent survey that we saw completed with the people who lived at the service was in early 2014. We saw that a recent survey had been sent to relatives of people. We saw that action had been taken by the provider following feedback given. For example, three relatives told us that they had raised the issue that carpets needed replacing and this had recently been completed. We saw that staff were now wearing name badges and this was an area raised in the 2014 survey of people living at the service.

The provider confirmed that they were unaware of a complaints log being kept. We were told that this was due to no complaints having been received. The provider told us that informal feedback was received but this had not been recognised as a complaint or recorded. We discussed some examples of comments made by relatives, including those about the carpets, and the provider agreed these should be logged as complaints. In the absence of records being kept the provider was unable to demonstrate that they were analysing feedback given for trends in order to recognise any areas of improvement needed within the service.

Inadequate

Is the service well-led?

Our findings

People living at the service and staff were not supported by a robust leadership culture or an effective management structure. The provider has not had a registered manager in place since January 2015 which is a breach of their conditions of registration with CQC. At the time of our inspection there was an acting manager in place but they had not yet applied to become a registered manager. The provider had not developed sufficient systems to ensure that the management structure was effective and that leaders were carrying out their roles effectively. We found that the manager of the service had not completed an induction into their new role. The provider had failed to identify the areas of improvement needed within the service and had not identified the issues that we found during our inspection.

The provider had failed to ensure that people were safe and receiving care that was appropriate to their needs due to not having implemented a quality assurance system. People's needs were not being effectively assessed and the care that they received did not always support their needs. Records did not reflect what we saw. For example, one person had been unwell during our inspection and we saw that they had been unable to move from a chair. The notes around their care for that period stated that they had good mobility. These notes were used to handover information to the next staff shift and therefore they would not have been given the correct information about this person's needs. The manager and the provider had not developed any systems to audit people's care files or the care being received and therefore this issue had not been identified and corrected. The lack of audits around medicines and whether people's care was effective had resulted in people's health and well-being being compromised and put at risk.

The provider had failed to ensure that effective risk management processes were in place. People's risk assessments were not unique to them and they did not identify specific issues of concern where risk needed to be mitigated. We found that an audit had been completed of accidents although this was a summary of events. There was no analysis of why the accidents had occurred, identifying any trends and what actions could be taken to reduce risks to people in the future. We saw that multiple falls had arisen and the provider did not ensure that learning was taken from prior events in order to manage risks to people and to drive improvements in the service.

Management had failed to implement systems and working practices that meant people's human rights were upheld and that care given was compliant with legislation. Staff were keen to learn and develop their skills but training and development needs had not been effectively identified. Training provided was not always effective at providing staff with the appropriate skills. For example we saw poor moving and handling of people, unsafe practices around managing medicines and an inadequate knowledge of how to effectively support people with dementia. We found that the provider was not ensuring that systems were in place to ensure that staff competency was not being checked in specific areas such as medicines administration. This resulted in people being put at risk, for example medicines were not given as prescribed and healthcare needs were not addressed responsively.

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

The provider is required by law to submit notifications to us of significant events, such as deaths or serious injury. We found that the provider had failed to send in notifications which they should have sent us. The provider confirmed that they would ensure these were submitted immediately. Since the inspection, the provider sent these notifications to us.

Some staff spoke positively about management. One member of staff told us that they felt they could talk openly and were listened to. Several members of staff told us about issues that they had not spoken to management about. One person told us that they felt their position would not be safe if they openly questioned practices or expressed their views. One relative told us that they did not know who the current manager at the service was.

Some staff told us that they would be confident in escalating concerns about people's safety and well-being outside of the service if required, others told us that they felt their job may be at risk if they contacted the local authority or ourselves directly. The provider told us that they recognised that the culture within the service needed to be supportive and open. We were told that the provider

Inadequate

Is the service well-led?

has begun to complete work within the service at weekends to develop a better understanding of the service and to make themselves more approachable to the staff team.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent People's consent to their care and support was not always sought in line with current legislation and guidelines.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment People did not always receive their medicines safely and as prescribed. People were not protected from harm due to inadequate risk management.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider had failed to ensure that an effective quality assurance system was in place to identify risks to people and to drive improvements.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed The provider had failed to ensure that people were protected by safe recruitment practices.