Haisthorpe House Care Limited

Haisthorpe House

Inspection report

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Ratings

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

Overall summary

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 and to pilot a new inspection process being introduced by CQC which looks at the overall quality of the service. This was an unannounced inspection carried out on 8, 9 and 11 July 2014. We last inspected the service in June 2013 and found they were meeting the Regulations we looked at.

Haisthorpe House is a care home registered to provide personal care and accommodation for up to 30 people with mental health needs or learning disabilities. There were 25 people staying at the home when we visited. The home has several communal areas including a lounge, dining room, conservatory and an outdoor area where people can sit. Accommodation is provided in three buildings. There are a mix of double and single rooms, seven of which have en-suite facilities.

The home has a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service and has the legal responsibility for meeting the requirements of the law; as does the provider.

When we visited the home people told us contradictory things about the service they received. Some people were happy, some were not. Some people said staff were

Summary of findings

caring, some said they were not. From our own observations and the records we looked at people did not always receive a personalised and caring service. Some people liked the meals, some did not. We found people's rights and safety were not always well managed. Sometimes people's choices were limited.

Staff were not always following the Mental Capacity Act 2005 for people who lacked capacity to make a decision. For example, the provider had not made an application under the Mental Capacity Act Deprivation of Liberty Safeguards even though people's liberty may have been restricted.

People's safety was compromised in a number of areas. This included how the equipment and building was maintained. People were not living in a clean, comfortable or pleasant environment. The provider did not have proper arrangements to make sure people received their medicines safely.

People told us they got good support with their healthcare. Care records showed where concerns about people's health were identified staff acted promptly to ensure appropriate healthcare services were accessed. One healthcare professional told us staff had shared any issues, listened and followed advice.

There were not always enough staff to provide people with individual support. The provider did not have a system to assess staffing levels and make changes when people's needs changed. Care staff were responsible for other tasks such as cleaning and this resulted in staff focusing on tasks rather than spending time with people.

Staff told us they received adequate training to equip them with the knowledge and skills, however the records showed staff had not received regular updates so their knowledge could be out of date. Staff told us the registered manager was supportive and available if they wanted to discuss any concerns or issues.

Leadership and management were poor and there were no systems in place to effectively monitor the quality of the service or drive forward improvements.

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.

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. The majority of people said they felt safe but some said they had been upset by the behaviour of others they lived with. The provider looked after people's monies but did not have proper systems to make sure their money was safeguarded.

People's rights and safety were not balanced because risks were not managed appropriately. People did not receive their medicines as prescribed. The premises were not clean or well maintained.

There were not enough staff to meet people's needs and safe recruitment practices were not always followed which put people at risk. People's liberty may have been restricted but the provider had not made an application under the Mental Capacity Act Deprivation of Liberty Safeguards.

Is the service effective?

Inadequate

The service was not effective. Staff had received a range of training but this had not been regularly updated. This meant people were at risk of receiving care from staff who were not equipped with the right knowledge and skills.

Some people enjoyed the food whereas others did not. There was no choice offered when the main meal was served.

People received appropriate support when healthcare needs were identified. A range of healthcare professionals were involved to make sure people's healthcare needs were met.

Is the service caring?

Requires Improvement

Some people were happy and felt well cared for whereas others did not.

Staff focused on tasks rather than spending time with people who used the service. Sometimes staff were not respectful when they were writing about people in their care records.

Is the service responsive?

Inadequate

The service was not responsive. Care plans did not always show the most up to date information on people's needs, preferences and risks to care.

Some people told us they could not make choices about their care. For example, meal times were not flexible. People who accessed the community independently chose when to go out. However, people who needed support from staff had less flexibility.

Summary of findings

Is the service well-led?

The service was not well-led. People's living conditions were poor. The environment was in need of updating and repair.

Systems to monitor the quality of the service were not effective. For example audits were not being regularly carried out to monitor the safety and quality of the service also risk were not being analysed to reduce further occurrences.

Inadequate

Haisthorpe House

Detailed findings

Background to this inspection

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.

During our inspection we used different methods to help us understand the experiences of people living at the home. We spoke with twelve people who lived at the home, three care workers, a senior care worker, the deputy manager, the registered manager and a health care professional. We observed how people were supported and how staff interacted with people. We looked around the home and checked how medicines were managed. We looked at five people's care records, seven staff training records, two staff records that were obtained prior to recruitment and records relating to the management of the service.

Before the inspection we reviewed the information we held about the home. We also looked at a provider information return (PIR). We were not aware of any concerns by the local authority, or commissioners.

At the last inspection in June 2013 the service was found to be meeting the Regulations we looked at.

Inadequate

Is the service safe?

Our findings

When asked if people felt safe the majority said yes. Nearly everyone said they knew what to do if abuse or harm happened to them or if they witnessed it. They said they would report it to the manager. Two people raised concerns and said the behaviour of others they lived with had upset them. Daily records also contained information which showed there had been incidents between people but there was no information to show if these concerns were followed up. The registered manager said the concerns we identified in the daily records had been were discussed with the person concerned but the allegations had not been reported to the local safeguarding team or to the Care Quality Commission (CQC). There had been a number of medication errors which had not been reported to the local safeguarding authority or CQC even though on one occasion a person went to hospital. This is a breach of Regulation 11 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Staff we spoke with said if they observed any incidents between people who lived at the home they provided support to diffuse situations and always made a record in the person's notes. Staff said they had completed safeguarding training and could identify different types of abuse. They said they would report any concerns or allegations of abuse to the manager and were confident these would be dealt with appropriately. Staff knew they could report concerns to other agencies.

We talked to a member of the management team about arrangements in place for managing people's finances. Most people had money held at the home which was kept in a communal float. We asked to look at one person's running balance but were told this was only totalled when the administrator visited the home twice a week. The home also purchased tobacco pouches on behalf of some people and distributed these daily. However, we were told they did not keep a stock record so could not account for the items. The home held a number of cash withdrawal cards that belonged to people who used the service. We were told only the management team had access to the PINs and accessed people's accounts. We looked at people's care records but they did not contain details of the financial arrangements. This meant the provider did not have suitable arrangements to protect people against the risk of misuse or misappropriation of money or property because they could not account for money that had been spent and items that were bought on their behalf. This is a breach of Regulation 11 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We talked to staff and management about risk management. Staff explained that they completed safety checks to manage risk and this included room checks. Staff carried out a number of fire checks every day which included checking people's rooms because they were known to smoke in their room. Some rooms were visited hourly. The frequency of room checks was not recorded in people's risk assessment or care plan. For example, one person's risk assessment stated 'monitor smoking' to minimise risk. There was no detail about how staff should monitor smoking or assesses the balance between safety with the rights of the person. This meant that risk assessments did not balance safety with the rights of people. Staff also carried out other room checks. This meant people were not involved or supported in decision making about risks. This is a breach of Regulation 9 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

There were some general capacity assessments but not around specific decisions such as drinking alcohol or eating to excess. The provider had not made an application under the Mental Capacity Deprivation of Liberty Safeguards even though people's liberty may have been restricted. This is a breach of Regulation 18 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Accident records showed one person had fallen in the last six months. However, the accident records did not contain sufficient detail to show action was taken to prevent repeat events. We looked at the person's care records but a falls risk assessment had not been completed. The person had restricted mobility and was dependent on staff for some transfers. The person did not have a moving and handling risk assessment. This meant risks to people were not assessed or managed safely. This is a breach of Regulation 9 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The registered manager told us they had experienced staffing difficulties in the last few months because a number of staff had left which had left them in a difficult position. They had struggled to recruit new staff with the right skills. One member of staff told us the staff team were

Is the service safe?

getting very tired and this had led to staff having less patience when they were assisting people who used the service. They said there had been occasions when staff had been abrupt with people and had had to apologise. One person who used the service described staff as "bossy". Another person said, "Staff were not flexible and had control."

The registered manager said they had a tool to assess staffing levels but this had not been completed. At the time of the inspection 25 people were living at the home and up to three people a day who lived in the community attended the home for day care support. The home did not employ any domestic staff which meant care staff had to do the cleaning and laundry as well as provide care and support to people. During the inspection we noted there was not enough staff to support people. Staff were busy carrying out tasks and didn't spend time with people. There was very little interaction between staff and people who used the service.

People told us they could not always do what they wanted because of a lack of staff. One person said there was no support to go out. They told us there had been trips to the seaside but not many people went. Another person said they wanted to play dominoes but couldn't because there were not enough staff around. We asked another person if there were enough staff. They said, "No not really, sometimes there is and sometimes there isn't. There are less staff at weekends." The registered manager said she and the deputy manager often provided support when they were on duty but did not work weekends. Through our observations and discussions with people we found there were not always enough staff to meet the needs of the people living in the home. This is a breach of Regulation 22 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Two staff said they went through a robust recruitment process before they started working at the home. They were interviewed and asked questions about their relevant experience. They said a number of checks were carried out before they could start work. We looked at two recruitment records, which confirmed all the appropriate checks had been completed. However, some information disclosed on an application form should have been clarified with a previous employer. There was no evidence to show the registered manager had clarified potential risks or carried out a risk assessment to ensure the appointments were safe. This is a breach of Regulation 21 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Before we carried out our inspection the provider sent us a PIR. This gave us written information on the areas we needed to look at during our visit. The PIR stated there had been 78 medicine errors in the last 12 months. When we spoke to the registered manager at the inspection they confirmed this information was accurate. The registered manager provided a sheet with a very brief summary of the errors. This showed there had been omissions in recordings, some people had been given other people's medicines and some people had missed their medicines because there was no stock.

Medicines were not stored safely. The majority of medicines were stored in a locked medicines cabinet but this was in an area which was very hot. If medicines are not stored at appropriate temperatures it can result in those medicines being ineffective. The medicine's fridge was not locked so all staff had access. The provider's medication policy stated that the medicines cupboard should not store any other items, however, we found it contained a number of pouches of tobacco. The provider's medication policy stated staff specimen signatures should be recorded but these were not available. The medication administration records (MARs) had a section to insert a photograph of each person and details of allergies, conditions and notes but these were blank. There was a record of the person's name, their date of birth and GP.

Staff did not record the actual time medicines were given to people. The MARs did not state specific times for administering medicines. A sticker in the medicines folder provided timeframes, for example, breakfast medicines could be administered between '8am and 11.59am', and lunch could be administered between '12 midday and 3.59pm'. These were broad time frames so it was unclear when medicines were given. This meant people were at risk of receiving medicines too close together.

Senior care staff were usually responsible for administering medicines but during the night and early morning, night care staff also administered medicines. Senior care staff placed medicines in a 'bag' for night care staff to administer. Some of the medicines were taken from their original container and placed into bottles and envelopes. This is called secondary dispensing and increases the risk

Inadequate

Is the service safe?

of medication errors. The bag also contained 'house paracetamol' for people who were not prescribed paracetamol. The home's household remedies policy dated 2010 stated paracetamol could be given and was agreed by local GPs. This had not been reviewed and there was no evidence that GPs had been consulted since 2010 to establish if they were still in agreement with the policy.

We checked some of the medicines stock. One person received a medicated adhesive patch which is a controlled drug and the stock balance for these was correct. However we looked at medicines for another person and the stock level was incorrect and they had one tablet too many. This meant either the stock levels were wrong or the person had not received one tablet. The shortfalls identified in medicine storage, administration and record keeping meant people were at risk as their medicines were not being managed safely. This is a breach of Regulation 13 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The registered manager said they carried out medication audits but these were not recorded and there was no evidence to show recommendations were followed up. Incident reports had not been completed when people had been given the wrong medication. We found information was recorded in people's daily notes section however information was not gathered and evaluated. This meant the provider did not have effective systems to identify, assess and manage risks to people. This is a breach of Regulation 10 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

When we arrived on the inspection the side door to the main house, which is used as the main entrance, was wide open. There was no one around and we could walk through freely into the dining room and the rest of the home. We noted scaffolding was around the building, including the areas where people walk. One person who used the service told us they did not feel safe because people could walk in from the street. They also told us the lock on their room was broken and had not been repaired for a very long time. We checked the lock and it did not work. We asked to look at the relevant environmental risk assessments but were told these had not been completed. This is a breach of Regulation 15 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The home and equipment was not clean. Furniture and carpets were stained. Some bathrooms and toilet areas looked dirty. A number of people showed us their rooms some of which were dirty. For example, the wall next to the bed in one person's room was heavily stained as was the bed, sheet and mattress. The person's carpet was dirty and there were cigarette butts and ash all over floor and table. One person said they wanted more help to clean their room but didn't get support. We asked the registered manager about mattress audits but these were not carried out. The home's infection control policy had a mattress audit tool but these were not used. Care staff were responsible for cleaning the home and had a list of cleaning duties that were included on the handover sheet. However, it was evident from looking around the building some of the tasks had not been completed properly. This is a breach of Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Inadequate

Is the service effective?

Our findings

We reviewed the PIR before we carried out our inspection. This told us no staff had had an annual appraisal in the last two years. At the inspection the registered manager confirmed this information was accurate and they had not done staff appraisals for between three and four years. The registered manager discussed the arrangements for supporting and supervising staff which she called 'live supervision', whereby she worked alongside staff and discussed her observations with them at the time. These sessions were not generally recorded although there was a supervision book that showed some discussions were held with individual members of staff about specific issues around performance and practice. Staff told us they did have opportunities to talk to the management team if they wanted to discuss anything but this was on an informal basis. The provider had guidance that stated 'supervision should be provided once every eight weeks' and this time should be used 'to help the supervisee to identify areas where they need to improve or change their working practice and to give them feedback on anything they are doing well'.

Staff said they had received training that had helped them to understand their role and responsibilities. One staff attended a safeguarding training session during our inspection and said it had provided her with the relevant knowledge. We looked at training records which showed staff had completed a range of training sessions. This included health and safety training, first aid awareness, food safety, Mental Capacity Act and Deprivation of Liberty Safeguards and mental health. The records showed some staff had not attended training recently or had refresher training. It was evident at the inspection that staff were not adequately trained. This was demonstrated in their practice and approach to the care, treatment and support people received. For example, staff did not understand that they must balance safety with the rights of the people who used the service.

The registered manager told us she kept up to date through research but said it was about five years since she had done any formal training and she was aware she needed to update her knowledge. It was evident at the inspection that the management team did not know about best practice and did not always recognise poor practice.

The provider's training policy did not state how often staff should receive training to make sure their knowledge and skills were up to date. This meant people could not be assured that staff had up-to-date knowledge and skills to meet their needs appropriately. This is a breach of Regulation 23 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We received a mixed response when we spoke with people about the meals. Some people told us they enjoyed the meals whereas others said they did not. One person said, "The food's good." Another person said, "We get a variety, all is well cooked. We have enough and I think it's nutritious." Another person told us they kept food in their room because they didn't like the meals. We observed people having meals at lunchtime. Staff and people who used the service ate together. The mealtime was relaxed and people were chatting to each other. The day's menu was displayed in the dining room although there was no choice at lunchtime when the main meal was served.

People told us they received appropriate support with their healthcare. One person said, "They're on the ball for me seeing the doctor. I can go to the optician." People's care records showed that other professionals were consulted and involved when concerns were raised about people's health. For example, staff noted a change in one person's health and the GP was contacted the same day. Another person had on-going health problems and staff had liaised with the relevant healthcare professional on a regular basis.

We spoke with one healthcare professional. They told us one of the people they supported had complex needs and the home had "tried really hard to support them". Staff had shared any issues, listened and followed advice. We also received confirmation from other healthcare professionals that they were comfortable with the service provided by the home and did not have any significant concerns about the care provided.

Requires Improvement

Is the service caring?

Our findings

We received a mixed response when we spoke with people about the service. Some people told us they were happy and well cared for whereas others said they were not very happy. One person said, "The staff are excellent, kind and listen to me." Another person said, "I'm quite happy here." Another person said, "Staff take care of the body but not the mind" and "The staff gossip."

Some people told us they could not make choices about their care. For example, people said the meal times were not flexible and if they didn't attend at the specified times they couldn't always get a meal. One person told us breakfast was served between 7.30am and 8.30am and if they missed this time they could only have cereal. Another person said, "They don't give you control. There's not much flexibility. If you get up late it's not easy to get breakfast."

People told us they were able to say how they wanted to spend their day. For example, whether they wanted to spend time in communal areas of the home or in their bedroom.

We reviewed care records and found people had signed their care plans which indicated they agreed with the contents. However, based on feedback from people who used the service, our observations and a review of the records we found the service did not always listen to or effectively consult people about how they would like to receive their care. We noted that sometimes staff used inappropriate terms which were not respectful about the people they were writing about. For example, they often described one person as grumpy and wrote 'a very grumpy little (name of person) today'.

Staff told us people were well cared for. One member of staff said, "I've worked in mental health before and this is a caring service." Another member of staff said, "People are well cared for and everything is done in their best interests." One member of staff said they thought things had "gone off the boil" in recent months and they needed to refocus. The management team and some staff had worked at the home for a long time so knew people very well.

During the inspection we noted staff focused on tasks rather than spending time with people. We did not observe staff sitting with people apart from at lunch time when staff sat with people to eat. One member of staff was allocated responsibility for cleaning but we noted other members of staff were also carrying out cleaning duties. One person who used the service said. "The care staff shouldn't have to do all the cleaning. The other day I wasn't feeling well and asked for a member of staff. One came and told me they were too busy cleaning."

The home provided a service to people with different needs but did not always recognise people needed different levels of care. For example, some people could carry out household tasks such as cleaning their room with very little support from staff whereas others needed much more help. This was not assessed or planned through the care planning process.

The registered manager said they did not employ domestic staff because care staff should involve people in the cleaning of their room and other areas of the home to help promote independence. However, we saw this was not always working successfully so the registered manager said they would review these arrangements.

At the time of the inspection only one person accessed an advocacy service and this was set up through a different service provider. When we looked around the home we did not see any information about accessing advocacy services.

Inadequate

Is the service responsive?

Our findings

People did not receive care and support that was personalised. Staff had not always appropriately assessed people's care needs. Clear instructions for care delivery were not provided. There was a record which indicated people's care needs had been reviewed but some important changes had not been documented so care plans were not up to date. For example, one person's daily records showed they had recently had a number of seizures. The person's care plan did not contain any information about how staff should support them when they were having a seizure. The person did not have a risk assessment. The care plan had been reviewed and stated they were 'currently seizure free' even though the daily records showed the person was having seizures at the time the review was carried out. Although there was no evidence to indicate the person was not adequately supported, the lack of assessment and care plan meant the person was at risk of receiving inappropriate and unsafe care. Another person's care plan stated they had high cholesterol and had been advised by their GP to have a low fat diet and watch their weight to improve mobility. Monthly weight records showed the person had gained over a stone in weight in ten weeks but there was nothing documented about this in the care plan reviews or to show what was being done to help the person achieve their goal. This is a breach of Regulation 9 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We also found some important information was missing from people's care plans. For example, a member of staff talked to us about one's person's needs in relation to their care. Staff needed to know this when assisting the person but there was no information about this in the person's care plan. A communal 'personal assistance sheet' identified staff should check for blood when assisting one person; however there was no reference to this in the person's care plan.

One person's care plan contained a negative statement about their response to certain situations. The person did not agree with the statement and had recorded this in their care plan. There was nothing in the care plan to show how this was followed up by staff. We discussed this with the registered manager who agreed the statement was negative and could have been more balanced and worded better.

One person told us they were not allowed to express their religion. We noted in the person's care records there was a recent entry where they had been unable to attend a religious service because there were no staff to support them. This meant people's care was not personalised and the service did not put them at the centre of their care. This is a breach of Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People who accessed the community independently told us they chose when to go out. People who needed support from staff had less flexibility because they were dependent on staff. One member of staff told us they planned community activities with people but it was not always possible to offer these because sometimes they did not have staff available. One person told us there had been trips to the seaside but not many people went.

People told us they could raise concerns although two people told us they didn't feel listened to. One person said if they speak up they get "fobbed off" and "things don't really get dealt with". Another person told us if they raised concerns the staff put everything down to their mental health rather than listening to their genuine concerns.

The provider had a complaint's policy although this did not contain enough information about what people could do if they were unhappy with the provider's response. The registered manager said in the last 12 months the provider had received one formal compliment and no formal complaints.

Inadequate

Is the service well-led?

Our findings

The provider had not gathered, recorded and evaluated information about the quality and safety of the service. Audits were not being completed routinely. For example, mattress audits were not completed, there was no information about how medication audits were followed up, staff were not being appropriately supported. Risks to people were not always identified, monitored and managed. There was no evidence of learning from incidents, such as medication errors and accidents.

The registered manager told us they had not been able to undertake a number of key management tasks because they had been short staffed. Care staff completed job lists for cleaning and personal care tasks, and senior staff completed 'senior checks lists'. However there was no evidence to show the quality of the work was checked by the management team or completed to a satisfactory standard. At the inspection we found multiple breaches in the regulations which evidences that the provider was not monitoring the quality and safety of the service provided. This is a breach of Regulation 10 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We looked around parts of the home and found people's living conditions were poor. Throughout the home walls and doors were dirty and damaged through years of wear and tear. Paintwork was peeling and wallpaper was coming off in places. People spent most of their time in the conservatory but this area was dismal. The décor was heavily stained from cigarette smoke and furnishings and flooring were dirty. The front door to the home was not in use and the entrance area was used for storing equipment such as walking frames and wheelchair. The registered manager said it was agreed at a house meeting several years ago not to use the door. One person who used the service said, "The place is shabby."

The registered manager told us the owner was starting to refurbish the home but they did not have a formal plan with timescales that identified what areas would be decorated and when. Scaffolding was in situ outside the home. The registered manager said the exterior of the home was being painted and this was the beginning of the refurbishment programme. Poor environmental conditions do not promote people's wellbeing. This is a breach of Regulation 15 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Armchairs, carpets and other furnishings were worn. A number of these were dirty and damaged and did not promote the comfort of people. The registered manager said they had recognised things needed replacing but they only had limited finances so it would need to happen through a planned programme. There was no planned programme available. This is a breach of Regulation 10 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The home's statement of purpose stated there were three double rooms. The registered manager said they had previously had four double rooms but one was very small so this was only used for single occupancy. When we looked around the home one of the double rooms was empty so we viewed this. The room was small and it would be difficult for two people to live together comfortably in this space. The registered manager told us at the beginning of the inspection that no one currently shared a double room, however, when we spoke to people we established two people were sharing. One person showed us the room they shared with another person. This was small and provided very limited space for two people. We also noted from the provider visit records it was agreed with the registered manager 'every effort would be made to have the most attractive rooms available for new residents. It also stated the registered manager agreed that they would encourage existing residents to share double rooms. Younger more mobile residents would be encouraged into the upstairs rooms. Converting double rooms into en-suite rooms would be agreed if it secured new residents'. It was evident from the records people were not treated with consideration and respect. This is a breach of Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider's 'care monthly meeting notes' contained detailed information. However, this mainly related to business and financial aspects. There was very little evidence that the quality of the service had been assessed by the provider. For example, there were no discussions with people who used the service or staff.

Resident meetings were introduced in spring and were monthly but the registered manager said people did not want to get involved. The registered manager told us they did not complete quality assurance surveys but received informal feedback from people. However we did not see evidence of this.

Inadequate

Is the service well-led?

The provider had a range of policies and procedures but some of these were very basic and did not provide sufficient guidance to promote good practice or reflect current published research and practice guidelines. Some were not dated. For example the complaints policy was not dated. It stated a response would be provided in five working days and investigated within three working days. The Commission's details were included but there was no information about contacting the local authority or the local ombudsman.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse **The registered person did not make suitable arrangements to ensure that service users were safeguarded against the risks of abuse by means of taking reasonable steps to identify the possibility of abuse before it occurs and responding appropriately to any allegations 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 did not take reasonable steps to ensure that service users and others were protected against identifiable risks of acquiring such an infection by the means of the effective operation of systems designed to prevent, detect, and control the spread of infection, and the maintenance of appropriate standards of cleanliness and hygiene.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises **The registered person did not protect service users and others against the risks associated with unsafe or unsuitable premises because of inadequate maintenance.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services

This section is primarily information for the provider

Action we have told the provider to take

The registered person did not have suitable arrangements in place to ensure that people's dignity and independence were maintained as far as practicable, or to enable service users to make, or participate in making, decisions about their care.

People were not always treated with consideration and respect or provided with opportunities to promote their autonomy, independence and community involvement.

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 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 21 HSCA 2008 (Regulated Activities) Regulations 2010 Requirements relating to workers The registered person did not operate effective recruitment procedures in order to ensure that no persons are employed for the purposes of carrying on a regulated activity unless that person is of good character, and ensure that information specified in schedule 3 is available in respect of a person employed and such other information as appropriate.

Regulated activity	Regulation
	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing The registered person did not take appropriate steps to ensure that, at all times, there are sufficient numbers of suitable

This section is primarily information for the provider

Action we have told the provider to take

qualified, skilled and experienced person's employed for the purposes of carrying on the regulated activity.

The registered person did not take appropriate steps to ensure that, at all times, there are sufficient numbers of suitable

qualified, skilled and experienced person's employed for the purposes of carrying on the regulated activity.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff The registered person did not have suitable arrangements in place to ensure that staff were appropriately trained to deliver safe care and support to 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 9 HSCA 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.**

The enforcement action we took:
We have served a warning notice and the provider was told they must become compliant with the Regulation by 31 October 2014.

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 did not have effective systems in place to monitor the quality of the service delivery.**

The enforcement action we took:
We have served a warning notice and the provider was told they must become compliant with the Regulation by 31 October 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines **The registered person did not protect service users and others against the risks associated with unsafe use and management of medicines.**

The enforcement action we took:
We have served a warning notice and the provider was told they must become compliant with the Regulation by 31 October 2014.