Care Quality Commission

Caromar Care Limited

Lane End House

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?	Inadequate
Is the service responsive?	Requires improvement
Is the service well-led?	Inadequate

Overall summary

This inspection was unannounced and took place on the 22 June 2015. Lane End House can accommodate up to 22 older people with a variety of long term conditions, including those living with dementia and physical disabilities. On the day of our inspection 13 people were living at the home.

The home has a registered manager. 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. In this home the registered manager is also the nominated individual of the registered provider.

There has been a history of non-compliance with the requirements of the law at this service since February 2014. At this time we issued three warning notices relating to care and welfare, infection control and quality assurance. In May and June 2014 inspections found non compliance remained with care and welfare. In November 2014 we inspected the service again and

Summary of findings

found non compliance was continuing, because we found risk assessments were not in place to prevent and protect people from injury, pain and harm. Care plans were not detailed enough to guide staff on how to meet individual needs. Medicine practices were not safe. The principles of the Mental Capacity Act 2005 (MCA) to ensure any decisions were made in the person's best interests had not been applied. People's independence had not always been promoted and people had not been involved in decisions regarding their care. Effective systems were not in place to ensure the quality of the service provided was good and incidents were learnt from. Staffing levels were not always planned to ensure they were adequate to meet the needs of people. As a result we issued the provider with a formal notice which prevented them from being able to admit any new person to the home. The provider sent us regular action plans detailing what action they were/had taken to reach compliance. The last action plan was received on 10 April 2015.

At this inspection 13 people were being accommodated. We found staffing levels had not been arranged to ensure the needs of people could be met at all times. We found not all areas of the home were clean. Staff were not competent regarding medicines administration practices. Appropriate checks had been carried out on staff before they worked in the home. Safeguarding policies and procedures were available and staff understood these.

We found staff had received training but the provider was not reviewing the training to ensure staff were putting their learning into effect. Staff did not demonstrate a basic understanding of the Mental Capacity Act. However, the provider had reviewed care plans and ensured the principles of the Act had been applied to people's records.

We found staff were not always caring or respectful when supporting people. Where people needed support with their meals this was not always offered in a respectful and dignified manner. People's privacy and dignity was not always promoted.

Care plans were person centred and had been developed with people and their relatives. Activities were offered but these tended to be larger group activities.

Quality assurance procedures in the home were not effective. It was not possible to establish an open culture existed within the home. The provider had failed to clearly display their previous rating given from the most recent inspection.

The overall rating for this provider is 'Inadequate'. This means that the service is therefore in special measures. The service will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

During this inspection we found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this 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.

Staffing levels were not adequate to meet the needs of people.

People were not cared for in a clean environment.

Medicines procedures were satisfactory but no plans of care to guide staff about the use of PRN (take as necessary medicines) had been developed.

Staff were aware of safeguarding policies and procedures.

Risk assessments were included in people's records and were relevant and up to date.

Is the service effective?

Requires improvement

The service was not always effective.

A programme of training was available but there was limited evidence that staff had put their learning into practice.

The Mental Capacity Act had been considered when developing people's care plans. Where required Deprivation of Liberty Safeguard applications had been made however, staff did not recognise any restrictions on people's liberty.

People's care plans included information on people's nutritional needs. Support to people at meal times was not always respectful of people's needs and choices.

Is the service caring?

Inadequate

The service was not caring.

Staff were not always caring or respectful towards people.

They did not care for people in a respectful and dignified manner.

People were not protected by staff from risks to their privacy and dignity.

Is the service responsive?

Requires improvement

The service was not always responsive.

People had care plans which were a reflection of people's current needs

People had been involved in the development of their care plans.

Activities were arranged but these were not tailored to meet people's individual's needs.

A complaints procedure was available.

Summary of findings

Is the service well-led?

Inadequate

The service was not well led.

We could not be assured the home had an open and inclusive culture.

The ratings from the previous inspection had not been displayed as required.

The quality assurance system was not effective.

Lane End House

Detailed findings

Background to this inspection

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

This inspection took place on 22 June 2015 and was unannounced.

The inspection team was made up of one inspector and a specialist advisor who had specialist knowledge in the care of frail older people, especially people living with dementia and those with end of life care needs.

Before the inspection, we examined previous inspection reports, action plans the provider had sent us, safeguarding meeting minutes, and other information we had received, along with notifications. A notification is information about important events which the provider is required to tell us about by law.

During the inspection we spent time talking to eight people, one health professional visiting the home, two members of staff, and the registered manager. We observed interactions between people and staff. Some people were not able to share their experiences of life at the home with us verbally 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 looked at the staffing records of one new member of staff and records of service quality audits, including minutes of staff and resident meetings. We looked at the care records of seven people.

Following the inspection we requested information from health and social care professionals and GP's who visit the home.

Inadequate

Is the service safe?

Our findings

People gave mixed feedback about feeling safe living in the home. One person told us they felt safe. Another person told us they felt "Safe some of the time", but did not want to elaborate further on this comment. When we asked if there was someone they could talk to if they felt unsafe they replied, "Not really". Another person told us, "Staff say things like you will have to wait I am doing so and so, that makes you feel a bit bad as I was only asking for the help I needed and this does happen from time to time. Sometimes I feel a bit rushed as well but the staff do not always understand we cannot hurry, then people get upset and cross, but then I keep it to myself. I may be a bit unfair though as the staff are so busy all of the time so all they can do is rush especially at meal times and bedtimes."

At the last inspection the provider was in breach of regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, because staffing levels were not always adequate in meeting the needs of people. At this inspection we found the provider was still in breach of the corresponding 2014 regulations regarding staffing.

It was unclear how staffing levels were decided in the home as the registered manager confirmed no dependency assessment based on people's needs was used. The duty rota showed inconsistencies in the number of staff working day to day. For example, five care staff were employed, plus a cleaner and a cook. An agency worker had been working a minimum of two shifts a week for the last three months. From the duty rota it was difficult to establish who actually worked and for what hours. On the day of our visit the duty rota recorded a cleaner was working, however they were not in the home. The rota also indicated one member of staff was on duty for an hour, when in fact they were present for the whole of the inspection visit. The registered manager was also recorded as working an 8 hour shift, but stayed for four hours after this. The duty rota showed the registered manager worked some shifts providing direct support, and at other times was supernumery. We were told by staff that when the manager worked supernumery they would "Pop in' on a regular basis. This meant we could not be assured the rota was an accurate reflection of the staffing levels supplied.

The duty rota showed only two staff were available from 3pm to 8pm on the week of the inspection for six days.

Observations on the day supported staff reporting to us that at least four people required the support of two staff to support them with personal care and their mobility. This meant in the afternoons when care staff were supporting one of these people there were no care staff to support other people. We were also told at least two people enjoyed going into the garden, but needed support whilst in the garden to keep them safe. This would mean at times there would only be one member of staff to support people in the home. During lunch time we observed a staff member supporting one person with their meal. Throughout this time the staff member left the person on six occasions to provide support to other people and staff. This demonstrated there was not enough staff to support people at mealtimes. From 8:00pm until 8:00am two members of staff were on duty with one of these staff working a sleep in duty from 10:00pm. Care plans gave no detail of the support people needed at night. There had been no analysis of staffing levels with regards to people's needs at night so it was not possible to establish there was enough staff at night to meet the needs of people.

The failure to ensure sufficient numbers of staff at all times to meet people's needs was a breach of Regulation 18 of the Health and Social Care 2008 (Regulated Activities) Regulations 2014.

The recruitment records of the only member of staff to be employed since the last inspection detailed all the necessary checks and references had been undertaken.

Staff had access to the policy on infection control and additional information on the subject was available to staff. The home looked superficially clean but there was a lack of attention to detail for some issues of cleanliness and infection prevention. Two toilets had faecal staining and under three commodes there was significant staining. Five rooms including a bathroom did not have hot water and in two toilets there was no hand towels. The prescribed creams of one person were found in the room of another person which meant that there was a risk of cross-infection. Two sheets on beds were stained and three bottom sheets did not fit the beds properly. One toilet seat was old and scratched which made it difficult to clean thoroughly.

There was a lack of attention to detail regarding the cleanliness and upkeep of the home's premises and equipment which meant that the provider was in breach of Regulation 15 of the Health and Social Care 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service safe?

At the last inspection the provider was in breach of regulation13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, because medicines were not being managed safely. At this inspection we found the provider was still in breach of the corresponding 2014 Regulations with regard to medicines.

The stock control and ordering of medicines was in order. Storage of medicines was safe. The provider had an effective system of the management, recording and storage of controlled medicines. However, there were problems with staff's knowledge and competency in administering medicines safely. A care staff member asked us why "CQC needed to check the drugs?" which demonstrated they were not clear about quality assurance processes to ensure the safety of people regarding medicines. When we asked them what a particular controlled drug was for they did not know. This did not demonstrate good product knowledge, even though the care staff member administered medicines. The staff member had worked at the home for a year and had undertaken medicines training when they started working at the home but had not had a competency assessment. We could therefore not be assured they were competent to administer medicines. We observed a staff member giving medicines which did not demonstrate the level of skill we would have expected. A person was given liquid paracetamol in a small measuring tub. This type of paracetamol tends to stick to the side of the tub. Drinking from one of these tubs is extremely difficult because it is necessary for the person to bend their neck fully backwards to empty the tub. For an older person with mobility impairments it would be impossible to bend the neck far enough back to ensure the fluid in the tub was emptied into their mouth. The person had three attempts but there remained some syrup in the tub. The care staff member did not seem to notice this and the person was not offered a drink of water during or afterwards as would be good practice. Four people had been prescribed parcetamol as necessary (PRN) and four people also had stronger analgesics prescribed to be given on an as required basis for pain relief. No PRN protocols or care plan had been developed to guide staff to the use of these and how to monitor their effectiveness.

The lack of staff knowledge regarding medicines and poor practice in administering them was a breach of Regulation 12 of the Health and Social Care 2008 (Regulated Activities) Regulations 2014.

At the last inspection the provider was in breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 because there were shortfalls in how the service safeguarded service users from abuse. At this inspection we found improvements had been made and the provider was compliant with the current regulations regarding safeguarding. Policies and procedures were available for staff regarding safeguarding people. Staff knew the principles of the safeguarding policy and confirmed they had received training in this area. The local authority has advised us the service now makes safeguarding referrals appropriately.

People's care records now included more detailed and relevant risk assessments. Staff had the time to read the care plans. These included areas where people may be at risk of harm or injury. Personal Evacuation Plans with maps of the exit routes to take in case of fire were included in people's care records. These included a diagram of the home with the person's room identified and the exit route from their room to the outside showing each fire door and how long people would be safe behind these doors. Records were being maintained and reviewed regarding accidents, incidents and pressure ulcers.

Requires improvement

Is the service effective?

Our findings

One person told us there is not always a choice about what food they have. They told us "Sometimes we just have to have what we are given even though we know it was not what we asked for, because I am not going to ask for something I don't like am I". Another person when asked told us the food "Is alright".

There was a programme of training which was provided to staff from an outside training company. The areas of training provided to staff included infection control, safeguarding, nutrition and hydration, health and safety, moving and handling and dementia. We could see there was a rolling programme of training, with subjects being booked annually. However from observations on the day we could not be assured staff were able to learn and put into practice their expected learning from such training. For example we observed inappropriate moving and handling techniques which put the safety of people and staff at risk. We saw a staff member lift a person's foot off the ground when they were standing to try and assist them to move. We witnessed staff not having the skill to care for people who were living with dementia. They spoke to people and offered care in inappropriate ways. For example, one staff member raised their voice when they could not get a person to move out of a chair in a timely way.

The one staff member who had joined since the last inspection had records to demonstrate they had received an induction programme. Staff received supervision and records were maintained of these sessions, but matters of training and observation of practice were not detailed at these supervision sessions. The learning undertaken by staff was not being monitored to ensure staff were putting into action their learning on a practical basis, and as such there was a lack of professional development and supervisions with such feedback/observations given to staff. When we looked at the training certificate for moving and handling, we found the following statement on the back, "The candidate has been shown how to use the equipment but will need to be supervised and have competencies agreed by the in-house moving and handling advisor". The manager had not considered this information and told us they believed staff were competent. There had been no assessments to deem competency and no records of the supervision of staff undertaking moving and handling practices had been completed. During our inspection, we identified concerns about how staff supported people to move. For example people were moved in wheelchairs without the foot guards being in place. On one occasion one person's feet were banged into the wall. On this occasion it was only gently and no harm was caused, but there was potential for harm due to inappropriate moving and handling.

The lack of effective training to ensure staff were competent and skilled was a breach of Regulation 18 of the Health and Social Care 2008 (Regulated Activities) Regulations 2014.

At the last inspection the provider was in breach of regulation18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 because matters of consent were not fully understood or implemented. At this inspection we found the provider was now compliant with the regulations with regard to consent to care and treatment

The Mental Capacity Act 2005 (MCA) provides a legal framework for acting and making decisions on behalf of people who lack the mental capacity to make particular decisions for themselves. The Care Quality Commission (CQC) monitors the operation of DoLS which applies to care homes. These safeguards protect the rights of people using services by ensuring if there are any restrictions to their freedom and liberty, these have been authorised by the local authority as being required to protect the person from harm. Two people in the home had a DoLS in place and an application had been submitted for another person. However, staff told us no one in the home was restricted in anyway. This demonstrated they did not know what having a DoLS in place meant. Both staff members told us they had heard of the Mental Capacity Act but could not explain what it related to. Despite staff not having an understanding of the MCA and DoLS people's care records gave a clear account of decision specific capacity assessments. Best interest care plans were in place. Where a DoLS application had been made this had been incorporated into the relevant sections of the care plan.

People's records included information on their nutritional needs. Where people had individual needs, for example diabetes or their food being liquidised this information was included in their care plans. Where appropriate, referrals had been made to the speech and language therapist and their advice had been recorded into care plans. Malnutrition Universal Screening Tool (MUST) and weight

Requires improvement

Is the service effective?

charts were maintained on a monthly basis. Ten people had their lunch in the dining room, during this time three people needed support and one person needed support in their room with eating their meal. A great emphasis was placed on people finishing their meals and people were told they were “Doing well” when eating and drinking.

People had access to a range of health professionals who visited the service. Their involvement was written in care plans. One health professional on the day told us the provider contacted them appropriately.

Inadequate

Is the service caring?

Our findings

One person told us "Most of the staff are nice and kind, some not so much."

At the last inspection the provider was in breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 as they were not meeting the standards with regard to respecting and involving people. At this inspection we found the provider was still in breach of the corresponding 2014 Regulations.

Some observations of staff interacting with people were friendly and staff at times seemed to know people well. However, at other times staff lacked the skills to know how to treat people with respect and dignity. We saw examples of staff interactions which were poor. For example, one person who was having difficulty moving had a staff member lean into their face, telling them, "Come on lets have another go". This demonstrated a lack of respect for the person. On another occasion a person was walking through the lounge to the dining room for lunch. A staff member in a loud voice said, "You need to go to the toilet". The person replied they had already been. This conversation took place in front of other people. This did not demonstrate privacy or respect for the person.

At lunch time a staff member sat supporting a person with their lunch. On one occasion the staff member turned around to another person at a separate dining table and asked them "Are you eating those carrots"? This was disrespectful to the person the staff member was supporting and to the person who may have not wanted to eat their carrots. Later when this person who was not being supported tried to leave the dining table the staff member moved to block their exit and told them, "…(name) sit down". The person replied, "I was just going to move away". The staff member replied, "No put your legs back and round and drink this please". The person had their cup of tea and glass of water placed in front of them. This showed a lack of respect of the person and their choice. The approach the staff member took did not demonstrate they upheld the person's dignity. The staff member then sat back down and continued to support the first person they had been supporting to eat their lunch. The staff member then got up again and said to a third person, "Drink your tea for me please". The staff member showed a lack of respect for the person they were supporting to eat their meal by repeatedly leaving them during the time they needed support. The third person was unable to leave the table as they were sat in a wheel chair and needed staff to support them with this movement. This person showed signs of distress, and started mumbling and knocking on the table. The staff member then went back to the person who had wanted to leave the dining table and thanked them for drinking their water and said to them, "Drink your tea now please, then I can wash your cup". Once the person had finished their drink the staff member asked them if they would like to leave. As the person left the dining room the staff member said in a loud voice, "Do you want the toilet, I do not want you to have an accident as we would have to change you over again". This again was said in front of other people in the dining room. When two staff had assisted a person into a chair in the dining room, one staff member "played" a game with them known as 'Incy Wincy Spider'. This was not likely to be an appropriate activity or game to play with the person and was more disrespectful in that it took place in the public lounge, risking further disrespect. These interactions demonstrated people were not treated with respect and dignity. They were not listened to or supported in their choices.

We observed a person lying asleep on top of their bed with their door open. Their top half was covered but from the waist down they were exposed down to their absorbent pad. We saw this person was in an exposed position for at least 45 minutes. Staff brought the person's supper up and left it on their side table but did not wake them or cover them up. This was an undignified position to leave the person in. We spoke with the registered manager about this who reported the person had eaten their meal. We explained we were not concerned about the meal but about the person's privacy and dignity. After some discussion the registered manager understood the issues we were concerned about.

The lack of respect for people and their dignity and privacy was a breach of Regulation 10 of the Health and Social Care 2008 (Regulated Activities) Regulations 2014.

Care records included evidence people had been involved with their care plans. It was also evident people's relatives and significant others had been included in the development of more person centred care plans.

Requires improvement

Is the service responsive?

Our findings

One person, who was independent and accessed the community alone, told us they were happy with the care they received. They told us they had a care plan but felt the manager knew their needs.

At the last inspection the provider was in breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 because there were shortfalls in care planning and risk assessment. At this inspection we found the provider had reached compliance with the corresponding 2014 Regulation but improvements were still needed.

At this inspection care records included details of people's pre admission assessments and care plans. Care plans and recording had improved. People and their relatives had been included in the development of care plans. Care plans had been reviewed on a monthly basis and included updated information.

Care plans were split into eleven main areas which then had a score next to them to give an indication of the level of dependency. Each section contained an assessment to test if the person had capacity to understand the care plan and associated risks. If it was deemed the person did not have capacity a best interest decision had been recorded. Care plans gave specific information relating to the person. For example, where someone had been diagnosed with diabetes there was information on this subject and how it could affect the person. Monthly reviews included a review of the Waterlow score (this gives an estimated risk for the development of a pressure sore in a given person), and MUST (Malnutrition Universal Screening Tool) which is a five-step screening tool to identify adults who are malnourished, at risk of malnutrition or obese. Monthly weight checks had been recorded.

There were small areas where care plans could have been improved. For example where a care plan identified a person was prone to urinary tract infections (UTI), this was detailed. However when someone had been diagnosed with a UTI, no short term care plan was in place. There were no charts recording triggers or details relating to behaviours from people who may challenge the service or other people, such as time of occurrence, frequency and interventions that helped to ease distress, including mindfulness about the possibility the person had pain. This meant that opportunities to intervene or implement individual tailored plans was not always well supported.

Whilst we found care plans and records had improved in their written form there was concern staff were not ensuring they followed the guidance in care plans. For example, when supporting a person who had problems with their mobility, the care plan detailed the person had 'good' and 'bad' days. Staff had not followed the guidance included in the care plan. When supporting this person two staff members showed signs of frustration. They did not offer the person reassurance and demonstrate patience as the care plan detailed. Whilst assisting the person, they regularly spoke over them. We heard staff saying to each other, "They hear they just don't do it", "She is difficult at times this one". This demonstrated that staff failed to follow the guidance in the care plan.

Activities took place in the home, but it was not possible to establish these were to meet individual needs. There was no programme of individualised activities that reflected individual preferences and interests. Late in the morning a staff member was sitting with eight people in the lounge area. They engaged people in a quiz. Only two people participated but the quiz continued. The staff member then suggested a sing-a-long. They started with "Old MacDonald's Farm". Two people participated briefly then appeared to not wish or be able to take part further. Another nursery rhyme was sung then the national anthem which also appeared to only get people briefly interested and involved. This was not an activity that involved all of the eight people because six people did not join in the activity. Despite this there was only one group activity on offer.

A complaints policy and procedure were available in the home and this was accessible to visitors. The registered manager told us they had received no complaints so they had none to record in the complaints log.

Inadequate

Is the service well-led?

Our findings

One person told us they were reluctant to speak with the manager, believing it would not do any good. Another person told us they would speak to the manager if they were unhappy.

The home has a registered manager in post who was also the nominated individual of the registered provider. We were told by them due to financial reasons they had started to carry out some duties on the rota in a caring role. These shifts were identified on the duty rota

At the last inspection the provider was in breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, because of ineffective quality assurance systems. At this inspection we found the provider was still in breach of the corresponding 2014 Regulation. Following the last inspection the provider sent us updated action plans detailing what action they were and had taken to reach compliance. When we arrived at the service for this inspection the provider told us they believed they were now compliant with all regulations. However we found evidence of continued and new breaches of regulations at this inspection and as such the provider's action plan and audits they used were not effective in driving improvements across the service.

A range of audits were conducted each month. These included an infection control audit. The last audit at the end of May 2015 found that the service was compliant with all the checks. However, we identified areas of the home which were not clean, which had not been picked up by the audits. This demonstrated the audit was ineffective. The medicines audit in May 2015 also showed things were satisfactory. This had not picked up the concerns about PRN medication or about the lack of skills and knowledge by the staff member we observed. This demonstrated the audit was ineffective. We have identified that training was offered in the home but were not assured during this inspection that staff's day to day practice in implementing areas of learning from training was taking place. There was no analysis of the training to ensure it was effective. Whilst staff had received training on moving and handling the registered manager had not completed competency assessments on staff to ensure they were competent. This made it difficult to demonstrate how the manager ensured quality was an integral part of the daily systems to ensure systems were effective and used to drive continuous improvement.

The lack of an effective quality assurance system was a breach of regulation 17 of the Health and Social Care 2008 (Regulated Activities) Regulations 2014.

When we arrived at the home we found the inspection report which was displayed on the notice board was not the latest inspection report. We also found the ratings from the previous inspection were not displayed which the provider was required to do. Providers must ensure that their rating(s) are displayed conspicuously and legibly at their care homes and on their website (if they have one). When asked the registered manager was unable to give an explanation as to why they had not displayed their ratings. They advised us they knew they had to, but had just not displayed them. They then went on to show us they had the ratings ready to display, but were unable to answer why they had not displayed the ratings and the latest report. Both these were displayed on the noticeboard before we left the inspection. A subsequent check on the provider's website showed this had not been updated recently. The website had not been updated to reflect the regulator had changed to the CQC, it reflected the regulator was the CSCI which was a predecessor organisation to CQC and ceased to operate in 2009. It was not possible to download any reports from the provider's website.

The failure to display ratings was a breach of Regulation 20A of the Health and Social Care 2008 (Regulated Activities) Regulations 2014.

It was difficult to establish if an open culture existed at the service. We could only speak to one member of staff and an agency worker. The permanent member of staff reported they felt able to discuss any issues with the registered manager. One person told us they would not want to speak to the manager as they advised "This would cause problems". Regular minuted staff meetings had taken place. In the minutes from the staff meeting in March 2015 the following was recorded. "How we speak to people. Treating people with respect and dignity (name) discussed their views with staff on their thoughts on this. (Name) discussed the power and control of people on a daily basis to vulnerable people and bottom line is no form of abuse will be tolerated. It is very important that all remain

Inadequate

Is the service well-led?

professional". This raised concerns that some of the staff interactions we saw which were inappropriate had already been recorded but had not been addressed effectively with staff.

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 18 HSCA (RA) Regulations 2014 Staffing **Staffing levels were not adequate to ensure at all time service user's needs could be met.** **Training was not monitored to ensure it was effective to give staff the skills they needed to care for people.**

The enforcement action we took:
We are considering the most appropriate enforcement action in response to this breach.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment **There was a lack of detail regarding the cleanliness and upkeep of the premises.**

The enforcement action we took:
We are considering the most appropriate enforcement action in response to this breach.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Staff had not been deemed competent and did not have the knowledge of medicines to ensure people's safety.**

The enforcement action we took:
We are considering the most appropriate enforcement action in response to this breach.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect **Staff demonstrated a lack of respect for people's privacy and dignity.**

This section is primarily information for the provider

Enforcement actions

The enforcement action we took:
We are considering the most appropriate enforcement action in response to this breach.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance The quality assurance system was not effective to ensure the health, safety and welfare of service user's.

The enforcement action we took:
We are considering the most appropriate enforcement action in response to this breach.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 20A HSCA (RA) Regulations 2014 Requirement as to display of performance assessments The ratings from the previous inspection had not been displayed.

The enforcement action we took:
We are considering the most appropriate enforcement action in response to this breach.