Tapton Care Limited

The Porterbrook

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**

Summary of findings

Overall summary

The inspection was carried out on 30 May and 2 June 2017 and was unannounced. This meant the provider and staff did not know we would be visiting. This was the first rated inspection since its registration with the Care Quality Commission on 7 November 2016.

The service had 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.

The Porterbrook is a purpose built home with accommodation situated on the ground and first floor. The home accommodates up to 44 people who require personal care. It is situated on the outskirts of Sheffield and is close to local shops and amenities. At the time of the inspection there were 21 people living at the home.

Before this inspection we received information of concern. Concerns were in relation to staffing levels, staff training and competencies and the management of medication. We therefore brought this comprehensive inspection forward.

The provider had safeguarding procedures in place and staff were aware of the procedures. However, we found people were not always protected from abuse. We sent safeguarding referrals to the local authority following our inspection.

Care records were not always fit for purpose. Some lacked detail, while others had not been completed. Risk assessments were not sufficiently detailed to ensure staff could meet people's needs. We identified instances where care was not being provided in accordance with people's assessed needs.

People were not always protected against the risks associated with the unsafe use and management of medicines. Appropriate arrangements were in place for the recording, safe keeping and safe administration of medicines but these were not always followed.

We found staff approached people in a kindly manner. However, most of the interactions were only brief as they were extremely busy meeting people's personal care needs. We observed people had to wait for assistance and staff were not always present in communal areas to ensure people's safety. This indicated to us that there was insufficient staff deployed to meet the needs of people who used the service.

Staff recruitment processes were not sufficiently robust. Some staff files only had one reference and others did not have any documents to confirm their identity. Staff did not receive sufficient support and formal supervision. Staff clearly told us that they did not feel supported. Yearly appraisals had not been completed as the home had only been providing care for a number of months.

Training and induction of staff was not sufficient to ensure staff had the competencies and skills to meet the needs of people who used the service. We were told by staff and relatives and we saw evidence that there was a high turnover of staff which was a concern.

We found the service was not always meeting the requirements of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS). The staff we spoke with had a satisfactory understanding and knowledge of this, and people who used the service had been assessed to determine if a DoLS application was required. However, we found it was not being carried out in practice and best interest decisions were not considered.

A well balanced diet that met people's nutritional needs was provided. However, we found people who were at risk of weight loss and people who required encouragement to eat, were not always supported appropriately.

Best practice guidance was not always followed for people living with dementia in respect of managing behaviour that may challenge and adaptations to the environment.

Activities in the home were infrequent. Relatives and people who used the service that we spoke with raised concerns about the lack of social stimulation.

People's needs were not identified and many people did not have plans of care in place. This meant staff were not always aware of people's individual needs and how to meet their needs.

People and their relatives we spoke with were aware of how to raise any concerns or complaints. They described some complaints they had raised. However, we found the registered manager had not recorded these and told us they were only aware of one that was received the day of our inspection.

There were processes in place to monitor the quality and safety of the service. However, these were not effective and had not identified issues we found at the inspection.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures.'

Services in special measures 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.

If not enough improvement is made within this timeframe so that there is still 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 this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to 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 so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than

12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

We found 5 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 end of this report. However, following our inspection the provider agreed to a voluntary suspension of any further placements until improvements had been made. They have also provided an action plan of intended improvements.

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.

People were not always protected from abuse.

Staffing levels did not enable people's needs to be met in a timely way or in keeping with their preferences.

Risk assessments were not sufficiently detailed to ensure staff could meet people's needs.

Recruitment procedures were not sufficiently robust to ensure the right people were employed to work with vulnerable people.

Medicines were not managed safely.

Is the service effective?

Inadequate

The service was not effective.

Staff supervisions had not been completed for all staff, as required by the registered providers policies and procedures. Induction and training was not adequate or up to date.

The service was not always meeting the requirements of the Mental Capacity Act 2005. We found best interest decisions were not considered.

We found lack of evidence that people received adequate nutrition to meet their needs.

Best practice guidance was not always followed for people living with dementia in respect of managing behaviour that may challenge and adaptations to the environment.

Is the service caring?

Requires Improvement

The service was not always caring.

Care plans were not always up to date. It was difficult to determine if people's wishes were listened to or respected.

Staff interactions we observed were kindly and caring. However, staff had very little time to interact in a meaningful way.

Is the service responsive?

Inadequate

The service not responsive.

Peoples care needs had not always been identified and some people did not have plans of care in place to guide staff.

People were unable to access regular activities. We saw no activities taking place on the first day of the inspection.

There was a complaints system in place; no complaints had been recorded. However, relatives we spoke with told us they had raised concerns.

Is the service well-led?

Inadequate

The service was not well-led.

There was a distinct lack of communication, leadership and direction within the service which had not been identified by the provider.

The culture of the service was not positive, open or inclusive.

The Porterbrook

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 30 May and 2 June 2017 and was unannounced.

The inspection team consisted of three adult social care inspectors.

Prior to the inspection visit we gathered information from a number of sources. We looked at the information we received from notifications sent to the Care Quality Commission by the service. We also contacted Sheffield commissioners and safeguarding to gather further information about the service.

We did not request a provider information return (PIR) from the provider because the inspection was brought forward due to concerns we had received. The PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We spoke with the registered provider, registered manager, three senior care workers, three care staff, the head of care, the facilities manager, the cook, the kitchen assistant and the activities co-ordinator. We also spoke with seven people who used the service and six visiting relatives. Observations helped us evaluate the quality of interactions that took place between people living in the home and the staff who supported them.

We used the Short Observation Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. We looked at other areas of the home including the outside garden space, some people's bedrooms, communal bathrooms and lounge areas.

We looked at documentation relating to people who used the service, staff and the management of the service. We looked at six people's written records and we looked at the electronic records of 20 people. We also looked at the systems used to manage people's medication, including the storage and records kept. We

also looked at the quality assurance systems to check if they were robust and identified areas for improvement.

Inadequate

Is the service safe?

Our findings

We spoke with people who used the service to assess if they felt safe in the home. People that we were able to speak with told us they did not always feel safe. One person said, "I have had to start locking my bedroom door as I found a person in my bedroom and this made me afraid." Another person said, "I like it here, the majority of staff are okay. We sometimes have to wait for them to come, they do come eventually." Relatives we spoke with told us that most staff were kind and caring but they were so busy that most interactions with people who used the service were very brief.

We brought this inspection forward because we received information that people may not be receiving the care they needed as there was not enough staff. The information also raised concerns that some staff had left and some staff were not trained to care for people who displayed behaviours that may challenge others.

We were shown a list of staff that had left the service from when it had been registered to commence providing personal care in November 2016. We found that 15 staff had either resigned or had been dismissed from their positions. This confirmed high levels of staff turnover. Relatives raised concerns that due to the high turnover of staff some staff were new to the home and did not understand their family member's needs. One relative said, "There have been a lot of changes. This has meant sometimes there is not enough staff. Agency staff are sometimes used but they are not familiar with people's needs."

We looked at the number of staff that were on duty on the days of our inspection. We checked the staff rosters to confirm if the number was correct with the staffing levels they had determined. We saw the rotas were not a true reflection of the staff on duty. For example, on the first day of the inspection the manager on duty was off work. We also identified that a member of staff on duty was not included on the rota. This meant the most senior person in the service on the first day of the inspection was a senior carer. We were told by staff that they had worked short staffed on many occasions due to sickness and lack of staff employed. On Friday 26 and Saturday 27 May 2017, staff told us they only had three staff on duty during the day, which was not enough to meet people's needs. Prior to our inspection there had been a large number of admissions to the home over a two week period however staffing levels had not been monitored or reviewed to ensure there were enough staff to meet people's needs.

We raised these shortfalls with the registered provider on the first day of the inspection. We were given assurances that the levels would be increased to ensure people were safe. When we returned on the second day of the inspection we found sufficient numbers of staff were on duty. However, three of the six care workers were agency staff who did not know people's needs as they had not worked at the service before and there was lack of care documentation that identified people's needs..

From our observations and discussion with staff we found there was insufficient staff to safely meet the needs of people who used the service. Two people were displaying behaviours that may challenge others. Staff found it difficult to divert or manage their behaviours as they were trying to meet other people's personal care needs. This had impacted on other people who used the service as they had to ensure the two people did not exit the service. Staff told us that on one occasion they were left alone to care for people.

They said that three other seniors care workers were on duty but were attending training. Therefore they were not able to offer assistance. The staff member told us that one person had left the building during this period which put them at risk of harm. The staff member told us they were not able to monitor their whereabouts to prevent them from leaving the home.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at eight staff recruitment files and found some files did not contain a second reference. The registered manager told us that they would start a new staff member with one reference only if their Disclosure and Barring Service (DBS) check had been received. The registered manager said the administrator/receptionist would then follow-up the missing reference. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with vulnerable adults. This helps to ensure only suitable people were employed by this service. The administrator/receptionist confirmed that at least 10 staff files where they had not obtained either a second reference or a photograph to confirm their identity. We looked at the recruitment policy which started that two references should be obtained prior to the commencement of employment.

This meant the registered provider was not following the services procedures when employing new staff to work with vulnerable people.

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

Staff told us that they had received training in safeguarding vulnerable adults. We spoke with five members of staff who were able to tell us how they would respond to allegations or incidents of abuse, and also knew the lines of reporting in the organisation. Staff were also aware of the registered providers whistle blowing policy and told us they would feel confident in reporting any concerns they had to the appropriate person. Whistleblowing is one way a worker can report suspected wrong doing at work by telling a trusted person in confidence.

However, we found people were not always protected from abuse. We identified four safeguarding incidents during the two days of our inspection and made referrals to the local authority safeguarding team. For example, we observed one person being moved inappropriately putting them at risk of harm. We also found one person had a pressure ulcer that care staff were not aware of and the advice given by a health care professional was not being followed. This also put this person at risk of harm.

Risks associated with people's care and support was not always managed positively and appropriately. For example, we found one person consistently tried to leave the building during the inspection. There was no risk assessment to guide staff on how they should manage the risk and to keep the person safe without the person feeling their freedom was unnecessarily restricted. We received information from a relative that gave us cause for concern around the management of this risk and prior to the inspection we raised this as a safeguarding alert to the local council.

We looked at the systems in place for managing medicines in the home. This included the storage, handling and stock of medicines and medication administration records (MARs).

We found medication procedures were not always followed to ensure people received medication safely. The medication trolley was left open and unattended when medicines were being administered. We saw

that one staff who was dispensing medicines was giving these to another staff member to administer to the person, this is secondary administration and this is unsafe practice. We saw the medication room was also used as an office and the door was not locked. There was a medication trolley full of medicines that was not locked in the room and the medicines to be returned were stored in an open box on the floor. This was not safe practice as anyone could gain access to this room and the medications. We saw medicines were not disposed of in line with the providers procedures. Both senior care staff we spoke with, were not aware of a returns book that should be completed when medicines were disposed of to ensure all medicines could be accounted for.

We found people were prescribed medication to be taken as and when required known as PRN (as required) medicine. For example, pain relief and medicines to alleviate agitation. We found people did not always have PRN protocols in place. These would detail when to give PRN medication and explain how people presented for example, when they were in pain and agitated. Staff told us people who were prescribed these medicines were not always able to tell staff when they were in pain or distressed due to their medical conditions. This meant that people who used the service could be in pain or distressed and not have medication administered as staff did not know what signs to look for to determine when it was required.

We found on occasions people did not receive topical medication as prescribed. We found an additional MAR was available in people's rooms for care staff to sign when the creams had been applied. We looked at a selection of these MAR's and found staff did not always sign that the creams had been applied as prescribed. These had not been reviewed or evaluated by the senior staff to determine the topical medications were being administered or if they were effective.

The medication was administered by staff who had received training to administer medication. However, it was not clear if this was effective as we observed staff not following safe procedures. When we spoke with the head of care they told us that two of the senior staff had not received any competency assessments since they commenced in post. The staff who had not received competency assessments were on duty on the days of our inspection administering medicines. Therefore the registered manager had not ensured people received their medicines by competent staff. We were also told that one other senior care worker had not passed their competency but was still administering medications.

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

The home was a well-proportioned two storey building with plenty of space for people to move around freely. The home was furnished to very good standard and there was an outdoor seating area on the first floor. We saw there was an enclosed outdoor space on the ground floor but this could not safely be accessed due to two steps leading from the lounge area. The surface in the area would not be suitable for people with poor mobility of for anyone using a walking frame or wheelchair. On the days of our inspection it was very warm yet people were not able to access the outside areas.

Inadequate

Is the service effective?

Our findings

Some relatives we spoke with expressed concerns about the care provided. However, most said they thought staff were kind, caring and friendly. They expressed that staff try to do a good job but they were often stretched so the quality of care was affected. One relative said they thought the regular staff were good at their job. However, another relative said they did not think staff had the right skills and competencies to care for people that were living with dementia or how to deal with people who presented with behaviours that may challenge others.

We spoke with staff about their induction at the home and looked at induction records for a number of staff. One record had not been fully signed off as competent. The head of care told us that it was an error and quickly completed the signing of the record. Staff told us that their induction consisted of one 12 hour shift. This covered things like employment rights, meal breaks, sickness procedures and other administrative records. They told us they also shadowed a more senior staff member for the remaining shift which including the completion of daily records. We discussed the induction with the registered manager who confirmed that they thought one 12 hour shift was sufficient before staff were counted in the number of staff on duty.

The registered manager was aware that staff that had no experience in care should be registered onto the 'Care Certificate.' The 'Care Certificate' looks to improve the consistency and portability of the fundamental skills, knowledge, values and behaviours of staff, and to help raise the status and profile of staff working in care settings. We asked if any members of staff were working towards the Care Certificate and the registered manager confirmed one staff member was working towards the certificate. We asked to see the records of progress but the registered manager was unable to access these as the staff member had taken the work home.

The training matrix showed the training courses each person had completed and what qualifications they had obtained and/or were working towards. All the courses were relevant to their roles and included subjects such as dementia, manual handling and safeguarding, as well as a number of others. However, when we looked at the dates on the certificates we saw some staff had completed training in seven topics in one day. This meant the training could not have been effective. The registered manager told us that they had identified that the training was not sufficient or effective. They told us that they had arranged to meet with the trainer to discuss improvements to the training provided. However, this had not been actioned in a timely way which could impact on the care delivered to people who used the service.

We spoke with staff about the support they received either formally in supervision or informally through staff meetings and hand overs. Supervisions are meetings between a manager and staff member to discuss any areas for improvement, concerns or training requirements. Staff told us they did not feel supported and felt there was a blame culture when things went wrong. We looked at 16 supervision files on the first day of the inspection. We saw three staff had not received any formal supervision. A further six staff had received one supervision on 27/03/2017. When we returned on the second day, the registered manager had produced a supervision matrix which showed nine staff had not received any supervision. However, she informed us that

she thought some supervision had taken place but had not been filed correctly. There was a lack of a systematic and effective approach to staff supervision and training to ensure staff were sufficiently supported and received appropriate training and review to carry out their role. Since our inspection we have received a number of whistleblowing concerns from staff that alleges the supervision records were falsified and staff had not been supervised appropriately.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met.

We asked staff on duty if they were aware of any of the people who used the service was subject to an authorised DoLS. Staff told us that they were unsure or did not know who had an authorised DoLS. On the second day of the inspection the manager was able to show us a file that had applications which had been submitted to the supervisory body. We looked at one of the applications in relation to the person who was constantly asking to leave the building. The application was dated 17/05/2017. However, the person had been admitted into the home on the 14/05/2017 and daily notes indicated that they had been asking to leave the home from their admission date. The urgent authorisation which lasted for seven days had not been followed up by the head of care in the absence of the registered manager. This meant staff had not acted in accordance with the requirements of the Mental Capacity Act 2005 and associated code of practice.

We also found where people lacked the capacity to make a specific decision there was no best interests considered or documented. These would ensure any decisions made in the person best interests were made appropriately following input form relevant staff, health care professionals and family. For example one person was refusing their medication which was having a detrimental effect on them and a best interest decision had not been considered to administer these covertly.

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

We observed meal times as part of the inspection; we observed that the kitchen assistants helped with meal service. The interactions between the kitchen staff and people who used the service was very good, they were inclusive, supportive and kind. We saw people were given choices meals were well presented and appetising. However, we identified staff did not always offer appropriate assistance or support to people who had lack of appetite and were at risk of losing weight. We observed one care worker say to a person, 'Have you been puking again today [person's name].' They replied, 'No.' However, the staff member gave no encouragement for them to go through to the dining room and have some food.

Requires Improvement

Is the service caring?

Our findings

We spoke with people who used the service and they told us the staff were nice. One person said, "The staff are kind and good." Another person said, "The staff are very good but just not enough of them."

All people we spoke with told us the staff were kind and caring. One person said, "They respect me and they look after me, but they are very short staffed."

People told us they had problems with the laundry and many of their clothes had gone missing or not been washed appropriately. One person said, "I found my wool jumper put back in the wardrobe and it had been shrunk, no one told me." Another person said, "I found another person's clothes put away in my room." This showed a lack of respect for people's belongings.

Relatives told us they thought the care was good, but felt that the home was short staffed, they said, "Staff do their very best but it's difficult when there are not enough of them." However, relatives we spoke with also told us staff lacked the skills to be able to meet the needs of people living with dementia. They felt this impacted not only of the people whose needs they were struggling to meet but on the other people who lived at The Porterbrook as the behaviour presented by some people impacted on the service.

We observed staff interacting and found these were inclusive, positive and kind. However, they were usually very brief as the staff were busy and on many occasions when we observed communal areas with no staff presence. Relatives we spoke with told us when they visited on some occasions they were sat in the lounge with their relative and other people for over two hours and said they didn't see staff in all that time.

Staff were not always aware of people's needs as there were no records in place. There was also no record of peoples likes, dislikes, choices or decisions in care files we looked at, therefore staff were not able to support people appropriately. There were no life histories documented for people, these would have helped staff understand people hobbies and lifestyle.

Inadequate

Is the service responsive?

Our findings

We looked at care plans and found they were not always a true reflection of people's current care needs. The care plans were on an electronic system and we found twelve people out of the twenty one did not have a care plan for staff to be able to understand what people's needs were and how to meet their needs. The system had a section for care plans and when we asked a senior care worker why there were no care plans; they told us, "I have not seen this section, don't know what it is, we use the forms section." We were shown this section and this was where it was possible to create forms for health care professional's visits', incidents and accidents. It was not intended for the care plans; however, we found among the forms in some people's records that the odd risk assessment and care need was documented. These were difficult to find and not user friendly. This meant care staff did not have access to records of peoples care needs. It was very difficult to ascertain what people's needs were and care staff we spoke with were not clear on people's needs and preferences. For example, one person was required to be weighed weekly to monitor any weight loss. The senior care worker we spoke with was not aware of this. This put the person at risk from further weight loss as they were not being appropriately monitored which could negatively impact on the health and wellbeing.

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

There was a dedicated activity co-ordinator employed at the service who worked five days a week. However, we were told they had been off over the bank holiday weekend so no activities had been provided. Relatives and people we spoke with told us there was lack of social interaction. Relatives told us they had been promised that people would be taken out to be able to access the community as there was transport available. They told us this hadn't happened and were very disappointed. One relative told us they had arranged an outing and on the day it was unable to go ahead as someone else was using the transport to go to a hospital appointment.

We saw activities taking place on the second day of our inspection; eight people were taking part in movement to music and reading newspapers. There was also a beauty therapist employed to work one day each week. Due to staff being busy we saw they were unable to effectively interact with people who used the service to provide social stimulation and inclusion to those who could not join in the planned activities. The complaints log showed there had been no complaints made to the home since the home opened in November 2016. We saw there was a policy and procedure in place for any complaint's received to be investigated and responded to. The complaints policy/procedure was on display in the home and included in the 'service user guide.' The policy included the details of relevant organisations such as the local authority should people wish to raise concerns directly to them and included timescales for responses.

We spoke with three relatives about the concerns they had raised with us. They told us that they had raised them with the registered manager. Their concerns were about the staffing levels, training of staff and the deterioration of the service. They also reported a number of missing items of clothing which had been sent to the laundry and not returned. One relative said, "I don't know what is happening but the atmosphere has

changed. Staff appeared stressed and extremely busy but no-one is telling us anything." Another relative told us communication was poor. They told us that they had been asked to take their family member to hospital for treatment but when they got to the hospital they had been given the wrong day for the appointment. Transport was provided by the home to return to the hospital for the appointment on the correct day but they were unhappy that they had to share the transport with another family who were going to another hospital. When they rang the home to be picked up they were told the driver had gone home which meant they had to sort out a taxi to get their family member back to the home.

Although the relatives told us they had raised this with the registered manager, they told us that the issues raised with us during the inspection had not been brought formally to her attention. There was a lack of recognition from the registered manager in what constitutes a complaint and what should have been recorded in the complaints file. The registered manager agreed to formally respond to the above concern and record the findings and outcomes in the complaints log.

Inadequate

Is the service well-led?

Our findings

Relatives we spoke with told us that they thought the staff were not adequately trained to meet the needs of people who used the service. The registered manager told us that they had identified that the training was not sufficient or effective. She told us that she had arranged to meet with the trainer to discuss improvements to the training provided. However, this had not been actioned in a timely way to ensure staff were suitably trained to carry out their role.

Staff we spoke with told us they did not feel supported in their role. Staff said they were unsure how to access the care records as information was not consistently stored on the electronic record. We found the two available laptops used by staff to record care plan entries required charging and staff could not find the cables to charge them. Care staff could only access one laptop as the other was used by the senior care worker when administering medication. Staff told us they did not feel as though they could contribute to the development of the service and there was a blame culture when things went wrong.

We looked at staff meetings minutes which told us that staff were not actively encouraged to go to the registered manager for assistance or advice. The minutes told staff to knock and wait until she says they can enter. This meant that staff felt this prevented them from seeking advice and support from the registered manager.

The head of care, the head of facilities manager and administrator/receptionist showed us their 'to do list' to complete in the absence of the registered manager. For example the lists included updating and compiling care plans and chasing missing documents from staff recruitment files. They told us that they found it difficult to work through the lists as they were often supporting staff with personal care and undertaking cleaning duties. We asked to see their job descriptions. However, the registered manager told us they had not been developed as she had created the positions. She told us that she was to arrange a meeting to discuss and develop the job descriptions. No timescales were given to complete this task.

There were processes in place to monitor the quality and safety of the service. However, we saw these were not effective. For example, the care plans had been audited but had not identified that they were inadequate as they did not detail people's needs or risk and how to manage these. We also found effective audits of medication had not been carried out. Medication audits had been completed on a monthly basis from January 2017 to April 2017, all had been assessed as 97% compliant, however we had found systems had not been followed. Every audit had identified that staff competency needed to be completed. Yet no action had been taken to address this issue as we identified staff still required competency assessments.

Prior to our inspection there had been a large number of admissions to the home over a two week period however staffing levels had not been monitored or reviewed to ensure there were enough staff to meet people's needs. Although some relatives told us they had raised a complaint these had not be recognised or logged as a complaint to ensure they were appropriately addressed and enable monitoring of themes and trends so that overall improvements in service provision to be made.

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

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 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 RA Regulations 2014 Need for consent People were not fully consulted about the care and treatment. Where people lacked mental capacity legal requirements were not always followed

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider did not ensure people were protected from abuse.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider has failed to deploy sufficient suitably competent staff to meet the needs of people who used the service. Staff should receive supervision and appraisals to develop their skills suitable for their role within the organisation.

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 17 Registration Regulations 2009 Notification of death or unauthorised absence of a person who is detained or liable to be detained under the MHA Quality monitoring systems were not effective to ensure compliance with the regulations.

The enforcement action we took:

We have issued a warning notice.

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 receive safe care and treatment and were not protected against the risks associated with the management of medications

The enforcement action we took:

We have issued a warning notice.