

Dr Sunita Nagpal and Partners

# Salisbury Residential Home

## Inspection report

20 Marine Crescent  
Great Yarmouth  
Norfolk  
NR30 4ET  
Tel: 01493 843414  
Website:

Date of inspection visit: 26 November 2014  
Date of publication: 26/01/2015

### Ratings

#### Overall rating for this service

Inadequate



Is the service safe?

Inadequate



Is the service effective?

Inadequate



Is the service caring?

Requires Improvement



Is the service responsive?

Requires Improvement



Is the service well-led?

Inadequate



### Overall summary

The inspection took place on 26 November 2014. The inspection was unannounced. At the last inspection, in July 2014, the provider was meeting the standards that were inspected.

Salisbury Residential Home is a service that provides accommodation and care to older people, people living with dementia, people with a physical disability and people living with a mental health condition. It is registered to care for up to 31 people. At the time of our inspection, there were 26 people living at the Salisbury Residential Home.

This service requires a registered manager to be in place. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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 and associated Regulations about how the service is run. The manager running the service is not currently registered with the CQC. An application has been received from them to register and this is being processed.

# Summary of findings

Staff knew what actions to take in the event of an emergency and how to reduce the risk of people experiencing abuse. However, risks to their safety had not been consistently assessed. Where risks had been identified, the actions required to reduce this risk had not always been identified or followed. People did not always receive their medicines when they needed them and there were not always enough staff to make sure that people were safe. Therefore, people were at risk of harm or of not receiving the care they required to meet their needs.

Staff told us that they were happy working at the service and that they received good support from the manager and provider. However, staff had not received sufficient training to give them the knowledge and skills they needed to care for people effectively, particularly those living with dementia or who lacked capacity to make their own decisions.

The CQC is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) Deprivation of Liberty Safeguards (DoLS) and to report on what we find. We found that the service was meeting the requirements of DoLS as they had recently requested authorisation from the Local Authority to deprive people of their liberty in their best interests. However, the provider had not always followed the principles of the MCA when making decisions for people and therefore, people who lacked capacity to make their own decisions may not have had their rights protected.

People told us that they enjoyed the food and the provider had referred people for specialist advice where they were concerned that they were at risk of malnutrition. However, some people did not receive the assistance they needed or were not provided with adaptive cutlery to eat their meals that the provider had assessed was needed. This placed people at risk of not receiving sufficient food to eat or not being able to eat their meals independently.

When staff interacted with people, this was done in a kind manner. However, staff did not always treat people with dignity and respect and there were no mechanisms in place for people to be involved in making decisions about their own care.

Some staff did not know the people that they provided care for very well. They did not know their preferences, likes or dislikes. People who were living with dementia were not always given a choice of what they wanted to eat or drink or where they wanted to spend their day. There was a lack of stimulation for people and they couldn't always follow their interests.

People's care needs had been assessed by the provider but guidance for staff on how to meet these needs was not always clear. This led to confusion amongst staff about what care people should receive which placed them at risk of receiving unsafe or inappropriate care.

The leadership of the service had embedded a culture amongst the staff that was not based on providing care to people that was based on their individual preferences and needs. Some practices used were regimental in nature such as providing people with personal care before mealtimes without offering them a choice and staff assisting people to get up in the morning from a written list in alphabetical order. Therefore the care that was being provided was institutionalised.

The systems in place to monitor the quality of the service provided was not effective and people's care records were often incomplete or contained inaccurate information which placed people at risk of receiving unsafe or inappropriate care.

There were 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?

The service was not safe.

Staff knew what action to take in an emergency situation to keep people safe and how to reduce the risk of people experiencing abuse. However, risks to people's safety had not always been assessed or actions to reduce these risks were not being followed.

People's medicines were not being managed safely. There were not always enough staff to help people when they needed it.

Inadequate



### Is the service effective?

The service was not effective.

People saw external healthcare professionals when they needed to. However, staff had not received sufficient training to enable them to provide people with effective care.

The provider, manager and staff did not understand the principles of the Mental Capacity Act 2005 or the Deprivation of Liberty Safeguards. Therefore, there was a risk that people who lacked capacity were not having their rights protected.

People did not always receive enough assistance with eating and drinking when they needed it.

Inadequate



### Is the service caring?

The service was not consistently caring.

When staff interacted with people, this was done in a kind and compassionate manner. However, some staff talked about people in a disrespectful way. Staff did not always understand people's individual needs or know the people well that they were caring for.

People were not involved in making decisions about their own care.

Requires Improvement



### Is the service responsive?

The service was not consistently responsive.

People's individual care needs had not always been assessed and staff were not always provided with clear information to guide them on how to provide people with the care they needed.

People were not always able to follow their individual interests.

Requires Improvement



### Is the service well-led?

The service was not well-led.

Inadequate



# Summary of findings

Staff felt supported and were happy in their work. However, the leadership of the service had embedded a culture where staff delivered care in an institutionalised way and not in line with a person's individual need or preference.

The quality of the service was not being effectively monitored and some people's records were inaccurate.

# Salisbury Residential Home

## Detailed findings

### Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection 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 26 November 2014 and was unannounced. The inspection team consisted of two inspectors.

Before the inspection we reviewed any information we held about the service. This included statutory notifications that the provider had sent us. A notification is information about important events which the service is required to send us by law. We also spoke to the Local authority safeguarding and quality assurance teams.

On the day we visited the service we spoke with nine people who lived at the service, one relative, the manager, the provider, nine care staff and the cook. We observed

how people received care. Some people were not able to tell us about the care they received. Therefore 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.

The records we looked at included; eight people's care records, three staff recruitment files, four staff training records, records relating to the maintenance of the premises, eleven people's medication records and records relating to how the service monitored staffing levels and the quality of the service.

After the inspection, we requested further information from the provider regarding the servicing of equipment that was used to lift and assist people to move, how risks to people's safety had been assessed where they had bed rails in place, information in relation to surveys people had completed regarding the quality of the service provided, how the provider analysed incidents and accidents and information regarding how the provider calculated the number of staff required on each shift. Some of this information was received but not within the time specified.

# Is the service safe?

## Our findings

The manager told us that a number of people living at the service lacked capacity to understand how to use their call bell when they were in their room alone. They confirmed that these people were required to be regularly checked by the staff to make sure that they were safe. However, this information was not always documented within the person's care record and therefore, there was no guidance for staff on how they should manage this risk. This led to confusion amongst staff who were not all able to tell us whether or not people should be regularly checked to make sure that they were safe.

We asked staff about one person who the manager told us could not use their call bell. We received different opinions from staff on how often this person should be checked. These ranged from every 15 to 60 minutes. Some staff were unsure whether the person should be checked at all. One care worker told us that they were not sure how often the person should be checked and said, "We just go into their rooms when we can." Another staff member told us that a person who was in bed during the day of our inspection should be checked every 15 minutes. The manager told us that they did not require any checks. However, this person lacked capacity to use the call bell themselves and therefore did require regular checking. We observed that this did not take place every 15 minutes as advised by the staff member. There was nothing documented within the person's care record about this. Therefore, there was a risk that people could be left unattended for long periods and not receive the care that they needed.

Where the provider had assessed risks to people's safety, the actions required to reduce this risk had either not been documented or were not always being followed. For example, one person who had been identified as being at high risk of falls had been visited by an external falls prevention specialist. The specialist had advised staff to use certain techniques when assisting this person to move. However, we observed staff not using these techniques, therefore placing the person at risk of falling. Another person who was not mobile had been assessed as being at risk of developing a pressure ulcer. There was no guidance in place to guide staff on how to manage this risk. The staff told us that this person required pressure relieving equipment to reduce this risk which included a specialist cushion and mattress. We saw that the person had a

specialist mattress on their bed but they were not seen sitting on the specialist cushion during the day. Therefore, the risk of them developing a pressure ulcer was not being managed effectively. This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Two people we spoke with told us that they did not always get their medicines when they needed them. One person said that they were in pain as they had been waiting for staff to give them their pain killers. Another person we spoke with told us they regularly had to wait to receive pain relief. Staff we spoke with told us that medicines were given to people in alphabetical order and that therefore, on occasions, people had to wait to receive their medicine.

We found that people did not always receive their medicines at the time of day they should have done. One person had been given their medicine at lunchtime when it should have been given in the morning. Other people had received their medicines late in the morning when they should have been given to them at breakfast time. Some psychotropic medicines such as sedatives had been given to people early in the evening when they should have been taken at night time. For example, one person received a night time medicine at 6.10pm and another person at 5pm. This was four hours earlier than they should have been given. This could have caused the person to be more drowsy than normal before their bedtime. The service was therefore not giving people their medicines as was intended by the person who had prescribed them.

People's medicines were stored securely and safely in a locked room. Medicines that needed to be stored at a low temperature were kept in the fridge and the temperature of the fridge was regularly monitored to make sure the medicines were safe to give to people. However, the temperature of the room where medicines were stored was not being monitored to make sure that they were safe to give to people.

We looked to see what supporting information was available to assist staff to help them give people their medicines safely. Each person's medication record contained their photograph to aide staff with their identification. However, there was a lack of guidance available to staff to advise them on when to give people medicines that had been prescribed for 'as required' administration (PRN). Therefore, some people may have received their medication inappropriately. For example,

## Is the service safe?

one person who had been prescribed a sedative PRN medicine to be given once a day, if needed, had been given this every day and not on a PRN basis as intended by the person who had prescribed it. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Four people that we spoke with told us that they did not think there were enough staff available to help them when they needed assistance. They said that they often had to wait for assistance when they rang their call bell or to get up in the mornings. One person told us, "The staff are generally good, there is just not enough of them. They get to me when they can." Another person said, "I think the staff are too busy. There aren't enough of them." One person told us how they had fallen the night before in a communal toilet and had had to wait for over 30 minutes to receive assistance from a staff member, as they were busy helping other people.

Our observations confirmed that there were not always enough staff available to help people when they needed it. We saw that one person was still in bed at 12.20pm. They told us they had been waiting to get up. They said, "I am fed up waiting for staff to come to me." We also saw that during lunchtime, some people had to wait for over 30 minutes to receive their lunchtime meal as there were not enough staff to assist them.

The majority of the staff we spoke with told us that they did not think there were enough staff to help people when they needed it. They said that this was particularly an issue at night time when a number of people needed two staff to assist them with their care, but that there were only two staff on duty. One staff member told us that due to a lack of staff, they started to assist people to bed at tea time and that in the morning, people were assisted to get up from 6.30am to make sure that the majority of people were up when the day staff started working their shift. This was a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

After the inspection, we asked the manager to send us information regarding how they calculated how many staff they needed on each shift to provide people with the assistance they needed. The manager did not send us this information.

We asked the manager to confirm to us that equipment used to help people to move such as hoists and the main lift in the building had been regularly serviced. On the day of the inspection, the records regarding this could not be found. After the inspection, the manager sent us some information but this was illegible. We therefore asked the manager to confirm to us in writing that these items had been serviced as required to make sure they were safe, but we did not receive a reply.

All of the people we spoke with told us they felt safe living at the Salisbury and that they did not have any concerns about their safety. One person told us, "I feel safe and don't have any worries on that front." Another person told us, "Yes, I feel safe here." The staff we spoke with demonstrated that they understood what abuse was and how they should report concerns if they had any. This included reporting to the appropriate outside agency such as the Local Authority if they were worried about anyone they provided care for.

Staff understood what action they needed to take in an emergency situation to keep people safe. The fire exits were clear and well sign posted to assist people to leave the building if they needed to. Staff confirmed to us that testing of the fire alarm occurred regularly. The provider had contingency plans in place should the service need to be evacuated in the event of emergency so that people would continue to receive support with their care.

The recruitment records of staff working at the service showed that the correct checks had been made by the provider to make sure that the staff they employed were suitable and of good character.



# Is the service effective?

## Our findings

All of the staff we spoke with told us they received an adequate amount of supervision from the manager where they could discuss their training and performance. However, the majority of staff said that they wanted more training or refresher training in certain subjects to update their skills and knowledge. This was in areas such as dementia, fire training, moving and handling and medication. The need for further training in moving and handling was confirmed when we observed staff using inappropriate techniques when assisting a person to move. This placed the person at risk of injury.

We checked four staff members training records. One staff member's record did not contain any evidence to say that they had received training in fire safety, health and safety, safeguarding adults or first aid. Another staff member's file showed that the majority of their training had 'expired' and that they required further refresher training. Only one of the four staff training records showed that they had received training in dementia, even though we were advised that most of the people living at the service lived with dementia.

The manager told us that staff who had administered medicines had been trained by other staff working within the service. There was no evidence provided to show that these staff had been trained by a competent individual as is required. The provider had not regularly assessed staff's competency to administer medication to people safely. The staff we spoke with about managing people's medicines demonstrated a poor knowledge about what the medicines were for and why they were being given to people. Therefore staff had not received the required training to provide effective care. This was a breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The manager told us that the majority of people living at the service were living with dementia. The staff we spoke with told us that a number of people lacked capacity to consent to the care and treatment they received. Therefore, the provider, manager and staff were required to follow the principles of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS). This is an Act that has been passed to protect the rights of those people who lack capacity to consent to their own care and treatment. However, we found that these principles were not being followed.

Where there was doubt about a person's capacity to give their consent, the provider had not carried out an assessment to determine whether or not the person was able to consent to the decision. They had also not always consulted the relevant individuals to determine whether any decision they made for a person was in their best interests. For example, some people had bed rails on their beds. The staff confirmed that these people lacked capacity to be able to consent to this but no assessment of their capacity had been made. Also, some people received their medicines covertly. This meant that they were hidden in food or drink. Again, people's capacity to consent to this had not been assessed. There were however some records to show that a best interests decision had been made by the person's GP in relation to this but this was not always the case. There was no evidence that a pharmacist had been consulted to discuss whether the medicines could be given to the person in a way that they could understand.

One person's care record that we reviewed contained a 'Do Not Attempt Cardio Pulmonary Resuscitation' (DNACPR) form. We noted that this had been completed by the manager and signed by the person's General Practitioner (GP). The form stated the decision to not resuscitate the person had been discussed with their relative. There was no documentation as to why the decision had not been discussed with the person. We discussed this with the manager who told us that the person did not have capacity to make the decision. There was no mental capacity assessment in place to determine whether this was the case. We spoke with the person about their care and support and noted that they could retain information and communicate effectively with us.

The majority of staff we spoke with were not aware of their duties under this Act and did not understand that any decisions they made for people who lacked capacity had to be in their best interests. They were also not able to demonstrate a good knowledge of the Deprivation of Liberty safeguards (DoLS). The provider's training records indicated that staff had not received training in MCA and DoLS. Therefore, we could not be sure that people who lacked capacity to make their own decisions had their rights protected.

The manager and provider did not demonstrate to us that they understood the MCA and DoLS. The manager told us that they had applied to the Local Authority for authorisation to deprive everyone who lived at the service



## Is the service effective?

of their liberty in their best interests. This was due to the service having a keypad on the door which prevented people from leaving. However, they had not assessed people on an individual basis to see whether they had the mental capacity to make their own decision about leaving the premises or whether they would be safe to do so. The manager and provider had assumed that everyone lacked capacity to make this choice. They had not explored how they could support people to make this decision and to help them stay safe if they wanted to leave the building. Therefore, some people may have had their human rights breached as they were not able to leave the service when they wanted to, even though they would be safe to do so. This is a breach of Regulation 18 of the Health and Social Care Act (2008) Regulated Activities (2010).

People were not always supported to eat their meals where it was required. We visited one person in their room and saw that they were struggling to eat their meal. They were attempting to use their cutlery but the food fell on the floor. We checked this person's care record. It stated that the person required full assistance to eat their meal but this had not been given. Another person was seen to be struggling to eat their food independently. We checked their care record. It was recorded that this person required adaptive cutlery to eat their meal but they were using standard cutlery. We spoke to a member of staff about this

who told us the person required adaptive cutlery and could not advise why this had not been given to them to use. This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Most of the people we spoke with told us that they enjoyed the food. One person said, "The food is very good." The provider had asked people what foods they liked and staff were aware of people's individual dietary needs. For example, some people preferred to have a soft diet and this was catered for. The kitchen staff told us that they were aware of people's individual dietary requirements and that they received this information from the care staff in a timely manner so they could ensure they met the person's dietary needs.

People's risk of malnutrition had been assessed. Where there were concerns, external healthcare professionals advice had been requested. For example, one person had been referred to the dietician because they had been assessed as being at risk from malnutrition. We saw that staff had followed the dieticians instructions to fortify their meals to increase their calorie intake.

People were referred to health and social care professionals appropriately. We saw that people had been seen by their GP or other healthcare professionals such as dentists, opticians, physiotherapists and district nurses where necessary for their advice.

# Is the service caring?

## Our findings

People's care records were generic in nature and were not based on the individual person's care needs. Everyone had received the same assessment of need and the same assessment of risks to their safety. There was not always information about people's personal history, their preferences or how they wanted to be cared for. Some of the staff we spoke with did not know the people they were caring for. They were not able to always tell us about people's preferences, their likes and dislikes or about people's life history. Some staff did not know whether the people they cared for had DNACPR (Do not attempt cardiopulmonary resuscitation) orders in place. This lack of knowledge could mean that at the end of their life, people's wishes were not respected.

When we spoke to some staff about people living at the service, they often referred to people by their room number rather than their name. When asked how dependent people were, some staff referred to them as a 'one' or a 'two' [referring to how many staff a person needed to assist them]. We asked one care staff how they made sure the social needs of one person were met. They replied, "Well, because of their dementia, they can't do a lot anyway." This demonstrated that some staff did not understand how to care for people with dementia and showed a lack of respect for people.

Staff did not always understand what person-centred or individualised care meant. One staff member told us that their job was a 'tick list of jobs to do'. We also heard staff talking about 'toileting' people before lunch. We asked one care worker what they would do if a person asked to be assisted to the toilet at a different time to what staff had determined. They shrugged their shoulders and did not answer us. We asked the manager about this. They told us that people were 'toileted' prior to their meals. This practice does not promote people's independence, individuality or dignity.

We saw that although some people were offered a choice of meals or where to eat or spend their day, other people, particularly those living with dementia were not offered any choice. For example, we saw one person receive their

lunchtime meal. They were not able to tell us whether they had chosen the meal. We asked the cook who said that the care staff decided what the person wanted. The care staff told us that they gave the person what they liked. However, they had not tried alternative measures to encourage this person to make a choice for themselves such as showing them the meals. When we raised this with staff they told us that they felt this was a good idea. This person was also not offered a choice of drink or asked whether they wanted to eat their meal in the main dining room. Their meal was placed in front of them in the lounge where they had been sitting all morning.

Some people told us that they had limited choice about when to get up or go to bed. One person living at the service told us that they went to bed, 'whenever staff put me to bed.' We spoke with staff in relation to the time people got up in the morning and went to bed at night and whether they had a choice. One staff member told us that they were given a list of tasks to do and were told to go 'round' getting people up. We asked if this reflected the times people wanted to get up. They told us that they were not sure, and that they 'just followed the list.'

People told us that they could not recall whether they had been asked about the care they received. One person told us, "I'm not sure if I was involved in my care planning. I can't remember". There was no mechanism in place for people to participate in making decisions about their care. No evidence was provided to us to demonstrate how the provider involved people or those close to them in decisions about their care. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

When staff did interact with people, we saw that this was done in a kind and sensitive manner and they spoke to people in a respectful way. The people that we spoke with told us that the staff were kind. Staff knelt down to the same level as people when talking to them and spoke to them quietly and discreetly. Some people were seen laughing and joking with staff. One person who became upset was comforted by a member of staff. They did this by holding their hand, distracting them and then taking them for a walk within the service.

# Is the service responsive?

## Our findings

The service was not always responsive to people's needs. Four of the nine people we spoke with told us they felt cold. One person we spoke with who was in bed said, "I'm really cold, really cold." The person was cold to touch. We informed a staff member who arranged for the person to receive another blanket. The front lounge felt cold. People who sat in this area told us they felt cold. One person said, "I'm cold, really cold. Can you close the curtain behind me? I sit here all day and I'm cold."

Two out of eight people had their coats on. Other people had blankets around them. We monitored the room temperature. It was 16 degrees Celsius. We informed a member of care staff of this. They turned the heating up. The care staff did not monitor if people were comfortable. We found that the room was still cold two hours later. We informed a member of care staff who turned the heating up some more.

The provider had assessed people's care needs. However, the care that was required to meet these needs had not always been planned or was not clear. For example, one person had been assessed as being at risk of developing a pressure ulcer but there was no information in their record to advise staff on how to manage this risk. This person had subsequently developed a pressure ulcer which was being treated by a district nurse. In another person's care record, the guidance given to staff to help reduce the risk of the person having a fall was not specific. It stated that, 'carers must use methods to minimise risk of falls.' This person had subsequently experienced a fall that had resulted in a visit to the hospital. One person did not have any care planned at all in response to their assessed need. Some of the staff we spoke with told us that they found that the care records did not contain enough information within them to enable them to understand what care people required. This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The majority of people we spoke with told us that there was little for them to do during the day and that they were not able to follow their interests. One person told us, "There could be more to do. All I do is just watch television. I can have a chat with some of the residents but each day is much the same." Another person said, "There's not much to do here. I just sit here in the lounge." A further person told us, "There is not enough to do. I go to bed early in the evening because there is nothing to do."

We did not see anyone taking part in any activities during the inspection and saw that there was little stimulation for those living with dementia. Most people sat in the main lounge areas, in their rooms or wandered around the service. We spoke to the manager about this. They told us that a new member of staff had recently been employed to provide people with activities to meet their interests. We spoke to this new member of staff who was visiting the service on the day of our inspection. They told us they were initially getting to know the people and their interests. Once this had been completed, they said they would be providing activities to meet people's individual interests. This would include reminiscence and other activities, as well as changes to the environment that would provide stimulation for the people living there.

People told us that they felt confident to complain if they were unhappy about anything. One person said, "I have no complaints but I would speak to the staff." A relative told us, "I have no complaints, 'I am very happy with the care my [relative] gets here. They get well looked after. I know how to complain if I need to.'" The service had received some complaints within the last 12 months. We tracked one of these complaints to make sure that it had been dealt with. The complaint had been recorded, investigated and responded to.

# Is the service well-led?

## Our findings

We found that some people's care records contained inaccurate information or that records were not being completed as intended. Therefore, people were at risk of receiving unsafe or inappropriate care as staff did not have access to accurate written information about the people they provided care for. Also, incomplete or inaccurate records meant that the provider was not able to monitor whether people were receiving the care they needed.

One person's care record stated they had a pressure ulcer. However, two different documents for the person regarding the pressure ulcer contradicted each other. One stated that the person had one pressure ulcer whilst the other said they had two. We spoke to some care staff about this and they were confused as to how many pressure ulcers this person had. Therefore, the person may not have received the correct level of care. Another person had no plans of care within their care record to guide staff on what care they needed. Other people's care records contained plans of care that were brief in nature or that did not contain assessments of a person's individual needs.

Some people's food and fluid intake was being recorded where there were concerns that they were not receiving enough. However, all of the food and fluid charts we checked had gaps in them. Therefore the provider could not effectively monitor whether these people were receiving sufficient amounts of food and fluid to meet their needs. All of the medication records we checked contained gaps. Therefore the provider could not be sure that people were receiving their medicines as they should have been. This is a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider did not have effective systems in place to monitor the quality of the service. Although some audits had been completed in relation to the accuracy of care records and medication, the current system used had failed to identify a number of issues that were found during this inspection. These included inaccurate information within people's care records relating to their care, records not being completed as required or being unclear or brief and issues relating to the management of people's medicines. Assessments of people's individual needs and risks to their safety had also not always been completed or actions taken appropriately by staff to reduce these risks. Staff had not all received the appropriate training to provide them

with the skills and knowledge they needed to provide safe and effective care. There was also no system in place to monitor the care that staff provided to people on a regular basis to make sure that it was safe and appropriate. This is a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) 2010.

The leadership of the service had embedded a culture that was not centred on the individual. Staff performed tasks rather than providing people with individualised care. People were routinely 'toileted' before breakfast, lunch and dinner. This demonstrated a lack of respect for individual choice. People's medicines were given to them in alphabetical order and they were assisted to get out of bed in the mornings in alphabetical order rather than staff responding to people's individual needs and preferences. This made the service feel institutionalised and that tasks were completed for the ease of the service rather than the person who lived there. Some staff did not appear to see people at the service as individuals but rather just as a number. Staff understanding of people's needs was often poor. There was confusion about what care some people should receive which indicated that communication between them and the management team was not effective. This showed us that the leadership of the service was currently not good.

The manager working at the service has been in post for a year. They are currently not registered with the Care Quality Commission as is required but we have received their application and this is in the process of being assessed.

The people who lived at the service had not been asked directly for their opinion on the quality of the service or how this could be improved. The provider told us that they were developing ways in which they could do this. A questionnaire had recently been sent out to people's relatives and there was a box available for people or relatives to leave suggestions about the service. The manager told us that they had not received any suggestions and that they encouraged people to speak to them if they needed anything.

All of the staff we spoke with told us that they felt supported by the manager and that they felt confident to raise any concerns about care practice, if they had any. Staff understood what 'whistleblowing' was. Whistleblowing is a term used where staff alert the service or outside agencies when they are concerned about care

## Is the service well-led?

practice. All of the staff told us they felt confident to raise concerns about other members of staff if they witnessed poor care being delivered. They told us they would do this to keep people safe.

Staff told us that they felt listened to, that they all worked well as a team and were happy in their work. They were able to pursue further qualifications within the social care

sector if they wished to with the support of the provider. A number of them were completing these qualifications. However, although staff were working towards these qualifications, the provider had not ensured that they had received the training they required to enable them to always provide safe and effective care to the people who lived at the service.

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	<p>Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services</p> <p>The provider had not taken proper steps to protect people from the risks of receiving inappropriate or unsafe care as they had not always assessed the risks to people's safety, carried out an assessment of people's needs or planned and delivered care to ensure people's welfare and safety. Regulation 9, (1), (a) and (b) (i) and (ii).</p>

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	<p>Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision</p> <p>People who use services and others were not protected against the risks associated with unsafe or inappropriate care due to ineffective systems to monitor the quality of the service provided. Regulation 10 (1) (a) (b) and 2 (b) (iii).</p>

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	<p>Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines</p> <p>People's medicines were not managed safely. Regulation 13.</p>

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

This section is primarily information for the provider

## Action we have told the provider to take

Staff did not always treat people with consideration or respect. People did not always have choice. There was little evidence to show that people were involved in making decisions about their care. Regulation 17, (1) (a), (b) and (2) (a).

### Regulated activity

Accommodation for persons who require nursing or personal care

### Regulation

Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment

Staff, the manager and the provider did not have a good understanding of the Mental Capacity Act (2005) or the Deprivation of Liberty Safeguards. Therefore there was a risk that people who lacked capacity to make their own decisions did not consistently have their rights protected. Regulation 18.

### Regulated activity

Accommodation for persons who require nursing or personal care

### Regulation

Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records

Some people's care records contained inaccurate information. Some records had not been completed as required by the provider. Regulation 20 (1) (a).

### Regulated activity

Accommodation for persons who require nursing or personal care

### Regulation

Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing

There were not always enough staff to meet people's needs or to keep them safe. Regulation 22.

### Regulated activity

Accommodation for persons who require nursing or personal care

### Regulation

Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff



This section is primarily information for the provider

## Action we have told the provider to take

Some staff members training was out of date and some had not received appropriate training to enable them to provide people with safe and effective care. Regulation 23 (1) (a).