Adiemus Care Limited

The Old Rectory

Inspection report

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Ratings

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

Overall summary

This inspection took place on 7 October 2014 and was unannounced.

The Old Rectory is a residential care home which provides accommodation and personal care support and is registered for up to 60 people. On the day of our inspection there were 47 people living at the service.

There was a registered manager in place. 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 and associated Regulations about how the service is run.

At our previous in inspection June 2014 the provider was not meeting the requirements of the law in relation to cleanliness and infection control, insufficient staffing levels, the deployment of staff to provide opportunities for people with social and leisure activities and how the

Summary of findings

quality of the service was monitored. We asked the provider to take action to make improvements. During this inspection we looked to see if these improvements had been completed.

People who used the service and their relatives told us contradictory things about the quality of the service they received. While some people told us they felt safe, were treated with kindness and respect by the staff, others expressed concern about the lack of social interaction provided and insufficient staffing levels.

The provider did not have a robust system in place to assess staffing levels and make the necessary changes when people's dependency needs increased. Everyone we spoke with raised concerns about the low number of staff available. This meant that the provider could not be sure that there were enough qualified staff to meet people's needs.

Care provided was mainly centred on providing for people's personal care needs. There were insufficient numbers of staff available to meet the social care needs of people living with dementia on Redwood unit.

Staff did not understand their roles and responsibilities with regards to the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). Staff were not always following the MCA 2005 for people who lacked capacity to make a decision. For example, the provider had not understood the need to make an application under the MCA 2005, Deprivation of Liberty Safeguards for two people, who we observed to have their freedom of movement restricted, which meant that there was a potential deprivation of their liberty.

The provider had a system in place to respond to concerns and complaints. All the people we spoke with did not know how to make a formal complaint but did however express their confidence in the manager to respond to any concerns they might have.

The provider had a range of checks in place that monitored the quality and safety of the service. The provider's audits had identified the shortfalls and risks associated with a lack of adequate maintenance of the premises. However, the provider had failed to plan and take action to ensure adequate maintenance of the service. The process for monitoring the quality of the service was not robust and effective in picking up some of the concerns we found and so had not led to the necessary improvements.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we have 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?
The service was not consistently safe.

People were being put at risk because the service was not adequately maintained and risks managed to keep people safe from harm.

There were insufficient staff available to meet the care treatment and welfare needs of people.

People received adequate support with access to food and fluid sufficient to meet their needs.

Is the service effective?
The service was not consistently effective.

Newly appointed staff received induction training and shadowing opportunities to provide them with the knowledge they needed to meet the needs of people living at the service.

People were not always involved in the decisions about their care as they had not been involved in the planning and review of their care plans.

The service was not fully meeting the requirements of the Deprivation of Liberty Safeguards as people who had their movements restricted had not been assessed by those qualified to do so.

Is the service caring?
The service was not consistently caring.

People were positive about the care they received, but this was not supported by some of our observations. Care was mainly focused on personal care tasks with little interaction with people.

Bathrooms did not have blinds or curtains to cover the windows and so people did not have their privacy and dignity maintained.

Is the service responsive?
The service was not consistently responsive.

There was a continued lack of consistent planning of a programme of activities and stimulation relevant and tailored to meet the needs of people living with dementia.

The provider had a system in place to respond to concerns and complaints. People told us they were not aware of the provider's complaints policy but would have confidence to speak with staff if they had any concerns.

Is the service well-led?
The service was not well led.

People were put at risk because systems for monitoring the quality and safety of people were not robust and effective enough in identifying risks and planning for improvement of the service.

Summary of findings

The culture of the service was in the main focused on meeting people's physical and personal care needs rather than taking time to engage with people on a personal level. People told us contradictory things about the quality of the service they received. While some people told us they found the manager approachable and staff treated them with kindness and respect others were not so complimentary.

The Old Rectory

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 7 October 2014 and was unannounced.

The inspection team consisted of two inspectors.

Prior to our inspection we asked the provider to complete a Provider Information Return (PIR). This 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 reviewed all the information we held about the service including statutory notifications. We considered information which had been shared with us by the local authority. We also looked at safeguarding concerns reported to the Care Quality Commission (CQC). This is where one or more person's health, wellbeing or human rights may not have been properly protected and they may have suffered harm, abuse or neglect. This enabled us to ensure we were addressing potential areas of concern.

On the day we visited the service, we spoke with five people living at The Old Rectory, two relatives, two local authority commissioners visiting the service, six care staff, two senior staff, four domestic staff, the cook, kitchen assistant, the manager and the deputy manager.

Following our inspection we spoke to four relatives of people who used the service.

We observed how care and support was provided to people throughout the day. Including the midday meal on two units. We used the Short Observational 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 five people's care records, three staff recruitment records, staffing rotas and records relating to how the service monitored staffing levels and the quality of the service.

Requires Improvement

Is the service safe?

Our findings

We asked people if they felt safe living in the service and what safe meant to them. Each of the people we spoke with told us they felt safe. Comments included, "I do feel safe, the staff are very good to you", "I cannot say I don't feel safe." And "I have no concerns about my safety here."

At our inspection in June 2014, we were concerned about the maintenance, cleanliness and hygiene of the service. We asked the provider to send us an action plan describing how they would make improvements. At this inspection we found some improvements had been made, but there were still some concerns. The manager had recruited some more domestic staff. However, our observation of the service, discussions with staff and a review of rotas confirmed that there was still insufficient staff available to effectively clean and maintain the necessary levels of hygiene required to keep people safe.

At our inspection in June 2014, we were concerned that the provider had failed to ensure that sufficient numbers of staff were available to meet the needs of people who used the service at all times. We asked the provider to send us an action plan describing how they would make improvements. The Providers Information Return (PIR) stated that there had been a 60% turnover of staff within the last year. The manager told us that since our last inspection they had recruited into vacant posts and that there was an almost complete team of staff with only one vacant night care post and one domestic post to fill.

The layout of the service consisted of three units. At this inspection we found that staffing levels remained insufficient to support people's needs across the whole service but with particular concern regarding the number of staff allocated to Redwood Unit. This unit is designated to care for the needs of physically frail people, living with dementia. One person told us, "You cannot find staff when you need them. Sometimes you sit and wait and don't see any staff in the lounge for ages. I think things have got worse lately. You can see now there is no one around. People have to wait for staff to come into the room to tell them when you want something like the toilet."

Four people living on Redwood Unit required the support of two staff for all personal care and moving and handling tasks. Care staff told us there was not always enough staff available throughout the whole service but in particular on Redwood Unit where staff told us this impacted on the ability to fully meet people's care needs. The provider's compliance audit for September 2014 had identified relatives concerns regarding the lack of staff available to meet their relative's needs. Two relatives we spoke with told us of recent occasions when they had arrived late morning to find their relative still in bed. Comments included, "There is not always enough staff to help people, particularly at the weekends. The staff do their best but there just aren't enough of them." Another said, "The staff here work 110% but they are stressed. They often go sick."

We asked the manager how staffing levels were determined. They told us that staffing levels had been assessed according to the dependency levels of people who used the service. The manager told us that three staff had been allocated to Redwood Unit on a daily basis to care for 15 people with complex needs as a result of their living with dementia. On the day of our visit three care staff had been allocated to Redwood and one senior. However, a review of staff rotas and discussions with staff showed us that only two care staff had been allocated to this unit for the majority of days for the months of August and September 2014. We discussed this with the manager who told us that they included the senior carer as the third member of staff allocated to each unit to support people with their personal care needs.

Senior care staff described the tasks they were involved in throughout a typical working day. They told us they had very little time to be involved in providing any personal care support to people as their responsibilities for the day included the administration of people's medication, responding to emergencies, arranging staff cover, requests to and contact with health and social care professionals, providing supervision support to staff and the reviewing of care plans. They also told us they were expected to arrive at work at least 15 minutes early for their shift to lead or take part in a handover meeting. They and the manager confirmed that staff were not paid for this time.

We used SOFI to observe the care provided to people living on Redwood Unit. We noted that there were significant periods of time when there were no staff available in the communal lounge and occasions when there was only one member of care staff available to respond to the needs of everyone.

We observed the morning medication administration round. We noted that this took 2.5 hours to complete.

Requires Improvement

Is the service safe?

Senior staff told us this was due to only two instead of three senior care staff being available. This resulted in some people not receiving their medicines until late morning. As a result of our findings we were not assured that the provider had taken steps to provide sufficient numbers of staff to meet the needs of people who used the service at all times.

This is a continual breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

A range of risk assessments in place evaluated the risks for people in managing their healthcare needs such as managing the risk of malnutrition and pressure ulcer prevention. These assessments were detailed and gave staff guidance as to what action to take to minimise risk. However, we noted that there was no assessment of the environmental risks on Redwood Unit. For example we observed people had access to a kettle and toaster which had been placed on a low table in the lounge. This meant that potential risks from burns and scalds had not been assessed.

We looked at how people's medicines were being managed to ensure they received them safely. We checked the stock of three people's medication against their Medication Administration Records (MAR) charts and found that these were accurate. This meant they were receiving their prescribed medicines correctly. The two people's medication profiles included a current list of their prescribed medicines and guidance for staff about the use of these medicines.

The manager and senior staff completed regular medication audits to check that medicines were being obtained, stored, administered and disposed of appropriately. The manager told us staff had received up to date medication training and had been competency assessed to confirm they had the skills needed to administer medicines safely. These measures ensured that staff consistently managed medicines in a safe way. However, we noted that senior staff's weekly audits of stock and medication administration records on Redwood unit had not been completed since July 2014. Records viewed showed us that the manager's monthly audits had been completed but had failed to identify the gaps in the senior staff weekly audits.

The provider's safeguarding adults and whistle blowing policies and procedures informed staff of their responsibilities to ensure that people were protected from harm. Staff confirmed they had received training in safeguarding people from the risk of abuse. They described their understanding regarding the different types of abuse and what they would do if they suspected abuse had taken place in the service. One newly appointed member of care staff told us they had received safeguarding training as part of their induction. The manager was aware of how to report safeguarding concerns to the appropriate local safeguarding authority.

Three staff files we looked at showed us that the provider had a safe system in place for the recruitment and selection of staff. This ensured that staff recruited had the right skills and experience to work at the service. Not all staff files contained relevant information, including evidence of Disclosure and Barring, criminal records checks (DBS). However, following our inspection the manager provided us with evidence which confirmed that appropriate criminal records checks had been undertaken and references had been provided to ensure that staff were suitable to work with people who used the service.

Requires Improvement

Is the service effective?

Our findings

The Providers Information Return (PIR) stated that all staff received regular supervision with a senior member of staff where opportunities had been provided for staff to discuss their training needs and performance. The manager had also identified within the PIR a need to enable staff access to annual appraisals and described their plans to improve this within the next 12 months. Staff told us that when they started working at the service they had been provided with a programme of training as part of their induction. This had also included opportunities to shadow other staff in learning their roles and responsibilities.

We asked staff about their understanding of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS). All the staff we spoke with confirmed they had received training in MCA and DoLS but could not tell us how they would identify when someone was being deprived of their liberty and what action they would take in response to this in accordance with their roles and legal responsibilities within the MCA 2005. Staff told us their MCA training was brief and that they could not recall what the training consisted of. We were not assured that staff had been provided with sufficient training and that staff had the required knowledge to enable them to support people who do not have the capacity to make safe decisions about their everyday lives.

The service was not fully meeting the requirements of the DoLS. The manager confirmed their understanding of their responsibilities and their knowledge of the MCA 2005 and DoLS legislation, and when these should be applied. However, we identified two people who lacked capacity and whose freedom of movement had been restricted with decisions made to instruct staff to constantly monitor their movements and implement aids such as sensor mats to alert staff of their whereabouts. This meant that these people had their freedom of movement restricted resulting in a potential deprivation of their liberty, but without any formal assessment of their best interests carried out by people qualified to do so. In response to our concerns the manager confirmed two days after our visit that they had submitted a referral for authorisation to the local safeguarding authority as is required.

Staff demonstrated a good knowledge of the people who lived at the service. This included a good understanding of people's health and nutritional needs. People had access to a range of health care professionals which include general practitioners, dieticians and community nurses in response to health concerns that had been identified.

When asked for their views regarding the quality of the food provided. One person said, "The food is good, I cannot complain, it beats having to cook for yourself." Another said, "The food is passable. We don't get asked what we would like to see on the menu."

We observed during lunch that people were supported with one to one assistance from staff when needed. People told us they had not been involved in the planning of menus but were however provided with a choice of food on a daily basis. One person said, "The food is adequate for my needs." Another person said, "The food is very good here. It doesn't compare with what you would have at home but I have no complaints."

We asked the cook about the menus provided and noted that the menu on display did not reflect the meal that was served. The cook told us that changes to the menus had been made following instructions from the provider to reduce costs. For example, on two occasions in the last month roast lamb had been changed to roast chicken and the starter meal described on the menu displayed as a choice of melon or prawns was no longer provided. Steak sandwiches had been replaced with spaghetti on toast. We asked people if they had been consulted regarding these changes. All the people we spoke with told us they had not. This meant that people were not always involved in decisions about what they liked to eat and informed when things changed.

However, people were offered and supported with drinks throughout the day to maintain adequate hydration. Bowls of fruit were available within lounges to enable people access to nutritious snacks.

Care records showed us that people's nutritional needs had been assessed and those at risk of malnutrition recorded with their care plans. We noted that for two people who had been assessed as at high risk of malnutrition action had been taken to refer to specialists for advice in reducing the risks for these people. Where advice had been given to weigh on a weekly basis records we saw showed us that action had been taken to monitor people as recommended.

Requires Improvement

Is the service effective?

Catering staff showed us a notice board where they kept a record of people who required soft diets and those who had special dietary needs. For example, people who had been diagnosed with diabetes. We noted that the two people identified as at risk of malnutrition and where dieticians had recommended a diet supplemented with increased calories, catering staff told us they had not been made aware of this recommendation. They did however explain what actions they would take if they were told that someone was at risk of malnutrition to provide additional calories to a person's diet by using cream and butter in potatoes and puddings. The lack of communication with kitchen staff could result in a risk of people not being provided with the supplemented diet they required to reduce the risk of malnutrition.

The manager showed us the meeting minutes of two residents meetings held within the last 12 months where people had been provided with the opportunity to share their views about the quality of the service. We noted that these were attended by less than 50% of people living at the service. Minutes from these meetings described mixed views from people regarding the choice and quality of meals provided. Meeting minutes did not describe any action taken in response to people's expressed views.

Requires Improvement

Is the service caring?

Our findings

The majority of relatives that we spoke with told us that the staff were kind and caring in their approach to people who used the service. One relative said, "The staff are wonderful. I cannot fault them." Another relative said, "They work hard and do their best."

We observed some staff interacting well and with kindness and compassion towards people. However, we also noted that people who were quiet were given very little attention. For example, when we used SOFI we noted that there were people who had not been supported with any social interaction from staff other than to offer a drink or their meal.

All of the people who were able to talk to us told us the staff treated them with respect and promoted their dignity when supporting them with their personal care. One person said, "Yes, they always make me feel comfortable when they give me a bath."

Relatives told us they could come and go more or less as they wished as there were no restrictions on visiting times. This supported people to maintain contact with their family and friends.

People were not always supported in the planning and making decisions about their care. All the people we spoke with told us they did not know they had a written care plan in place. They also told us they had not been involved in the planning of their care or provided with opportunities to participate in reviews of their care. However, two relatives we spoke with told us they had been consulted with on a regular basis regarding the care and support provided to their relative.

Care plans did not evidence that people had been consulted about their needs, wishes and preferences regarding their end of life care. For example, if they required palliative care, where they would choose for this care to be provided. This meant that staff did not have the relevant information they may need to respond to any decisions people might have in planning for their end of life wishes and needs.

We noted that two bathrooms did not have window blinds and the coating applied to the glass windows to obscure vision into the bathrooms had worn away in places. This had been discussed with the manager at a previous inspection. This demonstrated that action had not been taken to consider and protect the privacy and dignity of people.

Requires Improvement

Is the service responsive?

Our findings

People who used the service and their relatives told us contradictory things about the quality of the service they received. One relative told us, "They provide pretty good care but there are no activities whatsoever for people like [my relative] who lives on Redwood Unit. I cannot fault the carers but there is a lot of window dressing. A wonderful garden but they never take people out into it. People need activities but they don't have the staff to provide them." Another relative told us, "My [relative] tells me they do not always get the baths they need; [relative] tells me they have to wait and remind the staff."

At our inspection in June 2014, we identified concerns regarding the lack of activities and stimulation planned and tailored to meet the needs of people living with dementia. At this inspection we spoke with the activities organiser who told us they were employed for 35 hours each week and described to us some of the activities they had recently organised. However, we remained concerned that time allocated for providing social and leisure interests for people had still not been deployed effectively to support people living with dementia.

We observed that people spent much of their time sleeping or watching TV with very little interaction from staff other than to respond to their personal care needs. We were not assured that people's individual needs for social stimulation, leisure interests and hobbies had been assessed and activities provided that were relevant to them and in accordance with their wishes and preferences. People living with dementia did not have access to items they could rummage through or touch which would aid stimulation or reminiscence. One person we spoke with told us, "We just sit all day. You can read the newspaper if you pay for it but then find that other people take it to read what you have paid for so I don't bother now. We sometimes have a church service, games and puzzles but my hands are shaky and so I can't get involved. What they provide is not what interests me." Another person told us, "We have been stuck in here all summer and can't get out into the garden; the door is locked because of the dangerous tree branches. I have always loved being outdoors. Summer has passed us by." We discussed this with the manager who told us work to make the garden safe was still outstanding and they did not have a timescale for this to be rectified. We were therefore not assured that people in particular those living with dementia had been appropriately supported and encouraged to explore their individual interests and hobbies.

This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Care plans had been regularly reviewed by senior staff. They included up to date information and demonstrated a full assessment of people's individual needs. Care staff told us they did not read people's care plans as these were kept in the manager's office where they felt they did not have the freedom to access. Staff did however have access to daily record books known as 'Monthly observation records' which gave a brief summary of a person's plan of care and daily observation records where they recorded regular checks on people and support with access to food, fluid and re-positioning to prevent pressure ulcers developing. The lack of access to people's care plans meant that staff had limited information available to provide them with guidance such as access to risk assessments, people's life histories and how to support people following risks identified from nutritional assessments.

There was a call bell evident on the wall within the communal lounges but noted that no one wore a pendant alarm. People we spoke with who had limited mobility and who were unable to use the call bells told us they relied on staff being present in the communal lounges when needing to ask for support with personal care tasks. One person told us, "You don't always see staff and have to wait to go to the toilet. I worry I will have an accident." This meant that people did not have access to equipment to enable them to call for staff assistance when this was needed.

We asked the manager how they routinely listen and learn from people's experiences, concerns and complaints. They told us they carried out regular residents and relatives meetings. The manager told us they held a weekly surgery for two hours where people could access the manager and discuss any concerns they might have. This facility was confirmed by a notice available for people to view on the notice board in the corridor. However, there was no evidence provided that people used this opportunity with any evidence of outcomes for people. We noted from a review of meeting minutes that only two residents meetings had been held within the last 12 months.

Requires Improvement

Is the service responsive?

The provider had a system in place to respond to concerns and complaints. People and their relatives told us they were not aware of the provider's complaints policy but would have confidence to speak with staff if they had any concerns. Relatives told us, "They used to have a suggestions box but this has stopped. The manager told me this is because they want useful suggestions." Another said, "I do not know about any complaints policy or procedure but whenever I have had concerns the manager has always listened and taken action." We were not assured that the provider routinely listened to the views of people, considered the impact of how care was provided and used their findings to plan for improvement of the service.

Inadequate

Is the service well-led?

Our findings

When we inspected the service in June 2014, we were concerned about the lack of robust and effective systems in place to assess and monitor the quality and the safety of the service. We asked the provider to send us an action plan to tell us how they would make improvements. At this inspection, we found that there were some improvements in some areas, but that the provider was still failing to identify, plan and manage risks relating to the welfare and safety of people who used the service.

At our inspection in June 2014, we were concerned about the lack of systems in place to effectively identify, assess and manage the risks to people's health, safety and welfare. We identified areas of the service that were in urgent need of refurbishment and repair. We also identified the need for effective systems to maintain adequate standards of cleanliness. One area of concern was the lack of effective cleaning of kitchenettes located on each unit and in particular the cleanliness and need for refurbishment and maintenance of the kitchenette on Redwood Unit. The manager showed us where they had requested refurbishment to this area but as yet the provider had failed to take action in response to these concerns other than to instruct staff not to use this area.

The impact of the closure of the kitchenette on Redwood Unit resulted in a management decision to place a kettle and a toaster on a low table within the open plan lounge/ dining room for staff use to prepare hot drinks and toast for people. We spoke with the manager about the risks we identified, risks of potential burns and scalding from people's unprotected access to these items. This was a particular concern given the complex needs of people living on this unit who we had observed people walking around this area. The manager told us that they had not risk assessed this area and would remove these items immediately. However, we were concerned to be informed two days later, following a visit from the local authority quality team these items had not been removed and were still in use. This demonstrated a continual failure to identify, assess and manage risks relating to the health, welfare and safety of people who used the service.

Kitchen, care and domestic staff told us of their concerns that food orders did not always arrive in a timely manner to enable cooks to provide food as described on the menus. The reason described for this was the provider's head office delay in authorising payment of invoices. We discussed this with the manager who confirmed that there had been recent occasions when orders for food and cleaning products including personal protective equipment for staff had not arrived or had been delayed as a result of decisions made by the provider's head office. The manager and staff also told us that on occasions they had needed to use the petty cash to buy goods locally due to supplies not arriving when expected. We asked the manager what impact this had on people who used the service. Their response was that people did not receive the food as described on the menu. The provider had failed to take action to ensure the welfare and safety of people from the risks we had identified.

This is a continual breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The culture of the service was in the main focused on meeting people's physical and personal care needs rather than taking time to engage with people on a personal level. People told us contradictory things about the quality of the service they received. While some people told us they found the manager approachable and staff treated them with kindness and respect others were not so complimentary. In addition, our observations and the records we looked at did not always match the positive descriptions people had given us. Relatives told us the service was, "Looking shabby in places and needs some investment. We pay enough money you would think they would spend some of it on a lick of paint." Another relative said, "[My relative] has not been able to go out into the garden on Redwood Unit all summer because they have not sorted out the falling branches from the pine tree".

Equipment such as wheelchairs and walking frames were found dirty. Carpets throughout the service were not properly cleaned and some were in need of replacement. Redwood Unit had a strong, unpleasant odour. During our visit social care professionals complained that they had observed one person's commode had not been emptied. We spoke with the manager regarding this. However, we found that four hours later this commode had still not been emptied. This meant that the cleaning of spills and substances that could cause an odour and the transfer of infection had not been effectively carried out.

Systems in place to monitor the regularity and quality of cleanliness of the service included the manager's

Inadequate

Is the service well-led?

monitoring of domestic staff daily cleaning schedules, where staff had signed to confirm the areas they had checked and cleaned. Records viewed showed gaps in staff recording the cleaning of Meadow View unit for 12 days in September and gaps of 10 days in September for Redwood unit. The manager had signed to confirm their audit of the cleaning schedules during this period but had not identified these gaps and neither identified action taken in response.

The provider had a range of checks in place that monitored the quality and safety of the service. The provider's audits had identified the shortfalls and risks associated with inadequate cleaning and the need for adequate maintenance of the service. For example, the provider's monthly audits for January 2014 through to October 2014 had repeatedly at each audit identified the need for refurbishment and maintenance of the premises. There was no action plan in place to show what the provider would do in response to their shortfalls identified. This demonstrated that the provider did not have appropriate measures in place to ensure that the service was adequately maintained which would enable people to live in safe, accessible surroundings that promoted their wellbeing.

This is a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

All of the care and domestic staff told us that morale was low. When asked what had contributed to this, staff stated amongst other reasons; high levels of staff sickness and the high turnover of staff experienced within the last 12 months. Staff described supervisions and staff meetings as provided only when, "staff needed a good telling off." We asked the manager to provide us with copies of staff meetings which had taken place within the last 12 months. They provided the meeting minutes of only one staff meeting which had taken place in July 2014. The focus of this meeting was in the main discussions around responding to people's personal care needs, the environment and performance management issues.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing Continual breach of Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing The registered person did not have suitable systems in place to ensure that there were sufficient numbers of people employed to meet the needs of people who used the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and Suitability of Premises. People who use services and others were not protected against the risks associated with unsafe or unsuitable premises because of inadequate maintenance. Regulation 15

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of service users The assessment, planning and delivery of care did not meet service users individual needs. Regulation 9. (1) (a) (b)(I)

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 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers Continual breach of Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of the service provision. People who use services and others were not protected against risks because the provider had continued to fail to identify, assess and manage risks to people's health, welfare and safety. Regulation 10 (1) (b).

The enforcement action we took:
We issued the provider with a warning notice with a date set for compliance 28 November 2014.