Care Quality Commission

Caring Homes Healthcare Group Limited

Moorlands Nursing Home

Inspection report

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Ratings

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

Overall summary

This was an unannounced inspection, which took place on the 16 December 2014. Moorlands Nursing Home provides residential and nursing care for up to 41 older people some of whom may be living with dementia. At the time of our inspection there were 33 people at the service.

At the time of inspection there was no 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 and associated Regulations about how the service is run.

People and their relatives said they felt they were safe with the staff. Not all staff had received updated safeguarding adults training but had knowledge of the safeguarding procedures and what to do if they suspected abuse.

There were not always enough staff to safely meet people's needs. This meant that sometimes people did

Summary of findings

not receive personal care in a timely way. People did not always have their medicine on time and some had to sit in a wheelchair all day as there were not enough staff to transfer them into armchairs.

Some of the emergency equipment around the home needed to be updated for example the fire door guards. Some people's bedroom doors were being propped open which was a fire risk.

Risk assessments for people were not up to date which meant that staff would not have the most up to date information for people.

There were gaps in the medicine records where a nurse should have signed to say that people's medicines had been given. There was not always guidance for staff on when to give people their PRN (as needed) medicines. All of the medicine was administered and disposed of in a safe way.

Pre-employment checks for staff were completed. For example in relation to their full employment history and reasons why they had left previous employment. This meant that only suitable staff were employed.

Some people felt their health care needs were being met but others did not. Health care professionals said that some staff did not have the support and skills to deal with some people's complex conditions.

Staff were not up to date with the service mandatory training and others had not had any training in some areas. This included first aid, fire training and infection control. This meant that staff would not have the most up to date guidance. Not at all staff had received a one to one supervision or appraisal with their manager.

Some staff knew about the Mental Capacity Act 2005. However we saw that mental capacity assessments had not taken place in relation to people where there was doubt about whether they could give consent. This related to people who were unable to access the front door or those people who had 'Do not resuscitate' (DNAR) forms.

People thought the food was good and felt that their nutritional needs were catered for. People were encouraged to make their own decisions about the food they wanted. We saw that there was a wide variety of fresh food and drinks available for people. However those people who needed additional support to eat were not always given that.

People had access to a range of health care professionals, such as chiropodist, community matron and doctor. A doctor visited regularly and people were referred when there were concerns with their health.

Some people thought that the staff were caring and that they were treated with dignity and respect. Other felt that they were left for long periods of time without any interaction from staff. People also felt that if they needed privacy then this would be given.

There was a strong smell of urine in the service which was present throughout the day. Staff were unable to identify where this smell was coming from.

Some activities were available and some people were out on a day trip on the day of the inspection. However there were no activities provided for people who remained in the service. There were not enough activities provided for people specific to their needs. Staff said that there was not enough for people to do.

People's health needs were not being monitored consistently. One person needed to be weighed weekly and this was not happening. They had lost weight and there was no information on the care plan about how this was being managed.

People and relatives said they understood how to make a complaint and felt comfortable to do so. There was a copy of the complaints procedure for everyone to see in the reception area. All of the complaints were logged but there was no evidence of any learning from these complaints.

People, relatives and staff were asked for their opinion and feedback on what they thought of the service. We asked the interim manager for the analysis of the feedback that had been provided by people and relatives but this was not available. We were unable to establish if any improvements had been made from people's feedback.

Summary of findings

People and staff did not feel that the service was well managed. The audits that took place were not effective and improvements had not been made as a result of the audits. For example in relation to the infection control and care plans.

The last inspection of this home took place on 3 September 2013. During that inspection we found that the provider was in breach of the regulations that related to people's care and welfare, meeting people's nutritional needs and staffing levels. The provider sent us an action plan stating what steps they would take to address the issues identified. At this inspection we confirmed that the provider had not completed the actions needed.

We found six breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate 

The service was not safe.

There were not enough qualified and skilled staff at the service to meet people's needs. Staff had not completed people's medicine records correctly. People did not always get the medicines in a timely way. All medicines were appropriately dispensed and stored safely.

People's risk assessments were not up to date and people's care was not being managed well.

Staff were recruited appropriately and they had the skills and knowledge to safely care for people. Staff understood what abuse was and knew how to report abuse if required

Is the service effective?

Inadequate 

The service was not effective.

Peoples rights were not protected as staff did not have a good understanding of the Mental Capacity Act 2005.

Staff did not feel supported and had not received up to date training to help meet people's needs.

People's weight and nutrition was not always monitored and where people had lost weight advice had not been sought from healthcare services to maintain good health.

People were supported to make choices about their meals and said that the food was good.

Is the service caring?

Requires Improvement 

The service was not always caring.

Some people said they were treated with kindness and compassion and their dignity was respected. Others felt they had been left on their own for long periods of time without interaction from staff.

Staff knew people's life histories, interests and personal preferences well but these were not always reflected in the care that was provided.

Is the service responsive?

Inadequate 

The service was not responsive.

People were not always supported to make decisions about their care and support. People's care were not regularly assessed and reviewed to ensure their needs could be met.

There were not always enough activities that suited people's individual needs.

Summary of findings

People knew how to make a complaint and who to complain to.

Is the service well-led?

Inadequate

The service was not well-led.

There were not appropriate systems were in place that monitored the safety and quality of the service. Where people's views were gained this was not used to improve the quality of the service.

People, relatives and staff felt that there was not a stable management structure at the service.

The providers stated vision for the service was not being met. Staff understood the values of the service but were unable to support them due to the lack of staff.

Moorlands Nursing 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 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 the 16 December 2014 and was unannounced. During the inspection we spoke with four people using the service, eight relatives and eight members of staff. Before and after the inspection we spoke with six health and social care professionals that visited the service on a regular basis. These professionals included a GP, community matron, chiropodist and social workers.

We observed care throughout the day on all of the floors including when meals were being served. We reviewed three care plans, three staff files, general information displayed for people and records relating to the general management of the service. This included audits, incident reports, minutes of staff meetings and staff training records.

The inspection team consisted of two inspectors and an expert-by- experience in living with people with dementia. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we reviewed records held by CQC which included notifications received from the service. A notification is information about important events which the service is required to tell us by law. Before the inspection we received information of concern that related to the low staffing levels, appropriate care not being provided to meets people's needs and care plans not being kept up to date.

We inspected the service on the 3 September 2014 where we found that the service was not meeting their staffing levels, people's nutritional needs were not being met and care records were not up to date. We needed to check on this inspection whether the service was now meeting these standards of care.

Is the service safe?

Our findings

People and relatives told us they felt safe from abuse. However they told us there were not enough staff to meet people's needs. One person told us "They look after us well but they are very short of staff." They said that when they pressed their call bell they sometimes had to wait a long time for a member of staff to come. One person told us that when the service was short staffed they had to wait longer for their medicine which had an impact on their health.

Risk assessments for people included measures that had been introduced to reduce the risk of harm. The deputy manager and staff told us that risk assessments should be updated monthly but that this was not happening consistently. The records we looked at showed that some risk assessments were not up to date. This included falls risk assessments, risk of malnutrition and risk of developing pressure ulcers. This meant that staff would not have the most up to date and appropriate guidance regarding people's care. Information from health care professionals stated that not all people's risks were appropriately managed. One person, who was at risk of falls before they moved in to the service, did not have the appropriate plans in place to minimise the risk. As a result this person suffered multiple falls which led to serious injuries. This is a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

All the rooms had door guards fitted. This was used to enable the door to remain open without the use of a wedge. Staff said that this meant that in the event of the fire alarm going off the doors should close automatically. However four rooms were being propped open by fans, a chair and a footstool with the door guards bleeping. A member of staff advised they were waiting for new door guards to replace ones which were broken. This meant that people were at risk in the event of a fire. There was also raised carpet on the stairway had which was stuck down with black tape and was becoming loose. One of the step guards on the stairway at the back of the home was missing, this also presented a slip risk and there were no warning signs present to warn people of the risk. This was in an area that was usually only accessed by staff.

In one person's en-suite bathroom a ceiling had leaked. Where parts of the ceiling had been taken down, the hole had not been covered which created a draft in the room. Rubble had not been removed from the room. The bathroom door had not been secured so the person living in this room could have accessed the bathroom and hurt themselves.. We were told by staff there this had occurred one week prior to our visit. Staff later removed this rubble before we left. This is a breach of regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We looked at Medication Administration Records (MAR) and found the daily checklist for medicine administration had not been signed by the nurse on 31 out of the 62 required occasions. The document, designed to reduce missing signatures on the MAR sheets, clearly explained that each time medicines were administered the individual must sign. This had not always happened. Within the MAR sheets there were missing signatures on 18 occasions for six people. There was a missing photograph on one person's MAR file. This meant that there was a risk of staff administering the medicine to the wrong person. There were missing PRN (as needed) guidelines for two people which meant that there was a risk that people may not receive medicines when they needed them. This is a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The medicine trolley was kept in a locked room and secured to the wall. Medicines were stored appropriately. All medicine was stored, administered and disposed of safely. Medication training was provided to nurses and people's medicines were reviewed regularly.

Staff had knowledge of safeguarding adults procedures and what to do if they suspected any type of abuse. Staff said that they would feel comfortable referring any concerns they had to the manager or the local authority if needed. They said that there was a safeguarding policy in the staff room if they needed to refer to it. There was a Safeguarding Adults and Whistleblowing policy in place and staff had received safeguarding training.

Recruitment files contained a check list of documents that had been obtained before each member of staff started work. The documents included records of any cautions or convictions, two references, evidence of the person's identity and full employment history. This gave assurances that only suitable staff were recruited.

Is the service effective?

Our findings

People and relatives had mixed views about whether they were receiving effective care at the service. One person said "My healthcare needs are not met, the carers have no time." whilst another person said "The staff know how to care for people, they look after me properly they are getting me walking again" One relative told us that their family member was being supported by staff who knew their role and how to support each person individually.

Health care professionals told us that they didn't feel that the nursing staff had the knowledge and skills needed to provide appropriate care to people. They told us that the nursing staff were newly qualified and needed a higher level of support from them than was normally required. Health care professionals told us that their visits to the service were more frequent that normal as they wanted to make sure that people were getting the level of care due to the inexperience of the current nursing staff.

Staff were not kept up to date with the required training. The interim manager told us that since the last inspection staff had been contacted in relation to getting their training up to date. One health care professional told us that they provided free training to clinical staff but that only minimal staff were made available for this training. Records showed that staff were not up to date with the service mandatory training. For example 32 members of staff had not received first aid training, seven had not received fire safety training, 11 had not received infection control training and 11 had not received manual handling training. We were not provided with the records that related to the training for clinical staff however the interim manager told us that this training was not up to date either. This meant that not all staff had the appropriate and up to date guidance in relation to their role.

Staff commenced training during their induction, and had a probationary period to assess their overall performance. Staff did not receive regular supervision or annual appraisals. The clinical supervision record showed that five nurses had not received any supervision with the manager in 2014 and six staff had only had one supervision with their manager since March 2014. This meant that staff had not had the opportunity to discuss any additional support and training needs they had. Only seven members of staff had received an appraisal in 2014. The interim manager told us that supervisions for all staff were behind and provided an action plan of when these were going to be done. Staff told us that they did not always feel supported and were unclear of what their roles were. These are breaches of regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We spoke with two social workers who had carried out reviews of people's care plans recently. They told us the care plans were incomplete and the daily care notes were either inconsistent or not completed with any level of detail. One social worker told us that one person had been diagnosed with dementia before they moved into the service but staff told them that they felt they could not meet this person's needs. We were told by the interim manager that the service did not have people with a primary diagnosis of dementia in the home, as staff did not have the knowledge or skills to care for them. However we found that there were people in the home living with dementia, and that the diagnosis had been determined prior to their admission. This meant that there was a risk of staff delivering care based on incomplete or out of date information.

People said that staff gained consent from them before delivering any care. Staff gave examples of where they would ask people for consent in relation to providing personal care. We saw several instances of this happening during the day.

Staff were informed about their responsibilities under the Mental Capacity Act 2005 (MCA), and the Deprivation of Liberty Safeguards (DoLS). The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. These safeguards protect the rights of people by ensuring if there are any restrictions to their freedom and liberty, these have been authorised by the local authority as being required to protect the person from harm. Records showed that people's capacity had not been assessed and the interim manager confirmed this. They told us that they were going to be undertaking these assessments where appropriate.

The front door had a coded door entry system. Care plans we looked at did not contain MCA or DoLS applications in relation to people not being able to access the code. We spoke with the deputy manager about the lack of MCA assessments and DoLS applications for those people that required them. We were told that they had not made applications to Surrey County Council in relation to people that lacked capacity where they felt their liberty may be

Is the service effective?

restricted. After the inspection the deputy manager provided us with an action plan to address this. We saw that where 'Do not resuscitate' (DNAR) forms had been completed for people who lacked capacity there was no evidence that capacity assessments had been completed. This is a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People and relatives said that the food looked good and that there was plenty of it. One relative said "They always cut it up for her." Another said "They always put the water within reach." One person told us that the food had improved over the last few weeks, but they had never been asked for their opinion on the meals. They said there was enough to eat and drink and water was left within reach. One relative said the food was prepared for their family member in a way so they could eat it as they had difficulties swallowing. We observed the meal had been pureed to meet this need and that each portion of the meal had been presented individually so the meal continued to appear appetising.

People had a choice of where to have their meals, either in the dining room or their own room. A menu was displayed outside the dining room. The chef explained that each person was asked what they wanted to eat from a choice and that they could change their minds if they wanted to.

People were supported in maintaining a balanced and nutritious diet. The chef told us that although the menu was set by the provider they also included meals that they knew the people liked. There was plenty of fresh fruit and vegetables available for the meals. The chef had records of people's individuals requirements in relation to their allergies, likes and dislikes and if people required softer food that was easier to swallow. For those people that needed it equipment was provided to help them eat and drink independently, such as plate guards and adapted drinking cups.

Nutritional assessments were carried out as part of the initial assessments when people moved into the home. These showed if people had specialist dietary needs. People's weights were recorded but this was not happening consistently. One person who was at a high risk of malnutrition needed to be weighed weekly. On the day of the inspection we found this person had not been weighed for four weeks. We saw that on the last three occasions they were weighed they had lost weight. The notes in their care plan mentioned on one occasion that the person needed 'Better food and fluids' but there was no evidence of what action had been taken to address this. There were no records to show that a referral had been made to the appropriate health professionals such as a dietician to gain advice. People were not always getting the correct care that met their needs. This is a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People had access to a range of health care professionals, such as chiropodist, community matron and doctor. A doctor visited regularly and people were referred when there were concerns with their health.

Is the service caring?

Our findings

There were mixed feelings from people and relatives about whether they felt cared for. One person said "It's a nice place, but (staff) never come in and they all stick together. The television is always on the same programme." One relative said the staff worked well and cared for their relative. They told us they were able to visit regularly, which was important to their family member. Other comments included "They (staff) are kind caring and respectful, they do whatever they can and we have respect for them" and "The only time they get to talk to you if when they are washing you, sometimes I don't see anyone all morning" and "The carers are always sweet, Mum always responds to them, more than us." Health care professionals told us that staff were caring and helpful.

Staff told us that there were not enough of them to always meet people's needs. They said they felt the care they were giving was too fast and that they would like to be able to spend more time people when bathing them, to be able to sit and chat with them about their interests. One member of staff said "Senior management are saying that the staffing ratio is enough but I don't think so, some people here are high dependency and we can't give the level of care needed (due to the staffing levels)." One member of staff told us that there were times people who used wheelchairs went straight from lunch to their bedrooms to be transferred to bed instead of a lounge chair. They said that this was to reduce the amount of times people had to be transferred due to the lack of staff.

People were not always treated in a dignified way. During lunch everyone in the dining room was sitting in wheelchairs; some of the tables were not high enough to be able to accommodate wheelchairs and as a result they were too far away from the tables. This meant that people were leaning across and spilling food onto their clothes. One member of staff was sitting in between two people trying to assist them to eat alternately. Two people in their rooms were left sitting in wheelchairs all morning and the television in the lounge was on the same station all day, we did not see anyone check on the single person who was left in there. One relative told us that during a visit they found their family member was left in soiled clothes. They said that they told a member of staff who then addressed this however it left them concerned about how often this might occur when they were not around.

On the day of the inspection there were concerns around people's oral hygiene. One person's toothbrush had solidified toothpaste on it where it had not been used for a considerable length of time. A relative told us that they had concerns that their family member's teeth had not been brushed lately. We heard this relative ask staff when they were last brushed and they were unable to say.

We saw an occasion where one person had been left in the dining room prior to lunch being served. The person was sitting listening to music which had been put on for them. A member of staff entered the room and turned the music down and then left the room. They did not ask the person if they were happy with the volume of the music or if they minded the music being turned down. One member of staff told us that not all staff were as caring as they could be.

Throughout the inspection there was a strong smell of urine that led from the hallway down one of the corridors that remained throughout the whole day. Staff were unable to identify where this smell was coming from. The interim manager told us that they were unsure where the smell was coming from but would address this. These are breaches of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The interim manager told us that there was no up to date 'Residents and relatives' survey as the information from the latest survey was still waiting to be analysed by head office. We asked for minutes of any residents meetings but these have not been provided. There had not been any residents meetings recently. This meant that people had not had the opportunity to regularly express their views on how the service was run.

We saw examples of where staff were respectful of people. Staff asked people where they would like to sit in the dining room and what music they would like to listen to. Staff chatted with people and responded in an appropriate manner to their comments. One person requested a drink and the staff member provided this and warned the person that their drink may be hot and to be careful. They checked that the person was okay and happy prior to leaving the room. Staff gave examples of how they would provide privacy and dignity to people. They said they would cover people when providing personal care and made sure the doors and curtains were closed.

Is the service caring?

Relatives told us that they were able to visit when they wanted to and we saw this happen regularly throughout our inspection.

Is the service responsive?

Our findings

Not all people said that they felt involved in their care planning. Relatives said they were involved in making decisions and had input in to their family member's care plan. One person told us their daughter was involved. Relatives said the service met with them to assess the needs of their relative prior to moving in to the service, they said they "Were happy this happened as it showed them their relative was going to be looked after".

Care plans were inconsistently completed, some contained more detail than others about the way staff needed to care for people. Some people were asked about the preferred times to get up. However those that asked if they could get up early didn't always get this as it depended on how many staff were available. One person, who had stated that they liked to get up early, told us "When they are short staffed its sometimes 10.30 or 11.00 and I am not dressed and still waiting for care." This person was still waiting for staff to assist them to get dressed at 11.00 on the day of our visit. One person stated in their care plan that they preferred a female carer yet on the day of the inspection a male member of staff was providing personal care.

People's health needs were not monitored appropriately. One person had been admitted with a high risk of malnutrition. Since moving in they had lost approximately seven kilograms of weight over a period of three months. Their care plan stated that they needed to be weighed weekly. Records showed that this person should have been weighed 24 times since they moved in but they had only been weighed 13 times. They had not been weighed since 13 November 2014. There was no information in the care plan to explain what staff were doing to address the weight loss and no evidence that advice had been sought from health care professionals.

One relative told us that her family member had to stay in bed. They said that this was because staff had told the family that they (the family) needed to buy a new cushion for their relative's wheelchair to reduce the risk of developing pressure sores. We asked a member of staff about this and they told us that they would contact the Tissue Viability Nurse to obtain advice about the right sort of cushion to buy. Staff were unable to tell us why this had not been done already despite knowing that this was an issue. We asked the regional manager why the family had been told that they needed to buy the new cushion and they stated that they should not have been told this and that they would order one for the person. This person needed to be turned in bed hourly yet the records showed that this was not being done consistently.

These are breaches of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The interim manager told us that there were not enough suitably skilled staff to meet people's needs. They told us that this had impacted on the quality of the care that was being provided. When we arrived at the service most of the staff were providing personal care to people in their rooms. Some people did not receive personal care until approximately 13.00 due to the shortage of staff. This meant that people were still sitting in their bed clothes until lunch was served. Around five people had gone out with staff on a day trip. This meant there were no staff available to support people left at the service with any meaningful activities. Some staff supported people to eat in their rooms but one person did not have their meal until 14.00 that day. One person needed support from staff to take a ten minute walk each day which had been recommended by the physiotherapist which the member of staff said was not happening. Healthcare professionals also told us that there were not enough staff to meet people's needs and as a result there was no continuity of care for some people. This demonstrated there were insufficient numbers of suitably qualified skilled and experienced staff employed to meet people's needs. This is a breach of regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. We observed occasions where staff responded to people's needs. One person became anxious. Staff supported them to wash and get dressed. They talked with the person in a calm manner, explaining what they were doing and why. Staff were able to clearly explain why the person behaved in this way and how they were required to support them.

A relative talked about how they felt their family member lacked stimulation and worried about what they did when they were not there. Some people were out on a day trip with staff on the day that we inspected but there was no activities left for the people that remained in the home. There was an activities coordinator who had made a note of what people liked to do. However the records of the activities didn't reflect what people's interests were. One person's record of activity stated that they had a one to one session with the activities coordinator four times since the

Is the service responsive?

13 October 2014. There was no mention of how this person's interests were incorporated into her daily life. One member of staff told us that although on paper it looked like there was plenty for people to do this was not happening in practice. Other staff said that if the activity co-ordinator was out of the service there was no other provision for people and they will stay in their rooms. The interim manager told us that the activities "Needed more organisation." This is a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Some people and relatives said they were confident they could raise any issues about care without any concerns. They said they were happy with the care provided and did not have any current concerns. However another comment from a person was that "They (staff) never listen if I make a complaint, I would never come here again, never" Staff clearly explained the complaints procedure, who to raise the issue with and the process. Staff gave an example of how a person had raised an issue of the timing of their medication and how it impacted upon their needs. The issue was investigated and the timings adjusted to meet the person's needs. The service had a policy regarding complaints which was displayed for people to see. We saw a copy of the latest complaint which related to the parking facilities at the service. This had been responded to by the regional manager and assurances had been made that this would be addressed when upgrades were due to the building and environment. Complaints were not used as an opportunity for learning and improvement of the service.

Is the service well-led?

Our findings

People and relatives had mixed views about the management of the service. One person said "They could do better" Comments from relatives included "More discipline; it needs someone to take responsibility" and "The management needs to be more professional." Leadership within the service was inconsistent.

Staff raised concerns regarding the change in management structure. Staff told us there had been three managers in the past 12 months and it was difficult for newer staff to know how to carry out their jobs. Staff said for the more experienced staff this was not an issue. Staff said they enjoyed working for the organisation and "generally" felt supported but not all staff understood their roles and responsibilities. For a period of time relief managers from the provider's organisation had been managing the service in the absence of the registered manager. The interim manager told us this was for the foreseeable future while the provider recruited a permanent manager.

Although there were systems to assess the quality of the service provided in the home we found that these were not always effective. Staff undertook internal audits on infection control, medicines and care plans. We found that although these had picked up some of the issues we had found they still had not been addressed since our last inspection on the 3 September 2014. An infection control audit was undertaken in November 2014 and had identified a shortfall in people's oral hygiene however these issues were still occurring. Despite requesting it we were not provided with evidence of any learning from accidents and incidents. This is a breach of Regulation 10 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We spoke to the interim manager and regional manager about the concerns we found at the service during our visit. The interim manager was committed to supporting the staff to make improvements. One of the concerns we discussed was about staffing levels. The interim manager said they understood that there were occasionally staff shortages and told us there were plans to look at the staffing levels in the home.

The provider's website states that 'Life in a Caring Home is viewed as a continuum of life, an opportunity to gain new experiences and learn new things, whilst maintaining your existing hobbies and interests'. This was not being put into practice. Staff understood the values of the service but felt that with the current staffing levels and lack of secure management they felt they couldn't support these values as well as they wanted.

Services that provide health and social care to people are required to inform the Care Quality Commission, (the CQC), of important events that happen in the service. The interim manager of the service had informed the CQC of significant events in a timely way. This meant we could check that appropriate action had been taken.

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 Treatment of disease, disorder or injury	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment **The registered person did not have suitable arrangements in place for obtaining, and acting in accordance with, the consent of service users in relation to the care and treatment provided for them in accordance with the Mental Capacity Act 2005 and the Deprivation of Liberty safeguards.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers **People were not protected against the risks of inappropriate or unsafe care or treatment.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff **People were not supported by appropriately trained and supported staff.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing **People were not protected against the risks of unsafe premises.**

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 Treatment of disease, disorder or injury	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing **The registered person did not have suitable systems in place to ensure there were sufficient numbers of suitably qualified, skilled and experiences persons employed.**

The enforcement action we took:
We issued a warning notice to the registered provider on the 23 December 2014 in relation to Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. We have set a timescale of 23 January 2015 by which the registered provider must address this breach.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services **People were not receiving safe and appropriate care, treatment and support because they did not have an up to date assessment of needs and care plan.**

The enforcement action we took:
We issued a warning notice to the registered provider on the 23 December 2014 in relation to Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. We have set a timescale of 23 January 2015 by which the registered provider must address this breach.