R S Property Investments Limited

Gresley House Residential Home

Inspection report

Gresley House
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Tel: 01283212094

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24 March 2016

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Inadequate**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

We inspected Gresley House on 17 March 2016 and 24 March 2016 and both inspections were unannounced. This was the first inspection for the new provider. The service provides residential care and support for people, some of whom are living with dementia. It is registered to provide care for 27 people and at the time of our inspection 26 people were resident.

The service had a new manager in place that was in the process of becoming registered. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations about how the service is run.

Risks to people's health and wellbeing were not adequately assessed and managed leaving people at risk of harm. Where risks had been identified the provider did not always take action to remove or minimise the risks. Changes to people's health were not always responded to by referring them to healthcare professionals. Some people did not receive enough support with eating and drinking. Staff did not always have the skills to be able to support people effectively and the provider did not have a system in place to routinely assess their competence.

There had been a number of safeguarding concerns which occurred at night and a report had been written by the manager which recommended increasing the staffing numbers to reduce the risk of harm to people. The provider had not responded to this recommendation and there were not always enough staff to respond to people's needs.

Medicines were not always available as prescribed and people did not always consent to the medicines they were given. Where people lacked capacity to make decisions for themselves, there was not an assessment completed to consider what decisions should be made in the person's best interest. Some decisions were made without the person's consent or the consideration of who should be included in deciding what was in their best interest.

The premises were not fully maintained and risks in the environment were not managed to reduce the possibility of harm to people. Plans to respond to emergencies such as evacuation were not adequate to ensure that people could be supported safely.

People's dignity and privacy were not always upheld and staff reported that they were not always able to spend quality time with people. When they did, we observed respectful relationships and that were people were treated with kindness.

Peoples care plans were not always altered to reflect a change in their support needs and so did not assist staff to provide a personalised service. Opportunities to pursue hobbies and interests were limited for some

people and some of the premises, such as the garden, were not maintained well enough for people to be able to use them.

Complaints were not well managed and formal complaints the provider had received had not all been responded to promptly and resolved to people's satisfaction.

The service was not well led because the provider did not respond to assessed risk and concerns in a timely manner to provide people with the adequate care and support to keep them free from preventable harm. Staff reported that they did not feel their concerns were listened to and this meant that issues around people's health and wellbeing were not always actioned. The systems in place to drive improvement were not effective because they did not identify areas for improvement or when they did these were not responded to.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.
People had not consistently received care that kept them safe from the risk of harm. There were not always enough staff at to meet people's support needs safely. Medicines were not always given as prescribed or with people's consent. The environment was not well maintained or managed to keep people safe from harm.

Is the service effective?

Requires Improvement

The service was not consistently effective.
Staff did not always have the skills and knowledge to meet people's needs effectively. People were not always supported correctly to meet their health needs or to access health care support when it was needed. Their food and fluid needs were not always monitored and responded to. People were not protected by staff who effectively and consistently applied the Mental Capacity Act 2005.

Is the service caring?

Requires Improvement

The service was not consistently caring
People's dignity and privacy were not always upheld. Most staff did have good interaction with people and knew them well. Relatives were always welcomed to visit.

Is the service responsive?

Requires Improvement

The service was not consistently responsive
People had not been involved in developing or reviewing care plans which met their needs. Some activities were available for some people but opportunities for other people were limited. Complaints were not always managed well.

Is the service well-led?

Requires Improvement

The service was not consistently well led.
The systems that were in place to improve the service were not

adequate to make changes to ensure that people were kept free from harm. Effective strategies were not in place to monitor and increase staff numbers. Staff were not always well supported by the provider.

Gresley House 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 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.

The inspection was unannounced and completed over two days on 17 March 2016 and 24 March 2016. On the first day it was completed by one inspector and an expert by experience. The expert by experience had personal experience of using or caring for someone who used a health and social care service. The second day was completed by two inspectors to follow up on concerns raised from the first day of the inspection.

The provider had completed 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 used this information to help us to plan our inspection and come to our judgement. On this occasion there was a new manager in place and when we discussed the PIR at the inspection some of the information was no longer relevant. We gave the manager the opportunity to share information they felt relevant with us.

We looked at information received from the public and the statutory notifications the registered manager had sent us. A statutory notification is information about important events which the provider is required to send to us by law. We spoke with one commissioner about their experience of working with the provider. Commissioners find care and support services which are paid for by the local authority.

We spoke with six people who used the service and four relatives about their experience of the support they received. Some people were unable to speak with us about the care and support they received. We used observation to help us understand their experience of care. We also reviewed the care plans for twelve people to consider whether the information in the records assisted staff to meet peoples' needs safely.

We spoke with ten members of staff, the manager and the operations manager. We reviewed four staff files to see how staff were supported to fulfil their role and to check that recruitment procedures were followed to make sure that staff were suitable to work with people.

We also looked at the systems the provider had in place to ensure the quality of the service was continuously monitored and reviewed to drive improvement.

Inadequate

Is the service safe?

Our findings

We saw that people were not always protected from risk of harm to their health and wellbeing and we observed that people were not always supported to move in a safe way. For example, one person was being transferred using the incorrect equipment. Staff we spoke with told us that they had been directed to use this for all the of that person's support. We saw the equipment being used should only be used in particular transfers such as for personal care in a bathroom. We saw this was used for all moving and handling and there was only one of them available. Records that we reviewed did not give clear guidance for staff and no professional input had been sought to ensure that they were meeting safe moving guidelines. We also observed one member of staff on several occasions assist people to stand by lifting them from under their arms. This does not follow national guidelines on the safe handling of people and could cause pain and injury to the person. Staff we spoke with told us that they did receive training in supporting people to move safely but that they were not observed afterwards to ensure that they knew how to put this into practise. We saw that some people did not have the equipment needed to meet their needs safely, for example one person did not have a bed that could be altered to support them to get in and out of it safely. This meant that additional equipment was needed to safely transfer them and staff we spoke with identified the difficulty that they had using this in bedrooms with limited space. There was no assessment to identify the risks to the person or the staff and no guidance had been provided to manage this situation safely. This meant the provider did not assess the risks to ensure people were safe from harm or that staff had the appropriate equipment, knowledge and support to carry out their role.

We saw when people's behaviour put themselves or others at risk of harm there was not a consistent approach agreed and shared with staff to support them. For example, we observed that one person who displayed self-harming behaviour was not supported in the same way by staff to help manage their behaviours. We saw that one person was able to help the person to calm down through reassurance and distraction but another person said that they did not know how to assist them and had not gone in to the bedroom even when they knew the person was distressed. Two further members of staff we spoke with said that they did not know how to support this person to reduce this behaviour and acknowledged they were often left alone in their room when they were distressed. One member of staff we spoke with said, "We have never talked about how to support them and I haven't seen a plan". Records that we reviewed were out of date and did not reflect the person's current situation. This meant that the risk of this person harming themselves or others had not been managed or actions taken to minimise it.

We saw that there were hazards in the environment which placed people at risk of harm. During some building maintenance work there had been no interventions to safely manage the environment. For example, one room was accessible to people and there were hazards which could cause harm, such as drills and step ladders. We saw three different people enter this room over a half hour period. There were no staff in the vicinity and no one noticed the people enter the room. We had to locate a staff member to assist one person to vacate the area, to ensure their safety. We spoke with the manager to raise our concerns and asked that they take immediate action to remedy the situation and reduce the risk of harm to people. The manager then arranged for the room to be cordoned off and for a member of staff to be in the vicinity. They said, "I should have put a risk assessment in place".

The premises were not managed to reduce the risk of harm to people. We saw hazards which could cause people to trip or slip in communal areas. For example, we saw that equipment such as wheelchairs, walking aids and seated weighing scales were stored in the lounge and the corridor. Other risks in the environment were not assessed and reduced to ensure that it provided a safe place for people. We saw that there was an insufficient barrier to some steep stairs and the manager told us that they did not think it was adequate. The gate that was there could easily be opened and on one occasion we saw that it was left open when a member of staff went through. In one of the bathrooms there were hot pipes which were exposed and within reach of people using the room. In the staff room we saw boxes of out of date paperwork, piled high to the ceiling. The manager told us, "I have raised this as a fire hazard with the provider". This meant that environmental risks had not been assessed and reduced to keep people safe from harm.

We looked at people's emergency plans and these did not provide guidance about the level of support people would need to be evacuated from the home in an emergency situation. For example, for people who lived upstairs, their plan did not describe how they would get down the stairs and the level of support they would require. The manager told us, "We have evacuation sheets in place now but we need training in using them". Staff we spoke with were unable to describe what plans were in place to assist people to leave the building in an emergency. This meant that the plans in place to respond to an emergency where the home needed to be evacuated were not adequate and placed people at risk of harm.

When records were kept to monitor people's health and wellbeing we saw that the information gathered was not always analysed and action taken as a consequence. For example, records showed that one person had several falls mainly during the early hours of the night. No action had been taken to reduce the risk of further falls and there was a delay in making a referral to health care professionals for additional support and guidance.

We saw that medicines were not always managed safely to meet people's needs. We saw that two people required medicine that was prescribed for them to use as required. There was no stock available of this medicine to alleviate their pain and discomfort. Staff we spoke with were unclear when these people needed to take this medicine. One member of staff said, "I think it should be given after three to five days but I would probably have to check with the G.P.". We saw that there was no PRN protocol in place to describe to staff when the medicine was needed. One person had refused to take their medication for over a month and there was not protocol in place to review this situation or seek advice from a healthcare professional. We could not review the person's records of the medicine that they should take because these were not available. This meant that people were not given their medicines as they were prescribed

We observed the administration of medicines and saw that people did not always consent to taking them. One person was told that the medicines they were given were to treat a certain condition which they were not. When we asked the member of staff why they told the person this they said, "Some days they refuse and say I don't need them and so if you say this then they will take them". We reviewed the person's care plan which stated that they always took their medicine and did not need additional support. This meant that the person did not consent to take the medicine that they were given.

We also saw that one person was asked whether they needed medicine for a certain condition and they said that they did. The member of staff did not return to the person with the medicine or to tell them what they were doing. When we asked them why they hadn't provided the medicine they said that they had checked the person's daily records and knew that they did not need them. They did not tell the person this, or follow up to check if there was another reason for their pain. This meant that the person did not get the medicine that they requested and did not have their needs adequately assessed.

This evidence represents a breach of Regulation 12 of the Health and Social Care Act 2008. (Regulated Activities)

We saw that there were not always enough staff at night to keep people safe and meet their needs. Staff we spoke with told us, "If there is an emergency at night where two staff are needed then we can't support the other people". Another member of staff said, "We need to care for the residents, some of whom are often awake and active through the night. We also have a cleaning rota which we are expected to complete and we also can have laundry to iron". We saw that the majority of falls and two safeguarding concerns had happened at night. One person had sustained an injury from a fall and the manager told us, "They were found at 7am and we assume it was a fall during the night". The manager had recognised that an additional member of staff was required to ensure that people could be monitored and supported. They had completed a report which evidenced the need for the additional member of staff however the provider had not taken action to increase the staffing. This meant that people did not have support from sufficient staff to keep them safe.

This evidence represents a breach of Regulation 18 of the Health and Social Care Act 2008. (Regulated Activities)

We saw that people were not always safeguarded from avoidable harm and abuse. Staff we spoke with had received training in safeguarding and were aware of their obligations to report any concerns that somebody may be at risk of harm. However, three staff we spoke with raised concerns with us about the wellbeing of one person. They told us that they had reported their concerns but no further action had been taken. When we spoke to the manager they were aware of the concerns and told us that they had made a referral to health professionals two months earlier but had not requested any support since. They said, "I think they have got worse and that we should probably organise a meeting". This meant that staff and the manager had not followed safeguarding procedures to protect people from harm.

We saw that people were not always protected from harm because the systems in place to control the risk of infection were not sufficient. We saw that the arrangements for collecting clinical waste were not adequate as there was only one clinical bin downstairs. One member of staff we spoke with said, "There is only one clinical bin downstairs and so we put aprons and gloves in the normal bin and when we are supporting people upstairs. We collect the used incontinence aids in one plastic bag and carry them down to the bin". We observed a bin in the bathroom with no lid on it that had used disposable gloves and paper towels overflowing from it. Another member of staff we spoke with said, "There is no equipment like gloves stored upstairs and so we have to carry them up". This meant that staff may not have sufficient equipment to protect them and the people they supported in an urgent situation.

We saw areas of the home that were unclean and in need of maintenance. We observed that the floor was peeling up in the bathroom and there was dirt collected there. There was stagnant water in a drain in the bathroom which had a film of grease on it and the bath-chair was dirty and dusty. The skirting board in the dining room was unclean and a member of staff told us, "When I was hanging decorations I felt that the wall was grimy in the dining room".

We saw that recruitment procedures were followed to ensure that staff were safe to work with people. Staff told us their references were followed up and a Disclosure and Barring Service (DBS) check was carried out before they could start work. The DBS is the national agency that keeps records of criminal convictions. One member of staff said, "They did the police checks before I started and I gave references". Records that we looked at confirmed this.

Requires Improvement

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) provides the legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack capacity to take particular decisions, any made on their behalf must be in their best interests and least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called Deprivation of Liberty Safeguards (DoLS).

We checked whether the provider was working within the principles of the MCA, and whether any conditions or authorisations to deprive a person of their liberty were being met. We saw that one person had been diagnosed with a serious condition and the decision had been taken for them not to receive medical treatment. The person had not been consulted on this and there was no assessment to review whether they could make the decision for themselves. The person's records said that they had capacity to make a lot of decisions for themselves. When we asked the manager about this they said, "I was under the impression that someone had spoken to them about it". Another person was refusing care. One member of staff we spoke with said, "It is hard to know about consent with them; yes day to day but they may not understand the consequences of their choices". An assessment had not been completed to review the person's capacity to make these decisions. This meant that people's human rights were not met and that they were unlawfully restricted.

We saw that there were locked doors with a code to stop people leaving the building which were not shared with the people who lived there. A capacity assessment had been completed for everyone to demonstrate that they did not have capacity to make the decision about whether they could leave the building and a DOLS application had been made for each person if necessary. When we discussed this with the manager they acknowledged that the assessments were not personalised to each person's needs. They said, "On reflection I think that some people do have the capacity to make that decision for themselves". This meant that some people were unlawfully restricted in their home.

This evidence represents a breach of Regulation 11 of the Health and Social Care Act 2008. (Regulated Activities)

We saw that staff did not always have the knowledge and skills to support people effectively. For example, we saw that one person's catheter was low on their leg and required emptying. Three members of staff interacted with this person but did not notice or respond to this. We had to ask a member of staff to support them. We saw that four other people had not been supported with maintaining their fluid levels in line with the guidelines that were given. When we spoke with staff about this they told us that they received training in supporting people who used catheters and they could describe what they would do. They said that they were not observed after the training to ensure that they were doing it correctly. A healthcare professional we spoke with said that staff did not always understand the training they had received. They told us, "We have provided training but it is not put into practise and so it seems the staff lack understanding or are not

responsive". The manager told us that they did not routinely check staff member's competency after training to check that they understood the training and how to reflect it in their practices. This meant that people did not receive care from staff with the skills and knowledge to support them effectively.

We saw that staff were not always prepared when they started work during their induction. One member of staff had not been fully informed of the risks associated with people that they were going to support. Another member of staff told us, "I was helping [name] when they first started and we both attended to the person in their room. It was only afterwards that one of my colleagues told me that they shouldn't work with them because of their age". This meant that the member of staff was in a situation that put them at risk of harm because they had not received adequate information and support from the provider when they started their employment.

We observed that people did not always have sufficient to eat or drink. For example, one person was given a meal that they said they did not want. After half an hour they had not eaten the food and during that time no staff members had sat with the person to support them. They were then given a second option which they said was too hot and a member of staff replied that it was not. This was removed after twenty minutes without staff supporting the person to try it. The records for this person had identified they had steadily lost weight since they had an injury earlier in the year. Although the amount that they ate was recorded, no action was taken to alter how they were supported with their meals, review what meals they had or refer them to a healthcare professional.

We saw that other people waited a considerable amount of time for their meals. Some people ate their meals away from the dining room and one person in a lounge had fallen asleep before they were served their meal after waiting for half an hour. Staff we spoke with told us that people chose to eat away from the dining room; however, there were no additional seats available in there for them to make a different choice.

We saw that people were not always supported to maintain good health or to have access to healthcare services. A healthcare professional we spoke with said, "Basic care is not being given and I have to remind staff about things like encouraging good hygiene". They also said, "On a recent visit I had to resolve a situation that had not been referred to me. I saw it on the charts that were filled in but nobody highlighted it to me". Records we reviewed were not in place for all people that needed them to be monitored and for others there were gaps. This meant that people were not always supported to have their health needs met, that monitoring of their health was unreliable and that referrals to healthcare professionals were not always made in response to changing health needs.

Requires Improvement

Is the service caring?

Our findings

We saw that people's dignity was not always upheld. For example, we observed that people's personal hygiene was not always maintained and that people had food left on their face after a meal. One person had breakfast on their face two hours after they had finished eating. Other people's hair was unwashed and some people had long dirty nails. One person had their nails painted but the nails underneath were dirty and had a poor odour. We looked at people's records and saw that some people had not had a bath for over three weeks and staff we spoke with confirmed that it was often difficult to do this. One member of staff we spoke with said, "I didn't do a bath today because I had to be on the floor and they do often get missed. A lot of people don't want showers and baths but if we had more time to reassure them then I think they would".

We saw that people's personal belongings were not always kept safely and were not available to them. One person we spoke with said, "I like knitting but the staff keep it in the office and I have to ask for it". There were several personal items, such as slippers, which had been left in a room where building maintenance was taking place, covering them in dirt and dust.

Some people we spoke with did not always feel valued. One person we spoke with said, "Look on the door, they spelt my name wrong, it's been like that for some months". Another person said, "I don't like [name] because they act like they are better than me and don't listen to what I say".
We saw that some people's privacy was not always respected. We heard one person's continence discussed openly with them in a communal area. Another person's behaviours were described to us by staff and other people who lived there, in front of the person. This meant that people were not always treated with dignity and respect.

This evidence represents a breach of Regulation 10 of the Health and Social Care Act 2008. (Regulated Activities)

We saw that most of the staff were kind to people and had warm relationships with them. They chatted freely and talked together about subjects that interested them. For example, we heard people talking about their families and previous holidays that they had taken. We saw that when someone was distressed staff spent time with them reassuring them and calming them. One member of staff we spoke with said, "I love my job because I love the people here".

Relatives and friends we spoke with said that they could visit when they wanted to. One relative said, saying "There are no restrictions; I mostly visit with family a couple of times a week

Requires Improvement

Is the service responsive?

Our findings

We saw that people did not always have their care reviewed when their needs altered. For example, one person had been diagnosed with a health condition. Staff we spoke with said that they had not been advised how to support the person differently and two staff said that they were unsure whether the diagnosis was correct, as they had not observed any further symptoms. The person's care plan had not been updated to reflect the change in their health so that staff would know how to monitor any deterioration or support with pain management. Another person was no longer participating in their own personal care but their plan did not reflect their current ability. One member of staff we spoke with said, "We don't know how much we should do for them or whether to let them make their own choice". People we spoke with were not aware of their care plan and there were no records to show that they, or people who were important to them, had contributed to them. Reviews were not routinely held to consider whether the plans in place to support people were meeting their needs. For example, we saw that one person had been prescribed medicine to manage their behaviour because it helped them to calm down when they were anxious or distressed. Staff had administered this medicine eight times in the past month, but they had not recorded the reason why they had given it. This meant that there was no analysis of the person's behaviour over this time to consider whether there were any patterns to it so that their care could be reviewed and possibly changed to avoid circumstances which may trigger the anxiety. Another person had required emergency care on two occasions in the past month to help them manage their health conditions. A healthcare professional said, "They do not have the correct bed to manage this person's health because they are unable to sit up. They have not reviewed this situation and so I ordered something which would adapt their current bed but it is not ideal". Records that we looked at were often out of date because they were not altered in response to changes in people's health and wellbeing.

We saw that there were some activities provided by a member of staff such as card games. However, there were also considerable periods of time when people did not have any interaction. One person we spoke with said, "I get on all right, but I have no close friends and there's nothing to do at night". Some people spent long periods of time alone in their rooms. For example, we observed one person who sat in a chair in their room with their bedroom door open showed some signs of distress. We saw that staff completed tasks to support them, such as bringing them meals but did not provide social interaction. One person we spoke with said, "I would like to be able to go out more but I can only go if my relative visits". There was an outside patio area but it was overgrown and in need of repair so people were not able to use it. One member of staff we spoke with said, "It is a shame because I know some of our gentlemen would really enjoy planting seeds and getting involved in the garden". Staff that we spoke with said that they did not have adequate time to support people with their interests and hobbies. One member of staff said, "We would love to be able to spend more time just talking to people and reassuring them but it is always non-stop".

We saw that the provider did not always respond to complaints in a detailed manner to demonstrate that they had been fully investigated. One relative we spoke with described a complaint they had raised. They noted things seemed better; however they had not received a formal response to their complaint and could not identify what action the provider had taken. We saw another complaint about an individual's belongings had not been fully responded to. The manager said, "This was before my time but I am aware of it. I don't

think it was ever really resolved and the person has now left".

Requires Improvement

Is the service well-led?

Our findings

We saw that the provider did not have systems in place to deliver quality care. They did not always respond to highlighted risks and issues to ensure that people received safe care and treatment. The manager had identified the need for additional staff at night to keep people safe. This related to the number of falls that happened but the numbers of staff were not increased. On the first day of the inspection we said that night time staffing levels were not sufficient. During the second day of the inspection, the manager told us they were now recruiting for additional night staff. We discussed our concerns with the manager who then obtained authorisation from the provider to increase the staffing levels with immediate effect. This showed that although the provider had identified that additional staff were needed they had not taken action to reduce the risk to people and keep them safe from harm.

The provider did not always respond promptly to changes in people's needs to ensure that they received the care and professional input that they required to maintain their health and wellbeing. People's records were not always up to date and there was not a system in place to review them so that staff had the correct information to support people safely and meet their needs.

A fire risk assessment had been completed by the provider which highlighted hazards which were still in place nine months later. The provider had not shared this assessment with the manager. The manager had raised concerns about storage which caused a fire hazard and they had completed a risk assessment three months ago. These hazards were still in place and no action had been taken by the provider to reduce the risk. This meant that the provider did not ensure that the property was safe for people.

The provider had neglected areas of the home which required maintenance. For example, maintenance of the bathrooms had not been completed which left them unclean and unhygienic. They had not completed an infection control assessment and did not have a named member of staff to lead this area of quality improvement. This meant that infection control was not adequately managed which put people at risk of harm.

We saw that the provider had converted two rooms into additional bedrooms and applied to increase the number of people that they were registered to provide support to. The rooms were small and situated in a corridor between the kitchen and dining room. The manager told us, "We are worried about supporting people in those rooms because they are not en-suite and we could therefore be transporting clinical waste near the kitchen. They will also be very noisy as the kitchen is in constant use". This meant that some of the developments in the home were not focussed on improving the quality of the service.

We saw that risks associated with one member of staff had not been assessed and that they had worked in a situation which put them in a vulnerable position. The manager was unaware that this assessment should have been completed under child protection safeguards. This meant that the provider had not taken precautions to ensure that staff worked in a safe environment.

The provider did not always complete audits of the service across a range of areas to support continued

quality checks and improvements. For example, we saw that although a medicines audit had been completed there had not been an action put in place as a consequence and staff were not observed to ensure that the same mistakes were not repeated. This meant that the systems which should drive quality improvement were not adequate to identify and implement the changes that were needed.

This evidence represents a breach of Regulation 17 of the Health and Social Care Act 2008. (Regulated Activities)

Staff we spoke with said that there was not a positive culture and they didn't feel listened to. One member of staff we spoke with said, "I don't feel as though we are listened to with the new people, there are new ideas and we don't get a discussion about it". Another member of staff said, "We have been told if you don't like it you can leave". We saw that staff were reminded to attend training through posters entitled 'the naughty list' which were in the staff bathroom and meeting room. One member of staff said, "This approach has not gone down well". Staff we spoke with told us that they were unclear of everybody's roles within the team and that colleagues in a senior role took different approaches to leading shifts and supporting them. They were unable to say which seniors took lead roles for certain management tasks and one member of staff said, "I think that [name] is now the deputy manager but nobody has told us. They do seem to be in charge of a lot of things though". They said that the way that shifts were managed often left them short staffed and unable to meet people's needs. One member of staff said, "Today we had to cover someone's training for over an hour which means that it was really hard to get to everyone and none of us had our fifteen minute break". This meant that not all staff were aware of their and others responsibilities and accountabilities to provide a good service to people.

Staff told us that they did have appraisals but that the meetings hadn't focused on them. One member of staff said, "I did have an appraisal but it didn't seem long enough to put my point of view across. The manager put their point of view but I didn't feel listened to". Other staff told us that they had raised concerns about some people's health and wellbeing but that no action had happened to resolve these. One member of staff said, "I don't think our concerns are taken seriously".

The manager had reviewed the training for staff and they had attended training sessions but the manager had not implemented competency checks to ensure that the staff understood the training and that it had a positive impact on the staff teams skills and abilities to meet people's needs. Some staff that we spoke with did not remember what training they had completed and one said, "I have completed a lot of online training but I can't remember what in". Healthcare professionals we spoke with told us that some staff were not skilled in meeting people's needs. This shows that the provider did not provide adequate support to staff to enable them to provide effective support to people.

The service has had a new manager in place for four months. The manager told us they were in the process of becoming registered and were aware of the registration requirements. They had notified us of some events that occurred in the service which meant we could check appropriate action had been taken. However, we identified other situations which should have been reported to the safeguarding authority. This meant that we may not have been notified of all of the necessary significant events that occurred in 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	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People were not treated with dignity and respect

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent People's capacity to consent to care was not assessed in line with Mental Capacity Act 2005

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment 12 f) and g) There were not sufficient quantities of medicine to ensure that people had their needs met and medicines were not adequately managed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were insufficient numbers of staff available to safely meet people's needs

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 12 HSCA RA Regulations 2014 Safe care and treatment 12 a), b) People were not provided with safe care and treatment because risks to their health and safety were not adequately assessed or reduced.

The enforcement action we took:

Warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The systems and processes in place did not adequately assess, monitor and improve the quality of the services provided.

The enforcement action we took:

Warning notice