Freeways

Hillsborough House

Inspection report

59-61 Charlton Road
Keynsham
Bristol
BS31 2JQ

Tel: 01179869880
Website: www.freewaystrust.co.uk

Date of inspection visit:
11 May 2016
12 May 2016

Date of publication:
24 August 2016

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We carried out a comprehensive inspection of Hillsborough House in January 2015. Four breaches of the legal requirements were found at that time. After the inspection, the provider wrote to us to say what they would do to meet the legal requirements in relation to these breaches. The breaches related to the management of medicines, staffing, care records and protecting people from abuse.

Following the inspection the provider wrote to us to say what they would do to meet the legal requirements. We undertook a focused inspection on 13 August 2015 to check the provider had followed their plan and to confirm they now met the legal requirements. We found that sufficient action had been taken to achieve compliance in the regulations previously breached.

You can read the report for previous inspections, by selecting the 'All reports' link for ' Hillsborough House' on our website at www.cqc.org.uk

This inspection took place on 11 and 12 May 2016 and was unannounced. Hillsborough House is a care home service without nursing for up to 14 people with physical and learning disabilities. On the day of our inspection there were 11 people living at the service.

There was a registered manager in place at the time of our inspection. 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.

At this inspection we found that the provider had failed to sustain improvement following the last inspection of the service. A number of the shortfalls at this inspection related to matters which had been brought to the provider's attention on previous occasions by the Commission.

The systems in place for monitoring quality and safety were not sufficient to ensure that the risks to people were identified and managed.

The provider's quality assurance systems to monitor records made by staff or records that related to the management of the service were ineffective.

There were not sufficient numbers of staff to support people safely. We had feedback from staff and people that the current staffing arrangements did not meet the needs of people using the service.

The provider had failed to protect people from the risk of abuse; they had not formulated a plan to prevent safeguarding incidents.

Care was not consistently person centred. Not all care plans were personalised and contained up to date

individual information and references to people's daily lives.

Staff supervisions were not undertaken as planned; there was a failure to monitor and feedback on staff performance. Staff training was not up to date.

The home was not suitably clean.

There were suitable arrangements in place for the safe storage, receipt and administration of people's medicines. However protocols for PRN (as required) medicines and topical medicines were not in place.

Staff respected people's privacy and we saw staff working with people in a kind and compassionate way responding to their needs.

Deprivation of Liberty Safeguards (DoLS) applications had been made for those people that required them. These safeguards aim to protect people living in care homes from being inappropriately deprived of their liberty. These safeguards can only be used when a person lacks the mental capacity to make certain decisions and there is no other way of supporting the person safely. The staff did not have a clear knowledge of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.

Meetings had been arranged in order to enable people's best interest to be assessed when it had been identified that they lacked the capacity to consent to their care and treatment.

People were supported by the staff to use the local community facilities and had been supported to develop skills which promoted their independence.

People had access to healthcare professionals when required, and records demonstrated the service had made referrals when there were concerns.

There was a complaints procedure for people, families and friends to use and compliments could also be recorded.

There was a robust staff recruitment process in operation designed to employ staff that would have or be able to develop the skills to keep people safe and support individuals to meet their needs.

The provider had made appropriate notifications to the Commission; notifications tell us about significant events that happen in the service. We use this information to monitor the service and to check how events have been handled.

We found five breaches of regulations at this inspection. 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?

Requires Improvement

The service was not safe.

There were not enough staff to meet people's needs promptly.

Improvement was required in relation to protocols for PRN (as required) and topical medicine administration.

People were not fully protected from the risk of abuse. The provider had failed to take action to keep people safe.

The home was not suitably clean.

Risk assessments were not up to date.

The service had safe and effective recruitment systems in place.

Is the service effective?

Requires Improvement

The service was not fully effective.

Staff supervision and training was not up to date.

DoLS applications had been made for those people that required them.

People were provided with nutritious food and sufficient drinks.

Is the service caring?

Good

The service was caring.

We saw observed instances of compassionate care from staff.

People told us staff were kind and caring and spoke positively about the support provided by staff.

Staff understood people's needs and preferences.

Is the service responsive?

Requires Improvement

The service was not fully responsive.

Care plans were not up to date and did not contain individual information and references to people's daily lives.

Daily records relating to people's care and treatment were not fully completed to protect people from the risks of unsafe care.

People were supported to use healthcare services.

There were systems in place to respond to complaints.

People's independence was promoted through activities and community involvement.

Is the service well-led?

Requires Improvement

The service was not well led.

The systems in place for monitoring quality and safety were not effective in ensuring that the risks to people were identified and managed.

The provider had failed to seek and act on feedback from people and their relatives regarding suggested areas for service improvement.

Statutory notifications had been made to the Commission for notifiable incidents.

People told us staff were approachable and said they could speak with the registered manager or staff at any time.

Hillsborough House

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 took place on 11 and 12 May 2016. This was an unannounced inspection, and was carried out by one inspector.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form the provider completes to give some key information about the service, what the service does well and improvements they plan to make. The provider returned the PIR and we took this into account when we made the judgements in this report.

Prior to the inspection, we viewed all information we held about the service including statutory notifications. Statutory notifications are information about specific important events the service is legally required to send to us.

As part of our inspection, we spoke to four people who used the service, two visiting health professionals, the registered manager and four members of staff. We tracked the care and support provided to people and reviewed three care plans. We also looked at records relating to the management of the home, such as the staffing rota, policies, recruitment and training records, meeting minutes and audit reports. We also made observations of the care that people received.

Requires Improvement

Is the service safe?

Our findings

There were not sufficient numbers of staff to support people. The registered manager told us there were three staff on duty during the day and late shifts; between 7.45am and 10pm. There was also an additional member of staff for a mid-shift, this was for an additional few hours each day to cover keyworker meetings. Shortfalls in care staff hours were covered by care staff or by the use of agency staff. The registered manager explained that there was a heavy reliance on agency staff as some people's needs had increased and that this situation was under review with the placing authorities and had been for over three months. There were no auxiliary staff; the care staff assisted with cooking and cleaning whilst undertaking their care role. At night there were two waking staff on duty who also undertook some cleaning as part of their role.

The number of hours care staff were required had increased due to people's needs. On regular occasions the number of staff members required to assist individuals with complex needs exceeded the number of staff allocated to assist them. The registered manager told us because of the additional staffing required, the staffing budget no longer allowed for the 12 hours of contracted cleaning the home had previously been allocated. The registered manager said that as well as losing the contracted cleaners there was also a full time (37.5 hours) team leader post and a part time administration (six hours) vacancy within the home. The registered manager told us that they had been undertaking some of the team leader and administration tasks whilst they waited for the vacancies to be filled. The service had fallen behind with some essential record keeping and staff supervisions whilst they had been without a team leader

All of the care staff we spoke with told us the staffing level was having a negative effect on people. Staff said, "It means that we can't always plan their days ahead because we don't know how many staff we are going to need." Another member of staff said, "I feel people are being neglected because we are rushing around trying to help rather than spending time supporting all of the residents." An example of this was in relation to the preparation and planning of people's meals. There was a plan in place for people to be enabled to go shopping each day to purchase the ingredients for their own meals to promote their independence. However due to the lack of staff this plan had not been implemented effectively and groceries were mainly ordered online. This was because staff were pre-occupied with assisting their colleagues who were providing care to people with more complex needs.

People told us that there was not enough staff to provide them with the time required to meet their care plans effectively. For example one person explained that staff were very busy with [other people] and sometimes they did not get the attention they needed. This person said, "There is usually enough staff but not when [another person] is ill, I understand why."

We spoke with two visiting health professionals who also told us that the atmosphere within the home had become 'tense' and that "Staff have good intentions but there are not enough staff at the moment, they're all running around."

These failings amounted to a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated

Activities) Regulations 2014.

The frequency of safeguarding incidents had increased over the last year. We saw that these incidents were reported appropriately to the local authority safeguarding team and to the Commission. The registered manager had acted on safeguarding recommendations; putting additional staffing into place to prevent recurrence of the incidents, addressing concerns with placing authorities and accessing additional advice from health professionals. We found however that although additional staff were in place the incidents were still occurring, and that this placed people using the service under unnecessary stress. Staff also voiced their concerns that in order to prevent some people from assaulting each other they often had to physically come between people and sustain an assault on themselves. The provider had not formulated a plan to review placements in order to prevent further safeguarding incidents. We found there was a failure of the provider to recognise the limitations of the service and to take action to keep people and staff safe.

These failings amounted to a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service had a policy and procedure regarding the safeguarding of people and guidance was available in the office area for staff to follow. Staff told us that they would report any issues of concern to the registered manager. Staff were aware of types and signs of possible abuse and their responsibility to report any concerns to senior staff or the registered manager. Staff also understood the term whistleblowing.

There were medication profiles for each person that provided staff with guidance on their diagnosed medical conditions and the medicines that had been prescribed. There were not PRN (as required medicines) protocols in place for all PRN medicines. PRN protocols assist staff by providing clear guidance on when PRN medicines should be administered and provide clear evidence of how often people require additional medicines, such as pain relief. Because the PRN protocols were not available with the medicine administration record (MAR) it meant that staff who were unfamiliar with people's needs would not have the information required when they were doing the medicine round. The reason for administering PRN medicines was also not documented. This meant it was difficult for staff to identify any trends or common themes in relation to when the person required the medicine. There was also a risk that some staff may not realise a person routinely required PRN at a certain time of day because it had not been documented.

Topical MAR did not always provide enough information for staff on why topical medicines needed to be applied, or the frequency. Body maps had not been used to indicate where creams should be applied. There was a risk that when creams were not applied as prescribed that people's skin might break down.

These failings amounted to a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Medicines were safely stored. Only staff who had completed medication training administered medicines and records demonstrated the training and planning for this.

The home had completed an assessment of people's risks and had recorded guidance on how to manage identified risks. The risk assessments showed that assessments had been completed for areas such as behaviour, mobility and medication. Behaviour that may be viewed as challenging had been identified and strategies to support people detailed. For example, one person could get anxious and sometimes aggressive towards others. Guidance showed how to reassure and support the person to move away from the situation. We found that although risk assessments were detailed and provided strategies on how to alleviate risk, not all risk assessments had been reviewed monthly as per the provider's policy. For example, one risk

assessment had not been reviewed between October 2015 and April 2016. The risk assessment had been updated in April 2016 when there had been an obvious change in the risk to the person; however the lack of a monthly review meant the service may have missed opportunities to apply preventative measures at an earlier date.

On speaking with staff it was clear that they knew when people's needs had changed and that these issues were often discussed at staff handover meetings. We did however raise concerns with the registered manager that some risk assessments had not been reviewed and that could be a risk particularly when agency staff were used to fill staff shortfalls.

The communal areas of the home were not suitably clean. Carpets were not thoroughly cleaned and soft furnishings were stained and dirty in places. There was also a film of dust over skirting boards and other surfaces. Care staff were expected to undertake cleaning duties. However, care staff were not always able to complete cleaning as thoroughly or as often as required due to combining this with their care duties. We looked at the cleaning records for the service and found that none had been completed during the day for May 2016. Records previous to May were sporadic. We asked the registered manager and staff about these records; they told us some cleaning was taking place during the day time but were not able to ascertain when and how often the cleaning had taken place. Night cleaning records for the same period showed that cleaning was being undertaken however the service was not clean.

Incidents and accidents were recorded by the staff. There was not a system to review reported incidents and accidents. This meant that the service may have missed opportunities to identify any patterns or trends in incidents and accidents to assist preventing or reducing reoccurrence.

Generally people told us they felt safe at the service and appeared at ease with staff. It was evident there was a good relationship between people and staff. One person we spoke with said "I feel safe living here and I get on with the other people."

Staff files showed there was a safe and effective recruitment procedure in place. An enhanced Disclosure and Barring Service (DBS) check had been completed. The DBS check ensured that people barred from working with certain groups such as vulnerable adults would be identified. We saw that the recruitment process also included completion of an application form, an interview and previous employer references to assess the candidate's suitability for the role.

Requires Improvement

Is the service effective?

Our findings

Staff received training provided by the service when they joined as part of their induction programme. There was a training programme in place which was monitored by the registered manager and the provider. All staff had to complete annual refresher training. Examples included safeguarding, health and safety, first aid, safe medicines administration, moving and handling, deprivation of liberty safeguards and mental capacity. Specialist training was given to enable the staff to meet people's specific support and health care needs. This training included supporting people with autism and epilepsy, and managing behaviours that challenge.

Staff we spoke with told us they had received the training programme. We reviewed current staff training records. We saw that staff received the training programme when they had joined the service however the annual refresher training was frequently out of date. Training specific to the needs of people using the service had been completed by approximately 50% of staff. The provider had not ensured that staff were given training to enable them to meet people's specific support and health care needs.

Staff said they had received performance supervision, however when we checked supervision records we found that this had been irregular. Supervision was expected six times a year; we found that staff had not received supervisions this frequently. Supervision is dedicated time for staff to discuss their role and personal development needs with a senior member of staff. The registered manager told us that supervisions had fallen behind whist they were short staffed and without a team leader to assist. The provider had not ensured that staff performance and progress was monitored effectively and that staff had an opportunity to voice their individual views.

These failings amounted to a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People's capacity to make decisions had been assessed and we saw examples of appropriate best interest decisions, for example in relation to people's medicines. The service had invited appropriate people such as family members to be involved with best interest meetings which had been documented.

The provider had met their responsibilities with regard to the Deprivation of Liberty Safeguards (DoLS). DoLS is a framework to approve the deprivation of liberty for a person when they lack the mental capacity to consent to treatment or care and need protecting from harm. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the Mental Capacity Act 2005 (MCA). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We found that people's capacity to make decisions had been assessed and appropriate DoLS applications had

been made.

We saw from the training records that staff had received training on the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS). We found however that staff knowledge was variable when they were asked about the principles of the MCA and DoLS.

People were involved in planning how to meet their nutritional needs and were supported to have the food and drink of their choice. People discussed with staff the meals they would like and the ingredients they needed to purchase. People told us that the menus for the home were agreed with them and staff worked with people to look at healthy eating options. During the inspection we saw that staff provided assistance with preparing people's meals and encouraged people to make healthy eating choices.

People were supported to maintain their well-being and good health. We saw from records that people had regularly accessed health care services. We saw that the service had supported people to maintain set appointments with healthcare professionals and effectively arranged
emergency appointments. The staff had then acted upon the actions agreed at the respective appointments.

We spoke with two visiting health professionals on the day of our inspection. They told us that although the service was short staffed staff they had no concerns about the care provided by staff at the service and told us they felt staff were, "Nice and polite" and described the registered manager as, "Very approachable."

People also had a 'hospital passport' which contained essential information about them should they need to be admitted to hospital in an emergency. We found however that some of the 'hospital passports' had not been reviewed for over two years and there was potential for the information to be incorrect.

Good

Is the service caring?

Our findings

People told us they made decisions about their daily living routines; this helped to ensure that their views were listened to and that they were involved in planning their own care. For example, what time people got up or went to bed. One person told us, "They know I like being left alone and don't want to mix, so they don't bother me unless I call for them which suits me." People said a lack of staff could affect choices they made but they were generally happy with their daily routines. One member of staff said "As staff we just want to enable people to be as independent as possible and make their own choices." We observed people being offered choices during the inspection, for example what activities they wanted to undertake during the day and what they wished to wear.

Staff were knowledgeable about people's care needs. When we spoke with staff they were knowledgeable about people's preferences and routines. For example, one staff member talked about how a person liked to have their personal effects arranged in their bedroom.

Staff communicated with people appropriately which demonstrated that staff knew people well. Where a person had difficulty in communicating staff utilised different techniques, such as using simple sentences and pictures to enhance their understanding of the person's requirements. Members of staff asked for people's consent before providing support to them. Some of the conversations observed were light hearted between staff and people. One person said, "I've got good friends and staff here, the staff help me with my life skills like cooking my own meals and they are gentle with my personal care; I couldn't get any better."

People's privacy and dignity was maintained. People said they felt well respected by the staff and that staff treated them with dignity. We observed that people's bedroom doors were closed when they were being supported with their personal care needs and when they were receiving their medicines. We saw that staff knocked on people's doors before entering and did not invade people's privacy if they wished to be alone.

People told us they generally got on well together and were supported to develop relationships with each other. We observed friendly interactions between staff and people which indicated a good relationship had developed between them. Generally throughout the day there was a warm and friendly atmosphere within the communal areas of the service although there were occasions when the behaviour of some people could have an impact on other people.

People could be visited by their friends and relatives at any time of day; people told us that their relatives were welcomed into the home.

Requires Improvement

Is the service responsive?

Our findings

Care and treatment was not always planned and delivered in line with people's individual care plans. People had been involved in planning and producing their care plan and risk assessments. People met with their key worker once a month to discuss how their care was going and to plan for the forthcoming month. A key worker is a named member of staff that is responsible for coordinating the care and ensuring care documentation was up to date for an individual person. We found that in the care plans we looked at keyworker monthly reviews had not taken place as planned and that key information relating to people's health, lifestyle and preferences had not been recorded accurately or updated when required. We saw for example that goal setting and planning for people's holidays had not been started. This has been raised as an action to complete during a resident meeting in February 2016.

The quality of person centred information was not consistent within the care plans. Some of the plans were person centred and described in detail people's preferences in relation to all aspects of their care. However other care plans did not contain up to date information and references to people's daily lives. For example we saw that one person's care plan had been started in February 2016 and remained incomplete. The previous care plan had not been reviewed since June 2015. In the interim the staff were working from both of these care plans. Neither of which contained up to date or sufficient information about the person's current needs. This meant there was a risk of people not receiving person centred care. Staff did not have the information available in relation to all of the people they were caring for. This can be significant in an environment with people who have learning and physical disabilities as the information can aid staff to provide care to people who have difficulty in communicating their needs. This is of particular relevance when new staff or agency staff are employed at the service to aid these staff in knowing and understanding people.

These failings amounted to a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Individual daily records help to ensure that staff keep up to date with people's needs and monitor changes in people's health and behaviour. We found that the quality and frequency of daily recording was variable and we found that information was similar in content. For example personal care was sometimes recorded as 'personal care' and on other occasions the notes detailed the actual care given such as bathing, etc. There were also gaps in records where staff should have documented the care they had provided. In one of the plans, staff were required to document every time the person had 'opened their bowels'. The last recorded date was three days previous to the inspection. We raised these issues with staff and were told it was likely that the person had opened their bowels and that the staff may not have had time to record it. We found however there were also gaps in these records of up to 6 days between 2 April 2016 and 8 May 2016. This meant that for this person the staff were not proactively assessing and reviewing their records to pre-empt the need for a reactive response when the person suffered from conditions relating to being unable to open their bowels.

These failings amounted to a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated

Activities) Regulations 2014.

People commented that communication between staff was sometimes lacking and records of requests were not always passed on. Staff told us that miscommunication was common because of the use of agency staff. They did not always pass on information or did not have enough time to complete records as expected.

People had access to group activities, 1:1 sessions and activities they undertook with other members of the local community. We saw that activities people undertook included swimming, walking groups, pottery classes, visiting a social club and drama groups. One person said "I do a lot of things here, they [staff] help me to do them I like going to the pub for a meal." Another person told us they enjoyed cookery classes and this had helped them to develop life skills. Another person commented that they enjoyed a particular activity that required two members of staff to assist them. However, they had not been able to do this recently as there were not enough staff to assist them. Staff told us that they liked to assist people to live the most fulfilling lives that they could but that the staffing situation had affected that goal. People also told us about the holidays they had taken abroad and at home the previous summer and how they had been assisted by staff to plan for them. People did comment that they were unsure of their holiday plans for this year as staff had been preoccupied.

We found that people's individual bedrooms were well furnished, and people were encouraged to personalise their rooms with photographs and memorabilia. This helped ensure that people's rooms were arranged in accordance with the person's wishes and preferences.

There were systems in place to respond to people's complaints, and we saw that the procedure for making a complaint was on display in the home. We viewed examples of complaints that had been addressed by the provider and registered manager, and saw that the concerns had been responded to. People confirmed they knew how and where to access the complaints procedure.

Requires Improvement

Is the service well-led?

Our findings

The provider's quality assurance systems and processes did not ensure that they were able to effectively assess and monitor the quality of the service and mitigate the risks relating to the health, safety and welfare of service users.

A number of the shortfalls at this inspection related to matters which had been brought to the provider's attention on previous occasions by the Commission. The provider had failed to sustain improvement and act on the risks that had been identified. These related to key aspects of the service. At the last comprehensive inspection of the service in January 2015, there were four breaches of regulations in respect of management of medicines, staffing, care records and protecting people from abuse. We found at this inspection that the same regulations had been breached again.

The provider had failed to ensure that measures put in place to ensure compliance following the last comprehensive inspection were reviewed to ensure sustained and continuous improvement. We saw an example of this in relation to the cleanliness of the service. Following the last comprehensive inspection the provider had allocated 12 hours of contract cleaning at the home to maintain cleanliness. We found when following up on breaches at the last focused inspection (August 2015) that this had resolved the cleanliness issue. At this inspection we were told that shortly after the focused inspection the contract cleaning hours were removed by the provider in order to increase care staffing hours at the service. There was no evidence of a review of this decision by the provider to ensure that the service was able to maintain cleanliness following the removal of contract cleaning. The provider's systems had also failed to adequately action other shortfalls found at this inspection. These included concerns around the completion of daily records, staff training and staff supervisions.

The provider did not have an effective system to monitor the quality of people's care records and ensure the service held current and accurate records about people. We found that the provider had altered the system of quality assurance from bi-monthly provider visits, to self-assessment by the registered manager and had also undertaken a mini inspection of the service. These quality assurance systems had picked on various issues around the staffing levels, safeguarding issues and care plan records. There were not however any robust action plans with set timescales to ensure improvement actions were carried out. For example despite it being noted that care plans did not contain enough information about people as part of the provider 'mini inspection' in January 2016, care plans were still incomplete at this inspection. Visiting health professionals also told us they had voiced their concerns with the registered manager in relation to the poor record keeping within care plans and daily notes. The absence of a robust governance system to ensure care plans and records were completed accurately by staff exposed people to risks of unsafe or inappropriate care or treatment.

The provider had failed to seek and act on feedback from people and staff for the purposes of continually evaluating and improving the home. Residents meetings' were expected to be held at least every three months for people living in the home. These meetings were to provide people with an opportunity to discuss their concerns and raise issues. Meetings had been undertaken in October 2015 and in February 2016; we

looked at the minutes from these meetings. We found that when actions were recorded there was no action plan to ensure that actions were completed or that actions were followed up at the next meeting. People also told us that they didn't always receive feedback for any requests that they made.

A service user survey was undertaken in August 2015; we found that although the questions within the survey were about the service's performance there was little for the service users to comment on with regards to what the service could do to improve. We also found that the last relative's survey had been undertaken in 2014 and another had not been sent for over a year. Through these processes the provider had not sought the views of people or their relatives in relation to improving the service.

Staff said they attended monthly staff meetings and that the registered manager and provider would listen to their views and that they felt able to raise concerns or issues. However this did not necessarily mean their views would be taken into account. For example, the staff had previously raised issues about the staffing and poor communication records but these issues had not been rectified. We looked at the meeting minutes and found that actions were raised. They were not always followed up at the next meeting to ensure that they were completed. Staff told us that this often led to issues being raised repeatedly and not being rectified in a timely way.

These failings amounted to a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Although people and staff commented on the shortfalls at the service they consistently praised the registered manager and told us they liked working at the service. One staff member said "I love it here there is a lot of stress on the manager but she does her utmost to help us and put people at the centre of everything" and another staff member said "There are great staff here and the manager listens and tries to work with you to improve things." Staff told us that the registered manager did their best to ensure that peoples care and support was the priority at the service. Comments included " [registered manager] tries her best I don't think the provider is being fair there's just not enough money in the budget for this service" and "Despite all the problems [registered manager] is always there to support us and help us through difficult times." People also said "[registered manager] she's always helping she doesn't mind mucking in" and "She explains things to me when I don't understand and I'm upset."

All services registered with the Commission must notify the Commission about certain changes, events and incidents affecting their service or the people who use it. Notifications tell us about significant events that happen in the service. We use this information to monitor the service and to check how events have been handled. We found that the registered manager had made appropriate notifications.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care Care and treatment was not always planned and delivered in line with people's individual care plans

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Improvement was required in relation to protocols for PRN and topical medicine administration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment People were not fully protected from the risk of abuse. The provider had failed to take action to keep people safe.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Daily records used to assess people's needs and monitor changes in people's health and behaviour were incomplete. The systems in place for monitoring quality and safety were not effective in ensuring that the risks to people were identified and managed.

	The provider had failed to seek and act on feedback from people and their relatives regarding suggested areas for service improvement.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were not sufficient numbers of staff to support people. The provider had not ensured that staff performance and progress was monitored effectively. The provider had not ensured that staff training was up to date to enable them to meet people's needs.