

Pinebird Ventures Limited

Fermoyle House Nursing Home

Inspection report

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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?

Good



Is the service responsive?

Requires improvement



Is the service well-led?

Requires improvement



Overall summary

The inspection took place on 14 July 2015 and was unannounced.

The service provides accommodation, nursing and personal care for up to 32 older people, some of whom are living with dementia. There were 29 people living at the home at the time of our inspection.

There was a registered manager in post at the time of our inspection. A registered manager is a person who has

registered with the Care Quality Commission (CQC) to manage the service and has the legal responsibility for meeting the requirements of the law; as does the provider.

People's medicines were not administered safely or recorded accurately. Medicines were dispensed into pots which presented an increased risk of errors as staff were

Summary of findings

unable to check the medicine, strength and dose at the time they administered people's medicines. Medicines were not signed for immediately following administration which presented a risk of inaccurate recording.

There were insufficient nursing staff on duty to ensure people's safety and well-being. The nurse on duty could not complete all the tasks required of them as they were the sole member of nursing staff on duty.

People were not protected by the provider's recruitment procedures. The staff recruitment files we checked did not contain all the information required by the Health and Social Care Act 2008.

Staff had not been appropriately supported through supervision and appraisal or had opportunities to discuss their professional development needs.

Restrictions had been imposed without justification on people who had the capacity to make their own decisions. For example, there was no rationale behind the decision to prevent people from managing their own medicines or leaving the premises if they wished to do so. We also found there were restrictions on people's freedom of movement within the service.

There were not enough activities arranged to keep people occupied and engaged. The lack of activities had been highlighted by the local authority quality assurance team and the most recent satisfaction survey but there was no evidence that action had been taken by the provider to address this issue.

The provider did not have effective systems for seeking and responding to people's views. There was no evidence that people's views were sought about how the service could be improved, what appeared on the menu or what activities they would like to try.

Some care records were incomplete and did not provide all necessary information about people's care and treatment. Daily care notes were maintained by staff but some entries were illegible, which meant it was not possible to determine the care people had received from day to day.

Hospital passports designed to ensure that medical staff had access to all the information they needed should a person require admission to hospital had only been developed for eight of the 29 people living at the service.

There was a programme of monthly audits designed to monitor quality in key aspects of service delivery but some audits were overdue, which meant the provider could not be sure that any shortfalls in service delivery would be identified and addressed in a timely manner.

Risks to people had been assessed and there were plans in place to ensure that people's care would not be interrupted in the event of an emergency.

Staff were aware of their responsibilities should they suspect abuse was taking place and knew how to report any concerns they had.

People told us that staff responded appropriately if they became unwell and supported them to obtain appropriate treatment when they needed it. Referrals were made to healthcare professionals where necessary to maintain people's health and wellbeing.

People told us that they enjoyed the food provided and that they could have alternatives to the menu if they wished. People's nutritional needs had been assessed and healthcare professionals had been involved in developing guidance for staff where people were at risk when eating or drinking.

People told us they had good relationships with the staff and that staff treated them with respect. Relatives told us that staff were caring and sensitive to their family members' needs.

Staff communicated effectively with people and provided support in a kind and sensitive manner.

People's needs had been assessed before they moved into the service to ensure that their needs could be met. Care plans were person centred and recorded people's likes and dislikes and how they preferred their care to be provided.

People told us that they would feel comfortable making a complaint if they needed to and were confident that any concerns they raised would be dealt with appropriately.

People said the registered manager was approachable and relatives said the registered manager was available if they wished to discuss the care their family member received. Staff told us that the registered manager promoted an open culture and was available for advice if needed.

Summary of findings

During the inspection we identified some 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.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not safe.

People's medicines were not managed safely.

There were insufficient nursing staff on duty to ensure people's safety and well-being.

People were not protected by the provider's recruitment procedures.

Staff were aware of their responsibilities should they suspect abuse was taking place and knew how to report any concerns they had.

Risks to people had been assessed and there were plans in place to ensure that people's care would not be interrupted in the event of an emergency.

Inadequate



Is the service effective?

The service was not always effective.

Staff had not been adequately supported or had opportunities to discuss their professional development needs.

Restrictions had been imposed without justification on people who had the capacity to make their own decisions and there were restrictions on people's freedom of movement within the service.

Staff responded appropriately if people became unwell and supported them to obtain treatment when they needed it. Referrals were made to healthcare professionals where necessary to maintain people's health and wellbeing.

People enjoyed the food provided and could have alternatives to the menu if they wished.

People's nutritional needs had been assessed and healthcare professionals had been involved in developing guidance for staff where people were at risk.

Requires improvement



Is the service caring?

The service was caring.

People told us that staff were kind and helpful. They said they had good relationships with the staff and that staff treated them with respect.

Staff communicated effectively with people and provided support in a kind and sensitive way.

Staff encouraged people to make decisions and respected their choices.

Staff understood the importance of maintaining confidentiality and of respecting people's privacy and dignity.

Good



Summary of findings

Is the service responsive?

The service was not always responsive to people's needs.

People did not have sufficient opportunities to take part in meaningful activities.

The provider did not have effective systems for seeking and responding to people's views.

People's needs had been assessed before they moved into the service to ensure that their needs could be met.

People told us they would feel comfortable making a complaint if they needed to and were confident that any concerns they raised would be dealt with appropriately.

Requires improvement



Is the service well-led?

The service was not consistently well- led.

Some care records were incomplete and did not provide all necessary information about people's care and treatment.

Some care notes were illegible, which meant it was not possible to determine the care people had received.

Hospital passports designed to ensure that medical staff had access to all the information they needed should a person require admission to hospital had not been developed for all the people living at the service.

There was a programme of monthly audits designed to monitor quality in key aspects of service delivery but some audits were overdue, which meant that the provider could not be sure that any shortfalls in service delivery would be identified and addressed in a timely manner.

People said that the registered manager was approachable and provided appropriate leadership for the service. Staff told us that the registered manager was available for advice if needed.

Requires improvement



Fermoyle House 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 was 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 14 July 2015 and was unannounced. The inspection was carried out by two inspectors and a specialist nursing advisor.

Before the inspection we reviewed records held by CQC which included notifications, complaints and any safeguarding concerns. A notification is information about important events which the registered person is required to send us by law. This enabled us to ensure we were addressing potential areas of concern at the inspection. On this occasion we did not ask the provider to complete a Provider Information Return (PIR) before our inspection. 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. This was because we had brought forward the inspection and the provider would not have had the opportunity to complete one.

During the inspection we spoke with 14 people, three relatives and seven staff. If people were unable to express themselves verbally, we observed the care they received and the interactions they had with staff.

We looked at the care records of five people, including their assessments, care plans and risk assessments. We looked at how medicines were managed and the records relating to this. We looked at four staff recruitment files and other records relating to staff support and training. We also looked at records used to monitor the quality of the service, such as the provider's own audits of different aspects of the service.

The last inspection of the service was in August 2013 where a breach of regulation was identified. Following the inspection, the provider supplied information which demonstrated they had taken action to become compliant with the regulation.

Is the service safe?

Our findings

People's medicines were not managed safely. We observed the nurse on duty administer the morning medicines. The nurse explained that the layout of the home prevented her taking the medicines trolley around when dispensing medicines. As a result all medicines were removed from the trolley and dispensed into medicine pots on trays, a practice sometimes referred to as 'secondary dispensing'. Secondary dispensing presents an increased risk of medicines errors as staff are unable to check the medicine, strength and dose at the time they administer people's medicines, which could result in people receiving the wrong medicines.

The way in which medicines were stored in pots prior to administration presented a risk. Pots for all the people who received medicines were placed on two trays. Each pot was identified by a slip of paper with the name of the person for whom the medicines were intended. The paper slips were laid on top of the pots and could have easily become separated from the pot to which they referred. If this happened, it would not be possible for staff to be sure which medicines were in each pot.

We observed the nurse took the trays containing the pots around the service and administered the medicines to each person. The nurse signed the medicines administration records (MAR) when all the medicines had been administered. This presented a risk as each person's medication administration record should be signed immediately they have received their medicines to ensure accurate recording.

We checked a sample of MAR charts following the lunchtime medicines round. We found that medicines that had been administered at 12pm had not been signed for by 2pm. The nurse on duty told us they had not had time to complete the MAR charts as they had been required to attend to a medical emergency immediately after completing the medicines round. This presented a further risk of inaccurate recording as medicines had not been signed for at the time they were given.

The failure to manage medicines safely meant that the provider was breaching Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were enough care staff available to meet people's needs but that there were insufficient nursing staff on duty to ensure people's safety. There was one nurse on duty, who was working a 12-hour shift. The nurse told us they did not feel able to take a break during their shift as they were concerned about the consequences should someone become unwell during their absence. This increased the risk of errors caused by fatigue. The nurse told us that their responsibilities included administering all medicines, writing daily care notes, liaising with healthcare professionals, managing pain and wound care and dealing with any medical emergencies that arose.

We observed that the nurse responded swiftly and appropriately when one person became unwell. The nurse took the person's vital signs and called the person's GP to seek advice about the best course of action. However this prevented them from completing all the other tasks assigned to them, such as signing the MAR charts to evidence that medicines had been given. The nurse told us that being the sole member of nursing staff on duty meant that they could not complete all the tasks required of them to a satisfactory standard. For example, the nurse said that they could not ensure best practice in standards of wound management and change dressings as often as they should.

The failure to deploy sufficient numbers of suitably qualified, skilled and experienced staff meant that the provider was breaching Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not protected by the provider's recruitment procedures. The staff recruitment files did not contain all the information required by the Health and Social Care Act 2008. For example the criminal record check equivalent to the Disclosure and Barring Service (DBS) certificate on one member of staff's file had been obtained four years previously when they were employed by another provider. The Health and Social Care Act 2008 requires that providers obtain a new DBS certificate when staff are appointed to a role unless they hold a DBS certificate issued within the last three months.. Two staff files contained no evidence that the provider had obtained references prior to employment to establish their suitability for the role.

Is the service safe?

The failure to operate effective recruitment procedures meant that the provider was breaching Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were procedures for safeguarding people at risk and staff were aware of these. Staff had attended training in safeguarding and told us what action they would take if they suspected abuse was taking place, including contacting external agencies if necessary. Staff also told us that they were aware of how to 'blow the whistle' if they were concerned about poor practice at the service.

Risks to people had been assessed and control measures had been put in place to mitigate against these risks. All accidents and incidents were recorded and there was evidence that the registered manager checked these records to identify any actions needed to prevent recurrence and any emerging themes.

There were plans in place to deal with emergencies and to ensure that people's care would not be interrupted in the event of an emergency. There was evidence that safety checks were carried out on the premises and equipment, such as gas and electrical safety. Some of the safety checks, including portable appliance testing and lifting testing were due for renewal in July 2015. Fire procedures were in place and the fire alarm system was serviced in June 2015. There was a fire risk assessment on file which was last reviewed in January 2015. The provider's fire safety policy stated that the fire risk assessment would be reviewed every six months, which meant that this document was also due for review.

We recommend that the provider review all documents related to the safety of the premises to ensure that a safe environment is maintained.

Is the service effective?

Our findings

Staff had not received regular supervision and appraisal, which meant that they did not receive feedback about their performance or have opportunities to discuss their training and development needs. In addition, the registered manager could not be sure that people were working to best practice in all areas of their work.

The report of the most recent visit by the local authority quality assurance team highlighted that staff were not receiving regular supervision. The provider's supervision policy stated that all staff would receive supervision every three months to ensure they had adequate opportunities to discuss their performance and professional development needs. We found that supervisions were recorded for only four staff, each of whom had attended one supervision session in 2015, the most recent of which was in March 2015. There were no supervision sessions recorded for any of the other staff employed.

We asked care staff whether they received supervision and appraisal from their managers. Staff were unable to recall when their last supervision had taken place and told us they had not had an annual appraisal. Care staff told us that their supervision should be provided by the qualified nurses but that nursing staff did not have the time to provide this support. There was evidence that this issue had been identified by the provider but had not been addressed. The minutes of the most recent staff meeting recorded that, "Supervision is not going well, we are very behind. RGNs [nurses] on duty cannot find the time [to carry out supervisions]."

The failure to provide appropriate support for staff through professional development, supervision and appraisal meant that the provider was breaching Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked to see the training record for the service but staff on duty were unable to supply this. The registered manager sent us the training record on their return to work after the inspection. The record provided by the registered manager demonstrated that most staff had attended training in elements of core training, including safeguarding, moving and handling and fire safety. Staff had also attended training in areas which were key to the delivery of people's care, such as diabetes, dementia and sensory impairment.

CQC monitors the implementation of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS). The MCA exists to protect people who lack capacity to make their own decisions and to ensure that their best interests are considered when decisions that affect them are made. The Deprivation of Liberty Safeguards ensure that people receive the care and treatment they need in the least restrictive manner.

We were advised by the registered manager that applications for DoLS authorisations had been submitted to the local authority for 18 people. However we found that restrictions had been imposed without justification on people who had the capacity to make their own decisions. For example we saw mental capacity assessments for ten people that had been carried out by the registered manager. The assessments recorded that all ten people had the capacity to make their own decisions. However the assessments also recorded that these people were unable to manage their own medicines or to leave the service unaccompanied. There was no rationale behind the decision. We found there were unauthorised restrictions on people's freedom of movement within the service. For example all the people sitting in the lounge had tables placed in front of their chairs which prevented them from getting up should they wish to do so.

Restricting people's choice and freedom of movement without lawful authorisation meant that the provider was breaching Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us that staff recognised when they became unwell and supported them to obtain appropriate treatment when they needed it. The GP practice used by the service did not make routine rounds but people told us that staff contacted the practice on their behalf if they needed an appointment. When checking people's care records, we found evidence that referrals were made to healthcare professionals where necessary to maintain people's health and wellbeing, such as chiropodists, opticians and dentists.

People at risk of developing pressure ulcers had appropriate pressure relieving equipment and these were set correctly according to the person's weight. Care plans for people with poor skin integrity stated that they needed to be regularly repositioned in bed to minimise the risk of developing pressure ulcers. The care plans provided

Is the service effective?

guidance for staff about how often each person needed repositioning. We checked the repositioning charts for these people and found that staff were following the care plans and recording each time they repositioned someone.

People told us that they enjoyed the food provided and that they could have alternatives to the menu if they wished. One person told us, “The food is good and there’s plenty of it” and another said, “If I don’t like what’s on the menu, they’ll make me something else.” Relatives told us that the menu suited their family members’ tastes and that they were able to join their family members for meals if they wished. One relative said, “The food is very good and there are ample servings.”

People’s nutritional needs had been assessed and any dietary needs recorded in their care plans. We saw evidence that a speech and language therapist had been involved in developing guidance for staff where people were at risk of choking. We observed that staff were available to support people with eating and drinking if required. We observed that one person was reluctant to eat their lunch and staff returned to the person a number of times to encourage them to eat. When it became clear that the person would not eat anything, care staff highlighted this to a senior member of staff for advice.

Is the service caring?

Our findings

People told us that they had good relationships with the staff and that staff treated them with respect. One person told us, “The staff are lovely, I get on really well with them” and another person said, “I love it here. I have a laugh and a joke with the staff.” People told us that staff were kind and caring in their approach. One person said of the staff, “They’re all kind and helpful. If I need anything I only have to ask.”

Relatives told us that staff were caring and sensitive to their family members’ needs. One relative said of their family member, “She’s very happy here. The staff are caring and kind and she has a laugh with them, which she enjoys.” Another relative told us, “She really didn’t want to move from her own home but the staff helped her to settle in and to feel at home and now she loves it here.” A third relative said, “All the staff are very caring, they all do their best.” Relatives said that they could visit whenever they wished and that they were made welcome by staff. They told us that staff kept them up to date about their family members’ health and welfare.

The atmosphere in the service was calm and relaxed and staff spoke to people in a respectful yet friendly manner. Staff were proactive in their interactions with people, making conversation and sharing jokes. We observed that staff supported people in a kind and caring way, ensuring their wellbeing and comfort when providing their care. Staff were sensitive to the needs of people living with dementia. They demonstrated that they understood people’s methods of communication and spent time with people to

ensure that they were relaxed and comfortable. Staff were attentive to small details that ensured people’s well-being, for example replacing a blanket that had slipped from a person’s knees and repositioning a footstool to ensure a person was comfortable.

Staff encouraged people to make decisions for themselves and respected the choices they made. Staff told us that they encouraged people to do things for themselves if possible to promote their independence. We saw that staff offered assistance if people needed support to mobilise or to eat or drink. Staff said that they encouraged people to make decisions about their day-to-day lives, such as what time they got up and went to bed, what they wore and what they ate. People told us that staff knew their preferences about their daily routines.

People had access to information about their care and the provider had produced information about the service, including how to make a complaint. The provider had a written confidentiality policy, which detailed how people’s private and confidential information would be managed. Staff understood the importance of maintaining confidentiality. People told us that they could have privacy when they wanted it and that staff respected their decisions if they chose to spend time in their rooms uninterrupted. Staff understood the importance of respecting people’s privacy and dignity. They spoke to us about how they cared for people and we saw them attending to people’s needs in a discreet and private way. The provider arranged equality and diversity training for staff and most staff had attended this training within the last two years.

Is the service responsive?

Our findings

People and their relatives told us that there were not enough activities arranged to keep people occupied and engaged. One person told us, “A singer comes now and again but apart from that it’s just the telly really” and another said, “Most people spend the day sleeping in their chairs and watching TV.” Relatives told us that they observed very little in terms of organised activities when they visited. One relative said, “The big problem here is the lack of activities. Just putting people in front of the TV is not good enough. Even if people cannot join in, they can watch others.” Another relative said, “When I walk through the lounge I see residents completely inactive and bored or just sleeping in their armchairs.”

The recent local authority quality assurance team report highlighted that there was lack of meaningful activities in which people could take part. Relatives had also highlighted this issue in the most recent satisfaction survey but there was no evidence that action had been taken by the provider to address this issue. We observed that people with greater levels of independence occupied themselves by reading or knitting and one person went to a local resource centre. However people who had greater levels of dependency were not supported to engage in activities and remained sitting in their armchairs without any stimulation throughout our inspection.

We found that the provider did not have effective systems for seeking and responding to people’s views. The most recent satisfaction survey on file was dated 2013/14 and the most recent residents’ meeting recorded took place in November 2012. There was no evidence that people’s views were sought about how the service could be improved, what appeared on the menu or what activities they would

like to try. The provider had not taken steps to meet the needs of people living with dementia. For example the environment had not been adapted to enable people to orientate themselves within the building and there were no activities tailored to the needs of people living with dementia.

The failure to provide activities that met people’s needs or to respond to the views of people who use their service and those acting on their behalf meant that the provider was breaching Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People’s needs had been assessed before they moved into the service to ensure that their needs could be met. Care plans were person centred and recorded the person’s likes and dislikes and how they preferred their care to be provided. Care plans also identified any needs each person had in relation to medicines, communication, personal care, continence, mobility, pain management, hydration, nutritional needs and tissue viability.

People told us they knew how to raise concerns and that they would feel comfortable making a complaint if they needed to. People said they were confident that any concerns they raised would be dealt with appropriately. One person told us that they had previously raised concerns about the support they received from one member of staff and that the matter was resolved to their satisfaction in a timely manner. The provider had a written complaints procedure, which detailed how complaints would be managed and listed agencies complainants could contact if they were not satisfied with the provider’s response. We checked the home’s complaints record and found that any complaints received had been investigated and responded to appropriately.

Is the service well-led?

Our findings

Some care records were incomplete and thus did not provide all necessary information about people's care and treatment. For example wound care charts did not record the size of wounds, which meant it was not possible to accurately gauge whether the wound was healing satisfactorily. In some cases, photographs of wounds were on file but these were taken from a variety of angles, which made assessing the progress of recovery difficult.

Daily care notes were maintained by staff but some entries were illegible, which meant it was not possible to determine the care people had received from day to day. Hospital passports had been developed which were designed to ensure that medical staff had access to all the information they needed should a person require admission to hospital. The passports contained information about people's individual needs including medical history, medicines, communication and physical health. However these passports had only been developed for eight of the 29 people living at the service. This meant that essential information for medical staff about people's needs was not available for all the people living at the service.

The provider could not be sure that any shortfalls in service delivery would be identified and addressed in a timely manner. There was a programme of monthly audits designed to monitor quality in key aspects of service delivery such as care planning, risk assessments, medicines and infection control. However some audits were overdue. For example the most recent infection control audit on file was carried out in April 2015 and the most recent medicines audit took place in May 2015.

The failure to effectively assess, monitor and improve the quality and safety of the service or to maintain an accurate, complete and contemporaneous record in respect of each person meant that the provider was breaching Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us that the registered manager was approachable and provided appropriate leadership for the service. Relatives said that the registered manager was available if they wished to discuss the care their family member received. Staff told us that the registered manager promoted an open culture and was available for support and advice. One member of staff told us, "We can approach her at any time if we need advice."

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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

Accommodation for persons who require nursing or personal care

Regulation

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

Regulation 12(2)(g)

The provider had failed to ensure that medicines were managed safely and properly.

Regulated activity

Accommodation for persons who require nursing or personal care

Regulation

Regulation 18 HSCA (RA) Regulations 2014 Staffing

Regulation 18(1)

The provider had failed to deploy sufficient numbers of suitably qualified, skilled and experienced staff.

Regulation 18(2)(a)

The provider had failed to ensure that staff received appropriate supervision and appraisal to enable them to carry out the duties they were employed to perform.

Regulated activity

Accommodation for persons who require nursing or personal care

Regulation

Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed

Regulation 19(2)(3)

The provider had failed to operate effective recruitment procedures.

Regulated activity

Accommodation for persons who require nursing or personal care

Regulation

Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment

Regulation 13(7)(b)

Action we have told the provider to take

The provider had restricted service users' freedom of choice and liberty of movement without legal authorisation.

Regulated activity

Accommodation for persons who require nursing or personal care

Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

Regulation 17(2)(e)

The provider had failed to establish effective systems to seek and act on feedback from relevant persons.

Regulation 17(2)(a)

The provider had failed to effectively assess, monitor and improve the quality and safety of the services provided.

Regulation 17(2)(c)

The provider had failed to maintain an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided.

Regulated activity

Accommodation for persons who require nursing or personal care

Regulation

Regulation 9 HSCA (RA) Regulations 2014 Person-centred care

Regulation 9(3)(b)

The provider had failed to design care with a view to achieving service users' preferences and ensuring all their needs are met.

Regulation 9(3)(f)

The provider had failed to seek the views of people who use the service and those lawfully acting on their behalf and to demonstrate that they took action in response to any feedback provided.