

Avonpark Village (Care Homes) Limited

Alexander Heights Care Home

Inspection report

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Date of inspection visit:
18 May 2016
19 May 2016
23 May 2016

Date of publication:
02 September 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?

Inadequate 

Summary of findings

Overall summary

Alexander Heights offers accommodation and personal care for up to 28 people. At the time of the inspection there were 14 people resident at the care home. The home is within the Avonpark Village where there are other care homes and independent living apartments and houses.

We carried out this inspection in response to concerns raised relating to the quality of care and support people were receiving. These concerns related to all three locations, Hillcrest Care home, Alexander Heights Care Home and Fountain Place Nursing Home which are all located in Avonpark Village. Due to this we inspected all three locations. The inspection took place on the 18, 19 and 23 May 2016 and was unannounced.

The service had a registered manager in post. 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. The registered manager was not present during our inspection. We found the service was not well led.

People were protected from the risk of harm and from the risk of abuse. Processes and procedures in place ensured members of staff knew how to identify abuse and they knew the expectations placed on them to report abuse.

Risks were managed appropriately. Where risks were identified action was taken to lower the levels of risk. Care plans were reviewed by staff but did not evidence involvement from people.

Safe systems of medicine management were in place.

The arrangements for staffing levels did not ensure there were sufficient staff on duty during peak periods.

Staff knew people well and supported them with maintaining their independence. People and their relatives told us staff treated them or their relative with kindness and respected their privacy and dignity.

People were supported to have sufficient to eat and drink to maintain good health. People told us the quality of the food was poor.

Suitable arrangements were in place for people to receive on-going support from healthcare professionals.

Mental Capacity Act (MCA) 2005 procedures were not clear for staff to follow. Records were not maintained to show the process followed by the staff to assess people's capacity and making best interest decisions. Staff did not always know who should be the decision maker in best interest decisions.

Problems with the service and required improvements were not always identified. We did not always see evidence of actions taken where concerns had been highlighted. Not all staff felt they were supported by management to raise concerns or question practice. They did not feel that concerns raised had been acted on and responded to appropriately.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulation 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?

This service was safe.

The arrangements for staffing levels did not ensure there were sufficient staff on duty during peak periods.

People were safeguarded from abuse and risks were managed appropriately.

Procedures and protocols ensured where risks were identified action was taken to lower the level of risk.

The systems of medicine management ensured safe administration of medicines to people.

Requires Improvement ●

Is the service effective?

This service was not effective.

Mental Capacity Act (MCA) 2005 procedures were not clear for staff to follow. Records were not maintained to show the process followed by the staff to assess people's capacity and making best interest decisions.

Staff told us they had received training and had the skills and knowledge to fulfil their role. Training records did not reflect this.

The meals served were adequate and helped people to maintain a balanced diet. People complaint about the quality of the meals.

Requires Improvement ●

Is the service caring?

This service was caring.

Members of staff were respectful and consulted people before they offered support. People said their care and treatment was delivered in a dignified manner.

Staff knew the people they were caring for including their preferences for how they would like to receive care.

Good ●

Is the service responsive?

The service was not responsive.

Care plans were personalised and summary profiles were in place showing important information about the person and their preferences. People told us they were not involved in reviews of care plans.

People's needs were not reviewed consistently and information was not always updated or actioned in response to these needs.

Requires Improvement 

Is the service well-led?

The service was not well-led.

The provider did not have effective systems in place to assess, monitor and improve the quality of care.

Problems with the service and required improvements were not always identified. We did not always see evidence of actions taken where concerns had been highlighted.

Not all staff felt they were supported by management to raise concerns or question practice. They did not feel that concerns raised had been acted on and responded to appropriately.

Inadequate 

Alexander Heights Care 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.

We carried out this inspection in response to concerns raised relating to the quality of care and support people were receiving. These concerns related to all three locations, Hillcrest Care home, Alexander Heights Care Home and Fountain Place Nursing Home which are all located in Avonpark Village. Due to this we inspected all three locations. All three locations are registered with CQC separately and as such all three have a separate inspection report. All reports can be found on the CQC website. As we found there were some similar themes relating to the service provision in all three locations some of the findings in the reports will be repeated. The inspection took place on the 18, 19 and 23 May 2016 and was unannounced. This inspection was carried out by two inspectors for each location with support from an inspection manager. On the third day two inspectors and CQC pharmacist inspector attended covering the whole site.

Before we visited, we looked at previous inspection reports and notifications we had received. Services tell us about important events relating to the care they provide using a notification. We used a number of different methods to help us understand the experiences of people who use the service. This included talking with seven people who use the service and one relative about their views on the quality of the care and support being provided. During the three days of our inspection we observed the interactions between people using the service and staff.

We looked at documents that related to people's care and support and the management of the service. We reviewed a range of records which included seven care and support plans, staff training records, staff duty rosters, staff personnel files, policies and procedures and quality monitoring documents. We looked around the premises and observed care practices for part of the day.

During our inspection we spoke with the regional manager, the deputy manager, four care staff, which included agency workers, and the activity co-ordinator. We spoke with housekeeping staff and staff from the catering department.

Is the service safe?

Our findings

The staffing arrangements were not always adequate to meet people's needs during peak periods. The number of staff employed were not adequate to cover all shifts and agency staff were used to cover any shortfalls. People told us they did not feel there was enough staff. Comments included "Sometimes it doesn't feel like anyone is around" and "Carers are terribly rushed. They never have enough time to talk." One person told us they felt staff did not have time for encouraging their independence, for example, staff taking over some personal care tasks, instead of allowing the person time to do things for themselves. A relative told us "I can sometimes sit with Mum all morning with no staff going by her room".

Some people said they felt more staff were required in the afternoon. They commented "There are some lovely staff but they have agency in, which is not the best thing. There are normally three (staff) in the morning and two in the afternoon. It's not enough, especially in the afternoon." People told us most people stayed in their rooms during lunchtime, which made it difficult for the number of staff available to see to everyone in their rooms, as well as giving out medicines. Some people also needed assistance with personal care during this time and people told us staff felt under pressure to ensure their needs were met.

Staff stated that it was difficult to spend time with and support people who choose to spend most of their time in their rooms with only two staff on. Staff said the staffing arrangements were not sufficient and this had been raised with the manager previously. At the time of the inspection we saw three staff delivering direct care (two permanent staff and one agency); in addition there was an activities coordinator and housekeeping staff carrying out cleaning tasks.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they felt safe living at Alexander Heights. Comments included "I'm happy here and safe; yes they (the staff) are nice enough." and "Yes, I feel very safe." A staff member said "It's their home, they need to feel safe."

Staff had the knowledge and confidence to identify safeguarding concerns and acted on these to keep people safe. Staff told us they had received training in safeguarding adults and knew what procedure to follow. One person and their relative told us of an incident where a piece of jewellery had gone missing. Appropriate action was taken by staff and it was reported to safeguarding and the police and a thorough investigation was completed. On the day of the inspection another person alleged their purse had gone missing. Staff told us they had reported this to the regional manager who was following procedure. Staff said due to concerns raised about items going missing, they were now making an inventory of people's belongings on admission and all people had access to a safe. Staff told us they were also aware of the whistleblowing policy and felt confident to raise concerns to outside agencies such as Care Quality Commission or the Local authority.

People's care plans had a monthly assessment of care needs, which staff used to calculate a dependency score. This assessment supported staff to identify areas of risk, such as risk of falls, skin breakdown or malnutrition. Where risks were identified a plan to lower the risk was developed.

Safe systems of medicine management were in place. Medicines were administered from a monitored dosage system and staff signed the medicine administration records (MAR) charts to show they had administered the medicine. MAR charts were all completed correctly and any errors or omissions had been documented. Medicines were stored, received and disposed of securely. The temperature of the medicine fridge and storage room was regularly checked to ensure that medicines were being kept at the appropriate temperature. We found that the fridge temperature had been recorded as above the recommended range for a period of 2 weeks. There was a record that this had been identified and action had been taken to address the issue.

Protocols for medicines to be administered when required gave staff guidance on the circumstances when the medicine was to be administered, for example pain relieving medicines for people who lacked verbal communication or who had a cognitive impairment. This meant people had their pain relief in a consistent manner.

A number of people were supported through a risk assessment to manage their own medicines. There was a record of medicines received into the service; however no record was kept when the medicines were supplied to the person. This was raised with the regional manager who agreed to address this at the end of the inspection.

We observed that within the MAR chart folder that copies of the relevant medicines policy had been printed out but the date for review of these was for March 2015. When we raised this with the Regional Manager who was present on the inspection he told us the policies had been reviewed but not printed out which he would ensure was done. The provider had arrangements in place to monitor the competency of people administering medicines.

Is the service effective?

Our findings

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 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 MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

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 there was some awareness among staff of the MCA and the concept of capacity. There was also awareness of some principles of the MCA, such as the presumption of capacity and acting in a person's best interests. Where people had the capacity to consent to their care and treatment, the consent was not recorded. Mental capacity assessments were completed for people who lacked capacity to consent to their care and treatment. These were not always decision specific and it wasn't always clear who the decision maker was. Staff told us there were best interests recording sheets; however these were not in use. The provider noted when people had a legal representative such as a Lasting power of attorney; however we did not see evidence of the documents to confirm they had legal rights to make decisions about people's finances or their health and welfare. Staff lacked understanding of the difference in decision making for Health and welfare Power of Attorney or Finance and Property.

Some relatives were making best interest decisions about people's medical treatment, for example they had informed the GP they did not want their relative to be resuscitated, however they did not have Lasting Power of Attorney for Health and Welfare. Another example was where a relative was making decisions about medicines, but did not have the legal power to do so. Staff told us the GP would be consulted about this.

The registered manager had made applications for DoLS authorisations as required. Applications had been submitted to the Local Authority Supervisory body and they were awaiting a response. People were receiving care and treatment in the least restrictive way and could move freely around the building. People were also able to go outside in the garden if they wished to do so.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The concerns raised with us contained issues about how new staff were inducted when they commenced employment. We asked to see the records relating to staff induction. The documentation related to all three locations and showed that not all staff had received a full induction when they commenced employment

and some records for some new staff were missing. The documents that we were given did not contain any evidence that new staff completed or had enrolled on the Care Certificate. We asked the managers, who were available on the day of the inspection, about the missing documents but these could not be found and the managers could not confirm if the induction for all staff had been completed.

The Nominated Individual told us that there was not a policy relating to the induction of new staff. They told us that new staff induction was managed at a local level and although it was expected that new staff would complete a two week induction this would be dependent on the staff member's previous experience and skills. The senior management could not confirm what proportion of the induction would be face to face learning, computer based learning or shadow shifts. The Nominated Individual told us that in response to the concerns raised a formal induction policy was being developed.

The concerns raised with us contained issues with regard to staff training. We asked to see the records relating to staff training. The records we looked at contained information for staff at all three locations. We looked at the records with one of the senior managers. The records were chaotic and did not contain information relating to all staff training. The senior manager agreed with this view. We asked to see a training matrix to confirm what staff had completed training to ensure that they had the skills and competencies to fulfil their roles. The training matrix was not available and the senior manager could not confirm if one was in place. The deputy manager who was available on the second day of our inspection visit could also not confirm if a training matrix was in place.

Staff told us they had received training for example in safeguarding adults, health and safety, nutrition and medicines management. Staff did not know when any updates in training were needed and stated a member of administration would alert them when required. One member of staff told us they had been there for seven months, but had not received any mental capacity training. We found there was no training matrix to record what training staff had, which meant staff training records did not reflect the training received and when updates were needed.

There was a lack of opportunity through staff supervision to review individual personal development and progress. We requested a copy of the supervision timetable for 2015 and 2016 for all staff, one was not provided to us. We looked at the documentation relating to staff supervision. Across all three locations 45 to 50 staff were employed. Of these only nine staff had received supervision in 2016. Only four staff had received an end of year appraisal. Staff told us they usually receive four supervisions per year.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's health care needs were monitored and any changes in their health or well-being prompted a referral to their GP or other health care professionals such as a district nurse or opticians. Staff said GP visits happened twice weekly and a record of the visit was maintained. One person we spoke with confirmed that they were able to access their GP when needed. They said "I will ring them myself or ask the staff to arrange it." Another said "They come whenever I ask to see them." Records in people's care files indicated they had been supported to access health care professionals, such as GP's, practice nurses, hospital consultants, district nurses, chiropodists, occupational therapists and physiotherapists. We saw staff recorded the nature of the visit from healthcare professional along with the outcome of the visit. We found people did not have regular access to a dentist, which increased the risk of poor dental hygiene. Staff told us most people had private dental arrangements and that most people were independent with their dental hygiene.

People were supported to have sufficient food and refreshments to maintain a balanced diet. People told

us they had enough to eat and drink, however described the food as "Very poor" and stated "It comes up from the kitchen and I think some may be cooked the day before. The vegetables are poor. You choose from a menu the day before. The scrambled eggs are like rubber." Other comments included "It's sometimes good, sometimes not. It seems as if it has just been warmed. It's not always inspiring; egg and chips, fish fingers, baked beans and poor quality sausages." People told us the food was cold by the time it was dished up. People had a choice of a starter, main meal and dessert at lunchtime.

People had access to specialist diets when required for example pureed or fortified food. We spoke with the catering staff; they had information of all people's dietary requirements and allergies. This also included people's likes and dislikes which staff would let them know each day. They explained that people had a choice of meals. Meal choices were made the day before and this information was given to the catering staff. They said if people did not like what was on the menu or had changed their mind about their choices then they were able to request alternatives. The kitchen was clean and tidy and had appropriate colour coded resources to ensure that food was prepared in line with food handling guidance. The kitchen had been awarded a Food and Hygiene rating 5 by the food standards agency. The food standards agency is responsible for protecting public health in relation to food in England, Wales and Northern Ireland.

Some people commented on how hot the dining room area got on a sunny day, which made dining an unpleasant experience. The dining area was situated in a conservatory with an opaque roof. Although air conditioning was available, the residents felt that this was inadequate. The balcony surrounding the dining area in Alexander Heights was in a poor state of decoration. The external air conditioning surfaces were surrounded by old leaves and moss. One person said "It's not particularly nice to look at."

Is the service caring?

Our findings

People and their relatives spoke positively about the care and support they or their relative received. Comments included "Staff are kind and caring", "I can't fault the staff at all. I've not heard a cross word since I came here. They take time to come and chat with me, which is lovely." and "The night staff are very nice."

People gave mixed reviews about agency staff. One person told us an agency carer that supported them was exceptional. They said "The carer always offers to wash my hair. She knows I like my cashmere jumpers and offered to wash it as it could not go in the normal wash." Another person said "I don't always like the agency people because sometimes I can't understand what they say. I don't always know them."

People were supported to make choices and decisions about their daily living. Staff were knowledgeable about the care and support people required. For example if people preferred a bath or shower or what clothes they liked to wear. People told us they were not involved in reviewing their care plan. One person said "I used to be, but not anymore. There's no monthly review." A relative told us they used to be updated all the time, but there wasn't much communication now. They said "I feel out of control with that."

We saw staff promoted people's privacy and dignity. Staff knocked on people's doors and waited to be asked in. Any care and support was conducted behind closed doors. Staff told us when supporting people with any personal care they would always ensure this was done with the person's door closed and the curtains drawn. They would always explain what was happening and encourage the person to do as much for themselves as they could. They said they would always ensure that people were covered when supporting with intimate tasks.

We saw that staff were caring and had positive relationships with the people they were supporting. We heard a person speaking in French and the activity coordinator responded back in French, to which the person replied "You are lovely."

People's bedrooms were personalised and decorated to their taste. It was spacious and people could move around freely. All bedrooms had en-suite facilities. Staff told us there had been some refurbishments and rooms had been redecorated.

Is the service responsive?

Our findings

We reviewed people's care plans which were personalised and each file contained information about the person's mental capacity, personal care, sleep, skin integrity, allergies, past medical history, mobility, eating and drinking; along with other relevant information about their likes and dislikes. There was a personal profile page in place which had a photo of the person displayed and summarised important information about the person such as their health, regular medicines and culture and faith. Staff told us they were in the process of transferring care plans to an electronic system, which staff would be able to access and update care plans as needed.

People's care plans had been reviewed by staff, however it did not evidence the person's involvement. One person told us "I used to be involved, but not anymore. There's no monthly review." People were not aware they had a care plan in place.

Systems were in place to identify risk and action was taken to manage the risk appropriately. Risk assessments were devised for people at risk of falls, developing pressure sores, malnutrition and for people with mobility needs. It was not clear how staff calculated the dependency score and what the score meant. One person's assessment had not been completed since January 2016, which could indicate that their risk assessments were not up to date.

There was an activity coordinator in post. They were new in post and told us they were currently reviewing the activities available in order to make it more focussed on people's needs and interests. They were also looking to update the resources available for activities. People told us there was a programme of activities and they participated in group activities. The programme of activities was on display in the home. Some people said they preferred to stay in their rooms and not to participate in group activities. On the day of the inspection we observed the activity coordinator taking a person out in the morning and taking part in a quiz in the afternoon.

Existing staff said there was a small team and communication between them was good. Handover between staff at the start of each shift ensured that important information was shared, acted upon where necessary and recorded to ensure people's progress was monitored. Staff and people told us there was not sufficient numbers of permanent staff to meet people's needs and therefore a high number of agency staff were used. One staff member said "Just look at the staff rota and you'll see how many gaps there are."

People and those important to them did not have opportunities to feedback their views about the home and quality of the service they received. People told us they used to have residents' meetings and could discuss various issues; however meetings had not taken place since December 2015.

People told us they had been encouraged by senior management to raise any concerns they had about the home, however one person said they had received an e-mail from a senior member of the management team stating that people could contact them should they be concerned regarding the current situation in the home. The person had sent an email expressing their concerns but had not yet received a reply.

Is the service well-led?

Our findings

The registered manager was not present during the inspection; however, members of the senior management team including the Nominated Individual, a regional manager from another area, a newly appointed regional manager for the Wiltshire area and a home manager from another area were present.

We found that there was a lack of quality auditing and governance processes. The lack of clear quality auditing process had not informed the senior management team including members the board and Nominated Individual of the concerns identified in this report nor were they aware of the whistleblowing and safeguarding concerns that staff had raised. As a result no actions had been taken to assess, monitor, mitigate risks and improve the quality of the service. Limited action had been taken to address shortfalls identified in previous CQC inspection reports and to prevent the reoccurrence of issues.

During the inspection we asked the Nominated Individual to explain how the service was monitored. The Nominated Individual told us that the registered managers of services were responsible for conducting a range of audits which were then sent to the Quality and compliance manager. The Quality and Compliance manager then highlighted any trends, patterns or issues and these were reported to the senior management team at board level. In addition to this Area Managers completed a monthly visit to each service to assess the quality of care and to complete additional audits. Records of these monthly visits were also sent to the Quality and compliance manager for review and formed part of the report sent to the board. We were informed during the inspection that the quality and compliance manager had been off sick for a period of time

We found a range of audits had been completed by the registered manager and these included audits relating to infection control and medicines. However when we asked to see audits relating to staff induction, staff supervision, a staff training matrix and a dependency tool used to determine safe levels of staffing (this had been completed by the second day of our inspection) and audits relating to care planning these were not available. We asked to see how the service had gained the views of people using the service, their relatives and other professionals we were told that surveys had been conducted but these "could not be found".

We saw a range of meetings had taken place with relatives, people who used the service and staff. These meetings had taken place in January 2016. The relatives meetings raised some issues including lack of activities and stimulation for people, a lack of staff presence in communal areas, and ongoing issues with staff recruitment. At the staff meetings discussions took place between the manager and staff asking what action had been taken since the last CQC inspection. Not all staff had read the CQC report and so were not aware of any improvements that were required.

In addition concerns were expressed by the manager that he was not receiving accident /incident and safeguarding reports. The minutes of the staff meeting state "I am receiving less forms each month but this is not due to less incidents" and "as with the accident forms all safeguarding issues must be reported to x at the time of the incident along with the completed form". We asked to see an action plan as to how concerns

raised at the meetings were going to be addressed. We were told that one was not available. The senior management team, who were available on the day of the inspection visits, could not assure us and were not aware of the issues raised at the meetings nor were they aware of any actions that had been taken to address these concerns.

During the inspection we reviewed the records relating to staff supervision. Only nine staff of the 45-50 staff employed had received supervision across all three locations from January to May 2016. We reviewed all nine supervision records. Of these three raised concerns with regard to the conduct of other staff or issues with performance. In addition during the inspection one staff member told us that she had raised concerns with regard to the conduct of another staff member. We reviewed the personnel files for all of these staff and could find no evidence of any action being taken including disciplinary action or increased supervision. The managers available on the inspection visits were not aware of these issues or of the actions taken in response to this whistleblowing.

During the inspection we saw a memo from the manager to staff dated 5 April 2016. The memo raised concerns that meals prepared for people were being taken by staff. The manager had highlighted that this was not acceptable and was to stop immediately.

We asked to see the records relating to the providers monthly visits. The folder we were given contained provider visits for the October, November and December 2015 and April 2016. We asked the regional manager and Nominated Individual for the documentation relating to the visits for January, February and March 2016. These could not be provided. The provider visit forms which we saw had not identified any of the concerns highlighted in this report with the exception of the ongoing issues with staff recruitment.

During the inspection we spoke to the Nominated Individual who stated that whilst he was aware of issues with regard to retention and recruitment of staff and that the locations were not the "best performing homes in the group" he was not aware of the whistleblowing concerns, the lack of ongoing supervision of staff, issues relating to staff induction and training, the lack of accidents and safeguarding forms or the issues highlighted in the memo to staff. The Nominated Individual confirmed that no action plan, that he was aware of, had been developed in response to these concerns. The Nominated Individual confirmed that the quality and compliance manager was off sick and had been for some time. They agreed that the lack of safeguarding and incident/accidents reporting should have been considered a risk and should have warranted further investigation. When we asked them if they felt that their oversight of the locations seemed overly reliant on one person and if that person was not available then the system did not appear robust, they agreed.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We spoke to the Nominated Individual about the concerns that had been received and any action that had been taken in response to this to keep people safe. The Nominated Individual told us that a number of staff had been suspended pending a full investigation. Following this any disciplinary action would be taken if this was required. Retirement Villages were developing a formal induction policy and would review the training provided to staff. The current Registered Manager was unavailable and so an interim manager was been sought to commence employment as soon as possible and in addition the senior management team would have a presence at the services for as long as required. The Nominated Individual provided assurance that they would work with both us and the local safeguarding team to ensure that any remedial action or improvements would be implemented as a matter of urgency. Following the inspection we formally wrote to the provider to seek these assurances. The provider confirmed this and agreed that the home would not

consider any additional admissions to any of the three locations until such time as the safety of people at the service could be assured.

The people, staff and relatives we spoke to told us that they felt that the registered manager was approachable and was working hard to improve the standards of care at the service. As the registered manager was not available we were unable to discuss with them their views on the concerns raised or how they hoped to develop the service in the future.

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 11 HSCA RA Regulations 2014 Need for consent
Treatment of disease, disorder or injury	We found people's consent to care and treatment was not consistently sought in line with the MCA 2005. Where people had the capacity to consent to their care and treatment, the consent was not recorded.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing
Treatment of disease, disorder or injury	<p>The staffing arrangements were not always adequate to meet people's needs during peak periods. The number of staff employed were not adequate to cover all shifts and agency staff were used to cover any shortfalls.</p> <p>People did not always receive effective care from staff who had the knowledge and skills needed to carry out their roles and responsibilities. Staff did not receive appropriate training, supervision and appraisal to enable them to carry out their duties.</p>

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 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	Problems with the service and required improvements were not always identified. We did not always see evidence of actions taken where concerns had been highlighted.

The enforcement action we took:

Condition