Elysium Neurological Services (Badby) Limited

The Bridge Care Centre

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 8 and 10 August 2018. The first day of the inspection was unannounced, which meant that the staff and registered provider did not know we would be visiting. The second day was announced.

The Bridge Care Centre is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service provides care for people affected by neurological disorders. The home is a detached 40 bedroom purpose built care home in Middlehaven, Middlesbrough. Accommodation is within four separate units each with ten ensuite bedrooms. At the time of our inspection three people were living at the service.

When we inspected the service the manager was going through the process of becoming a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered person's'. 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.

This was our first inspection of the service since it registered with the Care Quality Commission (CQC) in August 2017.

We identified a range of discrepancies in medicine records. We found risk assessments were not always available to give guidance to staff as to how to help keep people safe.

We found that the service did not have clear governance systems in place. The issues we found during this inspection with record keeping, risk assessments and medication had not always been identified and addressed.

We found that some staff did not always have the required up to date training they needed to meet the needs of the people supported by the service. Nurses did not always have the regular training they needed or their competency checked.

We saw that where some people were unable to make some decisions for themselves some decisions made in their best interest were not recorded. We noted that one person's family member had signed their care plan without having the legal authority to do so.

Policies and procedures were in place to protect people from harm such as safeguarding and whistleblowing polices. Staff knew how to identify and report suspected abuse.

Safe recruitment practices were in place. Pre-employment checks were made to reduce the likelihood of employing staff who were unsuitable to work with vulnerable people.

Staff told us that they were supported through supervision. Most staff said felt they could approach the management team if they had any issues.

The premises were spacious and tidy however the furniture available to people did not help enable them to become more independent.

Learning took place following reviews of accidents and incidents where themes and trends were addressed.

People had access to a range of healthcare such as GPs, hospital departments and dentists.

We observed that staff members were kind and caring towards people in their interactions with them however we also saw that people were left in front of a television with minimal staff intervention from staff for long periods of time. We received mixed feedback on care staff from relatives.

Staff told us that activities were very limited due to the complex needs of people supported. We have made a recommendation about activity provision within the service.

People's privacy, dignity and independence were respected. The policies and practices of the home helped to ensure that everyone was treated equally. End of life care procedures were in place.

Meetings for staff took place. The manager told us that the people supported were unable to engage with team meetings. People supported were unable to express their views about the service provision and management.

Relatives told us they had had difficulty in developing a positive relationship with the manager of the service.

We were informed that feedback was sought to monitor and improve the service however the manager told us this was carried out by the provider and that they did not yet know the outcomes of any surveys carried out with families and people who had used the service.

Most staff were positive about the management team and confirmed they were able to raise concerns. A clear complaints policy and procedure process was in place.

We found three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, which related to safe care and treatment; staffing; and having good governance systems in place.

You can see what action we told the registered provider to take at the back of the full version of the report. You can read the report, by selecting the 'all reports' link for (location's name) on our website at www.cqc.org.uk

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 always safe.

Risks associated with people's care were not always documented.

Medicines were not always managed safely and were not always recorded appropriately.

Staff had been trained in safeguarding people and were knowledgeable about the potential signs of abuse.

There were enough staff available to meet people's needs. Staff recruitment practices were safe.

Is the service effective?

Requires Improvement

The service was not always effective.

Nursing staff had not always received the up to date training they required to meet people's needs.

The requirements of the Mental Capacity Act 2005 were not always being followed.

People's nutrition was not always managed in line with professional guidance.

Is the service caring?

Requires Improvement

The service was not always caring.

Staff did not always spend time with people or attempt to engage them in a meaningful way.

People's dignity and privacy was respected.

Staff were aware of the importance of promoting people's independence.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's care plans did not always provide staff with up to date, detailed information about people and the support they required.

Staff did not engage people in the activities they preferred.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Robust quality assurance systems were not in place.

We received mixed feedback about the manager.

We saw that the management team had a shared vision to improve and develop the service. They responded positively to our feedback on the day of inspection and were open to making changes to improve the service.

The Bridge Care Centre

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 checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This unannounced comprehensive inspection took place on 9 and 11 August 2018 and was carried out by two adult social care inspectors and a nurse specialist.

We contacted the commissioners of the relevant local authority, the local authority safeguarding team, the fire service and other professionals who had worked with the service.

Before the inspection we reviewed all the information we held about the service, which included notifications submitted to CQC by the provider. Notifications are changes, events or incidents the provider is legally obliged to send us within required timescales.

We used information the provider sent to us in the Provider Information Return. This is information we require providers to send us to give us some key information about the service, what the service does well and improvements they plan to make.

During the inspection we spoke with two relatives of people using the service. We reviewed a wide range of records, this included two people's care records and two people's medicines records. We looked at four staff recruitment files, including supervision, appraisal and training records, records relating to the management of the service and a wide variety of policies and procedures. We spent time observing people in the communal areas of the service.

We spoke with 11 members of staff, including the manager, the business support manager, one nurse, six care staff, the maintenance person and a laundry assistant.

Requires Improvement

Is the service safe?

Our findings

We found that risks to people had not always been assessed. This meant staff may not always have the guidance they need to help people remain safe. For example, one person received support with managing food and nutrition via a Percutaneous Endoscopic Gastrostomy (PEG) feeding tube but there was no guidance for staff in how to identify signs of problems with the use of the system such as redness around the tube site. For another person who had a catheter fitted there was no risk assessment in place to guide staff as to what signs and symptoms to look out for should a problem with the device occur.

We saw that one person had displayed episodes of aggression to staff however there was no information available to staff about the potential triggers which may cause such behaviours to be displayed or information about how to reduce the risk of harm occurring to the person or others. This meant there was limited guidance to staff to help them manage such situations in a positive way which protected the person's dignity and rights.

The service was unable to provide evidence of the completion of general risk assessments to ensure that people were safe such as outings, transfer and movement and providing personal care.

We saw that where risks had been identified appropriate records were not always kept. For example, for one person we saw that their falls risk assessment stated it was to be reviewed every two weeks however at the time of this inspection there had been no recording of a review since 6 June 2018. We saw that for one person it was expected that staff completed hourly observations however there was no associated documentation to confirm this had taken place.

Medicines were not always managed safely. Records relating to medicines were not always completed correctly. One person had a handwritten Medication Administration Record (MAR). Only one person had signed the MAR sheet. A second member of staff should have also signed the sheet as correct prior to its use.

Some people were prescribed PRN (as required) medicines. PRN protocols were in place to assist staff by providing guidance on when PRN medicines should be administered however these required more detail. They did not describe the ways that people who did not communicate verbally might express pain such as facial expressions, changes in behaviour or sounds. One person's PRN protocol noted the medicine would be given if a person 'showed signs of agitation' but did not state how this would be presented. One person's record did not state if they had any allergies which meant there was a risk of the person receiving a medicine they were allergic to.

Where people were prescribed medicinal creams body maps were not in place to show where the cream should be applied. We saw that medicinal cream had been applied inconsistently, this meant we could not be sure that people were having their medicines administered as prescribed.

This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 related to Safe care and treatment.

The manager told us that they thought there might be one qualified first aider employed and recognised that this needed to increase so that 24-hour cover could be provided. We were informed by the provider following the inspection that there were enough qualified first aiders employed to provide 24-hour cover.

We discussed the issues we found with medicines with the manager of the service who told us that a clinical lead had recently been appointed whose role it would be to oversee use of and audit medicines.

Staff who administered medicines had their competency assessed. Medicine audits had taken place which identified some of the issues we found during this inspection however there was inconsistent completion of action plans to address the issues found.

Systems and procedures were in place to keep people free from abuse. Staff had access to the provider's safeguarding policy. Records showed that the staff team received training in safeguarding. The staff we spoke with understood how to keep people safe including what to do if an allegation of abuse was made.

Relatives told us there were enough staff on duty to support people with their needs.

The manager regularly assessed staffing levels however at the current time a dependency tool was not required as only three people were living at the service.

We looked at four staff files which showed that safe recruitment procedures were in place. Staff completed an application form and any gaps in their employment history were checked out by the provider. Two references were obtained prior to staff starting work at the service. A Disclosure and Barring Service (DBS) check was carried out before staff commenced work. The DBS carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults. This helps employers make safer recruiting decisions and minimises the risk of unsuitable people from working with children and vulnerable adults.

Staff inductions had been completed. This helped to ensure recently recruited staff were suitable for the roles in which they had been employed.

People were transferred using equipment in a safe and competent manner. Regular checks of hoists and lifting equipment had taken place to ensure the manual handling of people was undertaken safely.

Equipment was maintained in line with manufacturer's recommendations. Checks were made regularly on items such as profiling beds, call systems and wheelchairs to ensure they were safe to use.

Records showed that regular maintenance checks of the building took place. Certificates showed that checks had been carried out in most areas. However, there was no evidence available to show that a full check of the emergency lighting system by a qualified electrician had taken place since March 2017.

Records confirmed that the fire alarm was tested on a weekly basis. Regular staged fire drills and evacuations had taken place. People had personal evacuation plans (PEEPs) which informed the staff of how to help them leave the building quickly in case of an emergency.

Contingencies were in place to keep people safe in the event of an emergency. The provider had a business continuity plan which set out how people's needs would continue to be met in the event of an unforeseen incident such as a flood or power failure.

During the inspection we looked around toilets, shower rooms and communal areas. Infection control policies were being followed by staff in their day to day practices such as wearing gloves and aprons to reduce the risk of infection however we did identify an empty hand gel dispenser at the entrance to the floor where the three people currently supported were living.

Adverse events were shared with staff. This supported the staff team to focus on lessons learned. The manager gave us examples of how lessons had been learnt including those learnt from previous admissions which were later judged to be unsafe.

Records showed systems were in place for reporting, recording, and monitoring significant events, incidents, falls and accidents. The manage informed us there had been no accidents.

Requires Improvement

Is the service effective?

Our findings

The manager and business manager told us that the training matrix and folder we reviewed was up to date. However, we found that some staff who no longer worked at the service remained on the training matrix and staff who did were working at the service were not on this document.

From a review of the training information we found that only one nurse had completed all of the provider's training and they were currently not working at the service. The same nurse had also completed an external trainer's on line training on management of wounds and infection management. Of the nurses who were working two nurses had completed a course on diabetes. Four nurses had completed equality and diversity, fire safety, food hygiene, moving and handling, health and safety, infection control training. Two nurses had completed immediate life support training.

Although, according to the training matrix three health care assistants had completed training in PEG feeding. We found that none of the nurses had completed training on PEG feeding, wound care, management of catheters and tracheostomies. The business manager told us that these staff had completed this training and it was stored in the training folder, however, the certificates in this folder predated when they commenced working at the service and some nurses' certificates dated back to 2012.

The manager assured us that the nurses had recently completed PEG feed training but there was no evidence to confirm this had happened. We could only establish that health care assistants had undertaken this training. We found that no competency checks had been completed of the nurses, therefore the provider could not be assured that staff had the skills to deliver, and oversee staff, PEG feeds.

One of the nurses had been working at the service for the two weeks and told us they had completed a wide range of training whilst working as a district nurse. They confirmed that they routinely completed PEG feeds at the service and had undertaken this task in the community. However, their competency in undertaking this work and other procedures had not been checked.

At present no clinical lead works at the service, the manager is not a nurse and none of the nurses had recently completed PEG training. Therefore, there was no one on site who could check any of the staffs' competency. The manager told us they would contact the community PEG nurse and ask them to complete competency assessments.

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

It is the intention of the provider to open the top floor of the service as a provision for people with extremely complex needs who will need support maintaining their airways via tracheostomies and ventilators. None of the nurses have completed this training but the manager told us they had sourced an in-depth course from the intensive care department at James Cook hospital. Also, the provider was yet to determine the level of medical cover they would require to support the needs of this group of people.

Care records included one page profiles about the person, pre-admission details, information about consent and a range of care plans. Care plans covered areas such as continence, skincare, nutrition and mobility. We found gaps in care plans and inconsistencies in recordings for example, for one person a skin care plan was not available to ensure their skin remained healthy. In addition, there was no record as to the appropriate setting and frequency of checks for their airflow mattress. We saw care plans did not always include the person's name.

People's nutritional health was monitored using the Malnutrition Universal Screening Tool (MUST). MUST is a screening tool to identify adults, who are malnourished, at risk of malnutrition (undernutrition) or obese. We saw that for one person their PEG feeding regime had been changed by a dietician on 2 August 2018 however this had not been actioned when we visited on 8 August 2018. We spoke to the manager about this who arranged for the correct regime to be implemented immediately. We saw that one person's PEG site was to be checked twice a day however there was no supporting evidence of this happening. We also saw inconsistent records, in regards to the rotation of the person's PEG tube.

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

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 authorisation 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. Records showed the service was following the requirements of the MCA in regard to one person's DoLS authorisation. However, for a second person there were no DoLS authorisation records held within the person's file. We were informed by the provider following this inspection that the authorisation records not made available to us on the days of inspection were in place. We spoke to staff and they showed an understanding of the principles of the MCA. For people who did not always have capacity some mental capacity assessments had been completed for their care and treatment, however assessments were not documented for a wider range of specific decisions. People did not have decision specific mental capacity assessment and best interest decisions for the use of bedrails, wheelchairs and splints. The manager had recognised this gap and was taking action to ensure appropriate documentation was in place.

We saw that for two people family members had signed consent to the person's plans of care however they did not have the legal authority to do so. Where people were unable to sign themselves best interest meetings had not taken place with people to agree decisions.

The manager discussed concerns they had around how people were supported by relatives. They had worked with the people's social worker to assist in making 'best interests' decisions and looking at how care and support can be delivered in a safe and effective manner.

The manager was aware that when people wanted to make decisions on behalf of people who lacked capacity that went against medical advice this would need to be referred to the Court of Protection.

Records showed that people's needs had been assessed before they moved into the service. The service employed a physiotherapist and a speech and language therapist and had recently recruited an occupational therapist. People were supported to access external professionals such as dentists. And dieticians. People's records contained information on communication with external professionals. Care plans clearly showed where referrals to healthcare professionals had been made.

Staff told us they had started to receive supervision from the management team and most told us that the manager was available for support if they had any concerns. Supervision is a process, usually a meeting, by which an organisation provides guidance and support to staff. Supervision sessions included staff development needs. One staff member said, "It's very useful if I've got any concerns or things I'd like to do with training."

Handovers were undertaken before staff started on shift. Handovers covered areas such as any concerns and medicine issues. These handovers provided staff with the opportunity to gather the up to date information they required to support people. Staff recorded how people had been throughout the day and overnight and records included information about care and support that had been given.

The building was presented in the style of a hospital. The manager told us, "It's more like a hospital really but they [the provider] have assured me it's a home." A range of facilities were available on the ground floor of the building however they were not currently in use. The service's hydrotherapy pool was out of order. People were unable to access the outside balcony areas on each floor of the building due to an issue with unsafe flooring in these areas.

People's bedrooms were personalised with people's belongings to make them feel at home. People were able to meet privately with friends or relatives. The design of the building did not restrict the use of equipment to aid people's mobility however we found that the furniture currently in use did not aid people with developing their independence. For example, tables in the dining area were at the wrong height for people to sit at in their adapted chairs.

Requires Improvement

Is the service caring?

Our findings

We received mixed feedback from relatives regarding staffing. One relative said, "Some staff are alright, quite nice but not all." Another said, "The carers are really good and caring but quite inexperienced, they are keen to learn though."

We observed that staff showed respect for people and ensured peoples dignity was maintained. Staff told us how they protected people's privacy and dignity; closing doors and curtains and knocking on doors prior to entering. We observed staff speaking respectfully to people, knocking on doors prior to entering and ensuring people's modesty was respected whilst transfer and movement procedures were taking place.

We observed that staff explained what they were going to do before doing it. We found however, that people were sometimes left in front of the television for long periods of time with staff interactions taking place only when a medical intervention was needed. We did not see staff spending time attempting to sit with or engage with people in a meaningful way, giving only brief acknowledgments or a very quick chat whilst a medical intervention took place.

The staff we spoke with understood the importance of promoting independence however found they opportunities to do so were currently limited due to the needs of the people supported. One staff member said of one person living at the home, "They can brush their own hair so I always give them plenty of time to do it before I help them with it." Another said, "We always talk to people and tell them what you are going to do before you do it." We saw the person's care plan stated that the person was, 'able to participate in some aspects of care such as brushing their hair and teeth'.

Some staff had completed training in equality, diversity and human rights and the provider had an equality and diversity policy. Records showed only four nurses had completed this training. The manager was aware of this and was sourcing additional training accordingly. The manager told us that at the current time everyone living at the home had a similar ethnic background and religious beliefs. Information regarding people religious and cultural needs was gathered prior to admission. The manager told us that were people had an identified need or preference in this area it would be recorded within the person's plan of care.

We saw that care files were stored securely. This meant that people's confidential information was only accessible to those people who needed to see it.

Advocacy information was available for people if they required support or advice from an independent person. An advocate acts to speak up on behalf of a person, who may need support to make their views and wishes known.

Requires Improvement

Is the service responsive?

Our findings

People's needs were assessed before they moved into the home. Where a support need had been identified, a care plan was developed setting out how it could be met. We saw care plans covered a range of areas including nutrition, mobility and medication. Care files contained information about people as individuals. A one-page profile was included giving important information to staff about the person and their care needs and preferences. An 'All about me' record had been written detailing lots of information about the person and their history. However, the plans of care we looked at did not always provide staff with guidance about the best way to support people. We found gaps and inconsistencies in care records.

The service had a complaints policy and procedure in place however one relative told us, "I tried complaining but it did no good." Another relative told us they would not feel confident complaining. One staff member told us they felt that complaints made by staff were not dealt with by senior managers appropriately.

The manager informed us that they had not received any complaints however they had received unofficial concerns. These had not been documented however once we brought this to the managers attention they assured us they would document all such concerns and their outcomes in future.

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

People's needs and plans of care were reviewed and updated at least once a month to ensure they reflected people's current support needs and preferences

Whilst plans of care noted people's preferences we observed that these were not always adhered to. For example, for one person who was unable to communicate verbally we saw their care plan stated they enjoyed watching football and listening to certain types of music. The person was placed in front of the television and the existing channel was left on was with no consideration given to putting on a programme or DVD they might enjoy. They were then left in the lounge alone until staff returned 20 minutes later to carry out a medical intervention.

We found very little in the way of activities taking place with people. We saw minimal occupation for people other than the television. On the first day of our visit two people were left alone in front of the television at various times of day without staff engaging them in any type of activity until a relative visited to take them out. The manager told us this was due to the very complex needs of the people supported. We recommend the provider consults current best guidance and provides staff with information in how to engage and support people with very complex physical health needs in activities.

The care plans we looked at contained some person-centred information on people's support needs. Person centred planning is a way of helping someone to plan their life and support focusing on what is important to the person, for example one person's plan stated, 'if it's a warm night [person] likes to have

their fan on overnight, likes to go to bed between 19:00 and 20:00 hours, likes having door open overnight'.

Procedures were in place to support people with end of life care. Where they preferences in this area these were recorded in peoples care plans. At the time of our visit no one was receiving end of life care.

The Accessible Information Standard requires staff to ask, record, flag and share information about people's communication needs and take steps to ensure that people receive information which they can access and understand, and receive communication support if they need it. Each of the care files we reviewed contained information on how the person communicated their wishes.

Communication care plans were individual for the person. For example, for one it stated, 'yes and no are often conveyed only by small head nod or shake, talk to them on their right side if wanting an answer promptly'. The information staff told us about how they communicated with people reflected the information available in peoples plans of care.

Staff told us that information would be made available to people in alternative formats such as large print on an individual basis, as and when they needed it. The manager told us they were giving consideration to sourcing tools to help people who were unable to communicate verbally communicate more effectively via technological solutions such as 'eye laser', which allows the person to look at words and letters which are then transcribed by a computer and spoken out by the computer activated voice.

Requires Improvement

Is the service well-led?

Our findings

The manager told us that since coming into post they had become aware that the service had not operated in line with expected practice. They had been taking action to make improvements, however, more improvements/actions were needed. They told us that at present it was their intention not to admit people and that plans to open a unit on the top floor for people with extremely complex needs was on hold.

We discussed with the manager the design of the top floor and intended service. We heard that the top floor had piped oxygen going to every bedroom and it was the provider's intention to open a unit for people who would need support to breathe via tracheostomies and ventilators. The manager told us that currently staff did not provide the skill set to deliver this level of treatment. However, they were ensuring training was put in place and nurses who had worked in this setting were being employed.

It was clear that the level of need people would have and the immediate risk to life if the tracheostomy or ventilator malfunctioned would be extreme. Therefore, the service would require constant medical oversight for this client group. We discussed with the manager that if this level of support was needed there would be the potential that the service would be redefined as an independent hospital. The manager agreed to discuss this with the provider and ensure appropriate action was taken to correctly register the service.

A comprehensive, up to date record for each person using the service had not always been kept. Care plans were lacking some required information and some of the records in place were inconsistent.

Medicines were not always managed safely and there were gaps in some medicine recordings. Medicine audits had not identified the issues we found in this area. Provider and management audits had not always identified the issues we identified during this inspection with records, risks, medicines and consent. Action plans that had been completed did not always accurately reflect work undertaken for example an audit identified that some names were missing off care plans, this action had been signed off as completed however we found it had not been fully addressed.

The manager of the service told us that there was currently no clinical lead in place and that person once they commenced in post would audit the care plans. The manager told us that at the time of the inspection they did not carry out any audits of the building or records themselves but that a more robust auditing regime would be implemented.

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

The manager told us they were aware of the issues with the records held and had a plan in place to address the shortfalls. Provider visits had taken place on an ad-hoc basis. Audits undertaken by the provider covered areas such as safeguarding, fire, the building, feedback and a review of the last visit. The manager informed us that the providers quality assurance tool did not fit in with the service provided at The Bridge and that there were plans in place to adopt a new auditing tool.

We received mixed feedback from relatives about the management team. One staff member said, "I couldn't ask to work in a better place." Another said that the manager was "definitely approachable".

Most staff told us the new manager was approachable and was a visible presence in the home. Staff told us there had been a number of changes in the management team, one said "Things are definitely better now", another said "I don't feel supported at all."

Relatives told us that they had found communication with the manager difficult. One said, "They are never around, there's only nursing and care staff on the floor".

We were unable to view any written feedback from people who had been supported at the service and their relatives. The manager told us this was because of the complex needs of the people and the fact that the provider sent out surveys but they had not received any feedback from these. One relative said of the manager "[The manager] is not interested in our suggestions. We are not listened to."

Meetings for staff were held at regular intervals. Minutes were maintained and made available to staff. These detailed the matters discussed, actions that needed to be taken and by whom. Records showed that staff were given opportunities to share their views and contribute to the development of the service. Care issues were discussed within team meetings so that staff were kept well informed about the needs of people who used the service.

There was evidence available of partnership working with other health and social care agencies to meet people's needs.

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

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to assess the risks to the health and safety of service users of receiving the care or treatment and do all that is reasonably practicable to mitigate any such risks. The provider had failed to ensure the proper and safe management of medicines.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity The provider had failed to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity. The provider had failed to maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care

Diagnostic and screening procedures

Treatment of disease, disorder or injury

Regulation 18 HSCA RA Regulations 2014 Staffing

The provider had failed to ensure there were sufficient numbers of suitably qualified, competent, skilled and experienced staff available to meet the needs of people supported.