Four Seasons (Evedale) Limited

The Sycamores and The Poplars

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

About the service

The Sycamores and Poplars is a nursing home providing personal and nursing care for older people, at the time of the inspection 13 people were using the service on Poplars unit and 24 people were using the service on Sycamore unit. The service can support up to 72 people across both units.

People's experience of using this service and what we found
People were not always supported with adequate numbers of staff. The checks around agency staff's suitability to work at the service were disorganised and did not show clearly that essential details were checked, or some agency staff had received an induction to the service.

People were not always protected from potential harm as safeguarding issues had not been clearly documented, and there was a lack of robust investigations documented following safeguarding concerns being raised.

There were aspects of the service such as the outside areas which had not been maintained to allow people to use and enjoy the facilities. There were improvements required to signage to support people living with dementia as they moved around the service.

People were not always supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; systems in the service did not support this practice. Mental capacity assessments and best interest decisions in place for people were not always consistent and the provider did not always follow the principles of the MCA.

Complaints were not always responded to in a timely way. The service was not always well managed, and the quality monitoring processes had not highlighted some of the issues we found during our inspection. Staff were not always supported in their roles and people and relatives did not always feel their views on how the service was run were listened to.

People's privacy and dignity was maintained, and their independence encouraged. They were supported by a staff group who knew their needs and cared for them in a respectful and kind way. However, the lack of permanent nursing staff impacted on the continuity of care for some people. Although there was good information on people's care needs there was some disorganisation of daily care records.

The risks to people's safety were assessed using nationally recognised assessment tools and measures were in place to mitigate risks but still support people's independence. People's medicines were managed safely. There were processes in place to protect people from the risks of infection and staff showed a good understanding of their roles in reducing the spread of infection. People's nutritional and health needs were well managed by the staff who supported them.

Rating at last inspection and update
The last rating for this service was Good (published 27 January 2017)
You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for The Sycamores and Poplars on our website at www.cqc.org.uk.

Why we inspected
This was a planned inspection based on the previous rating.
We have identified breaches in relation to adequate staffing, and governance at this inspection.
Please see the action we have told the provider to take at the end of this report.

Follow up
We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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.

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service caring?

Requires Improvement

The service was caring.

Details are in our caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Details are in our responsive findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-Led findings below.

The Sycamores and The Poplars

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
This inspection took two days to complete. One inspector and a specialist adviser visited the service on the first day and the inspector returned to the service for a second day.

Service and service type
The Sycamores and Poplars 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.

At the time of our inspection the service had a manager registered with the CQC. A registered manager and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had about the service prior to our inspection. This included previous inspection reports, details about incidents the provider must notify us about, such as abuse and accidents. We spoke with the local authority quality monitoring team who work with the service.

The provider was not asked to send us a provider information return form prior to the inspection. This is information providers are required to send us yearly with key information about their service, what they do well, and improvements they plan to make.

We used all this information to plan our inspection.

During the inspection
We spoke with five people at the service and four relatives to ask about their experience of the care provided. We used the Short Observational Framework for inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We spoke with five members of care staff, the cook and a housekeeper. We also spoke with the deputy manager, the registered manager, the quality assurance manager and the regional manager. We also spoke with a visiting health professional.

We reviewed a range of records. This included all or sections of nine care records, medication records, agency and staff files. We also looked at the training matrix, audits, accident records and records relating to the management of the home.

After the inspection
We reviewed further information sent by the service for the report.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Requires Improvement.

This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Staffing and recruitment

● Safe recruitment processes were in place when new staff were employed. However, the processes for checking agency staff's suitability to work at the service were disorganised and did not show clearly that registered nurses registration details were checked. There was a lack of evidence to show some agency staff had received an induction to the service. Agency nurses were regularly in charge of shifts and this lack of robust checks put people at risk of being supported by staff who did not have the necessary checks to show their suitability to work at the service.

The above issues meant the provider was in breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

● People were not always supported with adequate numbers of staff and as a result their needs were not always met in a timely way and increased the risk of them receiving inappropriate and poor care.

● Relatives told us there were times when their family members did not receive the care and support they needed in a timely way. One relative told us on one occasion they had found their family member in a soiled and wet bed. They raised this with staff but as the person required two staff to assist them and staffing levels were low, the person had waited two hours for staff to change the bed.

● Other relatives told us their family members were left in bed when they were able to sit up in a chair for periods of time. One relative was concerned as the longer their family member stayed in bed their ability to sit out of bed reduced. This then affected the person's ability to access the communal areas and day to day activities. The relative told us after they had raised it staff addressed their concern. However, the second relative we spoke with told us leaving their relative in bed continued to be an issue for them.

● Further relatives told us there were times when the communal areas at the service were not manned by staff and relatives had needed to intervene and support people. One relative told us they regularly needed to support staff when they visited. They said, "The staff are wonderful but there is just not enough of them. They struggle to give the time to people."

● We saw evidence that issues around staffing levels had been raised to the registered manager by relatives but there was a lack of evidence to show how they had responded to these concerns.

● A health professional who had been supporting the service on a regular basis told us the staffing levels were not sufficient to provide the level of care people needed due to the high dependency of some of the people using service. This view was supported by staff at the service.

● These views were also supported by the evidence we found relating to people's care. On each day of our

inspection we saw there were times when people were not being repositioned in line with their care plan guidance. We viewed three records for people who had been assessed as requiring four hourly repositioning. One person had been left for a period of six hours between repositioning and another two people had been left for over five hours between repositioning.

The above issues meant the provider was in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong
● People were not always protected from potential harm as the registered manager had not clearly documented safeguarding issues which had occurred at the service and there was a lack of robust investigations documented following safeguarding concerns being raised.
● The safeguarding file contained an outcome letter from the local authority safeguarding team in relation to one safeguarding issue. The registered manager was tasked to investigate this incident and feed back to the safeguarding officer. However, the safeguarding officer had noted they had not received this and there was no evidence of the investigation in the safeguarding file. The letter noted the person's relatives were happy the service had reassessed their family member. However, the lack of investigation meant we could not be sure lessons had been learned from this incident.
● Staff had access to a whistle blowing telephone line provided by the provider. There was evidence that this facility had been used by staff to raise a concern. However, the response to the concern had not been robustly investigated by the registered manager. This lack of thorough investigation meant there was a lack of credibility to the conclusion of their investigation.

The above issues meant the provider was in breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

● People told us they felt safe at the service and trusted the staff who cared for them. Staff we spoke with were aware of their responsibilities in keeping people safe. They told us they had regular on-line training to help them understand the types of abuse people may be exposed to. Staff were aware of the external agencies they could contact should they need to.

Assessing risk, safety monitoring and management
● Personal emergency evacuation profiles were in place on both units. However, we identified the red bag which contained safety items such as torches and first aid equipment was missing from Sycamore unit. We highlighted this to the registered manager. It was not clear how long this had been missing as the service's maintenance person had been off for a period of time and the regular environmental checks they undertook had not been carried out. Following our inspection, the registered manager addressed the issue and put measures in place to ensure it was checked regularly.
● The risks to people's safety were assessed using nationally recognised assessment tools and measures were in place to mitigate risks but still support people's independence.
● People's risk assessments were reviewed monthly and actions to reduce the risks were identified in their care plans. Moving and handling assessments were completed and provided details of the equipment needed to move each person safely when they required assistance. When bed sides were used to prevent people falling out of bed, risk assessments were completed to ensure they could be used safely.
● There was clear evidence to show people were being supported with their independence with positive risk assessments in place. One person had a kettle and fridge in their room to allow them to make their drinks independently when they wished. Staff reviewed the person's ability on a daily basis as they had an underlying health condition that on some days effected their ability to undertake the task. The person told

us staff supported them when they needed it, but they valued their independence and wanted to continue making their own drinks when they could.

Using medicines safely

● People's medicines were managed safely as people received them from staff who had received training in the safe handling of medicines. However, there was a complacency among staff on Sycamore unit in relation to the storage of medicines.

● Medicines were stored in a clinical room with a keypad lock, the room was beyond a locked door so people without capacity would not be able to enter the area. On the first day of our inspection the clinical room was unlocked allowing us to access a variety of medicines awaiting return to pharmacy. The medicines fridge within the room was also unlocked. This meant relatives or staff who were not designated key holders could access this room.

We recommend the provider consider current legislation on safe storage and management of medicines to ensure safe practices.

Preventing and controlling infection

● People were protected from the risks of infection as the staff supporting them had undergone training in infection prevention and undertook safe practices when providing care. We saw staff using personal protective equipment (PPE) and effective hand washing techniques when providing care for people.

● The environment was clean and there were cleaning schedules in place to ensure regular cleaning took place.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has remained the same.

This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- People's needs were assessed using nationally recognised assessment tools such as the malnutrition universal scoring tool (MUST) to assess people's nutritional needs and the Waterlow assessment tool for people's skin integrity needs. However, there was a lack of clear information in people's care plans to show how some of the guidance had been used to support people.
- Some people with high risk waterlow scores were cared for in bed and had a history of skin integrity issues. Their care plans did not give a clear repositioning regime, this lack of clear regime and rationale for the level of care provided meant people were at risk of not receiving care that met their needs.

Staff support: induction, training, skills and experience

- People told us staff worked confidently when supporting them and staff told us they received training that supported them in their roles. We viewed the training programme that showed staff received appropriate training for their roles. Staff were supported with an induction when they started work at the service and one staff member told us they felt very supported by their colleagues.
- There was a lack of clarity around staff supervisions. We saw some records to show staff supervisions covering particular areas of care had been undertaken. However, there was a lack of clarity as to why some staff had received these supervisions. There was also no indication as to whether all the staff meant to receive the supervisions had received them.

Supporting people to eat and drink enough to maintain a balanced diet

- When we last visited the service we saw some people had a poor dining experience and their nutritional needs were not always met. There had been improvements to the way people were supported with their meals. Our observations of the mealtime experience were positive. People were offered support by staff in a timely and dignified way. Where required people had adaptive cutlery to facilitate their independence.
- People were offered food and drink at frequent intervals throughout the day. Those people who were at high risk of malnourishment had their fluid and food intake recorded and monitored. Where people were at risk of choking or required a specialist diet, staff were knowledgeable about their needs and worked with the kitchen staff to ensure their needs were met.
- Staff were following guidance from health professionals when people required specialist nutritional support. One person was receiving their food by a tube which went directly into their stomach. Their nutritional needs had been reviewed by a dietitian and records indicated they were receiving their nutrition in line with the feeding regime supplied.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

● The majority of people's health care needs were met by the staff at the service, who worked collaboratively with people and health professionals to support people's needs.

● However, a relative told us their family member had missed a dental appointment even though the relative had reminded staff of the appointment the day before. We noted there was a record of the appointment in the staff communication diary for the day of the appointment. The person's care record confirmed the appointment had been missed. There was no information as to why the person had not attended, but the relative told us staff had said they had forgotten.

● There was evidence in people's care records of access to opticians, chiropodists, GPs, dietitians. People's care records showed staff had accessed medical advice when people showed signs of ill health. Relatives said staff were alert to signs of deterioration in their family member and contacted the doctor when necessary.

● We witnessed a conversation between the unit manager on the Poplars unit and one person who had not felt well over night. The unit manager sat with the person and discussed their symptoms and whether they wanted the G.P telephoning. The unit manager and the person decided together there was no need for the doctor, but the person required some pain relief for a chronic condition. We saw throughout the day staff monitored the person and on the second day of our visit the person had improved.

Adapting service, design, decoration to meet people's needs

● People lived in an environment that had been adapted to meet their needs. However, there were aspects of the service such as the outside areas which had not been maintained to allow people to use and enjoy the facilities. There were improvements required to signage to support people living with dementia as they moved around the service.

● Our observations of the outside areas when we arrived at the service showed an unkempt and overgrown area leading up to the entrance. The enclosed garden area outside the Poplars unit was in a state of poor repair. Staff told us people had been unable to use this area during the summer as the lack of repairs had made it unsafe to do so. We discussed this with the regional manager who told us they had plans to address this issue and refurbish the garden area.

● The service did have some signage at the service to support people who were living with dementia find their way to communal areas. However, further improvements were needed to help people find their way to their own bedrooms. The bedroom doors were all one colour with no identifying features such as photographs to support people find their way to their rooms.

We recommend the provider consider current guidance on providing a dementia friendly environment for people who were living with dementia at the service.

Ensuring consent to care and treatment in line with law and guidance

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 to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures 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 had the appropriate legal authority and were being met. We found the conditions for one person had not been met in a timely way.

● The condition on the person's DoLS re-authorised in September 2018, related to covert medicines and as required medicines. The condition was for these medicines to be reviewed. The authorisation recorded that this was a recommendation from the previous authorisation put in place in September 2017 and had not been carried out by staff. The person's records showed a GP medicines review was not requested until February 2019. This was not followed up by staff until May 2019 and a decision about the medicines had not been taken until August 2019, 23 months following the condition being imposed.

● We also saw that although there were mental capacity assessments and best interest decisions in place for some people this was not consistent, and the provider did not always follow the principles of the MCA. One person did not have any mental capacity assessments and best interest decisions, despite their care plan saying these were required for medicines management and some other decisions relating to their care.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as Good. At this inspection this key question has remained the same.

Good: This meant people were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; respecting equality and diversity
- Due to staffing issues people were not always supported in a person centred way.
- Both relatives and staff told us due to staff shortages staff were often moved from one unit to the other. One relative said this impacted on continuity of care and their family member did not always get the personalised care planned for them. For example, they asked one staff member to wash their family member's hair, and assist them with a bath, but the staff member was moved from the unit on that day and this resulted in this not being done. The relative told us this was not an isolated incident.
- People and their relatives told us the staff who supported them were caring and kind. One relative said, "It is a lovely home, there is a lovely atmosphere and staff are very caring, but there aren't enough of them." Other relatives told us they were made to feel welcome when they visited the service.
- The interactions we saw were positive, with staff and people engaging well with each other. One person was teasing and laughing with one of the care workers whilst we were chatting. One member of staff had sat at a table undertaking some paperwork, whilst they did this they chatted to people about the activities some people were engaged in.
- One member of staff who was relatively new to the service had been supporting a person who was confused and anxious. They engaged with the person in a non-confrontational way, talking calmly, standing so they were able to support the person with their mobility but not invading their space. After a few minutes the person was still anxious, and another member of staff came to support them, and they became calmer. The person's relative told us staff consistently worked together to offer kind and compassionate support for their family member.
- At the time of our inspection no one at the service had any particular cultural needs. However, the staff at the service told us they would support people should they have any particular wishes and there were policies in place to guide and support staff with this area of care. There was information on Advocacy services should people need this support. An advocate is an independent person who supports people make their views and wishes known. There was no one at the service who required an advocate at the time of our inspection.

Supporting people to express their views and be involved in making decisions about their care
- People's views on their care were used in their care plans to provide care the way they wanted.
- There was evidence in the care plans of people's care being reviewed with either themselves or their relatives. There was collaboration between people, relatives and staff. One person provided information

about their care, but due to a health condition found it difficult to sign their plans, they had given permission for their relative to sign their care plans.

Respecting and promoting people's privacy, dignity and independence

● People and relatives told us the staff worked to protect people's privacy, maintain their dignity and support their independence. Staff gave examples of how they supported people to be independent when they supported them with their daily routines.

● We saw staff knocked on doors before entering people's rooms and spoke respectfully with both people and their relatives.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Requires Improvement.

This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- Although people received care from a group of care staff who knew them well, the lack of permanent nursing staff impacted on the continuity of care for some people. The majority of information about their care was detailed and reflective of their needs. However, there was some disorganisation of some of the daily records and there were some examples where information did not reflect people's needs.
- People's charts stored in their rooms showed the recording of application of creams was inconsistent. We highlighted this to the registered manager who told us they had moved the charts from people's rooms to a central folder. However, this had not been clearly communicated to staff and we saw some charts were still in people's rooms. As a result not all staff were using the same tools to record their actions, putting people at risk of receiving inconsistent care.
- One person who had been admitted to the service for respite care, had information showing they required a soft diet. However, our observations and discussions with staff showed this information was not correct and had been supplied by a relative. The person had capacity to make their own decisions and staff had worked with the person to ensure they were able to safely eat a normal diet. However, this lack of up to date information in their care plan put them at risk of receiving an inappropriate diet.

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

- The registered manager worked to provide people with accessible information about different aspects of their care.
- We saw communication support plans provided staff with information about people's communication and sensory needs to support communication. We saw staff using this information when they supported with people.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

- The staff at the service worked to support people maintain relationships with other people at the service. There were some social activities in place but the feedback from people and their relatives about the level of activities showed a lack of meaningful events for people at the service.

● One relative told us there just didn't seem enough for people to do and people were just sat for long periods. Another person said, "There's nothing much going on." "Nothing is organised other than a bus trip and that wasn't accessible."
● On the day of our inspection we saw the activities co-ordinator undertaking a group activity on one of the units during the morning. However, people on the other unit had little stimulation.

Improving care quality in response to complaints or concerns
● People and relatives knew who to complaint to if they had any concerns. However, we saw a number of complaints raised had not been responded to in a timely way.
● Relatives told us they had made complaints and we saw written complaints to the service from relatives. We saw one letter which raised a large number of issues that the complainant wanted addressing. However, there was no evidence to show the complaint had been addressed and managed to the relative's satisfaction. We raised this with the registered manager who was unable to provide an explanation as to why the complaint had not been dealt with.

End of life care and support
● The information around the wishes and support people required at the end of their life was variable. We viewed one person's care plan and it had a detailed end of life care plan in place and anticipatory medicines had been provided. However, two other people did not have any record of their wishes in relation to the end of their life. This meant people were at risk of receiving inconsistent care at this sensitive time of their lives.

Requires Improvement

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Requires improvement.
This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- People and their relatives did not always feel the care on Sycamore unit was well managed and delivered in a person-centred way. Some relatives highlighted the lack of permanent nursing staff meant there was a lack of ownership when they raised their concerns to them. One relative felt there was a lack of leadership, for example, staff going on breaks together leaving the unit short of staff without this being monitored.
- Both relatives and staff told us due to staff shortages staff were often moved from one unit to the other. One relative said this impacted on continuity of care and their family member did not always get the personalised care planned for them. For example, they asked one staff member to wash their family member's hair, and assist them with a bath, but the staff member was moved from the unit on that day and this resulted in this not being done. The relative told us this was not an isolated incident.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

- There was a lack of openness and clarity from the registered manager when issues were raised by relatives about the care provided. As previously mentioned some of the complaints we viewed were not responded to clearly, and relatives we spoke with did not always feel the issues they raised with the service were addressed.
- It is a legal requirement that a provider's latest CQC inspection report is displayed at the service and online where a rating has been given. This is so that people, visitors and those seeking information about the service can be informed of our judgments. The provider had displayed their most recent rating in the service and on their website.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- Quality monitoring processes had not always identified the issues we found in some areas of care.
- Changes made to practices such as the recording of some aspects of care had not been monitored robustly and as a result the staff were not following new guidelines. This had led to inconsistent recording of care. Some safeguarding incidents had not been analysed and investigated thoroughly and the quality monitoring processes had not highlighted this. Complaint responses had not been audited and resulted in a poor standard of response to complainants. Agency staff files had not been audited and had resulted in a lack of robust checks of staff suitability to work at the service.

● Environmental audits had not highlighted issues we found on the day of inspection. This included the lack of essential fire safety equipment on Sycamore unit. There was also a lack of evidence to show what actions were being undertaken about the lack of maintenance of the outside areas of the service. On the second day of our inspection the regional manager told us there were plans in place to address the maintenance concerns for the outside of the service.

These issues showed a lack of learning and clear oversight of the service and resulted in people being at risk of receiving care that did not meet their needs. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● People and relatives did not always feel their views and opinions of the service were listened to. Although there were meetings between relatives and the management team the concerns raised were not recorded or responded to.

● Some staff we spoke with did not always feel supported and there were some inconsistences with the management of the service.

Working in partnership with others

● On the first day of our inspection we spoke with a health professional who was attending the service regularly to support staff with a number of aspects of care. Staff we spoke with told us this support was useful. This collaboration had resulted specific training opportunities for staff at the service to support their knowledge of different aspects of care.

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 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment People were not always protected from potential harm as safeguarding issues which had occurred at the service had not been clearly documented and there was a lack of robust investigations following safeguarding concerns being raised.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance There was a lack of learning and clear oversight of the service and resulted in people being at risk of receiving care that did not meet their needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The processes for checking agency staff's suitability to work at the service were disorganised and did not show clearly that registered nurses registration details were checked. There was a lack of evidence to show some agency staff had received an induction to the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or	Regulation 18 HSCA RA Regulations 2014 Staffing

personal care

Treatment of disease, disorder or injury

People were not always supported by adequate numbers of staff to ensure their needs were met in a timely way.